

CONNECTICUT INSURANCE LAW JOURNAL

Volume 20, Number 2
Spring 2014



University of Connecticut School of Law
Hartford, Connecticut

Connecticut Insurance Law Journal (ISSN 1081-9436) is published at least twice a year by the Connecticut Insurance Law Journal Association at the University of Connecticut School of Law. Periodicals postage paid at Hartford, Connecticut. Known office of publication: 55 Elizabeth Street, Hartford, Connecticut 06105-2209. **Printing location: Western Newspaper Publishing Company, 537 East Ohio Street, Indianapolis, Indiana 46204.**

Please visit our website at <http://www.insurancejournal.org> or see the final page of this issue for subscription and back issue ordering information.

Postmaster: Send address changes to Connecticut Insurance Law Journal, 55 Elizabeth Street, Hartford, Connecticut 06105-2209.

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Cite as CONN. INS. L.J.

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2013-2014

ISSUE 2

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OVERLOOKED AND UNDERUSED: CLINICAL PRACTICE GUIDELINES AND MALPRACTICE LIABILITY FOR INDEPENDENT PHYSICIANS

RONEN AVRAHAM, SJD*

This paper discusses how the use of Clinical Practice Guidelines (CPGs) can improve the quality and delivery of healthcare in America. The author states that with the passage of the Patient Protection and Affordable Care Act of 2010 the American healthcare system is in need of re-alignment, specifically challenging the established norms for promulgating CPGs. The article explores the legal evolution of CPGs and new legal avenues for their promulgation by examining their history and purpose. The author concludes by identifying three accountability models and arguing in favor of a private competitive regime for CPGs.

I. INTRODUCTION

American medical care is plagued by overuse, underuse, and misuse.¹ Overconsumption of medical care is one of the main contributors towards rising health care costs in the United States. A recent Institute of Medicine report estimates that unnecessary services cost \$210 billion each year.² However, even though Americans consume an enormous amount of health care, they only receive optimal care – or the care that is

* Thomas Shelton Maxey Professor of Law, University of Texas School of Law; Professor of Law, Tel Aviv University. I thank Bill Sage for help with prior drafts. All remaining errors are mine.

¹ Elise C. Becher & Mark Chassin, *Improving the Quality of Health Care: Who Will Lead?*, 20 HEALTH AFF. 164, 165–66 (2001) (defining quality problems as underuse, overuse, and misuse); Ronen Avraham, *Private Regulation*, 34 HARV. J. L. & PUB. POL'Y 543, 548–49 (2011) (discussing same) [hereinafter Avraham, *Private Regulation*]. Other papers refer to these concepts as defensive medicine, offensive medicine, and medical errors. *E.g.*, Ronen Avraham, *Clinical Practice Guidelines: The Warped Incentives in the U.S. Health Care System*, 37 AM. J. L. & MED. 7, 9 (2011) [hereinafter Avraham, *Warped Incentives*].

² INST. OF MED., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA, 3-10 (Mark Smith et al. eds., 2012).

recommended by the best available information – 54% of the time.³ President Obama recognized the danger of this mounting issue when, during the 2013 State of the Union, he identified rising health care costs as the biggest driver of long-term debt.⁴ The million, or trillion, dollar question is how to reduce costs while simultaneously improving quality. This article explores an answer to that question.

Following the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), it has become clear that there needs to be a major realignment of incentives for the various players in the health care system, and this cannot occur without significant shifts in payment, the structure of care delivery, and accountability for quality and safety. PPACA contemplates, for example, bundled payment for inpatient acute care that combines revenue streams for hospitals and for physicians, episodic payment for periods of illness or complete courses of treatment, Accountable Care Organizations (ACOs) that are held to transparent standards for performance and bear financial risk for utilization of services, and patient-centered medical homes that offer comprehensive primary care services. With different models for payment, transparency, and organizational affiliation, the hope is that hospitals and other large practices will have incentives to develop or adopt protocols for optimal delivery of care even if medical liability laws are unchanged.

Because of these and other developments, physicians have been leaving solo and small-group practice for employment in larger practices and hospitals.⁵ Notwithstanding these trends, American health care will remain more fragmented than someone unversed in history would predict given the complexity, capital requirements, and interdisciplinary nature of diagnosing and treating serious illnesses. Many physicians will continue to practice medicine in small settings,⁶ and other health professionals, such as

³ INS. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST 146 (Robin Graham et al. eds., 2011) [hereinafter 2011 IOM Report].

⁴ FOX NEWS (Feb. 12, 2013), <http://www.foxnews.com/politics/2013/02/12/transcript-obama-state-union-speech/>

⁵ See Mark Hagland, *One-Third of U.S. Physicians Plan to Quit Private Practice Within 10 Years*, HEALTHCARE INFORMATICS (Aug. 8, 2012), <http://www.healthcare-informatics.com/news-item/one-third-us-physicians-plan-quit-private-practice-within-10-years>.

⁶ APA Executive Director Keynote Address to 2011 State Leadership Conference (Mar. 31, 2011) (“Eighty nine percent of all physicians work in solo practice or small group practices of 10 or fewer physicians.”), available at <http://www.apapracticecentral.org/update/2011/03-31/evolving-health.aspx>.

advanced practice nurses, are likely to secure legal privileges for independent practice as well.

This paper focuses on physicians in small practice settings and on norms rather than incentives as a way to improve the delivery of care. Incentives – sticks and carrots – dominate most discussions, particularly bonuses and penalties associated with reimbursement schemes. The problem is that these measures often provide only weak incentives to avoid errors but strong incentives to both over- and under-treat patients. In this paper, I explore a more *direct* way to influence how practitioners deliver care: clinical practice guidelines (CPGs).

CPGs are written statements of the best clinical practices to be applied to patient care based on the professional judgment of a given group of medical professionals who review the scientific evidence and assess the benefits and harms of alternative care options. CPGs can be promulgated by public or private organizations, such as specialty societies, advocacy groups, state agencies, health plans, commercial entities, and in the future, perhaps even by computers. Even IBM's supercomputer Watson is reportedly getting into the field of medical advice.⁷ There are over 2,700 CPGs in a U.S. government run depository called the National Guideline Clearinghouse – promulgated by more than 350 groups.⁸

The history of CPGs in the United States is intertwined with medical malpractice liability. This is particularly true for physicians in solo or small-group practice. As small businesspeople, these physicians tend to be very sensitive to the potential economic and reputational harm that allegations of malpractice can cause, and often feel very personally and intensely the uncertainty associated with litigation. As described in more detail below, early experiments with CPGs were designed to assuage physicians' fears of meritless suits and tendencies toward self-protection through costly defensive medicine. These malpractice-oriented CPGs were often the first to be debated in legislatures and tested by the courts. However, treating CPGs as relevant primarily for litigation purposes is why CPGs are overlooked and underused, as the title of this paper suggests. The potential for cost reduction and quality improvement from CPGs is much greater than malpractice reform alone could induce.

⁷ NEWSER (Feb. 8, 2013, 6:09 PM), <http://www.newser.com/story/162517/ibms-watson-to-start-dispensing-medical-advice.html>.

⁸ NATIONAL GUIDELINE CLEARINGHOUSE, <http://www.guideline.gov/browse/by-topic.aspx> (last visited Feb. 12, 2014).

CPGs have the potential to reduce the prevalence of unnecessary, and often incorrect, medical procedures in fragmented environments because their focus is directly on the proper way to deliver care, rather than on providing incentives (sticks and carrots) for the providers to find the proper care themselves. As a doctor, especially as a solo practitioner, it is impossible to keep up with current medical research. So many studies are published each year that a cardiologist would have to read 10 articles per day, 365 days a year, to stay current.⁹ Not only is this impossible, but it is a waste of the doctor's time. As science continues to build on itself, the number of studies increases exponentially, and no one person can be expected to synthesize and master it all.¹⁰ Advances in technology will contribute as well. Today's young doctors use smart phones, tablets, and laptops on the job. This allows CPGs to be readily available, easily accessible, and instantaneously updated when new information is developed.

Although the concept of medical best practices may seem uncontroversial, there are substantial challenges involved in achieving compliance by practicing physicians. In 2012, for example, the U.S. Preventive Services Task Force released a new recommendation against PSA-based screening for prostate cancer.¹¹ The recommendation advised doctors to stop testing for Prostate-Specific Antigen because of its high false-positive rate for adenocarcinoma (80%), complications arising from follow-up biopsies, and its limited ability to change health outcomes from diagnosed cancers.¹² A survey fielded after the recommendation was issued found that 49% of physicians agreed with its reasoning, but surprisingly, only 1.8% actually planned to stop using the test.¹³ Some doctors felt

⁹ IAN AYRES, SUPER CRUNCHERS: WHY THINKING-BY-NUMBERS IS THE NEW WAY TO BE SMART 92 (2007).

¹⁰ Justin Kung et al., *Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards*, 172 ARCHIVES OF INTERNAL MED. 1628, 1628 (2012) (describing a "dizzying array" of CPGs that expands year after year).

¹¹ U.S. PREVENTIVE SERVICES TASK FORCE, SCREENING FOR PROSTATE CANCER: CURRENT RECOMMENDATION (May 2012), <http://www.uspreventiveservicestaskforce.org/prostatecancerscreening.htm>.

¹² Sarah Kliff, *Many Doctors Think PSA Tests Don't Work. But They'll Keep Doing Them Anyway*, WASH. POST, May 29, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/many-doctors-think-psa-tests-dont-work-but-theyllkeep-doing-them-anyway/2012/05/29/gJQA0l0qyU_blog.html.

¹³ *Id.*

patients expected to receive the test,¹⁴ others did not think they had time to explain the changes to their patients, and still others worried that patients would feel their health care was being rationed.¹⁵ Indeed, even doctors who wish to rely on CPGs are faced with numerous challenges because of how CPGs are currently created and regulated. Authors often have conflicts of interest that may or may not be disclosed, guidelines are created that recommend conflicting treatments, and there is no system in place to ensure that CPGs are updated or that outdated recommendations are removed from circulation.¹⁶

The importance of guaranteeing the trustworthiness of CPGs has not escaped Congress. Through the *Medicare Improvements for Patients and Providers Act of 2008*, Congress called on the Secretary of Health and Human Services (HHS) to contract with the Institute of Medicine (IOM),¹⁷ through the Agency for Healthcare Research and Quality (AHRQ),¹⁸ to undertake a study that focuses on how to make CPGs trustworthy. In March 2011 the IOM issued its report, which was entitled “Clinical

¹⁴ *Id.*

¹⁵ *Id.* Guidelines for dealing with prostate cancer are just one example. Many more examples exist. For example, a recent study by pediatricians from the Cohen Children's Medical Center of New York that more than 90 percent of medical specialists who diagnose and manage ADHD in preschoolers do not follow treatment guidelines. See SCIENCE DAILY (May 4, 2013), <http://www.science.daily.com/releases/2013/05/130504163310.htm>.

¹⁶ See *infra* Part II(B).

¹⁷ “The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863. Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as the National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.” See *About the IOM*, INS. OF MED., www.iom.edu/About-IOM.aspx (last visited Feb. 12, 2014).

¹⁸ “The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used.” See *AHRQ Profile*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <http://www.ahrq.gov/about/mission/glance/profile.html> (last visited Feb. 12, 2014).

Practice Guidelines We Can Trust.”¹⁹ The IOM made eight recommendations (or standards) regarding various issues related to the optimal development of CPGs.²⁰ These issues, such as transparency, conflict of interest, external review, and updating are indeed crucial for ensuring trustworthy CPGs. Importantly, the IOM called on the Secretary of HHS to “establish a public–private mechanism to examine, at the request of developer organizations, the procedures they use to produce their clinical practice guidelines and to certify whether these organizations’ CPG development procedures comply with [eight] standards for trustworthy CPGs.” In other words, the IOM’s proposed model is one where a public–private entity issues a seal of approval that the *procedures* taken by guidelines developers fit the standards.

As this article argues, this is not the only possible model for optimal promulgation of CPGs.

In this article, I examine various legal models for creating and disseminating CPGs in light of the PPACA and other aspects of the new health care environment, focusing on uses by independent physicians rather than large health care organizations. In the course of analysis, I update research from almost two decades ago regarding how courts view and apply CPGs, primarily in malpractice litigation. I also critique the recent endorsements by the IOM and the AHRQ of a model of public–private certification of CPG promulgators. Recent articles by physicians “on the ground” have similarly found the IOM’s method for ensuring CPG reliability problematic.²¹

¹⁹ INS. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST, (Robin Graham et al. eds., 2011), *available at* http://www.nap.edu/catalog.php?record_id=13058 (last visited Feb. 12, 2014).

²⁰ These standards include: 1) transparency, 2) management of conflicts of interest, 3) the composition of guideline development groups, 4) the intersection of CPGs and systematic review of technology, 5) evidence foundations for guidelines and rating the strength of recommendations, 6) articulation of recommendations, 7) external review of developed guidelines, and 8) updating guidelines. *Id.* at 78-139.

²¹ For example, a recent publication by the American Medical Association found that conflicts of interest were present for 91% of the committee co-chairpersons of guideline producers. Justin Kung et al., *Failure of Clinical Practice Guidelines to Meet Institute of Medicine Standards*, 172 ARCHIVES OF INTERNAL MED. 1628, 1628 (2012). This same study found conflicts of interest present in 71% of chairpersons. *Id.* In other words, despite IOM standards that called for transparency and the removal of conflicts from guidelines, little has actually changed. Another article reported that the IOM standards are impractical

The IOM's approach asserts that CPGs on any given topic should be unbiased, expert, and convergent if not fully unitary (definitive). I suggest that these conditions often cannot be met. I advocate for a more thorough review of options, including those that accept bias as inevitable and that tolerate more diversity among CPGs. One example, particularly suited to use by independent physicians, is a market-based system that would hold private CPG creators liable for their *outcomes*, rather than only their *process* of guideline development and promulgation. CPGs produced in this market would be accurate and trustworthy because of accountability as well as transparency.

Consider, for example, conflict of interest. The IOM Report ultimately recognizes the myth of neutrality surrounding current CPGs, and acknowledges that CPG authors inevitably bring their personal and professional biases to the table. Funding of CPGs by interested parties such as medical device makers or pharmaceutical companies can also be problematic because of pressure to recommend the funder's products. Pharmaceutical companies stopped funding the creation of CPGs in 2010, but still pay for their distribution and updating.²² The IOM Report attempts to address conflict of interest using procedural rules, such as requiring that the chair of the guidelines development group will have no conflict of interest, and that members of the group divest themselves of relevant financial investments. I propose that in many circumstances a different approach should be considered. If one cannot beat market forces, one might be better served by *harnessing* them to the process of creating CPGs.²³ In other words, a structured marketplace for guidelines may be optimal under certain circumstances.

In Part II, I describe the history of CPGs and explain their purposes. I focus on the connection between CPGs and specific attributes of the U.S. health care system. I evaluate the relative strengths of government, self-regulatory organizations, and the private sector in producing guidelines. I then outline a conceptual framework for understanding and evaluating possible accountability and governance mechanisms for the legal oversight of CPGs.

because 0 of 114 randomly selected CPGs met the IOM's definition of trustworthy. David F. Ransohoff et al., *How to Decide Whether a Clinical Practice Guideline is Trustworthy*, 309 JAMA 139, 139–40 (2013).

²² Avraham, *Warped Incentives*, *supra* note 1, at 29.

²³ *See infra*, Part IV(C).

Part III presents an empirical study of cases from the last decade and shows how courts regard CPGs as a practical matter. In this part, I also review more comprehensive government initiatives involving guidelines.

Part IV identifies and analyzes three accountability models for CPGs that have attracted attention from commentators and policymakers. Early guideline projects contemplated the direct development and issuance of CPGs by government. By contrast, recent reports on CPGs issued by the IOM and the AHRQ endorse a model of legal governance based on government certification of acceptable guidelines promulgated by various parties.²⁴ I argue that exclusive reliance on public models is misplaced, and other alternatives, including private competitive regimes, should be considered as well.²⁵ I conclude by identifying ways in which a private competitive regime for CPGs might develop in the market for physician services.

II. OVERVIEW OF CPGS

A. WHAT ARE CPGS AND WHERE DID THEY COME FROM?

Ideally, a clinical practice guideline is a clear, succinct statement of optimal medical care based on current professional knowledge. It should provide an individual practitioner with the information needed to make a fully informed decision consistent with scientific evidence of treatment effectiveness. It should also be updated regularly as new information about medical best practices becomes known.

CPGs have existed for the last fifty years but were little known until the 1980s, when the number of guidelines being disseminated increased dramatically. Guidelines began to be produced by a variety of organizations, including professional societies, hospitals, professional review boards, and state health departments. The federal government

²⁴ Rosoff proposes a system that would use the federal government not to develop guidelines, but to certify privately developed CPGs. See Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 395 (1995).

²⁵ Under Avraham's model, called the Private Regulation Regime (PRR), private firms would develop and continually update medical practice guidelines, and they would compete to license their own CPGs to medical providers. Additionally, the private firms would be held liable for putting forth sub-optimal guidelines. Avraham, *Private Regulation*, *supra* note 1, at 591.

became involved as well, most notably through the Agency for Health Care Policy and Research (AHCPR), a small branch of the U.S. Department of Health and Human Services that spearheaded the development of roughly twenty different guidelines across key clinical practice areas.²⁶

The rise of CPGs is relatively easy to explain. Beginning in the 1970s, studies by John Wennberg and his colleagues revealed substantial differences in clinical practice patterns from state to state and even from town to town that were not correlated with the severity of illness or the clinical outcome of each case.²⁷ These “small-area variation” studies quickly generated concerns about both excessive spending and suboptimal care quality. These concerns were compounded by research revealing that even published results of randomized clinical trials – the gold standard for scientific evidence – changed the delivery of care in the community very slowly, if at all. John Eisenberg, the first administrator of the Agency for Health care Research and Quality (AHRQ), suggested the root cause of this phenomenon was physician reluctance to incorporate new scientific evidence into practice.²⁸ The logical solution was the practice guideline.

The conditions that make guidelines an appealing health policy tool have developed over the course of several decades. Four assumptions plausibly comprise the foundation for guideline-based policy responses to clinical variation. These attributes of the U.S. health care system are normatively contestable and subject to various economic and social pressures. Even those that perhaps should change, however, will not change quickly.

²⁶ This initiative attracted political opposition and the agency no longer performs this role. Eleanor M. Perfetto & Lisa Stockwell Morris, *Agency for Health Care Policy & Research Clinical Practice Guidelines*, 30 ANNALS OF PHARMACOTHERAPY 1117 (1996).

²⁷ See generally John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFFAIRS, May 1984 at 6. For example, a study published in the early 1980s described how in Maine, the likelihood of a woman’s having a hysterectomy by the time she reached age 70 varied from 20 to 70 percent in different hospital markets. In Iowa, the likelihood that a man who reached the age of 85 would have had a prostatectomy varied from 15 to 60 percent in different areas. In Vermont, children who had undergone a tonsillectomy varied from 8 to 70 percent depending on geographic area. *Id.* at 9.

²⁸ John M. Eisenberg, *Quality Research for Quality Health Care: The Data Connection*, 35 HEALTH SERVS. RESEARCH xii (June 2000).

As such, it is assumed the following to be accurate characteristics of U.S. health care that are considered desirable by a substantial percentage of health care professionals and the public:

1. Confidence in the physician as a legitimate source of clinical decisions affecting patients. Respect for physicians as trained professionals, for example, conceptualizes CPGs as advisory rather than directive, rejects “cookbook medicine,” and accommodates patient variation and the exercise of medical judgment.
2. Acceptance of solo and small-group practice models, with decentralized organization and fragmented care delivery, continuing to play an important role in the delivery of health care.
3. Belief that accurate, up-to-date, and useful information about medical practice is under-produced, that and supplying this information contributes a “public good” for physicians and the health care system.

B. PITFALLS AND PROMISES FOR CPGS

1. What is wrong with current CPGs?

Scholars have been complaining for a long time about the quality of CPGs.²⁹ One major issue is the unstructured oversight system now in

²⁹ Researchers at the University of Maryland summed up the complaints as follows:

Their concerns have focused on the quality of the evidence on which clinical practice guidelines are based, the tendency of guidelines to promote more care rather than more effective care, their narrow focus and use as marketing and opinion-based pieces rather than road maps to improved medical care, and the difficulties involved in customizing population-based recommendations to individual patients. Also of concern has been the lack of transparency in the process by which clinical practice guidelines are created and potential conflicts (COIs) that might bias those preparing them.

place, which the IOM Report attempted to address. Self-regulatory standards have existed for a decade. The Appraisal of Guidelines, Research and Evaluation (AGREE) was published in 2003, and since that time has become the most widely accepted standard for assessing the quality of the *process* of guideline development.³⁰ The IOM report built on and improved AGREE by addressing questions such as the funding of guideline development and managing conflict of interest.³¹ The IOM Report does not consider accountability for drafters of CPGs, or legal recourse for injuries attributable to incorrect guidelines, even though holding drafters accountable could help ensure that guidelines are properly drafted and regularly updated.

A recent University of Maryland study of 130 clinical practice guidelines found that many do not meet IOM standards.³² Fewer than half of the guidelines listed conflicts of interest, many did not offer differing committee member views, and few committees included an information scientist, a patient, or a patient representative.³³ It is often difficult to know what methods a drafter used in writing the guidelines or whether there are conflicts of interest of which potential users should be aware.³⁴ As mentioned above, the approach taken in this paper is that instead of accepting the myth of neutrality of current CPGs and assuming there are minimal conflicts of interests, the default view should be the opposite: CPGs are likely to be riddled with conflicts of interest.

Even if guidelines were perfect, physicians face information overload when they are willing to use guidelines. Although the number of guidelines is far less than the number of new research studies involving

Kung et al., *supra* note 21, at 1628–29.

³⁰ See generally The AGREE Collaboration, *Development and Validation of an International Appraisal Instrument for Assessing the Quality of Clinical Practice Guidelines: The AGREE Project*, 12 QUAL SAFETY HEALTH CARE 18 (Feb. 2003).

³¹ The IOM Report improved on other frontiers as well. It developed standards for the updating of guidelines, external review and public comment and requiring a systematic review of the literature as a necessary stage in the development. See David F. Ransohoff et al., *How to Decide Whether a Clinical Practice Guideline is Trustworthy*, 309 JAMA 139, 139 (2013).

³² Kung et al., *supra* note 21, at 1629–30.

³³ *Id.*

³⁴ See 2011 IOM Report, *supra* note 3, at 2.

medical care,³⁵ the National Guideline Clearinghouse (NGC), a database of CPGs in the United States, currently indexes over 2,700 guidelines.³⁶ In 2008 alone, the NGC added 722 new CPGs.³⁷

Alas, many CPGs are not user-friendly. Guidelines are often long and dense.³⁸ Even with the large amount of information they provide, they still may not offer clear instructions for doctors attempting to apply them to a specific patient.³⁹

Moreover, it remains unclear which CPGs are still authoritative. Optimal medical procedures change over time. It is often difficult to determine when the weight of evidence has caused a justifiable shift against a certain treatment that should result in a change to the relevant CPGs. On average, CPGs cost at least \$200,000 to produce and substantial amounts to revise.⁴⁰ Many of the parties that can most easily afford these sums, such as pharmaceutical companies,⁴¹ are particularly prone to conflicts of interest.

There is also the semi-myth of uniformity. Guidelines do not always agree even when they cover the same medical conditions or procedures. This may partly result from varying incentives for each producer. For example, a guideline created by a managed care plan may be more concerned with cost implications of treatment recommendations than a guideline created by a physician specialty society. To be clear, different guidelines based on patients' willingness to pay for procedures could make sense, like economy, business, and first-class airline seating. But there must be a good reason for the different treatment. If the reason for conflicting guidelines is just that the authors came to conflicting recommendations about the best treatment (regardless of costs) then that is an issue. In that case both guidelines cannot both be correct.

In many situations, available evidence regarding best practices is scarce. While some would argue that this means no recommendation should be made, others argue that doctors need CPGs even *more* in these

³⁵ From 1994 to 2001, there were around 25,000 randomized controlled trials published on MEDLINE, a medical literature database. *Id.* at 1. No organization, let alone a single doctor, is able to review 70 studies per day, evaluate their credibility, and apply their findings to their practice.

³⁶ *Id.* at 2.

³⁷ *Id.*

³⁸ *See id.* at 146.

³⁹ *See id.*

⁴⁰ *See id.* at 62 (internal citation omitted).

⁴¹ *See Avraham, Warped Incentives, supra* note 1, at 29 and accompanying text.

instances.⁴² Without a consistent rating scale that indicates the level of support for a particular guideline, however, it can be difficult to determine which guidelines are the most reliable.⁴³ A study by Grilli and others found that 82% of guidelines studied did not expressly state the strength of their recommendation.⁴⁴

The IOM Report recognizes that “[n]on-standardized development results in substantial troubling variation in clinical recommendations.”⁴⁵ However, the IOM Report does not attempt to eliminate this problem but only predicts that, with increased oversight and stricter CPG production procedures, the problems of inconsistent recommendations can be reduced.⁴⁶ In doing so the IOM Report seems to waive its hands in an attempt to address the semi-myth of uniformity with respect to current CPGs.

2. What is the Potential of CPGs?

Legal commentators often focus on CPGs in connection with medical malpractice reform.⁴⁷ In fact, CPGs’ benefits can be divided into three major categories: improving the quality of care and reducing errors, decreasing defensive medicine, and decreasing offensive medicine (overtreatment).

a. *CPGs Can Improve Quality*

First and foremost, CPGs should assure and improve the quality of medical care. The standard for measuring quality used in health policy, articulated by Donabedian in the 1960s, distinguishes *interpersonal aspects* of quality, such as compassion, from *technical aspects* of quality, such as surgical precision. It further divides technical aspects into three categories: structure (e.g., the number of nurses per hospital ward), processes (e.g., whether patients with bacterial infections receive antibiotics), and

⁴² See 2011 IOM Report, *supra* note 3, at 63.

⁴³ See *id.*

⁴⁴ *Id.* at 64 (internal citation omitted) (reviewing 431 guidelines developed by specialty societies between 1988 and 1998). This study also concluded that CPGs were making moderate progress over time. *Id.*

⁴⁵ *Id.* at 65–66 (internal citations omitted).

⁴⁶ *Id.* at 198–99.

⁴⁷ See *infra* notes 93–128.

outcomes (e.g., percentage of cancer patients who survive for five years after treatment).

Few will disagree that the best way to improve health care is to evaluate outcomes such as cures, survival rates, and symptom relief. These outcome measures represent the third prong of the Donabedian definition of quality, and they are the preferred approach of proponents of new incentive systems for health care providers, such as pay-for-performance systems (P4P), and of systems that rely on transparency to motivate improvement, such as public “report cards” for hospitals and HMOs. There are various problems with evaluating outcomes. The most relevant here is that measuring outcomes in a statistically reliable manner requires large datasets. Individual physicians cannot reasonably be held accountable for clinical outcomes because of their small patient populations.⁴⁸

What is, then, the role of CPGs in improving care? CPGs are primarily designed to define (technical) *processes*.⁴⁹ Though this may seem obvious, it establishes the limitations of CPGs and distinguishes them from other instruments that can be governed separately. Thus, interpersonal aspects of quality are monitored, if at all, through an uneasy balance between professional codes of ethics and consumer preferences. CPGs do not attempt to address these dimensions of medical performance. Similarly, structural features of care, especially those involving large capital investments, often remain absent from CPGs because they are not viewed as within the control of individual physicians, who are the principal audience for guidelines.⁵⁰ Governance mechanisms for structural features

⁴⁸ See, e.g., Arnold Milstein & Thomas H. Lee, *Comparing Physicians on Efficiency*, 357 NEW ENG. J. MED. 2649 (2007) (discussing the pitfalls and challenges facing solo and small practitioners).

⁴⁹ See generally AVEDIS DONABEDIAN, *THE DEFINITION OF QUALITY AND APPROACHES TO ASSESSMENT: EXPLORATIONS IN QUALITY ASSESSMENT AND MONITORING* (Health Admin. Press 1980); Avedis Donabedian, *Evaluating the Quality of Medical Care*, 44 MILBANK MEM’L FUND Q. 166 (1966).

⁵⁰ Technology assessment has also been outside the mainstream of practice guidelines. To gain greater political acceptance, technology assessment will probably need to incorporate professional standards and work in tandem with practice guidelines because the public looks to physicians as experts on inventing and evaluating new clinical technology as well as on deploying it. Efforts are ongoing to integrate technology assessment with specific clinical recommendations. Notably, Congress recently chartered a new comparative effectiveness institute in the American Recovery and Reinvestment Act and the Patient Protection and Affordable Care Act, but it placed significant legal

tend to be mandatory, implemented via compliance with regulatory or accreditation standards, and are usually applied to institutions as opposed to professionals.⁵¹

Moreover, guidelines are increasingly intertwined with health information technology such as electronic health records with computerized decision support. Proponents of CPGs have generally assumed that users can easily recognize a functional guideline and therefore that using it would reflect a conscious decision to access a discrete set of recommendations. Indeed, existing technology, including tablets, smart phones, and other handheld devices with internet connectivity, makes reference information and decision support readily available to individuals performing both clinical and administrative functions.⁵² Some of these resources can be accessed on demand by users seeking guidance, but others are seamlessly incorporated into medical information systems. Emerging technologies are likely to embed algorithms directly into the equipment, facilities, and systems that are used to deliver and manage care. Individual users may even be unaware that a guideline is being followed.

restrictions on how findings of relative ineffectiveness can be used. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3011, 3501, 6302 (2010).

⁵¹ Examples are the conditions of participation that Medicare regulation imposes on health care facilities, and the accreditation standards for hospitals promulgated by the Joint Commission. The Center for Medicare and Medicaid Services (CMS) issued an amended guideline on December 30, 2009 for ambulatory surgical centers. *See generally* DEP'T OF HEALTH & HUMAN SERVS. CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. 100-07, REVISED APPENDIX L: INTERPRETIVE GUIDELINES FOR AMBULATORY SURGICAL CENTERS (2009), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r56soma.pdf>.

⁵² These technologies are already in use by doctors. *See, e.g.*, Anne Eisenberg, *Those Scan Results Are Just an App Away*, N.Y. TIMES, Oct. 15, 2012, *available at* <http://www.nytimes.com/2011/10/16/business/medical-apps-to-assist-with-diagnoses-cleared-by-fda.html> (discussing one doctor's use of the Mobile MIM app, which allows his iPhone or iPad to act as a diagnostic medical instrument).

b. *Clear Standards of Care Can Decrease Defensive Medicine and Improve Safety*

Fear of malpractice liability has long been regarded as a major cause of physicians' clinical idiosyncrasies, and therefore, it seems an obvious area where CPGs should be applied. In the 1960s, the number of malpractice claims and the cost of physicians' malpractice insurance premiums began to rise rapidly. Some commentators attributed this rise to unscrupulous lawyers and corrupt expert witnesses who persuaded sympathetic juries to impose a higher "standard of care" on physicians than was required by the law or indicated by medical science.⁵³ Moreover, this trend seemed to be self-reinforcing, as customary practice was defined upwards by the courts, creating a vicious circle of defensive medicine, waste, and litigation.

The first CPGs offered a potential liability shield against frivolous claims by countering adverse expert witness testimony. Using national standards rather than customary practice in specific localities to define the standard of care seemed like a logical step to address the issue of unnecessary and potentially dangerous variation in quality across disparate medical practices.⁵⁴ Early guideline proponents hoped judges and juries would accept CPGs to define the standard of care in individual lawsuits and that states would eventually amend their laws to make compliance with CPGs a formal defense to liability. When the standard of care is clearly defined, there is no incentive to run unneeded tests or provide treatments solely for fear of future litigation.

It took several more years for policymakers and medical professionals to acknowledge that rates of medical error were unacceptably high,⁵⁵ and that, because of the expense and unpredictability of malpractice

⁵³ See, e.g., Louis J. Regan, *Medicine and the Law*, 250 NEW ENGL. J. MED. 463 (1954) (blaming malpractice suits on unscrupulous lawyers and physician turncoats rather than poor care).

⁵⁴ Over time, the localism of malpractice law has faded both with respect to the "locality rule" for standard practice and in terms of evaluating care based on whether it was reasonable rather than merely customary. See generally E. Lee Schlender, *Malpractice and the Idaho Locality Rule: Stuck in the Nineteenth Century*, 44 IDAHO L. REV. 361 (2008); Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at The Millennium*, 57 WASH. & LEE L. REV. 163 (2000).

⁵⁵ There are estimates that medical errors still cause almost 100,000 deaths each year. Indeed, about 1 in 50 people who enter a medical facility will suffer an

litigation, few of these avoidable injuries were being compensated by the courts.⁵⁶ Revelations of rampant medical error in the late 1990s made avoiding misuse of tests and treatments a further goal of guideline compliance. The problems of medical error and defensive medicine are interrelated, as both often stem from the lack of a clear guidepost against which to measure physician performance. From this perspective, CPGs could also serve as a “liability sword,” identifying physicians who misused a given treatment.⁵⁷ Predictably, the potential inculpatory application of CPGs in court was far less appealing to physicians than their use in a purely exculpatory role.

c. Guidelines Can Combat Offensive Medicine and Reduce Wasteful Spending

The current fee-for-service payment system gives physicians a direct financial incentive to run additional tests and perform unnecessary procedures. Combined with the easy availability of advanced clinical technologies (particularly in hospitals), the financial insulation of most insured patients from the cost of this care through health insurance, and physicians’ tendency to over-test to avoid potential malpractice suits, fee-for-service payment is a major reason why the United States spends the most on health care but lags behind many developed nations in terms of health care quality.⁵⁸

The FBI investigation of the Redding Medical Center in California highlights the dangers of offensive medicine. At Redding, one thousand coronary artery bypass graft operations, a very profitable surgery, were performed each year, nearly three times the average rate for a facility of its

adverse event that could have been prevented, and most of this harm is due to negligence. Avraham, *Private Regulation*, *supra* note 1, at 548–49.

⁵⁶ See TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 22–44, 68–77 (2005); William M. Sage, *New Directions in Medical Liability Reform*, in *MEDICAL MALPRACTICE: A PHYSICIAN’S SOURCEBOOK* 247–78 (Richard E. Anderson ed., 2005).

⁵⁷ See generally Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PENN L. REV. 645 (2001).

⁵⁸ See Uwe E. Reinhardt et al., *U.S. Health Care Spending in an International Context*, 23 HEALTH AFF. 10, 10–12 (May/June 2004).

size. The investigators alleged that a large portion were not medically justified, but were done to boost profits for the hospital and its physicians.⁵⁹

Although cost-effectiveness has rarely been an explicit element of CPGs, they can generate health care savings. Discouraging overuse of medical care is the clearest but not the only connection between CPGs and health care costs. Reducing misuse both improves safety and averts costly complications. Even rooting out underuse can have desirable economic effects. Many cost-effective tests supported by CPGs are overlooked and left unused by physicians lacking guidelines. CPGs can also align pricing with care by having gold and platinum treatment levels for those who pay more. Much like one can purchase more insurance to ensure coverage of more procedures, one could pay more to be in a higher CPG tier.

3. Who Might Produce and Regulate CPGs?

Guidelines may be produced by public agencies, self-regulatory bodies, or private organizations. As one might expect, the desired regulatory oversight scheme would differ significantly according to the guideline issuer's identity. Choosing among these alternatives should reflect serious thought about regulatory design. Political feasibility is also important and should be prospectively considered.

a. *Government*

One of the characteristics accepted in the introduction of this paper was the idea that CPGs are a public good. With that in mind, one would think that the government should be responsible for their promulgation.

Government promulgated guidelines are a more attractive policy option in countries where the government acts as a single health care payer because the government internalizes the cost of health care and, for that matter, the cost of medical liability. In Britain, the National Institute for Health and Clinical Excellence (NICE), an independent organization closely linked to the British government, evaluates new technologies for coverage by the UK's National Health Service (NHS), and considers both

⁵⁹ See Kurt Eichenwald, *Operating Profits: Mining Medicare*, N.Y. TIMES, August 12, 2003, available at <http://www.nytimes.com/2003/08/12/business/operating-profits-mining-medicare-one-hospital-benefited-questionable-surgery.html?pagewanted=all&src=pm>.

quality and cost. NICE is thus well positioned to suggest best practices for NHS physicians.

In the US, the federal government exerts considerable influence over the health care system by funding the Medicare and Medicaid programs, while state government plays a more direct regulatory role in addition to its Medicaid oversight function. Payment policy offers a straightforward justification for issuing CPGs and monitoring compliance with them. Moreover, the government's incentive and ability to influence clinical practice may grow stronger as national health reform following the PPACA is implemented, creating an opportunity for a comprehensive approach to public guideline development that combines clinical quality with cost and coverage for conditions where research has revealed suboptimal quality and/or economic waste. A significant caution, however, is that political polarization over the risks of "socializing medicine" or rationing may discourage the creation of CPGs by the government, particularly for medical procedures influenced by powerful special interest groups. Indeed, despite its size, budget, and power, the government has significant drawbacks as a source of CPGs. Physicians and the public usually view the government with suspicion when it seeks to intrude on the autonomy of the medical profession in diagnosing and treating patients. Hence we have a conflict between CPGs as a public good and the autonomy of doctors. This is particularly true when the government attempts to alter a clinical norm regarding risk-benefit calculations, as exemplified by PSA-screening for prostate cancer, the recently renewed debate over mammography for middle-aged women, or the continuing controversy over the potential side-effects of childhood vaccination.⁶⁰

The government has insufficient personnel with the appropriate skills to produce a large number of detailed guidelines. The cost of developing guidelines through public processes is also high and politically

⁶⁰ See Sarah Kliff, *Many Doctors Think PSA Tests Don't Work. But They'll Keep Doing Them Anyway*, WASH. POST, May 29, 2012, available at http://www.washingtonpost.com/blogs/wonkblog/post/many-doctors-think-psa-tests-dont-work-but-theyll-keep-doing-them-anyway/2012/05/29/gJQAO10qyU_blog.html; Eliot Marshall, *Brawling Over Mammography*, 327 SCIENCE 936 (2010) (describing the public reaction to recent mammography guidelines); H. Gilbert Welch, *Screening Mammography: A Long Run for a Short Slide?*, 363 NEW ENG. J. MED. 1276 (2010) (suggesting that the mortality benefits from mammography may have declined as treatment options have improved); Liza Gross, *A Broken Trust: Lessons from the Vaccine-Autism Wars*, 7 PLOS BIOL. (2009) (describing the long battle over thimerosal and autism).

exposed. Because guidelines must be routinely updated and corrected, the administrative burden and associated political risk would resurface frequently.⁶¹ In order to properly promulgate and update CPGs, a government agency would need to be well funded, closely connected to care delivery, and sheltered from political pressure by special interest groups.⁶²

b. *Self-Regulation*

Self-regulation in the health care system is most commonly associated with physicians and other health professionals, but it may also include health care facilities, suppliers, and even insurers. Professional organizations such as the American Medical Association and societies in each medical specialty promulgate ethical rules and standards of conduct that guide physician members' behavior. In the US, law and tradition allow the organized medical profession to maintain a surprising degree of collective control over physician education, training, licensing, disciplining, hospital affiliation, and even liability insurance. Nurses,

⁶¹ Guidelines are time-consuming and expensive both to develop and to update. See Richard Amerling et al., *Guidelines Have Done More Harm Than Good*, 26 BLOOD PURIFICATION 73 (2008). Often, the result is that guidelines are not based on the full evidence available. A 2001 study examined 17 guidelines developed by U.S. Agency for Health Care Research and Quality. See Paul G. Shekelle et al., *Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated?*, 286 JAMA 1461, 1461 (2001). Seven of the guidelines needed to be updated with new "diagnostic or therapeutic guideline recommendations" or withdrawn. *Id.* Six warranted marginal adjustments to their recommendations. *Id.* The methodology and development process for AHRQ guidelines were considered to represent a drastic improvement in the "science of practice guideline development." *Id.* at 1462. Yet, half of them were obsolete in 5.8 years and the study recommended that the guidelines be reevaluated for suitability every three years. *Id.* at 1461. Another cost-related concern is that providers do not have the necessary resources to comply with the guidelines. Ronni P. Solomon, *Clinical Guidelines in the United States: Perspectives on Law and Litigation*, in CLINICAL GUIDELINES: LAW, POLICY AND PRACTICE 137, 146 (John Tingle ed., 2002).

⁶² See generally Bruce C. Vladeck, *The Political Economy of Medicare*, 18 HEALTH AFF. 22 (1998) (explaining interest group politics); Lawrence R. Jacobs, *Politics of America's Supply State: Health Reform and Technology*, 14 HEALTH AFF. 143 (1995) (arguing that no collective force counters the political power of provider and supplier groups).

pharmacists, and other practitioners claim similar but generally lesser privileges to regulate their own professions.

Self-regulation may be preferable to direct government control when technical expertise is required, when cooperation from the regulated entities is important, or when the regulated industry is undergoing rapid change that outpaces public oversight. Self-regulation usually will seem cheaper for the government than direct regulation because it is off-budget and less visible politically, and it may also be cheaper if compliance costs are lower. On the other hand, self-regulation can be insular, self-serving, and anti-competitive if improperly executed. Despite those concerns, medicine has historically enjoyed wide latitude to self-regulate because of public deference to physician expertise and professional ethics.

Self-regulation can take various forms pertaining to guidelines. Self-regulatory organizations can issue guidelines directly. Many current guideline producers are non-profit, educational organizations. In the US, the most prominent category of issuer is made up of medical specialty societies and other professional organizations, which promulgate guidelines focused on the effectiveness of treatment.⁶³ However, these entities are seldom well funded and may not be able to afford to update CPGs on a continuing basis in a rapidly changing world. In general, such organizations usually do not feel pressed to account for costs of care, and may be biased towards quality over efficiency.

Self-regulatory organizations can also certify guidelines produced by others and also may accredit those producers. The imprimatur of an accrediting or certification body is typically used to convey information about superior quality or reliability to a purchaser or user of a product or service. As noted above, the IOM recently recommended the establishment of a public-private partnership to certify guideline issuers in terms of compliance with best practices regarding guideline production that an IOM committee had identified.

State professional licensing boards exemplify what is often called “statutory” or “delegated” self-regulation. In this model, a legislature confers broad discretion on what is a nominally governmental body but that is practically controlled by the regulated class of individuals. Physicians often have considerable influence over medical licensing boards, for example, although public concern about safety has eroded the profession’s

⁶³ Stefan Timmermans & Emily S. Kolker, *Evidence-Based Medicine and the Reconfiguration of Medical Knowledge*, 45 J. HEALTH & SOC. BEHAV. 177, 184 (2004).

dominance in recent years. The Joint Commission is a very powerful self-regulatory body for hospitals and other health facilities in the US, and has delegated authority insofar as its accreditation substitutes by law for direct government qualification of health facilities for participation in Medicare and Medicaid. Because of its reliance on convened groups of private experts, NICE in the UK often functions as a statutory self-regulatory body. Although existing statutory self-regulators in the US could issue or certify CPGs, none has yet done so. Even the Joint Commission standards, designed to ensure quality of care, do not specify treatment processes.

An alternative model is “supervised self-regulation.” This is something like what used to happen in the US in healthcare, as outlined in the Public Model section of Part IV. In this model, a formal government regulatory body backstops a self-regulatory organization. A prominent example of this in another field is the Securities and Exchange Commission. The SEC has the right and obligation to review the work of various self-regulatory boards that adopt standards for matters such as corporate accounting practices and the operation of securities exchanges and to overrule them if it deems necessary.

In health care, certain Medicare contractors – particularly those engaging in quality improvement activities under explicit statutory authorization – function as supervised self-regulators. Unlike delegated self-regulation, a supervised model empowers an existing agency such as AHRQ, the Center for Medicare and Medicaid Services (CMS), or the Food and Drug Administration (FDA) to ensure that self-regulatory organizations charged with issuing guidelines are honest and competent. This might take the form of certifying the processes used by each producer, as suggested in the 2011 IOM Report.

Self-regulation can operate locally as well, with monitoring and compliance systems internal to organizations being self-imposed or expressly required by the government or another self-regulator. For example, internal self-regulation by a “self-governing medical staff” is required for most hospitals by state law and by the Joint Commission accreditation standards. History, however, cautions us against locally produced or approved CPGs. The principal justification for pursuing guidelines as a regulatory enterprise was the failure of reliable professional norms to develop in local, self-regulated physician communities. It would

be ironic to turn to the same communities to create or bless guidelines.⁶⁴ National self-regulatory organizations would likely create better, evidence-based products.

c. *Private Sector*

Many types of private organizations produce and deploy clinical practice guidelines. These efforts vary widely with respect to the quality and impartiality of the guidelines produced and also with respect to the transparency of the process of producing them. They also vary in the degree to which guidelines are considered corporate assets intended for internal use as opposed to external dissemination.

Increasingly, guidelines are developed and/or purchased or modified prior to implementation by large clinical entities. These include closed-panel HMOs, hospital-based integrated delivery systems, prepaid group practices, multispecialty clinics, and less unitary but still structurally coherent networks ranging from the independent practice associations (IPAs) of the 1990s to the accountable care organizations (ACOs) of today. Many, but far from all of these organizations, are non-profit corporations. Health care providers compete primarily on the underlying services and may view guidelines as proprietary business tools rather than common educational resources.⁶⁵

Among private, guideline-producing organizations targeting independent physicians, several are interested in reducing health care costs as well as improving quality. These producers, including managed care organizations, health insurers, and a handful of large, self-insured employers,⁶⁶ similarly may have business-related objectives for issuing and using guidelines on a competitive basis.⁶⁷

⁶⁴ See Katherine Baicker & Amitabh Chandra, *Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care*, 23 HEALTH AFF. 184 (2004).

⁶⁵ A search of private, for-profit guidelines yielded only seven guidelines, whereas the nonprofit search yielded 154 guidelines from a wide array of organizations. A search for guidelines from Hospital/Medical Centers yielded 38 guidelines (of the approximately 2356 available) from only 3-4 organizations.

⁶⁶ Rosoff, *supra* note 24, at 374. A search in the NGC dataset revealed, for example, that Kaiser Permanente (an MCO) has about 10 guidelines posted.

⁶⁷ Two private for-profit firms that came up in NGC's database were the Reed Group, which is a company dedicated to getting injured employees back to work at

Benefits consultants, pharmacy benefit managers, disease management companies, and similar entities may also regard guidelines as proprietary. Health care suppliers, such as pharmaceutical and medical device companies, frequently see guidelines as critical marketing tools for their products, or, if a particular guideline does not support that purpose, they view them as a threat to revenue. Malpractice insurers for physicians or hospitals may also issue or use guidelines in connection with their risk management activities. Some of these organizations already have the structures in place to organically develop a private model of CPGs similar to the private regulation regime discussed in Part IV.

These various entities are usually well funded and have the requisite expertise to write useful guidelines. However, they all have very different financial goals, particularly if the cost of suboptimal guidelines is borne elsewhere. For example, CPGs produced by third-party payers may emphasize cost control over quality, possibly externalizing costs onto liability insurers if injury ensues.⁶⁸ In contrast, guidelines issued by physician groups anticipating fee-for-service payment may emphasize quality over cost control. CPGs produced by liability insurers, in turn, may emphasize claims avoidance, with safe care a secondary objective and efficient care not prioritized, which tends to externalize costs onto both patients and third-party payers.⁶⁹ Thus, physicians are sometimes forced to choose among conflicting guidelines with different goals.⁷⁰

Other private producers of guidelines have primarily political objectives. Certain professional and trade groups seek to influence public

full-productivity and the Smith & Nephew, which is primarily a medical device manufacturer in Ireland.

⁶⁸ For example, HMOs may prefer fewer treatments to contain costs because they fully bear the costs of treatments, but do not fully bear the costs of malpractice.

⁶⁹ For example, malpractice insurers would require doctors to perform mammograms every year to prevent breast cancer, even if they are not needed, because the malpractice insurers do not bear the costs of extra mammograms, but do bear the costs of lawsuits from late diagnosis of breast cancer.

⁷⁰ Patricia R. Recupero, *Clinical Practice Guidelines as Learned Treatises: Understanding Their Use as Evidence in the Courtroom*, 36 J. AM. ACAD. PSYCHIATRY L. 290, 298 (2008). Guidelines need not all be the same – for example a guideline could call for a more expensive treatment than is necessary – but to be covered under this premium guideline, rather than a standard guideline, one should be required to pay more into the system and thus be financially accountable for their choice of coverage.

opinion, legislation, and regulation that determine which health professions and which treatments receive favorable consideration. Similar risks may arise when leading physician researchers are called upon to develop CPGs because they may have financial relationships with pharmaceutical or medical device manufacturers who wish to have their products recommended by experts.

If guidelines are challenged in court, these varying incentives and potential biases may become a focal point of litigation rather than the guidelines being regarded as “a generally recognized standard of care within the medical profession”.⁷¹ During the 1980s and 1990s, courts were sensitized to the risk of bias in health insurance contracts as managed care became more aggressive about denying coverage for lack of medical necessity.⁷² More recently, financial relationships between pharmaceutical manufacturers and health care providers have raised concerns about conflicts of interests influencing clinical standards and practices.⁷³ Fortunately, we now recognize neutrality as the myth that it is and can adjust our governance models to account for the fact that CPG authors bring their own biases to the drafting process.

d. Courts

In the US, the health care system tends to be monitored by an ad hoc mixture of public law (i.e. Medicare and Medicaid) and private law represented by individual litigation over contractual agreements or personal injuries. In this system, it is possible for judges – typically those serving on state rather than federal courts – to create “common law” regarding CPGs by interpreting contracts, determining the scope of fiduciary duties, allocating property rights, and holding producers of CPGs and other health

⁷¹ See *Quigley v. Jobe*, 851 P.2d 236, 238 (Colo. App. 1992) (holding that guidelines written by a liability insurance carrier did not meet the relevance test for scientific evidence, because they were created “by a private insurance company as part of an insurance contract and did not reflect a generally recognized standard of care within the medical profession.”).

⁷² *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989)

⁷³ See COMM. ON CONFLICT OF INTEREST IN MED. RESEARCH, EDUC., & PRACTICE, INST. OF MED. OF THE NAT'L ACADS, CONFLICT OF INTEREST IN MEDICAL RESEARCH, EDUCATION, AND PRACTICE (Bernard Lo & Marilyn J. Field, eds., 2009); William M. Sage, *Some Principles Require Principals: Why Banning “Conflicts of Interest” Won’t Solve Incentive Problems in Biomedical Research*, 85 TEX. L. REV. 1413 (2007).

care providers liable to patients under tort law. Should such cases occur frequently, an accountability regime for guidelines might emerge organically without the creation of an explicit legislative or regulatory framework. But this seems unlikely to occur as the most victims of medical errors are not aware of them, and of those aware the vast majority does not file suits, and of those filing suits, the vast majority settle, never making it to courts.

A more plausible outcome is episodic litigation resulting in judicial decisions that send strong, albeit indirect, signals to health care stakeholders regarding the value and enforceability of CPGs. Normally, CPGs are brought up in the context of medical malpractice litigation, which usually plays an important role in molding physicians' opinions about the acceptability of any proposed alteration to their clinical practices and standards.⁷⁴ Product liability lawsuits are also important indicators for manufacturers of drugs, medical devices, vaccines, and diagnostic tests. For health insurers, guidelines typically surface in disputes over benefits and coverage denials, such as in the interpretation of policy provisions regarding medical necessity or experimental treatment.⁷⁵

Medical malpractice litigation, for example, generates accountability mechanisms for guidelines that have particular characteristics. Civil litigation ordinarily gives considerable deference to the discretion of individual judges in making evidentiary rulings. Accordingly, only a small number of structured guideline programs have been attempted in the malpractice context, and those have been heavily negotiated to respect judicial prerogatives and to operate through presumptions and affirmative defenses as opposed to conclusive determinations of liability or immunity from liability.

⁷⁴ William M. Sage, *Reputation, Malpractice Liability, and Medical Error*, in ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 159 (2004).

⁷⁵ Like medical malpractice, insurance coverage law has both a technical and a symbolic importance to oversight of health care quality. See Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL'Y L. & ETHICS 93 (2006); William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

III. HOW ARE CPGS CURRENTLY USED?

Although systematic efforts to provide governance and accountability mechanisms for CPGs have been lacking in the US, substantial experience has accumulated over the last two decades regarding the relationship between guidelines and the law. While these experiences underscore the desirability of consciously creating accountability in the world of guidelines, they do not offer clear lessons for how such accountability should be achieved.

The success of CPGs in replacing customary care with evidence-based medicine depends primarily upon the level of acceptance of CPGs within the medical profession.⁷⁶ The law's treatment of guidelines is critical to this process and to their acceptance by other stakeholders whose confidence in guidelines as a policy innovation is affected by how such guidelines are perceived by independent legal decision-makers such as judges and legislators.⁷⁷ This section surveys the way CPGs have been treated by courts, insurance companies and various state level initiatives.

A. CPG USE IN LITIGATION: A CASE STUDY FROM 2000-2010

How courts and lawyers are actually using CPGs in malpractice litigation has not been definitively established. The most comprehensive study of court usage of CPGs was published almost two decades ago by Hyams, Shapiro, and Brennan.⁷⁸ They conducted surveys of medical malpractice attorneys and reviewed of all relevant case law from January 1, 1980 through May 31, 1994.⁷⁹ That study and subsequent articles suggest

⁷⁶ Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Healthcare Reform: An Update*, 21 ANNALS HEALTH L. 21, 25-26 (2012).

⁷⁷ Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POLIT., POL. & L. 327, 331 (2001) [hereinafter Rosoff, *Evidence-Based Medicine*]; see also Arnold J. Rosoff, *On Being a Physician in the Electronic Age: Peering into the Mists at Point-&-Click Medicine*, 46 ST. LOUIS L.J. 111, 115 (2002) (outlining the use of Clinical Decision Support Systems as a form of Clinical Practice Guidelines).

⁷⁸ Andrew L. Hyams et al., *Medical Practice Guidelines in Malpractice Litigation: An Early Retrospective*, 21 J. HEALTH POLIT., POL. & L. 289 (1996) [hereinafter Hyams et al.].

⁷⁹ *Id.* at 295.

that courts have historically been hesitant to use CPGs in medical malpractice cases.⁸⁰

Hyams and colleagues found only thirty-seven published cases involving the use of CPGs. Of those published decisions, the Hyams study identified twenty-two cases of successful inculpatory use and six cases of successful exculpatory use.⁸¹ However, the attorney surveys indicated that the profession was indeed aware of CPGs, and that guidelines aided in settlement negotiations and even in the decision of whether or not to take certain cases.⁸²

I extended the Hyams study by finding and analyzing judicial decisions involving CPGs in any context published between January 2000 and March 2010.⁸³ The review indicates that use of guidelines by courts continues to be sporadic and mostly conservative. The use of guidelines for inculpatory purposes has tended to increase, though the sample size is so small that few conclusions can be drawn. Of the twenty-eight cases found with parties using guidelines in some form, sixteen (57%) involved their use by plaintiffs as swords compared to 78% of cases in the Hyams study. Twelve cases (43%) involved CPG use by defendants as shields compared to 22% in the Hyams study.⁸⁴ Interestingly, in eight of the twelve

⁸⁰ *Id.* at 310. See also Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 352; see also Mello, *supra* note 57 (discussing the different ways in which courts have approached medical malpractice). For a more detailed discussion of the Hyams et al. study, see Avraham, *Warped Incentives*, *supra* note 1, at 18–19.

⁸¹ Hyams et al., *supra* note 78, at 296.

⁸² Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 341.

⁸³ The search was performed looking for the appearance of “medical” or “medicine” as well as “guideline” in all 50 state jurisdictions and in federal courts. Sometimes courts may discuss guidelines without necessarily referring to them as such, so a second search was run using terms like “algorithm” and “standard.” To attempt to weed out results where “standard” appeared merely as a part of “standard of proof” or a legal “standard,” cases also were required to have “medicine,” “medical,” “hospital,” “doctor,” or “physician” in the text. While these results are likely not comprehensive (and there were surely cases missed which might have discussed clinical practice guidelines in some form), it’s most probable that these cases would not have dealt with guidelines extensively and thus would not have added a great deal to the discussion.

⁸⁴ Hyams et al., *supra* note 78, at 296.

cases where guidelines were used for exculpatory purposes, the defendant was successful.⁸⁵

These cases devoted little significant analysis to what organization drafted the relevant guidelines, and there was not a clear plurality of any one association's guidelines being used successfully. Guidelines written by the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control did appear repeatedly, but whether this was a function of the guidelines or a correlate of the type of injury alleged is not clear. Discussion tended to center on applicability, relevance, or evidentiary acceptability and not on the quality of the guidelines themselves.

While the full extent of court use of CPGs is unknown, if they are to eventually be effective in reducing the costs of medical malpractice litigation, the legal system will need to accept generalized use more definitively than published cases suggest. As reflected in the cases, current obstacles to CPG adoption in court include the connection between evidence-based guidelines and the concept of a professionally determined standard of care, hearsay objections,⁸⁶ the battle between competing guidelines or experts,⁸⁷ and how seemingly "one-size-fits-all" guidelines should yield to physician judgment in individual cases.⁸⁸

⁸⁵ There are several caveats. First, our findings are based on published judicial decisions, which are uncommon in medical malpractice litigation. Second, trials are rare events in malpractice litigation, so that the evidentiary use of guidelines does not necessarily capture the impact guidelines may have on the vast majority of malpractice cases that settle. Lastly, because it is so difficult to determine when the use of guidelines is dispositive, these figures do not necessarily indicate whether the cases were successful *because* of the use of guidelines.

⁸⁶ The Hyams study notes increasing willingness of courts to use the hearsay exception for learned treatises as an avenue to admitting guidelines as evidence. The trend towards the admissibility of guidelines has continued, although they are still not accepted to prove standard of care on their own. Rather, litigants almost always employ an expert witness to act as the conduit for admitting guidelines. Hyams et al., *supra* note 78.

⁸⁷ See Mello, *supra* note 57, at 684; see also Avraham, *Private Regulation*, *supra* note 1, 618–19 (discussing the so called "battle of the guidelines" and the solution provided by Avraham's private model for CPGs).

⁸⁸ 978 So.2d 1257 (La. App. 2008). In *Bond v. U.S.* the court quoted the ACC/AHA guidelines to make this point: "These practice guidelines are intended to assist physicians in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific

B. CPG USE BY THE INSURANCE INDUSTRY

The law has also accounted for guidelines in regulation and litigation concerning health insurance coverage. Before the 1960s, health insurers and the community of medical professionals maintained a general understanding that those responsible for payment would not interfere with clinical decisions. As the cost of health care began to rise, however, this understanding was revisited and eventually abrogated, particularly in the 1980s and 1990s.⁸⁹

CPGs have been connected with the insurance industry primarily through regulation and litigation over the definition of “medically necessary care,” and the related question of whether or not a proposed treatment should be excluded from coverage because it is “experimental” or “investigational.” Over the last few decades, hundreds of judicial decisions have interpreted these contractual exclusions from coverage in disputes between patients and private insurers, Medicaid, and Medicare.⁹⁰ A common theme in the decisions is the desire of judges to assure themselves that coverage denials are not merely financially motivated efforts that incidentally deprive patients of scientifically correct care. As a result, the law has struggled to find preferred sources of evidence about optimal practice procedures – in other words, CPGs.

diseases or conditions . . . The ultimate judgment regarding the care of a particular patient must be made by the physician and patient in light of all of the available information and the circumstances presented by that patient.” 2008 U.S. Dist. LEXIS 19881 at *25 (D. Or. 2008). For more information on these problems and more see Avraham, *Warped Incentives*, *supra* note 1, at 18–20.

⁸⁹ Indeed, virtually all the fashionable innovations in health care organization, payment, and accountability today – including ACOs – are direct descendants of 1990s-style managed care. See Kip Sullivan, *The History and Definition of the “Accountable Care Organization”* (October 2010), Physicians for a National Health Program California, <http://pnhpcalifornia.org/2010/10/the-history-and-definition-of-the-%E2%80%9Caccountable-care-organization%E2%80%9D/>.

⁹⁰ See Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992); Mark A. Hall, Teresa Rust Smith, Michelle Naughton & Andrea Ebbers, *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1056, 1058 (1996); William M. Sage, *Judicial Opinions Involving Health Insurance Coverage: Trompe L'oeil or Window on the World?*, 31 IND. L. REV. 49, 49 (1998).

During the 1990s, some state lawmakers also began to combine health insurance benefit mandates with evidence-based coverage standards in particularly contentious scenarios, like in regard to access to clinical trials and denials of coverage involving potentially lifesaving treatments.⁹¹ These laws are important to a discussion of governance and accountability for CPGs because they involve the government in establishing a hierarchy of evidence and mandatory procedures to be used to regulate access to cutting-edge clinical resources.

More generally, mandated benefit laws for a variety of health care services are common at the state level, although the federal ERISA statute prevents them from being applied to self-insured employer-based coverage. Requirements that health plans in a state cover certain benefits are typically enacted at the behest of providers with focused interests and/or patient groups with sympathetic needs. This has resulted in a large set of statutes that define a specific, favored clinical service. Mandated benefit laws are not CPGs in intent or substance, but they are important to understanding how the law can explicitly specify clinical tasks that were historically left up to physician discretion.

C. SYSTEMATIC GUIDELINE INITIATIVES

Both state and federal governments have attempted to confer a larger public policy role on clinical practice guidelines in the recent past. These efforts have tended to coincide with periods of interest in comprehensive health care reform, with peaks in the late 1980s and the early 1990s, and another peak just emerging in connection with the advent of Obamacare. Systematic guideline initiatives have focused on medical malpractice reform as well as more general improvements in the cost-effectiveness of health care, with unnecessary health care spending (such as defensive medicine) representing the conceptual connection between them.⁹²

1. AHCPR's Guideline Program

The first major attempt at using medical guidelines reform to spur broader healthcare improvement was in 1989 when Congress created the

⁹¹ See CAL. WELF. & INST. CODE §14132.98 (West 2002).

⁹² For more on state specific projects, see Avraham, *supra* note 1 (discussing other projects in Vermont, Minnesota, Kentucky, Maryland, and Texas).

Agency for Health Care Policy and Research (AHCPR) to “enhance the quality, appropriateness, and effectiveness of health care services” through, among other things, “the development and periodic review and updating of . . . clinically relevant guidelines.”⁹³ Several years later, the Clinton administration attempted to take this initiative a step further by proposing a medical liability pilot program based on the practice guidelines developed by the AHCPR. Under the pilot program, doctors who could show that their actions were consistent with relevant practice guidelines could avoid medical malpractice liability.⁹⁴

Because of political opposition to President Clinton’s healthcare reform and fierce interest group politics, President Clinton’s experimental initiative stalled and the AHCPR was almost completely eliminated in 1995.⁹⁵

⁹³ Mello, *supra* note 57, at 651 (quoting Stephen M. Merz, *Clinical Practice Guidelines: Policy Issues and Legal Implications*, 19 JOINT COMMISSION J. ON QUALITY IMPROVEMENT 306, 307 (1993)).

⁹⁴ U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: MAINE’S USE OF PRACTICE GUIDELINES TO REDUCE COSTS 1–2 (Oct. 1993), *available at* <http://biotech.law.lsu.edu/policy/150172.pdf>.

⁹⁵ The conflict that nearly eliminated the AHCPR emerged from a debate regarding spinal fusion surgery. Following many years of controversy over the merits of surgical procedures for low-back disorders, AHCPR funded a study that concluded that there was no evidence to support the use of spinal fusion surgery, that such surgery commonly had complications, and that more randomized controlled trials were needed to compare fusion surgery with non-surgical treatment. An association of back surgeons who disagreed with the conclusions launched an attack on the study and the agency itself. Bradford H. Gray, et al., *AHCPR and The Changing Politics Of Health Services Research*, HEALTH AFFAIRS W3-283, W3-297, *available at* <http://content.healthaffairs.org/content/early/2003/06/25/hlthaff.w3.283>. The Center for Patient Advocacy, which was formed by a back surgeon to lobby on the issue, mobilized an effort in the House of Representatives to end the agency’s funding. Only on the night of the vote was an amendment to reduce the agency’s budget to zero withdrawn, leaving the agency instead with a 21% budget cut. *Id.* at W3-295. The 1995 battle between the AHRQ and the back physicians was not the first time AHRQ faced attacks by physician groups. Earlier in 1993, an AHCPR study came under attack from various ophthalmology associations. *Id.* at W3-297. However, that attack never extended to attempts to defund AHCPR, and it came to an end when the ophthalmologists discovered they could use the data to discredit a GAO study alleging that inappropriate cataract surgery was widespread and to get insurers to pay for some surgery. *Id.*

One of the consequences of this battle was that the agency dropped its CPG development program and initiated support for external evidence-based practice centers that organize data to help private-sector organizations develop CPGs. In 1999, Congress passed legislation that changed the agency's name to the Agency for Healthcare Research and Quality (AHRQ). AHRQ has since become a major force in the dissemination of medical guidelines, though the actual creation of CPGs was eliminated from its mission.⁹⁶

2. Maine's Malpractice Guideline Project

Maine was home to the most famous project that established clinical practice guidelines as statutory standards of care for physicians to use as a defense in malpractice suits.⁹⁷ The Maine Medical Liability Demonstration Project was a ten-year pilot study that began in 1989 and expired in 1999. It instituted special advisory committees in charge of developing CPGs for four practice areas viewed as hotbeds for malpractice litigation and suspected defensive medicine. Maine subsequently adopted twenty guidelines in anesthesiology, emergency medicine, obstetrics/gynecology, and radiology.

Physicians, hospitals, and managed care organizations that elected to participate could use the guidelines as an affirmative defense against any malpractice claim. Plaintiffs bringing such claims, however, could not introduce the guidelines into evidence to argue that failure to comply was malpractice.⁹⁸ The guidelines were only available as a shield because the purpose of the reform was to reduce overall liability, a common purpose for reforms adopted during or after the malpractice insurance crisis of the mid-1980s.

The Maine project had little practical effect.⁹⁹ Few doctors believed these regulations had any discernible impact on the malpractice system, and

⁹⁶ See Avraham, *Private Regulation*, *supra* note 1, at 577–78.

⁹⁷ Linda L. LeCraw, *Use of Clinical Practice Guidelines in Medical Malpractice Litigation*, 3 J. ONCOLOGY PRAC. 254 (2007).

⁹⁸ ME. REV. STAT. Tit. 24, §§ 2975, 2977 (1993).

⁹⁹ LeCraw, *supra* note 97. By one estimate, the guidelines affected only about three to four percent of medical practice in Maine. See Gordon H. Smith, *A Case Study in Progress: Practice Guideline5 and the Affirmative Defense in Maine*, 19 Joint Commission J. ON QUALITY IMPROVEMENT 355, 361 (1993).

the affirmative defense was raised in only one case.¹⁰⁰ The superintendent of the Maine Bureau of Insurance concluded “the medical demonstration project had no measurable effect on medical professional liability claims, claims settlement costs, or malpractice premiums.”¹⁰¹

3. Florida’s C-Section Guideline Project

In 1994, concerns over the cost of defensive medicine prompted Florida to initiate its own CPG project to be administered by the state’s Agency for Health Care Administration (AHCA).¹⁰² Similar to the Maine project in many respects, the Florida project created an affirmative defense for participating physicians, provided that they followed specific clinical practice guidelines.

The primary difference from the Maine project was that Florida did not explicitly prevent plaintiffs from using the guidelines to help prove physicians failed to meet the standard of care, or from using the guidelines as a liability sword.¹⁰³ However, lack of physician compliance with guidelines did not create a prima facie case of negligence, and physicians were given leeway to demonstrate whether their decision to deviate from the guidelines was prudent given the specific circumstances of the case.¹⁰⁴

Florida’s guideline project concentrated on only one procedure.¹⁰⁵ Florida chose deliveries by caesarean section for their test project because it was the most common surgical procedure performed in Florida hospitals

¹⁰⁰ Howard Zonana, *Commentary: When Is a Practice Guideline Only a Guideline?*, 36 J. AM. ACAD. PSYCHIATRY L., 302, 303 (2008).

¹⁰¹ LeCraw, *supra* note 97, at 254 (citing ME. BUREAU OF INS. AND BD. OF LIC. IN MED., MEDICAL LIABILITY DEMONSTRATION PROJECT 2 AND 5 (2000)). Similar to Maine, in 1992 Minnesota also attempted to use clinical practice guidelines as a tool for health care reform, but the state never created the required guidelines to get the project off the ground. 1992 Minn. Sess. Law Serv. Ch. 549 art. 7 (H.F. 2800); 1995 Minn. Sess. Law Serv. Ch. 234; *see also* William Trail & Brad Allen, *Government Created Medical Practice Guidelines: The Opening of Pandora's Box*, 10 J.L. & HEALTH 231, 247 (1995).

¹⁰² FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, PRACTICE GUIDELINES AS AFFIRMATIVE DEFENSE: THE CESAREAN DEMONSTRATION PROJECT REPORT (1998).

¹⁰³ Trail, *supra* note 101, at 246.

¹⁰⁴ *Id.*

¹⁰⁵ FLA. STAT. § 408.02(9) (1996).

at the time.¹⁰⁶ Supporters predicted that the C-section rate would decline if physicians practiced in accordance with the guidelines. However, the affirmative defense proved to be an inadequate incentive to convince physicians to participate. Only 20% of eligible physicians participated, and it was determined that the ones who did participate were already less likely to perform C-sections.

Overall, Florida's effort had little effect on physician behavior. The primary barriers included lack of awareness, lack of familiarity with the guidelines, and lack of agreement with the validity of the guidelines.¹⁰⁷

4. Ongoing Initiatives

This section provides a brief overview of some of the current attempts to improve quality and reduce health care costs using CPGs.

a. *Federal Malpractice Reform Demonstrations*

The Obama administration's 2012 budget proposal included \$250 million for state-based alternatives to tort litigation for medical malpractice, with guidelines prominently featured among the favored reform approaches.¹⁰⁸ These funds were not authorized or appropriated by Congress, but the proposal still represents a renewed interest in CPG use.

Previously, AHRQ had awarded \$25 million for planning and demonstration grants in states, communities, and provider organizations that integrate improvements in patient safety with improvements in medical malpractice litigation.¹⁰⁹ CPGs fit this description, along with programs of error disclosure and offers of compensation, health courts, and a few other

¹⁰⁶ J. Rosser Matthews, *Practice Guidelines and Tort Reform: The Legal System Confronts the Technocratic Wish*, 24 J. HEALTH POL. POL'Y & L. 275, 284 (April 1999).

¹⁰⁷ In a study of the project, 54.5% of doctors surveyed attributed their failure to adhere to medical guidelines in part to a lack of awareness that relevant guidelines existed. Lack of familiarity with Florida's guidelines was cited by 56.5% as a cause of failure to adhere.

¹⁰⁸ Emily P. Walker, *Obama's Budget Includes \$250M in Malpractice Grants*, MED PAGE TODAY (Feb. 16, 2011), <http://www.medpagetoday.com/Practice-Management/Medicolegal/24904>.

¹⁰⁹ *Medical Liability Reform and Patient Safety*, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, <http://www.ahrq.gov/qual/liability/>.

innovations.¹¹⁰ However, only one of the 13 small planning grants – a project from the Office of Oregon Health Policy and Research – and none of the seven larger demonstration grants initially awarded involved CPGs.¹¹¹

b. *The Oregon Health Authority*

Between 1987 and 1994, the Oregon Legislature ratified several laws that established the structure for a public and private partnership that cumulatively constituted the Oregon Health Plan (OHP).¹¹² The Oregon Health Plan was originally designed to increase access to health care for lower income groups while controlling costs. Under the plan, prioritized medical services were to be incorporated into the basic benefit package for both Medicaid beneficiaries as well as people covered by private insurance in the state.¹¹³ In order to maintain budgetary restraint, the plan aimed to ration care by limiting the range of services covered under the basic benefits package.¹¹⁴ The program was cancelled in 2003 due to rising costs.

¹¹⁰ Additional funds were committed to AHRQ for malpractice and patient safety demonstrations in connection with the new health reform law, and a substantial expansion of federally funded experimentation is possible.

¹¹¹ *Medical Liability Reform & Patient Safety Grants*, AGENCY FOR HEALTHCARE RESEARCH QUALITY, <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/mediabrep.html> (last updated June 2010).

¹¹² See generally OR. REV. STAT. §§ 413.006 – 413.100, 414.065 (2013) (discussing the Oregon Health Authority and its policy-making and oversight body the Oregon Health Policy Board).

¹¹³ Seventeen types of health ailments (including fatal acute conditions that can be fully treated, less serious acute problems, chronic conditions, maternity care, and preventative treatments) were established. Then, all diagnoses and corresponding care in both medical and surgical arenas were assigned to a particular category of health ailments. These diagnosis-treatment pairs were subsequently prioritized according to thirteen attributes (including life expectancy, quality of life, cost containment, clinical efficacy, net benefits, and number of people assisted by the treatment). Finally, based on the prioritized list and the state's appropriations for the OHP, services and practices on the prioritized list above a certain level or ranking would be covered and those below the ranking would not be reimbursed.

¹¹⁴ Vidhya Alakeson, *Why Oregon Went Wrong*, 337 BRITISH MED. J., 900, 901 (2008); *Oregon Health Plan: An Historical Overview*, OREGON DEPARTMENT OF HUMAN SERVICES, 3 (July 2006), available at

The rise in the number of uninsured residents, increased medical expenses, and reductions in employer-based health care prompted Oregon to revisit reform. In 2009, the state ratified HB 2009, which established the Oregon Health Authority (OHA) and empowered it to streamline and harmonize the state's health care programs.¹¹⁵ The OHA is responsible for improving efficiency, coordinating health administration, and executing the reforms mandated by HB 2009.¹¹⁶ These reforms included developing "evidence-based clinical standards and practice guidelines that may be used by providers."¹¹⁷ The guidelines promulgated by the OHA, though not expressly given the force of law, could eventually come to represent the standard of care in disciplinary proceedings and malpractice suits.

As noted, the OHA received one of the initial AHRQ planning grants for liability and patient safety innovation. The results of the planning process were mixed. In a report to AHRQ, the grantees estimated that 5% of malpractice injuries could have been avoided if clinicians had followed guidelines, but also found that cost savings from reduced defensive medicine and safe harbor laws would be minimal or non-existent.¹¹⁸ Although Oregon would have saved \$4 million in medical liability costs under a safe harbor program, the additional administrative costs of such a program likely would have negated any savings.¹¹⁹ Given the patient safety benefits, one of the two pillars that support an increased role for CPGs, the report recommends additional research.¹²⁰

<http://www.oregon.gov/oha/healthplan/DataReportsDocs/Oregon%20Health%20Plan%20-%20An%20historical%20overview.pdf>.

¹¹⁵ Establishing Oregon Health Policy Board, H.R. HB 2009-C, 75th Leg. §20 (Or. 2009).

¹¹⁶ *Id.* at §§1, 9. HB 2009 effectively dissolved the Oregon Health Fund Board and replaced it with the Oregon Health Policy Board (OHPB), which formulates policy and acts as the oversight body for the Oregon Health Authority. The nine-member group is required to widen access, control the cost and quality of the health care delivery system, and enhance the health of Oregonians by developing state public health objectives, policies, initiatives, and benchmarks.

¹¹⁷ OR. REV. STAT. § 413.011(e) (2013).

¹¹⁸ *Medical Liability & Patient Safety Planning Grant: Final Progress Report*, AGENCY FOR HEALTHCARE RESEARCH QUALITY 1, 10-11 (2012), http://www.oregon.gov/oha/OHPR/PSDM/AHRQ_MLPS_Report.pdf.

¹¹⁹ *Id.* at 11.

¹²⁰ *Id.* at 14.

c. *The American Recovery and Reinvestment Act*

Signed into law in 2009 by President Obama, the American Recovery and Reinvestment Act (ARRA) included funding and administrative support for comparative effectiveness research, an area where CPGs play a prominent role.¹²¹ The ARRA appropriated \$1.1 billion for comparative effectiveness studies, including comparative trials, medical registries, clinical databases, and methodical appraisals.¹²² Furthermore, ARRA directed the IOM to conduct a national study of critical areas that could utilize comparative effectiveness and could capitalize on the appropriated funds.¹²³ The 2009 law also created the Federal Coordinating Council for Comparative Effectiveness Research; a committee chaired by the Secretary of DHHS and composed of federal administrators and clinicians.

Interestingly, while the council was directed to propose and organize research efforts, it was *prohibited* from using the studies to specify clinical practice guidelines or implementing changes in coverage and reimbursement procedures.¹²⁴ Still, this series of studies can provide once completed important information that can be used by others to create effective CPGs

d. *Patient Protection and Affordable Care Act*

Paralleling renewed interest in evidence-based guidelines and cost-effective treatment, the 2010 Patient Protection and Affordable Care Act (PPACA) expands comparative effectiveness research.¹²⁵ The federal government designated a minimum of \$500 million to pursue statistical studies that judge the efficacy of drugs, devices, and treatments. PPACA also experiments with “new payment systems for doctors,” fines hospitals

¹²¹ American Recovery & Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009).

¹²² *Id.* The Agency for Health care Research and Quality (AHRQ) was designed to oversee \$300 million of the \$1.1 billion total, with \$400 million directed by the National Institute of Health (NIH) and \$400 million administered by the Department of human and Human Services (DHHS).

¹²³ *Initial National Priorities for Comparative Effectiveness Research*, INSTITUTE OF MEDICINE 2 (2009).

¹²⁴ Robert Steinbrook, *Health Care & the American Recovery & Reinvestment Act*, 360 NEW ENG. J. MED. 1057, 1058 (2009).

¹²⁵ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

for “high readmission rates,” and establishes an independent commission to determine which procedures Medicare should reimburse. The studies will be overseen by the newly created Patient-Centered Outcomes Research Institute (PCORI), which is authorized to determine research needs and perform studies that evaluate the relative usefulness of medical therapies.¹²⁶

Lastly, under the PPACA, AHRQ will occupy an integral role in designing, pursuing, and disseminating clinical effectiveness research. The Act places AHRQ on the Board of Governors for the PCORI, and the agency must also work with the NIH to train researchers for the new studies and convey its findings. In concert with DHHS, AHRQ and CMS will be granted \$75 million over five years to jointly formulate quality standards. To improve the quality of the provision of medical care, the PPACA also allocates \$20 million to the AHRQ for the agency to determine, formulate, assess, and teach new processes and approaches in clinical practices between 2010 and 2014.¹²⁷

The next section of the paper discusses three main models for ensuring trustworthiness of CPGs: the Public Model, the Semi-Public Model, and the Private Model. The first two models exist or existed in the U.S and the U.K, the third is novel. These discussions will highlight the benefits and drawbacks of each method.

IV. MODELS FOR STRUCTURED ACCOUNTABILITY FOR CPGS

In its 2011 Report, the IOM lays out eight standards that focus on the procedures by which CPGs are to be developed. To enforce these standards the IOM recommends forming a private–public entity, which will provide a seal of approval to CPGs that meet those eight standards. But that is just one possible model (and one that I argue cannot work well in practice). In this section I describe the several broad approaches to CPG quality control and explain the advantages and disadvantages of each one. One option is to approve the guideline itself. Here the certifier (public, semi-public, or private) reviews the CPG and makes sure that it is optimal. A regime with a public certifier existed in the US in the past but no longer exists in pure form in the US or in the UK. Part of this is because it can be

¹²⁶ Alex Nussbaum et al., *Obamacare’s Cost Scalpel*, BLOOMBERG BUS. WK., Apr. 5, 2010, at 66.

¹²⁷ Patient Protection & Affordable Care Act, Pub. L. No. 111-148, §§ 3013, 3501, 6301, 10602, 124 Stat. 119, 381, 507, 727, 1005 (2010).

difficult to employ due to the time, resources, and expertise necessary to approve an individual guideline. The more realistic method focuses on approving the *process* used to develop individual CPGs. Professor Rosoff offered this model almost two decades ago.

Alternatively, the certifier can approve the legitimacy of the institution that develops them. In this system, the certifier provides a seal of approval for the entity promulgating the CPGs. This gives the entity an approved status based on more general checkups and not based on any one individual guideline. The downside of this approach is that the individual CPGs are not reviewed. Such a system exists in the UK with a public certifier, and was proposed by the IOM (but with a public-private certifier) for the US.

Lastly, there is a private model, proposed by Avraham, where guidelines are promulgated by private entities and compete in the market for the endorsement of practitioners. The private model can take hold in two ways. First, and most obvious, it can be created by legislation that changes our current system such that new organizations will emerge. Secondly, and perhaps more realistically, the regime will evolve incrementally from organizations that realize it is in everyone's best interest to implement a private model of accountability to ensure high quality guidelines are drafted and used by physicians.

The following table roughly summarizes this and demonstrates how the different models match the analysis:

Table 1: Models of CPG Quality Control

		Certifier		
		Public Model	Semi Public Model	Private Model
Inspected	Output (CPGs themselves)	US (old model), UK		Avraham
	Credentials of Promulgators	UK	US (IOM)	
	Procedures Used in specific Guidelines	Rosoff		

A. THE PUBLIC MODEL

The Public Model actually consists of three variations, each of which is covered in this section of the Article. The government can be the entity that actually drafts and publishes CPGs, it can certify entities that it deems qualified to publish reliable CPGs, or it can itself provide an approval system that evaluates the process by which CPGs are created and approves CPG meeting the stated requirements on an individualized basis.

1. Government Promulgating CPGs (UK & Old US Model)

In general, the UK uses a public model, although promulgation of CPGs in the UK is not entirely centralized. The Department of Health (DH)¹²⁸ oversees the government health care system, the National Health Service (NHS).¹²⁹ The NHS, in turn, coordinates with the DH's various Arm's Length Bodies (ALB),¹³⁰ which are financed by the government but act independently, in order to help implement various functions of the NHS. The ALB for standards of promulgation is the National Institute for Health and Clinical Excellence (NICE),¹³¹ which is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health within the NHS.¹³² Through collaboration and a series of researching steps, NICE develops guidelines that suggest optimal practices for NHS health care practitioners.¹³³

¹²⁸ *The Department of Health*, GOV. UK, <https://www.gov.uk/government/organisations/department-of-health> (last visited Sept. 3, 2012).

¹²⁹ *The National Health Service*, GOV. UK, <http://www.nhs.uk/Pages/HomePage.aspx> (last visited Sept. 3, 2012).

¹³⁰ *Arm's length bodies*, DEPT. OF HEALTH, <http://www.dh.gov.uk/government/publications/arms-length-bodies/our-arms-length-bodies> (last visited Apr. 26, 2014).

¹³¹ THE NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE, <http://www.nice.org.uk/> (last visited Sept. 2, 2012).

¹³² *About NICE*, NAT'L INST. FOR HEALTH & CARE EXCELLENCE, <http://www.nice.org.uk/aboutnice/> (last visited Feb. 16, 2014).

¹³³ Nat'l Inst. For Health and Care Excellence (NICE), *Developing NICE Clinical Guidelines*, http://www.nice.org.uk/aboutnice/howwework/developing-niceclinicalguidelines/developing_nice_clinical_guidelines.jsp (last visited Feb. 11, 2014).

In the US, as mentioned earlier in the paper, after a fierce political battle in the early 1990s, the AHRQ stopped promulgating guidelines. The AHRQ now perceives itself as facilitating the creation of CPGs by other actors.

Still, there are good reasons to think that the government *should* write and publish guidelines. Other government agencies – such as CMS – write guidelines, and governments in other countries like the UK do as well. For example, in September 2006, the Center for Disease Control and Prevention issued its “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.”¹³⁴ These examples of the public model point towards government agencies as a potentially desirable source of CPGs.

On the surface there is something appealing about the government writing guidelines because CPGs are, after all, a public good. But how does this model of promulgation affect the quality of health care? The foremost concern with this model is the issuing agency’s ability to keep its guidelines up-to-date. Because medical research evolves very quickly, it is likely that government CPGs would fail to keep up with current medical research. A 2001 study found thirteen out of seventeen CPGs developed by the AHRQ to be outdated.¹³⁵ The study also found that it was estimated to cost \$4 million per guideline to properly update them using the AHRQ’s Evidence Based Practice Center Program.¹³⁶ Unfortunately, medical research does not evolve on a rigid timetable, so agency guidelines may significantly lag behind cutting-edge medical advances. There are, therefore, reasons to think government promulgation of CPGs may actually impede quality improvement.

In addition to quality problems, government authorship of guidelines could easily create greater cost-inefficiency in the health care system. Various dynamics suggest that government agencies may create overly lax guidelines (or under-enforce them).¹³⁷ First, agencies will often lack the resources to set the regulations efficiently (and as discussed above,

¹³⁴ *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, CENTER FOR DISEASE CONTROL & PREVENTION (2006), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> (last visited Feb. 11, 2014).

¹³⁵ Shekelle, *supra* note 61, at 1464.

¹³⁶ *Id.* at 1462.

¹³⁷ See Catherine M. Sharkey, *Products Liability Preemption: An Institutional Approach*, 76 GEO. WASH. L. REV. 449, 494-95 (2008).

update them regularly).¹³⁸ Second, as the history of the AHRQ revealed, agencies are vulnerable to the political preferences of the administration in power, to self-aggrandizing administrators, and interest group capture.¹³⁹ A change in the government can lead to ossification of standards. Administrators operating in a revolving door environment may advance their post-agency careers by catering to interest groups that favor lax standards. Most importantly, interest group capture can lead to under enforcement and, as in the case of the AHRQ, may hamstring guideline development or even cause the abandonment of CPG promulgation altogether.¹⁴⁰ Interest group capture can also lead to subtle biases and conflicts of interest in the guidelines that promote one company's products or services over another's at the expense of the patient.

At the same time, there are reasons why some federal agencies might adopt overly strict guidelines. Occasionally, agencies regulate in response to crises, and this may lead to reactionary guidelines being promulgated. Second, agencies lack the financial accountability necessary to incentivize efficient rulemaking. Government agencies cannot be sued for making poor guidelines in a classic example of who watches the watchmen.¹⁴¹ As it is, an agency rule maker would be less likely to fully internalize the financial consequences of their own guidelines and may choose to overregulate. Third, the overregulation may become even more exaggerated because, while the regulator may not be financially accountable, they will be *politically* accountable, which usually leads to more defensive policies. If the agency errs by failing to regulate, its political accountability assures their punishment. However, an agency can scarcely be punished politically for overly stringent regulations.¹⁴² More

¹³⁸ Jeffrey J. Rachlinski, *A Positive Theory of Judging in Hindsight*, 65 U. CHI. L. REV. 571, 609 (1998).

¹³⁹ Interest group capture occurs when special interest groups gain a disproportional share of influence over a government agency. This can happen because of, for example, campaign donations or the revolving door between government and the private sector.

¹⁴⁰ See *supra* note 95 and accompanying text (describing how the AHRQ had to stop promulgating guidelines due to interest group pressure).

¹⁴¹ In the US one cannot sue the FDA or any other agency for a wrong decision within their discretion. See 28 U.S.C. §2680(a) (2006) (imposing this exception to the general waiver of sovereign immunity created by the Federal Tort Claims Act).

¹⁴² See Richard A. Epstein, *Why the FDA Must Preempt Tort Litigation: A Critique of Chevron Deference and a Response to Richard Nagareda*, J. Tort L., at

likely they will be commended for taking such a stern stance against liability prevention, but this does nothing to alleviate the economic pressures faced by the modern health care system.

Due to these countervailing considerations, there is uncertainty whether agencies would regulate in an overly strict or overly lax manner. The efficiency, however, would be diminished in either scenario.¹⁴³ As a result the pure public model would probably do little to contain health care costs and might impair quality. In sum, the chance that government promulgation of CPGs would directly improve the quality of care while being systematically and continuously efficient is slim.

2. Certification of CPG Promulgators (UK Model)

While part of the UK Model involves the government promulgating CPGs, the part of the UK Model I want to focus on is when the government approves other entities that in turn create CPGs. This certification process is done by the NHS Evidence Advisory Committee, created by the Board of NICE as an independent, standing committee. The NHS Evidence Advisory Committee does not verify the efficacy of the individual guidelines, but chooses to focus on the methods used by guideline creators in guidelines production.¹⁴⁴ These guidelines, along with others from accredited and non-accredited producers alike, are posted to the

22 (2006) (arguing agencies have incentives to regulate in an overly risk-adverse fashion because of self interest); *see also* Daniel P. Carpenter, *The Political Economy of FDA Drug Review: Processing, Politics, and Lessons for Policy*, 23 HEALTH AFFAIRS 1, (2004).

¹⁴³ Most agencies seem to regulate only minimum standards of care. A possible exception is the FDA. *See Colacicco v. Apotex, Inc.*, 432 F. Supp. 2d 514 (E.D. Pa. 2006) (acknowledging that the FDA seeks to encourage the optimal level of use in light of reasonable safety concerns, by requiring scientific evidence that establishes an association between a drug and a particular hazard before warning of that association on a drug's labeling).

¹⁴⁴ NAT'L INST. FOR HEALTH AND CARE EXCELLENCE (NICE), PROCESS MANUAL FOR ACCREDITING PRODUCERS OF GUIDANCE, ADVICE, AND RECOMMENDATIONS FOR PRACTICE: A GUIDE FOR PRODUCERS AND STAKEHOLDERS, *available at* <http://www.evidence.nhs.uk/Accreditation/Documents/NHSEvidenceAccredManual.pdf> [hereinafter *Accreditation Manual*].

committee's website, NHS Evidence.¹⁴⁵ Since 2009, NICE has accredited sixty organizations.¹⁴⁶ Guidelines from these organizations are marked on the NICE website with a symbol indicating the approval from the government.

How is the quality of care impacted by guidelines and guideline promulgation in the UK? To try to understand the impact on health care costs and quality of the NICE accreditation system it is helpful to think about the themes of accountability, guideline agreement, and consistent use by doctors that an ideal CPG system would have. Beginning with accountability, it is easy to see that a system focusing on process rather than output may have some issues. Organizations that have been accredited are accountable to NICE for their processes, but not for the contents of the guideline. If an organization creates a guideline that turns out to be incorrect, there is no liability that would hold that organization responsible for its recommendation. There is also no promise that CPGs created by certified organizations will not be biased. With no accountability, doctors would instead be on their own in defending their actions and would have less of an incentive to adopt CPGs.

A second issue with the UK Model flows out of the lack of accountability. Having a certification process that does not review individual guidelines or compare them to each other allows for the certification and publication of conflicting guidelines. In the case of CPGs, more information is not always a good thing. Conflicting CPGs, especially when both are stamped with government approval, may make doctors less likely to follow any guideline because they will not know which guideline actually represents the current best practices. As we mentioned above, it is unrealistic for doctors to keep up with ongoing medical research given the enormous volume of studies and reports that are published each year. Synthesizing new studies and providing recommendations is one of the benefits of CPGs because they can reduce the information costs to doctors, especially those in solo practice. When conflicting guidelines are certified, however, this benefit is largely lost and the implementation rate by doctors will likely drop.

¹⁴⁵ *Frequently Asked Questions*, NAT'L INST. FOR HEALTH & CARE EXCELLENCE (NICE), <http://www.nice.org.uk/aboutnice/accreditation/FAQs.jsp> (last visited Feb. 11, 2014).

¹⁴⁶ *NICE Accreditation*, NAT'L INST. FOR HEALTH & CARE EXCELLENCE (NICE), <http://www.nice.org.uk/aboutnice/accreditation/index.jsp> (last visited Feb. 11, 2014).

Relatedly, a third issue with the UK Model is inconsistent use of guidelines by doctors. This final and equally important issue with the UK Model is that it does not take full advantage of CPG's potential to increase the quality of health care. While having a system that certifies certain organizations that follow a specific process will improve the quality of guidelines, it will not achieve the same level of quality that could be achieved if, for example, the guideline producers were held accountable for the correctness of their guidelines. If doctors are faced with a multitude of options, they may choose none since they will have reduced incentives to use CPGs and their trust in the system will have diminished. If we assume that CPGs represent that best and most cost effective treatment for a disease, then when doctors do not follow CPG recommendations, the quality of health care drops.

3. Certification of CPGs (Rosoff)

Rosoff puts forth a CPG model where the government would stamp adequate guidelines with a seal of approval. Rosoff is primarily interested in the role of CPGs in courts, yet he keeps one eye on the impact they have on the optimal delivery of care.¹⁴⁷ Rosoff calls for a system of voluntary federal government certification for CPGs in order to clarify the role they play in medical malpractice litigation. CPGs would continue to emanate from "all interested and qualified parties"¹⁴⁸ as is currently the case. Out of this free-market for guidelines, those that are submitted for review and satisfy the government's criteria would receive a seal of approval.

The government review process would focus primarily on guideline development. The certification would require that the guideline be developed:

- (1) through solid, scientific outcomes research, using an appropriate and adequately large clinical practice data base;
- (2) using appropriate methodology, as defined by DHHS regulations;
- (3) with input from qualified medical professionals; and
- (4) with provision for prompt, periodic updating The applicant would pay both the

¹⁴⁷ Rosoff, *The Role of Clinical Practice Guidelines*, *supra* note 24, at 371.

¹⁴⁸ *Id.* at 395.

cost of the initial review process and subsequent updating or recertification.¹⁴⁹

As Rosoff acknowledges, difficulties would arise in implementation because, while certification would be a part of a national program, the litigation process it intends to affect mostly occurs in state courts. Of course, any number of states could voluntarily accept the certification program via their legislatures.¹⁵⁰

¹⁴⁹ *Id.*

¹⁵⁰ For those states that do not join, Rosoff offers four mechanisms to force implementation. The first possibility is the commerce power. Rosoff proposes that Congress preempt state law regarding medical litigation by use of the commerce power. Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 364. He acknowledges, however, that such preemption would be problematic, as the object to be regulated in this instance is not commercial like health care or insurance, but the legal mechanisms usually reserved to the states. Indeed, a similar Congressional provision that preempted such state law, the Employee Retirement Income Security Act of 1974 (ERISA), received criticism. *Id.* Rosoff next proposes attaching the requirement of acceptance of the certification program to federal funding, an exercise of the spending power. This would likely be a legitimate use of the spending power, provided the funding to which the program was tied was optional to the states. *See* *South Dakota v. Dole*, 483 U.S. 203 (1987). Similarly, Rosoff suggests attaching the CPG program to other federal health care programs. Citing the example of the Emergency Medical Treatment and Active Labor Act of 1985 (EMTALA), he recommends tying his proposed use of CPGs to the Medicare and/or Medicaid programs. Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 365. Finally, there is the possibility of a less straightforward approach, which Rosoff describes as “an artful use of ‘carrot and stick’ mechanisms.” *Id.* Presumably, an act could be written that would incentivize adoption of the CPG certification program. Implicit in each of these possibilities (other than the use of the commerce power) is that states would still ultimately have the power to decide whether to join in the program. As with all such scenarios, however, the incentives to accept the program could be structured to leave little for states to ponder. The second and third possibilities are the spending power and attachment to other health care programs. Citing the example of EMTALA, Rosoff recommends tying his proposed use of CPGs to the Medicare and/or Medicaid programs. *Id.* The last method he suggests is “the carrot and stick” approach. *Id.* He points to the National Health Planning and Resources Development Act of 1975, which permits the granting of funding to states “on the basis of an established competitive review process” to be used for a variety of programs aimed at reducing the incidence and mortality rate of breast and cervical cancer. 42 U.S.C. § 300k (2006).

Similar to the case with NICE, the stamp of approval for these guidelines focuses on the process by which the guidelines were created, not the properness of the actual CPG. Yet, while NICE gave a stamp of approval for a guidelines *developer*, under Rosoff's model the stamp of approval will be for each individual guideline.

Rosoff argues the certification program would increase the quality of care and also the quality of the guidelines themselves. Increased reliance on CPGs would eliminate the guesswork of choosing between alternatives, which would result in faster, more effective treatment.¹⁵¹ Rosoff asserts that another benefit of his model would be the reduction of health care costs nationwide. Because CPGs would have to be derived from evidence-based research, they would provide direction for medical professionals from a much larger cost-conscious perspective than such practitioners typically consider in treatment.¹⁵² Further, CPGs will typically recommend the *most* cost-effective treatment considered in light of its success rate and that of similar treatments.¹⁵³ Finally, clinicians should be more inclined to follow the guidelines given the prospect of proposed liability shields. Combined, these aspects of the Rosoff model should generally reduce costs.

Rosoff also envisions significant changes to the current medical malpractice regime by using CPGs to set the standard of care at trial and raising a presumption against negligence rebuttable only by "clear and convincing evidence."¹⁵⁴ Rosoff intends to substantially reduce the expenditures associated with medical malpractice litigation. The implementation of this proposal would reduce the actual need for litigation and those disputes that do reach litigation would be resolved in a less costly manner. Using CPGs to set the standard of care would streamline one of the major questions present in malpractice cases.¹⁵⁵

¹⁵¹ Rosoff, *The Role of Clinical Practice Guidelines*, *supra* note 24, at 371.

¹⁵² *See id.* at 372.

¹⁵³ *Id.*

¹⁵⁴ Rosoff, *Evidence Based Medicine*, *supra* note 77, at 361. It should be noted that the opposite application of the presumption is also true: noncompliance would raise the same, strong presumption of a breach.

¹⁵⁵ *Id.* at 363. Rosoff argues this conclusion must follow if doctors are permitted to use the guidelines in defending malpractice suits. *Id.* Though Rosoff brushes over the possibility of liability of developers in the current system, another commentator suggests that possibility is a very real one. *See supra* note 45 and accompanying text.

Putting aside issues with feasibility,¹⁵⁶ Rosoff's model is problematic because there are doubts as to its ability to ensure CPGs meet the goals of improved healthcare quality and reduced costs. To begin, the proposal itself ignores the problem of convergent guidelines recommending different treatments for the same conditions. In fact, Rosoff seems to encourage this occurrence rather than deter it.¹⁵⁷ While the problem may be resolved by the courts, it does nothing for medical professionals seeking evidence-based clarity. Conflicting guidelines also likely means wasteful offensive and defensive medicine costs if the guidelines differ because solo practitioners, concerned about litigation, will not know *ex ante* if they will be protected by Rosoff's proposed liability shield.

Looking closer at Rosoff's proposal, the basic idea of a federal certifying agency poses special problems. If the certification standards are too low, as some claim the NGC standards are, then the certification is essentially useless. If, in contrast, the standards are too high, the agency will suffer criticism for being a government enforcer of only one "right way" to conduct medical practice.¹⁵⁸ How to determine which standards are too stringent or which are too lax remains an open question. For example, the National Guidelines Clearinghouse (NGC), supported by the AHRQ,

¹⁵⁶ It is worth mentioning that even if Rosoff's model was consistent with the goals set out at the beginning of this section, there may still be other issues with its implementation. First, the IOM's endorsement notwithstanding, it would be difficult for the proposal to garner the political support necessary to push through Congress a certification program that impacts the courts in such a broad manner. Also, the sheer size of a federal agency such a system would require in order to address the volume of extant and newly produced guidelines would make the undertaking prohibitive. It would also be difficult to ensure the competence of the people certifying the guidelines in such a large agency. The roller-coaster ride of Obamacare is evidence enough of Congress's reluctance to directly alter the health care delivery system. There would also be a constitutional question as to whether Congress could alter state medical malpractice rules to the extent of wholly extinguishing state law claims or providing an alternative federal remedy meeting Seventh Amendment standards. See Abigail Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 846-47 (2009). It is possible that courts could develop a more friendly view of CPGs, but as discussed above, this has not happened yet.

¹⁵⁷ See Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 356.

¹⁵⁸ The same is not true for other countries such as the UK, where the health care system is structured differently than in the US and there is much more trust in the government and willingness to accept its mandates for medical care.

looks to “maintain a certain degree of quality control.”¹⁵⁹ The NGC’s criteria offer similar points of evaluation to those suggested by Rosoff. One criterion requires, for instance, that “a systematic literature search and review of existing scientific evidence published in peer reviewed journals [be] performed during the guideline development.”¹⁶⁰ This is consistent with Rosoff’s criteria (1) and (2) above.¹⁶¹ For the NGC, a CPG must also be “produced under the auspices of medical specialty associations; relevant professional societies, public or private organizations, government agencies at the Federal, State or local level; or health care organizations or plans.”¹⁶² This is consistent with Rosoff’s criterion (3).¹⁶³ Moreover, the NGC does not review the guidelines themselves, but instead outsources that task to private entities. Thus, but for this latter point it is not entirely clear how Rosoff’s model differs from the existing NGC model. And higher standards cannot always be met. Indeed, in a recent study it was found that the majority of guidelines sampled from the NGC website meet less than half of the IOM’s stricter requirements.¹⁶⁴

The final problem with Rosoff’s model is that it suffers from the same lack of accountability found in the public model. While there will be reputational incentives to promulgate accurate CPGs, this may not be enough to achieve the maximum result. Without accountability, removing conflicts of interest is more difficult. A recent study in the *Journal of the American Medical Association* supports this theory, finding that for the committees that produced guidelines appearing on the NGC website, 71% of the committee chairpersons had a conflict of interest and 91% of

¹⁵⁹ See NATIONAL GUIDELINE CLEARINGHOUSE, <http://www.guideline.gov/index.aspx> (last visited Feb. 12, 2014).

¹⁶⁰ *Inclusion Criteria*, NATIONAL GUIDELINE CLEARINGHOUSE, www.guideline.gov/about/inclusion-criteria.aspx (last visited Feb. 18, 2014).

¹⁶¹ “(1) through rigorous, scientific outcomes research, based upon an appropriate and adequately large set of clinical practice data; (2) using appropriate methodology, as defined by AHRQ regulations” Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 360.

¹⁶² NATIONAL GUIDELINE CLEARINGHOUSE, *supra* note 160. NGC lists only the following types of qualifying organizations: medical specialty associations; relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level; or health care organizations or plans.

¹⁶³ “(3) with input from qualified medical professionals” Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 360.

¹⁶⁴ See Kung et al., *supra* note 21 and accompanying text.

committee co-chairpersons also had a conflict of interest.¹⁶⁵ This is a huge problem, and will require a more comprehensive approach than that provided for by Rosoff.

The lack of accountability, conflicts of interest, and potential for conflicting guidelines that appear in the Rosoff model will likely lead to inconsistent use among physicians, especially those who are solo-practitioners. Doctors face their own set of incentives and costs when it comes to the care that they provide to patients, and the best model is one that will align these incentives with those of the guideline producer and the other healthcare players.

B. THE SEMI-PUBLIC MODEL (IOM)

Rosoff rejects the possibility of private certification for CPGs in favor of a federal certification program. Because an objective of his certification program is to assist judges in distinguishing reliable, valid guidelines from those that are not, he argues that private certification would lack the “official” certainty necessary to achieve that objective. Courts, he continues, would be confused over the validity of conflicting guidelines if private certification reigned.¹⁶⁶ Indeed, if one assumes that helping courts is the main goal of a certification program, as Rosoff does, a governmental system might make more sense.

But CPGs should do more than just help courts gauge the standard of care. CPGs should, above all, foster better delivery of care. When viewed with this objective in mind, a private entity could implement the same criteria as Rosoff’s proposed government certifier. This would allow the government to outsource its quality control to a private entity.¹⁶⁷ I call this the Semi-Public Model and this is what the IOM recommended when it called for the establishment of a public–private mechanism to certify CPG development processes.

¹⁶⁵ See *id.* at 1630. Other authors have discussed different ways that companies try to influence CPGs. See, e.g., Marc A. Rodwin, *Conflicts of Interest, Institutional Corruption, and Pharma: An Agenda for Reform*, 40 J.L. MED. & ETHICS 511, 518 (2012) (“[F]irms fund physician and medical society activities to influence their clinical practice guidelines, which influences physician prescribing.”).

¹⁶⁶ Rosoff, *Evidence-Based Medicine*, *supra* note 77, at 357-58.

¹⁶⁷ The National Commission on Quality Assurance (NCQA) and the Joint Commission (JC) are examples of similar private certification programs.

As was mentioned above, the IOM Report is based around eight standards that all CPGs should attempt to achieve compliance with. These standards are process oriented such that they focus on the creation of the guideline rather than its contents. Now is the time to review them more closely. The IOM's first requirement for CPGs is transparency, with a focus on ensuring that the way the guideline was developed and the source of its funding are easily accessible.¹⁶⁸ Second, CPGs must be free from conflicts of interest. To achieve this, the IOM Report calls for the disclosure of any and all COIs by guideline authors, the divestment of financial investments that could be affected by CPG recommendations, and the exclusion of authors with a COI whenever possible.¹⁶⁹ The chair and co-chairs of the guideline committee especially should not have a COI.¹⁷⁰

Third, the guideline development group members should come from a variety of backgrounds including experts, clinicians, and patients.¹⁷¹ This will help to ensure that all voices are heard during the process. Fourth, systematic review is the desired method for guideline drafting.¹⁷² Fifth, and relatedly, the strength of the recommendation should be included in the guideline.¹⁷³ This rating should include a description of the harms and benefits, also an explanation of the role that opinion and theory (as opposed to facts and systematic review of the evidence) played in the recommendation.¹⁷⁴ Sixth, the recommended action should be stated precisely so that it can be more easily understood and implemented by doctors.¹⁷⁵

Seventh, CPGs should undergo a process of external review from all the relevant health care players, including the public and the federal government.¹⁷⁶ These reviewers should be allowed to comment confidentially and the guideline authors should keep a record of why (or why not) they took the comments into account.¹⁷⁷ Eighth, and lastly, CPGs should be regularly updated. This includes monitoring the literature so that

¹⁶⁸ 2011 IOM Report, *supra* note 3, at 6.

¹⁶⁹ *Id.* at 7.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.* at 7–8.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 8.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

new evidence can be incorporated when it becomes known and the continued validity of the CPG can be ensured.¹⁷⁸

Given the similarities between this Semi-Public model and Rosoff's and the UK models, it seems likely the same general effects would be observed and the same criticisms raised above will apply here as well. Well-defined development and evaluation criteria should elevate the quality of care, while financial incentives for developers should increase efficiency and reduce costs. One important point of divergence, though, could be the role of CPGs in malpractice litigation under this model. Without government involvement, courts might still be reluctant to give weight to guidelines.

As discussed in the previous section, there is also the problem of conflicts of interest. Although the standards may call for screening such guidelines out during the certification process, it has been shown that the vast majority of CPGs on the NGC website were created by a committee for which the chairperson or co-chairperson had a conflict of interest.¹⁷⁹ The Semi-Public Model also suffers from the same issues related to conflicting guidelines.¹⁸⁰ All of these problems make CPGs certified under this model less helpful to doctors, and especially unhelpful to solo practitioners who have little time to review multiple guidelines for every procedure.

At their most basic level, CPGs should be trustworthy. The IOM attempts to implement a system whereby trustworthy guidelines can be easily identified. However, it has become clear that “[w]hile the IOM committee provided a comprehensive set of standards, it imposed an impractical definition of trustworthiness.”¹⁸¹ By requiring adherence to eight standards, the system established by the IOM Report resulted in none of the current CPGs meeting the IOM's definition of trustworthy.¹⁸² Not only do none of the existing CPGs meet, and perhaps can never meet, all eight standards, the majority of the CPGs in the NGC meet less than half of the IOM standards.¹⁸³ While an unregulated system of CPGs does not help

¹⁷⁸ *Id.* at 8–9.

¹⁷⁹ *Id.*

¹⁸⁰ See *supra* note 222 and accompanying text.

¹⁸¹ David F. Ransohoff et al., *How to Decide Whether a Clinical Practice Guideline is Trustworthy*, 309 JAMA 139, 140 (Jan. 9, 2013).

¹⁸² *Id.*

¹⁸³ See Kung et al., *supra* note 21, at 1629.

doctors, neither does a model where no guideline can be certified. This is what is happening in practice with the Public and Semi-Public Models.

C. THE PRIVATE MODEL (AVRAHAM)

In a series of recent popular press articles and papers Avraham proposed a model for private regulation of CPGs.¹⁸⁴ While it is still a new proposal in the field, it has received some attention in the literature.¹⁸⁵ In contrast to Rosoff, Avraham's *main* goal is to use CPGs to achieve optimal

¹⁸⁴ Avraham, *Private Regulation*, *supra* note 1 at 547; Avraham, *Warped Incentives*, *supra* note 1; Ronen Avraham, *Private and Competitive Regulation of Medicine*, 34 THE ECONOMISTS' VOICE 546, 547 (2009); Ronen Avraham, *A Market Solution for Malpractice* (N.Y. TIMES, Mar. 28, 2011) available at http://www.nytimes.com/2011/03/29/opinion/29Avraham.html?_r=1&ref=opinion; Ronen Avraham, *Private Regulation of Medicine: A Win-Win-win For Doctors, Patients and Public*, HUFFINGTON POST (July 22, 2009) http://www.huffingtonpost.com/ronen-avraham/private-regulation-of-med_b_242937.html.

¹⁸⁵ See, e.g., Alex Stein, *Toward A Theory of Medical Malpractice*, 97 IOWA L. REV. 1201, 1245 n.248 (2012) (describing Avraham's Private Model as "an insightful reform proposal"); Nathan S. Richards, *Judicial Resolution of Emtala Screening Claims at Summary Judgment*, 87 N.Y.U. L. REV. 591, 629 n.194 (2012) (noting Avraham's proposal as "fascinating and novel"); Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2080 n.309 (2012) (citing Avraham's model for CPG regulation as a way of enhancing quality of care while decreasing healthcare costs); Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 201 n.9 (2012) (citing Avraham's model as a way to privatize the regulation of medical care); Jonathon H. Roth, *Regulating Your Medical History Without Regulations: A Private Regulatory Framework to Electronic Health Record Adoption*, 91 B.U. L. REV. 2103, 2122 (2011) ("Professor Ronen Avraham proposes a unique solution to rectify the inherent deficiencies in self-regulation: private regulation."); Adam Candeub, *Contract, Warranty, and the Patient Protection and Affordable Care Act*, 46 WAKE FOREST L. REV. 45, 58 (2011) (arguing for warranties but admitting that "as medicine becomes more algorithmic, Avraham's position makes complete sense"); David A. Hyman & Charles Silver, *Medical Malpractice and Compensation in Global Perspective: How Does the U.S. Do It?*, 87 CHI.-KENT L. REV. 163, 172 (2012) (citing to Avraham's proposal while discussing clinical practice guidelines); Nadia N. Sawicki, *Patient Protection and Decision-Aid Quality: Regulatory and Tort Law Approaches*, 54 ARIZ. L. REV. 621, 635, n.75 (2012) (citing to Avraham's op-ed in the NY Times on private regulation).

care delivery.¹⁸⁶ The role of CPGs in court proceedings is only one aspect of achieving this goal. In contrast to the IOM proposal, Avraham's model focuses on the guidelines themselves, and not on the procedures by which they were developed. In contrast to the old US model and the current UK model, Avraham's certifiers are not the government but the private market. The proposed regime purports to align society's incentives in a socially and economically efficient manner, thereby improving the quality of care and reducing costs.¹⁸⁷

In the most general terms, the Private Model would consist of private firms competing to provide evidence-based medical guidelines and to offer liability protection to complying providers. Doctors, especially solo practitioners, would be (at least in the beginning) required to purchase guidelines from a provider in order to be licensed by the state or as a condition of participation in government health programs. Because of the proposed "private regulatory-compliance defense" doctrine that is part of the model, CPG subscriptions fees under the Private Model would replace the medical malpractice insurance premiums that doctors currently pay.¹⁸⁸ As will be discussed, the price paid for CPGs should be lower than current medical malpractice insurance premiums because, assuming the doctor follows the guidelines, there will be no liability.

The Private Model achieves the triplet goals of improving the quality of care, increasing cost-efficiency and respecting patients' preferences for the tradeoff between risk and coverage.¹⁸⁹ Free market

¹⁸⁶ Michelle Mello also sees only a limited role for CPGs. She has argued that, given the current state of CPGs, they should not be used for inculpatory or exculpatory purposes. This is because CPGs did not generally represent the best practices in medicine. Mello instead advocated for expert's use of CPGs to supplement their testimony. Given the advances in CPGs since the 2001 article was published, it could be that Mello's views have changed. *See generally* Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645 (2001).

¹⁸⁷ The contours of the proposal are laid out in full in Avraham, *Private Regulation*, *supra* note 1.

¹⁸⁸ If a doctor was concerned about potential liability that much being incurred by the failure to follow a guideline for a given procedure, he or she might obtain insurance coverage but since the chance of that happening should be very small the corresponding premium would also be very low.

¹⁸⁹ Under the current system a patient can have no insurance, insurance with a high deductible that does not cover every treatment, or a "Cadillac" health insurance plan that has a low deductible and covers every conceivable treatment

competition should keep costs low and legal liability for producing inadequate guidelines would force private firms to keep patient safety high. In order to attract customers (patients) seeking to minimize costs, private regulators would be forced to offer competitively priced guidelines without sacrificing quality or ease of use. To achieve this, private regulators would have to discard unduly expensive or ineffective procedures. Defensive medicine would not be an option. At the same time, in contrast to current regimes in the US and the UK, and to the proposed regime by the IOM or Rosoff, patients would have a cause of action against the promulgating firm if the firm issued substandard guidelines that, directly or indirectly, caused injury to a patient. The fear of liability may well cause firms to push medical standards higher, elevating the general quality of health care.

Unlike other models, accountability is one of the pillars of the Private Model. This will ensure that the neutrality of CPGs is not a myth. Instead of a government agency that is subject only to administrative review of its rulemaking, the private firms would be held liable for damages caused by inefficient prescriptions. Moreover, unlike an agency, a private firm could expect to legitimately profit from making safer, more efficient standards. This proposal would also eliminate biased guidelines because they would be disciplined by market forces or legal liability. As a result, the influence of other interested actors – namely drug and device manufacturers – would substantially decrease. Lastly, unlike current medical practices a private firm's profit margin would be closely aligned with patient safety, so these firms would have the financial incentive to invest in continuous improvement without relying on groups that have a conflict of interest. At the same time, these firms would not feel so held hostage by the threat of litigation that they would advocate wasteful defensive medicine like unnecessary tests and procedures. Outside influences from other actors in the healthcare industry can probably not be eliminated completely, but the introduction of market forces via the Private Model should cause conflicts to substantially decrease.¹⁹⁰

The Private Model also successfully addresses the issue of inconsistent use. Health care providers, especially solo practitioners,

option. Under the Private Model there would also be variations. One can imagine a tiered system with different levels of CPGs that patients can choose much like they select their health insurance plans today. This model would more directly reflect patients' preferences regarding the cost and quality of care. For more on this, see Avraham, *Private Regulation*, *supra* note 1, at 631.

¹⁹⁰ Avraham, *Private Regulation*, *supra* note 1, at 584.

would be incentivized to use guidelines for two primary reasons. First, reduction in bias would lead to better guidelines, allowing doctors to trust their recommendations. The financial interests and professional responsibilities of providers would align, making it likely that they would utilize the techniques prescribed by the guidelines. With hundreds of available CPGs, often with conflicting recommendations, doctors will benefit from having the guideline producer review, synthesize, and approve CPGs. Through the Private Model doctors would not have to worry about multiple CPGs being certified for the same procedure. As it stands now it is impossible for doctors to keep current with new guidelines because of their volume, something the guideline producer is better situated to deal with. Second, if a doctor purchased the guidelines and followed them in treating patients, that person would be immune from malpractice liability. In other words, purchasing a CPG subscription from a firm would dilute the need for malpractice insurance, as long as the provider followed the guidelines. The sum effect of increased reliance on better guidelines and decreased liability should reduce costs throughout the entire system.

To provide optimal incentives to putative private “regulators”, the legal infrastructure would have to have these five characteristics: (1) guideline evaluation from the ex ante perspective, (2) recognition of a new legal doctrine called the private regulatory-compliance defense, (3) provision of intellectual property protection for issued guidelines, (4) elimination of the state-of-the-art defense, and (5) imposition of solvency requirements on private firms producing guidelines. It is possible that many of these will develop organically as healthcare players and judges recognize the benefits of such a system, but it is also possible that legislation would be required to fully implement this model. The five characteristics are detailed below.

First, in order to properly incentivize private guideline producers, those firms must be exposed to legal liability for promulgating sub-optimal guidelines. To create these optimal incentives, this liability must be judged in a courtroom from the ex ante perspective. This would avoid hindsight bias and, importantly, it would take into account all potential beneficiaries, not just the specific plaintiff in a case. Because firms know they could be subject to review at any time, they would be incentivized to develop efficient, impartial, and reliable guidelines.¹⁹¹

¹⁹¹ Without further protection, however, there would still be an incentive for overly safe guidelines. A simple way to deal with the problem is by using contracts between payers and providers that link reimbursements to the optimal level of

Second, in order to incentivize providers to purchase and follow guidelines, a private regulatory compliance defense, essentially a safe-harbor, would have to be added to the legal landscape. This defense would be available to any doctor or hospital that purchased guidelines *and* then followed them, and private regulatory compliance with guidelines would have to be a complete defense.¹⁹² Third, it may be necessary to provide intellectual property (IP) protection for CPGs. The concern is that, without protection, no private firm would have an incentive to develop CPGs. The fear is that as soon as a guideline was published, other firms would free-ride, thus making the production unprofitable.¹⁹³ Fourth, it would be necessary to eliminate the state-of-the-art defense. Some states currently allow defendants to escape liability if their product or procedure was state-of-the-art at the time it was originally made, even if research since that time has proven it to be dangerous.¹⁹⁴ Under the Private Model, this defense would have to be eliminated in claims against the guideline producers in order to incentivize firms to continuously research better medical procedures and incorporate them into their guidelines.

Fifth, the solvency of the private firms promulgating guidelines would be necessary. Otherwise, firms would have an incentive to

safety and cost-effectiveness. *See* Avraham, *Private Regulation*, *supra* note 1, at 594.

¹⁹² In order to maintain doctors' discretion failure to comply with CPGs will not determine she was negligent – the physician still has the opportunity to convince the court that its deviation was clinically justified. (Granted, given the respect CPGs will get in court the task of convincing the court will not be an easy one.) Thus, CPGs serve as a “short sword” to distinguish from a regular sword because deviating from them does not determine liability, but only make it harder for the defendant to win the case. We do not find this asymmetry problematic on Equal Protection grounds at all. Patients are not a suspect class and there is no fundamental interest involved. The Equal Protection analysis would follow the traditional rational basis review standard. The rational basis is the legislature's interest in lowering health care costs and rewarding doctors that follow certain standards of care while enabling individualized care when needed. Moreover, counter-intuitively, the short-sword property of CPGs, benefits doctors because it is this property that conserves their autonomy to deviate from the guidelines. And doctors' autonomy, as is well known, is extremely important to them. *See* Avraham, *Private Regulation*, *supra* note 1.

¹⁹³ *See* Avraham, *Private Regulation*, *supra* note 1.

¹⁹⁴ Traditionally limited to product liability cases, this defense has penetrated medical malpractice law. *See* RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY §§ 1–2 (1998).

promulgate overly risky guidelines because they would know that the worst thing that could happen is bankruptcy. The solvency guarantee could be obtained by requiring firms to have minimum assets or liability insurance.¹⁹⁵ These requirements would mirror the solvency requirements currently in place for insurance companies. As one can see, much of this reform could be accomplished with willing judges and/or private arrangements between relevant healthcare organizations.

While the multitude of changes needed to make this model work make it seem like more of a theoretical solution, entities in the medical field already operate under similar arrangements. In the health care market, there are already private companies that create and market guidelines. For example, McKesson is a company that provides CPGs as a part of its service package.¹⁹⁶ These proprietary guidelines are not made publically available and McKesson has research staff that continuously reviews new literature and revises its recommendations as new information emerges.¹⁹⁷ Other companies providing similar services include UpToDate, FirstConsult, and Dynamed, several of which cater specifically to general practitioners.¹⁹⁸ Further, these CPGs are integrated with other software tools to improve workflow and cost efficiency. This model is close to the Private Model proposal and provides hope that this system could be successful.

V. CONCLUSION

Putting effective CPGs in place is only one part of reforming the health care delivery system. Major structural reorganizations of health care delivery are also necessary – particularly for specialty services and the management of complex patients with multiple chronic diseases – and will be accompanied by radical changes in payment policy (e.g., bundled payment) and a serious commitment to outcomes measurement.

Still, process-based health policy tools such as CPGs will be very useful in the transition to an improved delivery system. An effective

¹⁹⁵ S. Shavell, *The Judgment Proof Problem*, 6 INT’L REV. L. ECON. 45 (1986); Steven Shavell, *Minimum Asset Requirements and Compulsory Liability Insurance as Solutions to the Judgment Proof Problem* (Nat’l Bureau of Econ. Research, Working Paper No. 10341, 2004).

¹⁹⁶ 2011 IOM Report, *supra* note 3, at 41.

¹⁹⁷ *Id.*

¹⁹⁸ Avraham, *Private Regulation*, *supra* note 1, at 612–13.

governance structure and accountability mechanism for CPGs need not solve every information or incentive problem in the health care system. But it must be broadly acceptable to physicians and the public, it must acknowledge the importance of cost-effectiveness as well as clinical effectiveness, and it must not become an independent power center that could end up working at cross-purposes to other goals and institutions that are critical components of health care reform.

Clinical practice guidelines serve an important role in helping physicians who will remain in independent practice navigate the challenging waters of health care reform. Going forward, CPGs should not be viewed primarily as a solution for problems with malpractice liability but as broader tools for quality improvement and cost reduction.¹⁹⁹ Moreover, malpractice liability itself should be accepted only as part of the solution to problems that plague the promulgation and dissemination of CPGs. Specifically, malpractice policies should be harnessed to help implement CPGs that can improve care.

I argue that the exclusive reliance on public or semi-public models by the 2011 IOM Report is misplaced, and other alternatives, including private competitive regimes, should be considered as well, especially for solo practitioners. Under the model selected by the IOM, issues with accountability and conflicts of interest in guideline production will continue to hinder the creation and widespread adoption of CPGs. CPGs must be promulgated with assurances of both substantive and procedural integrity, disseminated to providers in an accessible manner, and used appropriately by consumers and payers in addition to courts. This is likely to be true whether CPGs remain as standalone protocols or become embedded in other practice tools used by physicians in independent practice such as electronic medical decision aids, electronic health records with decision support, coding/billing software, and malpractice risk management guides. It is also applicable to new models of primary care based on advanced practice nurses rather than physicians or using interdisciplinary teams that constitute “medical homes” for patients. In the battle to reduce healthcare costs while improving patient care, CPGs are a powerful tool; but to be utilized to their full potential policymakers must

¹⁹⁹ Of course there still remains a place for CPGs in malpractice reform. For example, the Obama administration’s \$250 million package of grants to encourage states to overhaul their malpractice systems by, among other things, creating “safe harbor” laws based on CPGs may well prove beneficial. *See Walker, supra* note 108.

keep an open mind and be willing to consider proposals that are outside the box.

THE SOCIAL COSTS OF CHOICE, FREE MARKET IDEOLOGY AND THE EMPIRICAL CONSEQUENCES OF THE 401(K) PLAN LARGE MENU DEFENSE

MERCER BULLARD*

This article explores the recent “hidden-fee” litigation trend that has consumed the 401(k) world and how recent decisions by these courts will likely result in reduced wealth for workers. The author challenges the “large menu defense” espoused by the Third, Seventh and Eight Circuit Courts of Appeals as not fitting within the intent of ERISA’s “safe harbor.” In addition, the author questions the logic of these decisions by suggesting that courts are evaluating the employers’ legal responsibilities using free-market ideology rather than the fiduciary duties prescribed by ERISA and questions the belief that “large menu” pension benefit plans are wealth-maximizing.

In October 2008, just after the peak of the financial crisis, former Federal Reserve Board Chairman, Alan Greenspan, testified: “I do have an ideology. My judgment is that free, competitive markets are by far the unrivaled way to organize economies. We’ve tried regulation. None meaningfully worked.”¹ In fact, regulation has often worked and worked well, as illustrated by reforms in pension plan regulation. Investors often do behave like the rational actors on which the efficacy of free, competitive markets is based, especially when they are deciding whether to participate in their employers’ 401(k) plans. Many employees do not participate, even when their employers offer to match employees’ contributions. In 2006, Congress amended the Employee Retirement Security Income Act of 1974 (ERISA) to permit employers to automatically enroll their employees in the company’s 401(k) plan. As a result, plan participation rates have risen

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¹ *Financial Crisis and the Role of Government Regulators: Hearing Before the Comm. on Oversight and Gov’t Reform*, 110th Cong. 46 (2008). As the financial crisis unfolded around him, however, Chairman Greenspan acknowledged that he had become aware of a “flaw” in this ideology. *Id.*

dramatically. This regulatory “nudge” has increased the wealth of millions of Americans.

In a series of recent decisions, however, federal courts have taken positions that effectively *reduce* employee participation rates in 401(k) plans. They have exalted free market ideology in derogation of express regulatory mandates on the assumption that substituting their economic assumptions for legal requirements will maximize the wealth of 401(k) participants. Yet their faith in free markets is not grounded in any empirical foundation. In fact, their economic theories are directly contradicted by the overwhelming weight of empirical research, which shows that the effect of their decisions will reduce workers’ wealth rather than increase it. This collision of judicial free-market ideology and financial reality, the subject of this article, is costing American workers billions of dollars in lost pension benefits every year.

Over the last decade, a slew of lawsuits have consumed the 401(k) world, making a substantial amount of new case law and sending employers in search of experts to find ways to protect them from liability. This so-called “hidden-fee litigation” generally involves claims that employers and other pension benefit plan fiduciaries violated ERISA’s “prudent man” rule by selecting investment options that charge excessive fees and hide information about fees from participants. Some courts have dismissed claims against employers that offer a large number of investment options in their plans on the ground that, regardless of whether the employer acted imprudently, the legal cause of any resulting loss was the participant’s choice of the option(s) in which to invest. These courts consider large 401(k) menus to offer a kind of marketplace that trumps employers’ fiduciary obligations. This “large menu defense” creates an incentive for employers to increase the number of options in their 401(k) plans in order to minimize their ERISA liability risk.

These courts have ignored ERISA’s express imposition of liability on plan fiduciaries for failing to exercise due care in choosing plan investment options. Section 404(a) of the Act establishes a “prudent man” standard that requires, among other things, that plan sponsors choose investment options with due care. Section 404(c) provides a safe harbor (“404(c)” or “control” safe harbor) from Section 404(a) liability to the extent that a self-directed plan permits a participant “to exercise control over the assets in his account.” Under Section 404(c)’s authority, the Department of Labor (DOL) has adopted rules providing that a participant may be deemed to have exercised control if, among other things, the plan offers a “broad range of investment alternatives” that enables participants

to create portfolios with risk-return characteristics that are appropriate for the participant.

Some courts have deemed participants to have exercised control under the 404(c) safe harbor if a plan's range of options is so broad that, in the court's opinion, it approximates the range of options that would be available in a free market.² The availability of a large range of options thereby abrogates employer responsibility for imprudently selecting investment options. The large menu defense effectively substitutes judicial economic theories for statutory fiduciary duties, based primarily on the courts' ideological view, like Chairman Greenspan's, that participants' choices should be regulated by free market principles rather than under ERISA's fiduciary duties. The courts' view, consistent with widely accepted rational choice theory, is that offering the largest range of choices will maximize workers' wealth. Indeed, they view increasing choice, in and of itself, as a central purpose of ERISA.

This *de facto* judicial nullification of ERISA's prudent man rule would not be of such concern if the courts were correct that larger menus create wealth for workers. In that case, employers that increased the number of options in their plans in order to reduce their ERISA liability risk would also maximize the social benefits of 401(k) plans. However, empirical research shows that larger menus are *inversely* correlated with workers' wealth. Large 401(k) menus result in lower participation rates, overly conservative allocations, inferior investment options and other adverse effects that, collectively, cost workers billions of dollars every year. Notwithstanding the courts' views on rational choice theory, "a fully informed and fully rational investor would prefer a smaller menu."³

Section I of this article describes the legal framework for employers' liability under ERISA in connection with the selection of plan investment options. Section II discusses the large menu defense adopted by courts that have dismissed fiduciary claims against employers that were alleged to have selected options impudently. The courts' free-market rationale for the large menu defense is described in Section III, and Section IV sets forth the empirical research on the wealth-reducing effects of large menus in 401(k) plans. Section V concludes.

² See *infra* Section II.

³ David Goldreich & Hanna Halaburda, *When Smaller Menus Are Better: Variability in Menu-Setting Ability* 4 (Harvard Bus. Sch., Working Paper No. 11-086, 2011), available at <http://www.hbs.edu/faculty/Publication%20Files/11-086.pdf>.

I. BACKGROUND

ERISA generally applies to “employee benefit plans,” which are defined to include employee welfare benefit plans and employee pension benefit plans.⁴ This article is concerned with pension benefit plans, such as 401(k) plans, which are defined as funds or programs maintained by an employer that “(i) provide retirement income to employees, or (ii) result in a deferral of income by employees for periods extending to the termination of covered employment or beyond.”⁵ If an employer offers a pension benefit plan, ERISA requires that it identify at least one “named” fiduciary who is responsible for the administration of the plan. For example, the plan trustee is a named plan fiduciary. A person can also become a fiduciary by exercising discretion over plan assets or providing advice for a fee to the plan. A plan fiduciary can designate another person as a fiduciary and thereby shift their fiduciary responsibilities to that person.

A plan fiduciary is subject to two primary sets of duties under ERISA. First, Section 404(a) of ERISA subjects fiduciaries to a prudent man standard of care. They must act with the “care, skill, prudence, and diligence” that a “prudent man acting in a like capacity” would use in selecting investment options and diversifying the plan’s investments “so as to minimize the risk of large losses.” Section 404(a) also imposes a duty of loyalty. Fiduciaries must discharge their duties “solely in the interests of the participants and beneficiaries and for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan.”

Second, ERISA prohibits plan fiduciaries from engaging in a broad range of transactions with the plan. Specifically, Section 406(b) of ERISA prohibits fiduciaries from dealing with plan assets in the fiduciary’s “own interest,” acting on behalf of an adverse party in a transaction, or receiving any consideration from any party dealing with the plan in connection with a transaction involving the assets of the plan. Plan participants have a private right of action against fiduciaries to recover losses resulting from a breach of their obligations under ERISA.⁶ The breadth of Sections 404(a) and 406(b), coupled with a private right of action for damages, presents employers with significant liability risk.

⁴ 29 U.S.C. § 1003(a) (2006).

⁵ 29 U.S.C. § 1002(2)(A) (2006).

⁶ 29 U.S.C. § 1109(a) (2006).

To mitigate this risk, ERISA provides a number of statutory safe harbors for fiduciaries, which are supplemented by prohibited transaction exemptions and interpretive safe harbors promulgated by the DOL.⁷ Plan fiduciaries generally attempt to limit their liability by conforming their conduct to these safe harbors and exemptions. One of the most commonly relied-upon safe harbors is provided by Section 404(c)(1)(A)(ii) (“404(c)” or “control” safe harbor), which insulates fiduciaries from liability for losses resulting “from the participant’s or beneficiary’s exercise of control” over the assets in his account.

The DOL has set forth a number of conditions on the availability of the 404(c) safe harbor. These conditions include offering a diversified set of investment options and providing participants with sufficient information to evaluate them. A participant has “exercised control” if, among other things, he “has an opportunity to choose, from a broad range of investment alternatives, the manner in which some or all of the assets in his account are invested.”⁸ A “broad range of investment alternatives” has been provided if the participant has an opportunity to: (1) materially affect the potential return and degree of risk of the account; (2) diversify so as to minimize the risk of large losses; and (3) choose from at least three diversified investment options.⁹ These investment options must have materially different risk and return characteristics such that they can be combined in a portfolio with aggregate risk-return characteristics that are

⁷ See, e.g., 29 U.S.C. § 1108(b)(19) (2006) (exemption from Section 406(b)(2) for certain cross transactions); Class Exemption To Permit Certain Loans of Securities by Employee Benefit Plans, 71 Fed. Reg. 63,786 (Feb. 2, 2006) (exemption from Section 406(b)(1) with respect to securities lending activities); Class Exemption for Cross-Trades of Securities by Index and Model-Driven Funds, 67 Fed. Reg. 6614 (Feb. 12, 2002) (exemption from 406(b)(2) with respect to certain cross transactions involving passively managed funds); Class Exemption for Securities Transactions Involving Employee Benefit Plans and Broker-Dealers, 51 Fed. Reg. 41,686 (Nov. 18, 1986) (exemption from Section 406(b) to fiduciaries that execute transactions on behalf of a plan); Class Exemption for Certain Transactions Between Investment Companies and Employee Benefit Plans, 42 Fed. Reg. 18,732 (Apr. 8, 1977) (exemption for fiduciary when acting in capacity of investment adviser to mutual fund in which plan assets are invested); see also 15 U.S.C. § 78bb(e) (2012) (no breach of fiduciary duty solely by reason of receiving soft dollar benefits limited to brokerage and research services).

⁸ 29 C.F.R. § 2550.404c-1(b)(1)(ii) (2013).

⁹ 29 C.F.R. §2550.404c-1(b)(iii) (2013).

within the range that is appropriate for the participant and that tend to minimize the risk of the overall portfolio.

Over the last decade, a series of lawsuits against plan fiduciaries has challenged the edifice of safe harbors and exemptions on which they have come to depend. The plaintiffs in these lawsuits – lawsuits which are often referred to as “hidden fee litigation” – have generally claimed that plan fiduciaries violated their duties by offering investment options that charge excessive and/or hidden fees. Plaintiffs allege that fees were hidden because they were not disclosed to participants and excessive because the plans invested in retail classes of fund shares that made side payments to plan services providers (known as “revenue sharing” payments) rather than in less expensive institutional classes of shares. The hidden fee litigation has generated dozens of judicial decisions addressing a broad array of issues under ERISA.

This article focuses on the role that the size of a plan’s menu of investment options has played in the application of the 404(c) safe harbor and the disposition of these cases. As discussed immediately below, a number of courts have found that offering a large menu of investment options supports a finding that participants exercised control for purposes of the safe harbor. These courts have expressly rejected the DOL’s “paternalistic” view that plan fiduciaries are responsible for any options that have been imprudently included in the mix even when participants have been able to choose from a large number of alternatives.

II. THE LARGE MENU DEFENSE

In one set of hidden fee cases, courts have held that offering a large number of investment options can protect an ERISA fiduciary from liability, while offering a small number may increase a fiduciary’s legal exposure. The leading case for the “large menu defense” is *Hecker v. Deere & Co.*, in which the Seventh Circuit found that Deere’s offering of thousands of investment options in its 401(k) helped establish that, even if some options had been imprudently selected, Deere’s imprudence could not have been a legal cause of the plaintiffs’ losses.¹⁰ The court found that the large menu of investment options effectively placed the participant in control of his investment decisions, thereby relieving Deere of potential liability.

¹⁰ *Hecker v. Deere & Co.*, 556 F.3d 575, 584–87 (7th Cir. 2009).

In *Hecker*, a class of participants in Deere's 401(k) plan sued Deere for breaching its fiduciary duty to the plan by, among other things, selecting investment options that charged excessive, hidden fees. The plaintiffs generally alleged that the fees were excessive because: (1) the administrator of the plan was compensated indirectly through revenue sharing payments by the investment options in which the plans invested rather than directly from the plans themselves; and (2) those fees were not reasonable in view of the services provided. They argued that Deere violated its fiduciary duty by failing to exercise proper care in evaluating and selecting the investment options.

The district court granted the defendants' motion to dismiss on the ground that Deere was protected by ERISA's 404(c) safe harbor. As noted above, the 404(c) safe harbor insulates fiduciaries from liability for any loss that "results from the participant's or beneficiary's exercise of control" over the assets in his account. The court found that Deere had satisfied the 404(c) safe harbor by offering a large number of investment options.¹¹ The plan offered twenty-three Fidelity mutual funds, two funds managed by Fidelity Trust, an employer stock fund, and an investment window that provided access to more than 2,500 funds managed by different companies.¹² The district court found that, in light of the large number of investment options and the impossibility of every one of them having an excessive expense ratio, "[t]he only possible conclusion is that to the extent participants incurred excessive expenses, those losses were the result of participants exercising control over their investments within the meaning of the safe harbor provision."¹³ Whether Deere exercised due care in selecting the investment options did not matter to the court: "[a]ssuming . . . that defendants failed to satisfy their fiduciary obligation to consider expenses when selecting mutual fund investment options, they are nevertheless insulated from liability by the safe harbor provision because of the nature and breadth of funds made available to participants under the plans."¹⁴

On appeal, the Seventh Circuit agreed that Deere had "include[d] a sufficient range of options so that the participants have control over the risk

¹¹ Although the 404(c) safe harbor is an affirmative defense that normally would not be available at the pleading stage, the court found that the plaintiffs had opened the door to defense by anticipating the safe harbor in their complaint.

¹² 556 F.3d at 578.

¹³ *Hecker v. Deere & Co.*, 496 F. Supp. 2d 967, 976 (W.D. Wis. 2007).

¹⁴ *Id.* at 976.

of loss.”¹⁵ Assuming that Deere had a duty to “furnish an acceptable array of investment vehicles,” the court found that the “wide range of expense ratios among the 20 Fidelity mutual funds and the 2,500 other funds available through [the plan]” satisfied this duty.¹⁶ Any losses experienced by participants were “attributable to their individual choices. Given the numerous investment options, varied in type and fee, neither Deere nor Fidelity . . . can be held responsible for those choices.”¹⁷

The Third Circuit adopted *Hecker’s* large menu defense in *Renfro v. Unisys Corp.*¹⁸ In *Renfro*, a class of participants in Unisys Corporation’s 401(k) plan sued Unisys for breach of fiduciary duty under ERISA. As in *Hecker*, the plaintiffs claimed that defendants’ selection of investment options was imprudent because the options charged revenue sharing payments that were hidden and excessive. The plan, one of the largest one percent of 401(k) plans in the U.S., held approximately \$2 billion in more than seventy different investment options. Nearly \$1.9 billion of that amount was held in “Fidelity-branded” retail mutual funds that plaintiffs alleged had charged excessive fees.

The district court granted Unisys’s motion to dismiss on the ground that “no rational trier of fact could find, on the basis of the facts alleged in the operative complaint, that the Unisys Defendants breached an ERISA fiduciary duty by offering this particular array of investment vehicles.”¹⁹ The court, citing *Hecker* in support, found that Unisys could not be held liable for the selection of investments because it had offered a broad range of investment alternatives, regardless of whether it had placed any inappropriate investment options in the plan.²⁰ The participants “could choose from among the investment options to create a portfolio tailored to meet their investment objectives,”²¹ which insulated Unisys from liability. The court considered Unisys’s large menu to support both a Rule 12(b)(6)

¹⁵ 556 F.3d at 589.

¹⁶ *Id.* at 586.

¹⁷ *Id.* at 590.

¹⁸ *Renfro v. Unisys Corp.*, 671 F.3d 314 (3d Cir. 2011).

¹⁹ *Renfro v. Unisys Corp.*, No. 07-2098, 2010 WL 1688540, at *5 (E.D. Pa. Apr. 26, 2010).

²⁰ *Id.* at *9.

²¹ *Id.* at *5.

motion to dismiss and a summary judgment motion based on the 404(c) safe harbor.²²

The Third Circuit declined to rule on the safe harbor issue, but affirmed the Rule 12(b)(6) dismissal of the complaint on the basis of the large menu defense. The court observed that the plan included “seventy-three distinct investment options . . . company stock, commingled funds, and mutual funds . . . [representing] a variety of risk and fee profiles,”²³ thereby accomplishing ERISA’s purpose of “offer[ing] participants meaningful choices about how to invest their retirement savings.”²⁴ Following *Hecker’s* lead, the court found that offering a large number of investment options insulated Unisys from liability as to the particular options it had selected for the plan.

The district court in *Renfro* took *Hecker* one step further by raising the possibility that, if the number of funds were a factor supporting liability, liability might arise from the offering of too *few* investment options in a plan, not too *many*. The court observed that, while the plan in *Hecker* included more than 2,500 options, “the *Hecker* court in no way indicated that fiduciaries to an ERISA plan breach their duty when they offer less than a few thousand investment options to plan participants.”²⁵ In fact, a court had already found that offering too few options might increase a plan sponsor’s liability risk.

In *Braden v. Wal-Mart*, the Eighth Circuit found that the relatively small number of investment options in Wal-Mart’s 401(k) provided support for plaintiffs’ claim that Wal-Mart had managed the plan imprudently.²⁶ As in *Hecker* and *Renfro*, a class of 401(k) participants alleged that the plan’s fees were excessive and hidden, and that Wal-Mart had failed adequately to investigate lower-cost alternatives. The Wal-Mart plan offered only “ten mutual funds, a common/collective trust, Wal-Mart common stock, and a stable value fund.” The court characterized the plaintiffs as alleging that the “[p]lan include[d] a relatively limited menu of funds which were selected by Wal-Mart executives despite the ready availability of better

²² Although the court did not rely on the control safe harbor *per se* in granting the motion to dismiss, it effectively adopted the safe harbor’s reasoning. The following discussion treats this court as having applied the control safe harbor.

²³ 671 F.3d at 327.

²⁴ *Id.*

²⁵ *Renfro*, 2010 WL 1688540, at n.6.

²⁶ *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585 (8th Cir. 2009).

options.”²⁷ It specifically compared Wal-Mart’s small menu of options with the 2,500 mutual funds offered by the plan in *Hecker*, and quoted the *Hecker* court’s finding that it was “untenable to suggest that all of the more than 2,500 publicly available investment options had excessive expense ratios.”²⁸ In contrasting the present facts with *Hecker*, the court concluded that “[t]he far narrower range of investment options available in this case makes more plausible the claim that this Plan was imprudently managed.”²⁹

The *Renfro* court made the inverse relationship between *Hecker*’s large menu defense and *Braden*’s small menu stigma explicit in describing the cases as sharing a “similar analytical framework”: “Both courts looked first to the characteristics of the mix and range of options and then evaluated the plausibility of claims challenging fund selection against the backdrop of the reasonableness of the mix and range of investment options.”³⁰ The court in *Renfro* viewed small-menu *Braden* as taking the same approach as large-menu *Hecker* in declining to dismiss “in light of a plan that had far fewer available investment options than the plan in *Hecker*.”³¹

The large menu defense caught the attention of the DOL, which objected to the Seventh Circuit’s analysis in *Hecker*. In an *amicus* brief, the DOL complained that the court’s decision would provide a defense for a fiduciary’s imprudent selection of investment options if the fiduciary

²⁷ *Id.* at 596.

²⁸ *Id.* at n.6 (quoting *Hecker*, 556 F.3d at 581).

²⁹ *Id.* (emphasis added); see *Ruppert v. Principal Life Ins. Co.*, 796 F. Supp. 2d 959, 963 (S.D. Iowa 2010) (citing argument that limited menu in *Braden*, compared with large menu in *Hecker*, made imprudent management claim more plausible); *Tibble v. Edison Int’l*, 711 F.3d 1061, 1083 (9th Cir. 2013) (reiterating the argument in *Ruppert*).

³⁰ *Renfro v. Unisys Corp.*, 671 F.3d 314, 326 (3d Cir. 2011).

³¹ *Id.* at 327. (“We agree with our sister circuits’ approach to evaluating these claims. An ERISA defined contribution plan is designed to offer participants meaningful choices about how to invest their retirement savings. Accordingly, we hold the range of investment options and the characteristics of those included options – including the risk profiles, investment strategies, and associated fees – are highly relevant and readily ascertainable facts against which the plausibility of claims challenging the overall composition of a plan’s mix and range of investment options should be measured.”).

simply selected a large number of options.³² In response, the Seventh Circuit acknowledged that such a strategy would “result in the inclusion of many investment alternatives that a responsible fiduciary should exclude [and] . . . place an unreasonable burden on unsophisticated plan participants who do not have the resources to pre-screen investment alternatives.”³³ This concession seemed to reflect the court’s reconsideration of the large menu defense, but the court said nothing about this “burden on unsophisticated plan participants” lessening their ultimate responsibility for losses under the safe harbor. Nor did the court disavow the dispositive weight afforded to the offering of a large number of investment options in determining whether the participant had exercised control over his account.

The Seventh Circuit soon removed any doubt about its commitment to the large menu defense. In *Loomis v. Exelon Corp.*,³⁴ the court relied on *Hecker*’s large menu defense to dismiss hidden-excessive fee claims against Exelon Corp.³⁵ Its understanding of *Hecker* and *Hecker II* was unambiguous: “By offering a wide range of options, *Hecker* held, Deere’s plan complied with ERISA’s fiduciary duties. Plaintiffs contend that the

³² Amended Brief of the Sec’y of Labor, Elaine Chao, as Amicus Curiae in Support of Plaintiffs-Appellants, *Hecker v. Deere & Co.*, 2008 WL 5731147 (7th Cir. April 4, 2008) (No. 08-1224).

³³ *Hecker v. Deere & Co.*, 569 F.3d 708, 711 (7th Cir. 2009) [hereinafter *Hecker II*]. Phyllis Borzi, the Assistant Secretary for the Employee Benefits Administration, has cited finding “‘a disturbing trend’ among plan sponsors seeking to avoid ERISA responsibility by ‘just giving choices’” in reference to 401(k) brokerage account windows. Hazel Bradford, *Borzi: Sponsors Have Always Been Responsible for Monitoring Brokerage Windows*, PENSION & INVESTMENTS (June 18, 2012), <http://www.pionline.com/article/20120618/DAILYREG/120619900/borzi-sponsors-have-always-been-responsible-for-monitoring-brokerage-windows>. This statement was made in the context of guidance issued by the Department of Labor (“DOL”) in May 2012 that took the position that employers may be responsible for decisions made within a 401(k) brokerage account window. See Robert Steyer, *Labor Department Stands Firm on Self-Directed Brokerage Account Guidance*, PENSION & INVESTMENTS (Aug. 6, 2012), <http://www.pionline.com/article/20120601/DAILYREG/120609983/labor-department-stands-firm-on-self-directed-brokerage-account-guidance>. The DOL later withdrew that position under industry pressure. See Robert Steyer, ‘Intensive’ Lobbying Behind DOL Turnabout on DC Plan Brokerage Window, PENSION & INVESTMENTS (Aug. 6, 2012), <http://www.pionline.com/article/20120806/PRINTSUB/308069984>.

³⁴ *Loomis v. Exelon Corp.*, 658 F.3d 667 (7th Cir. 2011).

³⁵ *Id.*

panel in *Hecker* retreated from this holding when denying a petition for rehearing [in *Hecker II*]. It did not.”³⁶

The court characterized *Hecker* as having “held that as a matter of law that [Deere offered] an acceptable array of investment options, observing that ‘all of these funds were also offered to investors in the general public, and so the expense ratios necessarily were set against the backdrop of market competition.’”³⁷

The *Loomis* court applied the *Hecker* large menu defense in finding that Exelon could not be faulted if it selected hidden excessive fee options for the plan because, with thirty-two investment options to choose from,

³⁶ *Id.* at 670. Notwithstanding the court’s definitive statement that *Hecker II* did not represent a change in the court’s position, the DOL has argued that *Hecker II* “backed away” from the “breadth of its earlier ruling,” citing the Seventh Circuit’s subsequent decision in *Howell*. *Howell v. Motorola, Inc.*, 633 F.3d 552 (7th Cir. 2011). *See* Brief for the Sec’y of Labor as Amicus Curiae in Support of Plaintiffs-Appellants, *Tibble v. Edison Int’l*, 2011 WL 2178417 at *24 (9th Cir. May 25, 2011) (No. 10-56415) (quoting *Howell*, 633 F.3d at 567 (citing *Hecker*, 569 F.3d at 708)). However, *Howell* involved the prudence of offering an employer stock option in the plan, and courts have applied a different, arguably inconsistent standard in cases involving employer stock. *Howell*, 633 F.3d. at 567. *Howell’s* position on the responsibility of employers for imprudently selecting employer stock as an option directly contradicts the same court’s position on the selection of other types of options: “The choice of which investments will be presented in the menu that the plan sponsor adopts is not within the participant’s power. It is instead a core decision relating to the administration of the plan and the benefits that will be offered to participants. . . . It is . . . the fiduciary’s responsibility . . . to screen investment alternatives and to ensure that imprudent options are not offered to plan participants. *Id.* Although beyond the scope of this article, it is worth noting that courts such as *Howell* have been more willing to second-guess employers’ choice of employer stock as an option than diversified mutual funds notwithstanding that ERISA provides a specific statutory safe harbor for employer stock. *See* 29 U.S.C. § 1104(a)(2) (2011); *see, e.g.*, *Pfeil v. State Street Bank & Trust Co.*, 671 F.3d 585 (6th Cir. 2012); *Peabody v. Davis*, 636 F.3d 368 (7th Cir. 2011); *DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410 (4th Cir. 2007); *Langbecker v. Elec. Data Sys. Corp.*, 476 F.3d 299 (5th Cir. 2007); *Dann v. Lincoln Nat’l Corp.*, 274 F.R.D. 139 (E.D. Pa. 2011).

³⁷ *Loomis*, 658 F.3d at 670 (quoting *Hecker*, 556 F.3d at 586). *See Spano v. Boeing*, 633 F.3d 574, 586 (7th Cir. 2011) (“*Cf. Hecker*, 556 F.3d 575, 584–87 (7th Cir. 2009) (noting that the record showed sufficient variety in investments and fee levels to satisfy ERISA requirements)”; *Loomis v. Exelon Corp.*, No. 06 CV 4900, 2009 WL 4667092 at *3 (N.D. Ill. Dec. 9, 2009) (endorsing *Hecker’s* “sufficient mix of investments defense”).

“[a]ny participant who want[ed] a fund with expenses under 0.1% can get it through Exelon's Plan.”³⁸ The court appeared to believe that the employer did not have a fiduciary duty to abjure excessive or hidden fee investment options for its plan because the large number of options offered ensured that at least one low-cost option was available.

Thus, the Third, Seventh and Eighth Circuits have taken the position that a large 401(k) menu can protect a plan fiduciary from liability for imprudently selecting investment options for the plan. Even assuming that the plan fiduciary violated Section 404(c)'s prudent man standard in the selection of investment options, the availability of a large number of options abrogated the fiduciary's legal responsibility under ERISA. Conversely, offering a small menu of investment options, as in *Wal-Mart*, made it “more plausible” that the plan was imprudently managed. The large menu defense courts view participants as having exercised safe harbor control when the number of investment options is large enough that the participants' choices become the effective, proximate cause of any losses resulting from, for example, excessive fees.

Although no other court has directly addressed the large menu defense, the Ninth Circuit has rejected the mainstay of the large menu defense theory that employers' responsibility for imprudently selecting investment options can be abrogated in the context of a menu of diversified investment options. In *Tibble v. Edison Int'l*, the court explained that treating a participant's act of choosing an investment option as abrogating the employer's responsibility for selecting options could not be reconciled with the plain meaning of the statute.³⁹ The court found that considering the participant's investment decision as an intervening cause of the participant's loss, *i.e.*, a safe-harbor exercise of control, “would render parts of the ERISA statute a nullity by making it nearly impossible for defined-contribution-plan beneficiaries to vindicate fiduciary imprudence.”⁴⁰ Defendants in ERISA cases would *always* be able to pass

³⁸ *Loomis*, 658 F.3d at 671.

³⁹ *Tibble v. Edison Int'l*, 711 F.3d 1061, 1074 (9th Cir. 2013). In *Tibble*, the court affirmed the district court's finding that the employer had imprudently failed to consider the potential cost savings of selecting institutional rather than retail classes of mutual fund shares. During the relevant period, the plan at issue offered from six to fifty investment options. *See* *Tibble v. Edison Int'l*, 639 F. Supp. 2d 1074, 1081 (C.D. Cal. 2009). Neither the district court nor the Ninth Circuit addressed the issue of the size of the menu.

⁴⁰ *Tibble*, 711 F.3d at 1074 (citing *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 256 (2008) (citing the DOL's regulations implementing section

responsibility for losses to participants because “there can be no loss without the participant selecting an investment.”⁴¹ The *Tibble* court agreed with the DOL’s view that the employer’s selection of investment options necessarily precedes the participant’s investment decision and therefore should reasonably be viewed as the most salient cause of losses arising from the inclusion of a particular option in the 401(k) menu.⁴² As explained in *Tibble*, the large menu defense contradicts the plain meaning of the control safe harbor.

The large menu defense interpretation of the control safe harbor also fails because it misreads the purpose of the safe harbor’s “broad range of investment alternatives” requirement. The courts view the broad-range requirement as reflecting a policy favoring large menus, as if its purpose were to maximize participant choice. The *Renfro* court stated that “[a]n ERISA defined contribution plan is designed to offer participants meaningful choices,”⁴³ which *Loomis* echoed in characterizing the 404(c) safe harbor as “encourag[ing] sponsors to allow more choice to participants in defined-contribution plans.”⁴⁴ The courts interpret the safe harbor’s diversification requirement as reflecting Congress’s wish that employers offer as many options as feasible to provide participants with the greatest possible control over their investments.

This choice-for-choice’s sake view misunderstands that the broad-range requirement is designed to promote diversification, not large menus. It is intended to incentivize employers to offer menus that enable participants to construct an efficient portfolio with appropriate risk-return characteristics.⁴⁵ The diversification purpose of the broad-range

404(c) in rejecting the converse interpretation) and *Langbecker*, 476 F.3d at 321 (Reavley, J., dissenting) (“All commentators recognize that § 404(c) does not shift liability for a plan fiduciary’s duty to ensure that each investment option is and continues to be a prudent one.”)).

⁴¹ *Tibble*, 711 F.3d at 1073 (“For a 401(k) (or for any defined-contribution plan for that matter), it is admittedly the case that monetary damage flowing from a fiduciary’s imprudent design of the investment menu passes through the participant, as intermediary. But is it proper to conclude that those losses, in the language of section 404(c), ‘result from’ the participant’s choice? This might seem an odd question given that, literally speaking, there can be no loss without the participant selecting an investment.”).

⁴² *Id.*

⁴³ *Renfro v. Unisys Corp.*, 671 F.3d 314, 327 (3d Cir. (2011)).

⁴⁴ *Loomis v. Exelon Corp.*, 658 F.3d 667, 673 (7th Cir. 2011).

⁴⁵ A “broad range of investment alternatives” has been provided if the

requirement is illustrated by the following example. If a participant who planned to retire in 2008 had invested 100% of her assets in stock funds (which would have declined precipitously that year), that unfortunate allocation decision would have reflected her exercise of control if the employer had provided a diversified menu of options, including fixed income options in which she could have invested to create a more appropriate portfolio.⁴⁶ The allocation would have been entirely outside the employer's control.⁴⁷ In contrast, if the stock funds that she chose were

participant has an opportunity to: (1) materially affect the potential return and degree of risk of the account; (2) diversify to as to minimize the risk of large losses; and (3) choose from at least three diversified investment options. These investment options must have materially different risk and return characteristics such that they can be combined in a portfolio: (1) with aggregate risk-return characteristics that are within the range that is appropriate for the participant and (2) that tends to minimize the risk of the overall portfolio. *See* 29 C.F.R. § 2550.404c-1.

⁴⁶ As stated by the Seventh Circuit in an employer-stock option case, "it would make no sense [under the 404(c) safe harbor] to blame the fiduciary for the participant's decision to invest 40% of her assets in Fund A and 60% in Fund B, rather than splitting assets somehow among four different funds, emphasizing A rather than B, or taking any other decision." *Howell v. Motorola, Inc.*, 633 F.3d 552, 567 (7th Cir. 2011). (As noted earlier, the Seventh Circuit has not applied its analysis in employer-stock cases to cases involving the selection of other types of investment options.) The *Hecker* and *Loomis* courts effectively held that choosing an excessive fee option over a non-excessive fee option from a large menu is the equivalent of choosing Fund A over Fund B, in that the participant's decision is the proximate cause of both decisions. But the *Hecker* and *Loomis* analysis does not make sense as an interpretation of the DOL's "broad range" requirement. That requirement is designed to produce a menu with diversified risk/return characteristics; it is not designed to produce a menu that is diversified in the sense of offering a mix of excessive and non-excessive fee options.

⁴⁷ Although the participant's allocation may have been the legal cause of the losses, research shows that the selection of the menu, even if it is adequately diversified, also bears a causal relationship to the participant's allocation. For example, participants will invest a much higher percentage of plan assets in stock funds when a plan offers a mix of four stock funds and one bond fund than when the plan offers a mix of one stock fund and four bond funds. *See* Shlomo Benartzi & Richard H. Thaler, *Naive Diversification Strategies in Defined Contribution Saving Plans*, 91 AM. ECON. REV. 79, 87 (2001) (finding that when equity options comprised a larger percentage of hypothetical options, study subjects invested a larger percentage of accounts in equities than when equity options comprised a smaller percentage of options), *available at* <http://www.anderson.ucla.edu/>

imprudently selected because they charged excessive fees, then the employer would be responsible for the losses due to the excessive fees. Although the employee chose the excessive fee option, and there may have been stock funds in the menu that did not charge excessive fees, the employer's selection of the options would have been the proximate, preceding cause of the loss. Whether the total number of options was large or small is irrelevant to the employer's responsibility for the imprudent selection of the excessive fee option.

In summary, some courts have dismissed claims that an employer violated the prudent man standard by placing excessive fee investment options in its 401(k) plan based on a large menu defense. The courts have reasoned that when a 401(k) plan offers a large number of investment options, any losses due to the imprudent selection of an investment option resulted not from the employer's selection of the investment option, but from the participant's exercise of control in choosing to invest in the option. This position is inconsistent with ERISA because the preceding proximate cause of losses due to the inclusion of an imprudently selected investment in the plan is, in fact, the employer's decision to include the investment in the plan. The courts' large menu defense cannot be reconciled with a reasonable reading of the control safe harbor. The courts also seem to misunderstand that the purpose of the safe harbor's legal incentives to offer a broad range of investment alternatives is not to inflate the size of 401(k) menus, but to encourage employers to offer an appropriately diverse set of options. However, the large menu defense may reflect less of a disagreement about the nature of causation or the meaning of the safe harbor than a more fundamental ideological view that the regulation of plan participants' 401(k) investments should be left to the marketplace rather than ERISA's fiduciary duties.

documents/areas/fac/accounting/naive_diversification.pdf; see also Jeffrey Brown et al., *Individual Account Investment Options and Portfolio Choice: Behavioral Lessons from 401(K) Plans* (NBER Working Paper, No. 13169, June 2007) (increasing equity fund representation from 1/3 to 1/2 of menu increased participants' equity allocations by 7.5%) ("*Behavioral Lessons*"), available at http://www.nber.org/papers/w13169.pdf?new_window=1; Anders Karlsson et al., *Portfolio Choice and Menu Exposure*, EFA 2006 Zurich Meetings (February 7, 2006) (likelihood of option being chosen increases with its representation in menu), available at <http://ssrn.com/abstract=888661> or <http://dx.doi.org/10.2139/ssrn.888661>.

III. FREE MARKETS, LARGE MENUS AND THE FIDUCIARY STANDARD

The remainder of this article discusses two major concerns regarding the large menu defense. The first concern is that the large menu defense evinces a judicial decision to evaluate employers' legal responsibilities on the basis of judges' free market ideology instead of employers' fiduciary duties under ERISA. These judges prefer that economic activities be allowed to operate pursuant to free market axioms, which conflicts with the imposition of a fiduciary duty on employers. The large menu defense reflects the particular free market axiom that offering plan participants the widest possible range of choice in their 401(k) plans maximizes social wealth. However, this position is fundamentally incompatible with the mandate in ERISA to enforce the paternalistic principles that a fiduciary duty inherently entails, as discussed further in this section. The second concern presented by the large menu defense, as discussed in Section IV, is that the courts' view that large 401(k) menus are wealth-maximizing is empirically false. Large 401(k) menus make workers poorer, not wealthier.

The large menu defense is generally based on the view that free market principles are superior to fiduciary duties in regulating employers' selections of 401(k) investment options. The defense views a large 401(k) menu as effectively a marketplace in which the only legally controlling factor is the participant's role in choosing an investment. Courts in favor of the large menu defense found that participants were responsible "because of the nature and breadth of funds made available," "the numerous investment options," and "the wide range of expense ratios among" the funds offered. The plans offered a "variety of risk and fee profiles" constituting "meaningful choices about how to invest their retirement savings" and included enough investment options from which "to create a portfolio tailored to meet [participants'] investment objectives."

A plan that replicates an open marketplace effectively abrogates the employer's legal responsibility for selecting investment options for the plan. In contrast, Wal-Mart's "narrower range of investment options" made "it more plausible . . . that the Plan was imprudently managed" because the invisible hand of the market was replaced with the visible hand of the employer. Where the number of plans is small, the employer may be faulted for interfering with free market forces by narrowing participants' investment decisions to an artificially limited set. If employers allow the invisible hand free reign, then they will be relieved of liability.

This ideology is illustrated in *Hecker*, as quoted approvingly in *Loomis*, where the court notes that Deere's 401(k) funds "were also offered to investors in the general public, and so the expense ratios necessarily were set against the backdrop of market competition."⁴⁸ The *Renfro* court was similarly skeptical of plaintiffs' claim that fees were excessive with respect to "funds that are available on the same terms to individual investors in the open market."⁴⁹ In *Loomis*, it did not matter that an employer chose excessive fee options for the plan; "[a]ny participant who want[ed] a fund with expenses under 0.1% [could] get it through Exelon's Plan."⁵⁰ The courts' marketplace theory of liability essentially finds that an employer can shed its fiduciary role in selecting 401(k) investment options by choosing a menu that replicates the marketplace.

The market-based criteria on which these courts based the large menu defense contradict not only the plain meaning of the control safe harbor, as discussed *supra* in Section II, but also the essential nature of the fiduciary duty. Judge Cardozo's iconic characterization of the fiduciary duty in *Meinhard v. Salmon* tees up the fundamental conflict between fiduciary duties and market-based principles:

Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.⁵¹

In the fiduciary context, pure market dynamics cannot be relied upon to yield the sought-after social benefits of commercial activities. Fiduciary principles, therefore, are not circumscribed by the rules that apply to commercial, "arm's length" relationships, but are based on non-market criteria because markets are not always efficient. Inefficiencies can reduce the social utility of market-based transactions. These inefficiencies may arise from a host of factors, including unequal bargaining positions, informational asymmetries, monopoly power, bounded rationality and/or

⁴⁸ See *supra* note 37.

⁴⁹ *Renfro v. Unisys Corp.*, 671 F.3d 314, 326 (3d Cir. 2011).

⁵⁰ *Loomis*, 658 F.3d at 671.

⁵¹ *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

rent-seeking regulation.⁵² Judge Cardozo may not have been thinking in terms of economic theory yet to take concrete form, but he nevertheless understood that, in the face of market inefficiencies, “honesty alone,” *i.e.*, requiring only that a fiduciary refrain from fraud or other misrepresentation, was inadequate to ensure that free market activities would increase, rather than reduce, net social wealth.

Common law and statutory fiduciary duties reflect, respectively, courts’ and legislators’ decisions to modify or supplant market forces with external rules in situations in which market-based principles are likely to fail to create the social benefits of commercial activities. While there is a robust scholarship about when and to what extent fiduciary duties are actually wealth-maximizing,⁵³ there is general agreement with the position that fiduciary duties are intended to and do, in fact, modify or supplant market forces. They reflect an inherently paternalistic view that, when fiduciary duties apply, courts and legislatures should redirect the natural course of commerce even if doing so replaces the usually wealth-maximizing decisions of rational economic actors with the judgment of government actors.

In short, courts applying the large menu defense simply disagree with Congress’s decision to impose fiduciary duties on employers when selecting 401(k) investment options. The *Loomis* court revealed the ideological nature of its disagreement with Congress in charging that the problem in that case was that the “[p]laintiffs’ theory is paternalistic.”⁵⁴ This statement, taken literally, is absurd because the legal theories underlying a fiduciary claim are necessarily paternalistic. ERISA is paternalistic to its core. The Congressional findings and declaration of policy in ERISA speak of protecting the interests of plan beneficiaries “by establishing standards of conduct, responsibility, and obligation for

⁵² See, e.g., Restatement (Third) of Trusts § 78 cmt. b (2007).

⁵³ See, e.g., FRANK H. EASTERBROOK & DANIEL R. FISCHER, *THE ECONOMIC STRUCTURE OF CORPORATE LAW* (1996) (discussing the scope of managers’ duties in the context of the corporation and the corporate contract). See also Paul Mahoney, *The Common Law and Economic Growth: Hayek Might be Right* (Univ. of Virginia Law School Legal Studies, Working Paper No. 00-8, Jan. 2000) (finding higher rates of real per capita growth in common law economies); Ross Levine et al., *Financial Intermediation and Growth: Causality and Causes* (World Bank Policy Research, Working Paper No. 205, Feb. 1999) (finding that common law systems enhance financial intermediary development, which causes higher economic growth), available at <http://ssrn.com/abstract=247793>.

⁵⁴ 658 F.3d at 673.

fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.”⁵⁵ Congress sought to protect the interests of participants “by improving the equitable character and the soundness of such plans.”⁵⁶ These broad, paternalistic goals look to decidedly non-market-based rules to regulate the operation of pension benefit plans.

The ERISA prudent man and prohibited transaction rules give concrete form to the paternalistic structure and purpose of ERISA. Employee pension plans are *required* to have a fiduciary and a fiduciary is *required* to assume fiduciary duties with respect to the structure and operation of the plan, including selecting investment options in the plan. ERISA’s prohibited transaction rules narrowly circumscribe or flatly prohibit transactions that normally would be subject only to the rules that apply to arm’s-length deals. ERISA empowers employers to automatically enroll employees in a plan and invest an employer-determined percentage of the employee’s wages in an employer-selected investment option when employees have not affirmatively taken these steps themselves.⁵⁷

Regardless of whether ERISA’s paternalism is good policy, its paternalism is undeniable. It is difficult to understand how the *Loomis* court could criticize the “[p]laintiffs’ theory” for being “paternalistic” when the private cause of action on which the theory is based is intrinsically paternalistic. This contradiction is sharpened by the fact that the *Loomis* opinion’s author, Judge Frank Easterbrook, established his reputation as a scholar by elucidating the paternalistic nature of fiduciary duties and identifying situations in which he believed that fiduciary duties should be waivable or eliminated.

As a member of the judiciary, Judge Easterbrook has previously attempted, albeit unsuccessfully, to substitute a market-based test for an express fiduciary duty under federal law. In *Jones v. Harris Associates*

⁵⁵ 29 U.S.C. § 1001(b) (2006).

⁵⁶ 29 U.S.C. § 1001(c) (2006).

⁵⁷ ERISA’s automatic enrollment provision is the regulatory policy most extensively discussed in Richard Thaler’s and Cass Sunstein’s best-seller, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS*, which is based on a regulatory model that they call “libertarian paternalism.” RICHARD THALER & CASS SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

L.P.,⁵⁸ he authored the opinion that affirmed the dismissal of a claim under section 36(b) of the Investment Company Act of 1940, which provides that “the investment adviser of a registered investment company shall be deemed to have a *fiduciary duty* with respect to the receipt of compensation for services.”⁵⁹ Prior to *Jones*, courts had generally interpreted section 36(b) under a fiduciary standard established by the Second Circuit twenty-five years earlier in *Gartenberg v. Merrill Lynch Asset Management, Inc.*⁶⁰ The Seventh Circuit rejected the *Gartenberg* standard in holding that the fiduciary duty under section 36(b) could only be violated if the fees paid were “‘so unusual’ as to give rise to an inference ‘that deceit must have occurred, or that the persons responsible for decision have abdicated.’”⁶¹ As in *Loomis*, the court’s decision was based on its view that market forces, not fiduciary duties, should be the exclusive determinant of prices, and that “honesty alone” *was* enough.

The Supreme Court unanimously reversed the Seventh Circuit’s *Jones* decision.⁶² The Court’s analysis is instructive as to the incompatibility of strictly market-based rules of construction and the intrinsically paternalistic nature of the fiduciary duty. It pointedly summarized the Seventh Circuit’s *Jones* analysis as follows:

The panel argued that this [deceit-based] understanding of § 36(b) is consistent with the forces operating in the contemporary mutual fund market. Noting that “[t]oday thousands of mutual funds compete,” the panel concluded that “sophisticated investors” shop for the funds that produce the best overall results, “mov[e] their money elsewhere” when fees are “excessive in relation to the results,” and thus “create a competitive pressure” that

⁵⁸ *Jones v. Harris Assocs. L.P.*, 537 F.3d 728 (7th Cir. 2008), *vacated* 559 U.S. 335, 353 (2010). In the interests of full disclosure, this author was an expert witness in *Jones*.

⁵⁹ 15 U.S.C. § 80a-35(b) (2006) (emphasis added).

⁶⁰ *Gartenberg v. Merrill Lynch Asset Mgmt.*, 694 F.2d 923 (2d Cir. 1982).

⁶¹ 537 F.3d at 732.

⁶² As the Wall Street Journal editorial page has noted, “It isn’t easy to lose 9 - 0 on the current ideologically divided Supreme Court.” Editorial, *Supremes 9, SEC 0*, WALL ST. J., Feb. 27, 2013, *available at* http://online.wsj.com/article/SB10001424127887324662404578330260976961512.html?mod=WSJ_Opinion_AboveLEFTTop.

generally keeps fees low. The panel faulted *Gartenberg* on the ground that it “relies too little on markets.”⁶³

The Court flatly rejected the idea that markets set the boundaries of Section 36(b)’s fiduciary duty.⁶⁴ Instead, it treated Section 36(b)’s “fiduciary duty” as a *fiduciary* duty. The Court adopted the traditional fiduciary standard that it applied in *Pepper v. Litton* in 1939—notably reaching back to the era of Cardozo’s fiduciary duty in *Meinhard*—which involved a “dominant or controlling shareholder’s claim for compensation against a bankrupt corporation.”⁶⁵ Under that classically paternalistic standard, the shareholder had the burden not only “to prove the good faith of the transaction but also to show its inherent fairness.”⁶⁶ The Court’s holding reflected its understanding that a statutory fiduciary duty represents the legislature’s decision not to defer blindly to the “morals of the marketplace” because free market forces will not always yield an optimal outcome.

One basis for the Court’s decision was its recognition that free markets are not, in fact, necessarily wealth-maximizing. It warned that, in applying Section 36(b), “courts should not rely too heavily on comparisons with fees charged to mutual funds by other advisers. These comparisons are problematic because these fees, like those challenged, *may not be the product of negotiations conducted at arm’s length.*”⁶⁷

In support of this statement, the Court cited the dissent from the Seventh Circuit’s denial of a rehearing en banc,⁶⁸ in which Judge Richard Posner had argued that “the panel base[d] its rejection of *Gartenberg* mainly on an economic analysis that is ripe for reexamination on the basis of growing indications that executive compensation in large publicly traded firms often is excessive because of the feeble incentives of boards of

⁶³ *Jones*, 559 U.S. at 342 (quoting *Jones*, 527 F.3d at 632).

⁶⁴ *Jones*, 335 U.S. at 353. *E.g. id.* (“By focusing almost entirely on the element of disclosure, the Seventh Circuit panel erred. An investment adviser ‘must make full disclosure and play no tricks but is not subject to a cap on compensation.’”) (quoting *Jones*, 527 F.3d at 632)).

⁶⁵ *Jones*, 335 U.S. at 346 (citing *Pepper v. Litton*, 308 U.S. 295, 306 (1939)).

⁶⁶ *Id.* at 346-47 (quoting *Pepper*, 308 U.S. at 306-07).

⁶⁷ *Id.* at 350-51 (emphasis added).

⁶⁸ *Id.* (citing *Jones*, 537 F.3d at 731); *id.* (“Competition between money market funds for shareholder business does not support an inference that competition must therefore also exist between [investment advisers] for fund business. The former may be vigorous even though the latter is virtually non-existent.”) (quoting *Gartenberg*, 694 F.2d at 929).

directors to police compensation.⁶⁹ Judge Posner continued, “[c]ompetition in product and capital markets can’t be counted on to solve the problem because the same structure of incentives operates on all large corporations and similar entities, including mutual funds.”⁷⁰ The *Jones* case suggests that, if the large menu defense reaches the Court, it will be struck down just as decisively as the Seventh Circuit’s holding in *Jones*.

Possibly concerned about being reversed on appeal again, Judge Easterbrook attempted to distinguish *Jones* from *Loomis* on the ground that the defendant in a section 36(b) case has a conflict of interest. A fund manager directly benefits from the receipt of fees that the section 36(b) plaintiff alleges are excessive. In contrast, “there is no reason to think that Exelon chose the funds to enrich itself at participants’ expense.”⁷¹ However, there is no support, and the *Loomis* court cited none, for the proposition that fiduciary liability under ERISA attaches only with proof of the fiduciary’s self-dealing motive. To the contrary, “the great principles of trust fiduciary law, loyalty and prudence, do not depend upon the transferor’s motive, whether making a gift or doing a deal.”⁷² A trustee is

⁶⁹ *Jones*, 537 F.3d at 730 (Posner, J., dissenting).

⁷⁰ *Id.*

⁷¹ *Loomis*, 658 F.3d at 671 (“[E]xelon had (and has) every reason to use competition in the market for fund management to drive down the expenses charged to participants, . . . Competition thus assists both employers and employees, as Hecker observed.”). It is hard to take this distinction seriously, as Judge Easterbrook made the same argument in *Jones* that a fund manager has the same market-based incentive to keep fees low:

Holding costs down is vital in competition, when investors are seeking maximum return net of expenses—and as management fees are a substantial component of administrative costs, mutual funds have a powerful reason to keep them low unless higher fees are associated with higher return on investment. A difference of 0.1% per annum in total administrative expenses adds up by compounding over time and is enough to induce many investors to change mutual funds. That mutual funds are “captives” of investment advisers does not curtail this competition. An adviser can’t make money from its captive fund if high fees drive investors away.

Jones, 527 F.3d at 631-32.

⁷² John H. Langbein, Essay, *The Secret Life of the Trust: The Trust as an Instrument of Commerce*, 107 YALE L.J. 165, 186 (1997).

bound to the duties it has assumed regardless of whether it may personally benefit from any alleged malfeasance, just as ERISA's prudent man standard applies regardless of whether violating it is accompanied by a financial benefit to the fiduciary.

The *Loomis* court's preference for free market principles in derogation of express statutory fiduciary duties reveals the ideological nature of its position that ERISA fiduciary claims must conform to an overriding, rational-actor model of human behavior. Yet the Supreme Court rejected precisely this approach in *Jones*, namely, the court's substitution of its own economic analysis for Congress's decision to qualify the primacy of the rational actor model by imposing a fiduciary duty in certain situations. If and when the market-based, large menu defense reaches the Court, it is likely to suffer the same fate as the market-based approach taken in *Jones*.

The large menu defense goes further than exalting free market principles over plain statutory mandates; it re-interprets ERISA's diversification requirement as a paean to the liberation ideology of free choice. Courts in favor of the large menu defense consider choice-maximization to be a central purpose of ERISA. *Tibble*'s "centerpiece" of ERISA was "participant choice."⁷³ *Renfro* viewed ERISA's diversification standard as "being designed to offer participants meaningful choices,"⁷⁴ as echoed by *Loomis*'s view that its purpose was, "[f]ar from reflecting a paternalistic approach, [to] encourage sponsors to allow more choice to participants."⁷⁵ *Loomis* applauded *Exelon* because, as directed by the safe harbor, it had "left choice to the people who have the most interest in the outcome, and it cannot be faulted for doing this."⁷⁶

The courts' view that the purpose of ERISA is to maximize participant choice, which turns the statute on its head. Congress did not enact ERISA to generate more investment choices for workers; it enacted ERISA to enhance their retirement security. As noted herein, ERISA reflects a strongly paternalistic view of pension plans.⁷⁷ Congress did not

⁷³ *Tibble*, 711 F.3d at 1083.

⁷⁴ *Renfro*, 671 F.3d at 327.

⁷⁵ *Loomis*, 658 F.3d at 673.

⁷⁶ *Id.*

⁷⁷ See 29 U.S.C. § 1001 (b)-(c) (2012); *Loomis*, 658 F.3d at 673; RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008) (showing that ERISA's automatic enrollment provision is the regulatory policy and is based on a regulatory model that the authors call "libertarian paternalism").

enact ERISA to free workers of some imaginary yoke of oppression imposed by employers that offer a limited menu of 401(k) investment options. Rather, Congress intended that ERISA *restrict* employers' and workers' discretion, respectively, in offering and choosing investments.

The large menu defense treats consumer choice as an end in itself; under ERISA, it is only a means to an end. The statute does not require choice for choice's sake. The 404(a) safe harbor mandates at least three diversified investment options as a means of maximizing plan participants' wealth, not as a means of promoting individual freedom. The DOL conditions the safe harbor on plans' offering a "broad range of investment alternatives" not in order to enhance rational actors' ability to maximize their personal utility, but to maximize the wealth of plan participants as a group based on the government's faith in a particular theory of investing (modern portfolio theory).⁷⁸

The incentives that ERISA offers to employers to offer multiple investment options, as well as related DOL regulations and interpretation, reflect patently paternalistic public policy decisions about what is best for workers. These policies are decidedly not motivated by a liberation ideology of individual freedom and choice. The safe harbors relieve employers of liability for following government guidelines in selecting investment options, not for seeking to maximize plan participant freedom. The courts' re-characterization of a government mandate based on modern portfolio theory as a policy of liberation designed to maximize worker freedom is nothing more than wishful thinking, statutory nullification, or both.

IV. JUDICIAL ECONOMICS AND THE EMPIRICAL CONSEQUENCES OF LARGE 401(K) MENUS

As discussed immediately above, the large menu defense is based on the courts' belief that ERISA's prudent man rule is rendered inoperative

⁷⁸ 29 C.F.R. § 2550.404c-1(b)(1)(ii) (2010). See Philip J. Ruce, *The Trustee and the Prudent Investor: The Emerging Acceptance of Alternative Investments as the New Fiduciary Standard*, 53 S. TEX. L. REV. 653, 666-68 (2012) (discussing relationship between modern portfolio theory and the prudent investor rule); W. Scott Simon, *Illuminating the 'Broad Range' Requirement of ERISA Section 404(c) With the Language of Modern Portfolio Theory Found in the Uniform Prudent Investor Act and the Restatement 3rd of Trusts (Prudent Investor Rule)*, 13 J. PENSION BENEFITS 87 (2005) .

as to an employer's selection of 401(k) investment options if the employer offers a large enough number of investment options. By offering a large menu of options, the employer in *Loomis*, for example, "left choice to the people who have the most interest in the outcome, and it cannot be faulted for doing this."⁷⁹ In contrast, employers such as Wal-Mart, that paternalistically limit the number of investment options, thereby increase their ERISA liability risk. This judicial exercise of extralegal authority is reason to be concerned, but if the courts' faith in the wealth-maximizing effect of choice in 401(k) plans is well-founded, then at least workers would be wealthier as a result.

However, larger 401(k) menus actually reduce workers' wealth. Research demonstrates that the assumption made by free market ideologues that increasing choice in 401(k) plans maximizes wealth is empirically false. The courts supporting the large menu defense do not cite any research to support their view of the economic benefits of large 401(k) menus; they seem entirely indifferent as to whether their theories bear any relation to reality. The effect of the large menu defense is to make workers poorer, while also creating a perverse incentive for employers to reduce their ERISA liability risk by adding more options to their 401(k) plans.

The large menu defense reflects the courts' view of the model of plan participants as rational utility maximizers. Traditional free market theory assumes that economic actors are rational. Consumers make choices to maximize their personal wealth, or "utility." A larger set of choices should enhance consumers' abilities to maximize their utility because with every additional choice, the chance that the set of options will include the most utility-maximizing option for a particular consumer increases.⁸⁰ Larger 401(k) menus should therefore be wealth maximizing because they increase the likelihood that the set of investment options will include utility-maximizing options for every participant. The more flavors of ice cream that are available, the greater the likelihood that the consumer's favorite flavor will be among them. Conversely, restricting the size of 401(k) menus should reduce participants' wealth because a smaller menu is less likely to include the particular investment that will maximize a participant's utility.

⁷⁹ *Loomis*, 658 F.3d at 673-74.

⁸⁰ See generally Sheena S. Iyengar & Wei Jiang, *The Psychological Costs of Ever Increasing Choice: A Fallback to the Sure Bet* 3 (Columbia Univ., Working Paper, 2005) (discussing rational choice theory).

In practice, however, offering more choices to consumers adversely affects their ability to maximize their utility. For example, numerous studies have shown that offering subjects a small set of purchase options increases the likelihood that they will make a purchase. One prominent study found that shoppers were more likely to buy jam when offered six flavors to choose from instead of twenty-four. One reason for the adverse effect of providing more choices may be that choice creates stress, which was illustrated by a study in which subjects were made to choose from among an array of Godiva chocolates. They reported feelings of regret and less certainty when offered thirty chocolates than when offered only six. Thus, *reducing* the number of available choices can create both material and psychological benefits.

While investment options in 401(k) plans are a far cry from jams and chocolates, the effects of offering more choice to plan participants is the same – and vastly more costly. Studies have shown that large menus have the effect of substantially reducing plan participation rates, thereby resulting in huge financial losses to workers. There is also empirical evidence that large menus result in investment options that are lower quality and more expensive, lead to inferior asset allocation decisions, and impair the effectiveness of disclosure due to information overload. The aggregate effects of the consequences of large menus are an annual deadweight wealth reduction of billions of dollars and a less secure retirement for millions of Americans.

A. LARGE MENU EFFECTS – REDUCED PARTICIPATION RATES

The most prominent study on the effect of large 401(k) menus is also the most comprehensive. Three Columbia University researchers studied the participation rates of more than 800,000 employees across 647 plans.⁸¹ In short, they found that, with every ten additional options, the plan's participation rate declined by approximately two percentage points. As the number of investment options increased from two to eleven, the participation rate declined steadily from 75% to 70%. The participation rate remained at approximately 70% as the number of options increased from eleven to thirty, at which point the rate began to decline approximately two percentage points for each ten-option increase. The

⁸¹ *Id* at 2. See also GARY R. MOTTOLA & STEPHEN P. UTKUS, VANGUARD CTR. FOR RET. RES., CAN THERE BE TOO MUCH CHOICE IN A RETIREMENT SAVINGS PLAN? (2003) (summarizing and commenting on Iyengar & Jiang, *supra* note 80).

participation rate declined to 67% when the number of investment options increased to thirty-five, and declined further to 61% when the number of options reached fifty-six.⁸²

These data take on a human face when applied to an actual 401(k) plan. As discussed herein, Deere's plan included twenty-five core mutual fund options and 2,500 additional funds. The plan had approximately 31,000 participants,⁸³ which would represent a participation rate ranging from 61% to 68%, depending on whether one treated the plan as offering more than fifty-six options (61%) or only twenty-five options (68%).⁸⁴ If the plan had offered only two options and achieved a 75% participation rate, it would have had approximately 38,000 participants under the fifty-six-plus-options assumption and 34,000 participants under a twenty-five-option assumption. In other words, by providing its employees with a large number of investment options, Deere effectively excluded 3,000 to 8,000 employees from its plan,⁸⁵ and reduced its ERISA liability risk by doing so.

The wealth reduction caused by large menus is staggering, primarily because nonparticipation deprives employees of the company match. About 85% of plan sponsors make matching contributions to defined contribution plans.⁸⁶ The most common match amount is either 50% or

⁸² A 2009 survey by Watson Wyatt found that the most common number of options in 401(k) plans was ten to fourteen, with 11% of plans offering more than twenty-four options. *See News Archives – August / September 2009*, BENEFITS AND PENSIONS MONITOR ONLINE, http://www.bpmmagazine.com/benefits_news_august_september_2009.html (last visited Apr. 3, 2014).

⁸³ Second Am. Compl. for Breach of Fiduciary Duty at para. 28(a), *Hecker v. Deere & Co.*, No. 06-C-0719-S (W.D. Wis., Mar. 6, 2007) 2007 WL 2891544, at *8.

⁸⁴ If 30,000 participants equaled a 61% or a 68% participation rate, then a 75% participation rate would equal, respectively, 36,885 and 33,088 participants ($.75 * (30000 / .61)$ and $.75 * (30,000 / .68)$). The participation rate estimates in this section are extrapolated from the Columbia analysis for illustrative purposes. They are not intended to reflect actual rates, which are generally available in a company's Form 5500 filings.

⁸⁵ Exelon's large menu probably had a similar effect. Approximately 23,000 Exelon Corp. employees participated in its thirty-two-option retirement plan, which, assuming a large-menu-suppressed 68% participation rate, means that 2,000 fewer employees participated than likely would have participated in a two-option plan. *See* Compl. for Breach of Fiduciary Duty at para. 27(a), *Loomis v. Exelon Corp.*, No. 06CV4900 (N.D. Ill., Sept. 11, 2006), 2006 WL 2791653 (23,000 participants in Exelon plan).

⁸⁶ *See* AON HEWITT, 2011 TRENDS AND EXPERIENCE IN DEFINED

100% of employee contributions up to 6% of their pay.⁸⁷ Deere offered a maximum 401(k) match of 6%,⁸⁸ which means that for every \$1 contributed by an employee up to 6% of their pay, Deere contributed \$1 to the employee's 401(k) account. For a Deere employee earning \$25,000 annually who contributed 6% of his pay to Deere's 401(k) plan, the 6% match would represent \$1,500 in additional annual income. The Deere employee who does not participate in the 401(k) plan receives none of this additional income. Assuming Deere's large menu effectively excludes 3,000 to 8,000 employees from its plan, these employees lose \$4.5 to \$12 million in income *every year*, even before taking into account lost investment gains.

By offering a large menu, Deere reduces not only its ERISA liability risk, but also its compensation expenses. The \$4.5 to \$12 million of foregone annual income directly increases Deere's profits. This means that the Seventh Circuit's assumption that employers do not have a conflict of interest in the design of their 401(k) plans is actually false.⁸⁹ Employers can increase their profits by increasing the size of their 401(k) menus because

CONTRIBUTION PLANS 4 (2011), available at http://www.aon.com/attachments/thought-leadership/2011_Trends_Experience_Executive_Summary_v5.pdf.

⁸⁷ *See id.*

⁸⁸ *See Hecker v. Deere & Co.* 556 F.3d 575, 579 (7th Cir. 2009).

⁸⁹ *Loomis*, 658 F.3d at 671 (Exelon "had (and has) every reason to use competition in the market for fund management to drive down the expenses charged to participants, . . . Competition thus assists both employers and employees, as Hecker observed."). It is hard to take this distinction seriously, as Judge Easterbrook made the same argument in *Jones* that a fund manager has the same market-based incentive to keep fees low:

Holding costs down is vital in competition, when investors are seeking maximum return net of expenses—and as management fees are a substantial component of administrative costs, mutual funds have a powerful reason to keep them low unless higher fees are associated with higher return on investment. A difference of 0.1% per annum in total administrative expenses adds up by compounding over time and is enough to induce many investors to change mutual funds. That mutual funds are "captives" of investment advisers does not curtail this competition. An adviser can't make money from its captive fund if high fees drive investors away.

Jones v. Harris Assocs. L.P., 527 F.3d 627, 631-32 (7th Cir. 2008).

that will result in fewer employees taking advantage of the employer match. The employer will still be able to attract workers by advertising employee compensation as including a 6% match. This cause-and-effect relationship is, of course, somewhat attenuated, but it is useful in illustrating the absurd position in which the large menu defense courts have placed employers.

In contrast with Deere's being rewarded for its large menu, Wal-Mart was punished for offering a limited menu that, precisely because it is limited, creates billions of dollars of wealth for its employees.⁹⁰ The Wal-Mart plan offered eleven investment options and had approximately one million participants, which would represent a 70% participation rate under the Columbia analysis. If Wal-Mart had offered fifty-six options, its plan's predicted participation rate would have been 61%, which translates into approximately 130,000 fewer employees participating in the plan. Wal-Mart offers a full match up to 6% of the employee's pay, which for 130,000 employees earning \$25,000 annually would total approximately \$2 billion over ten years, even before taking into account investment gains. Thus, Wal-Mart employees' wealth has been increased by billions of dollars because Wal-Mart's plan has a limited menu of options. The large menu defense creates an incentive, however, for Wal-Mart to increase the number of options in its plan in order to reduce its ERISA liability exposure. If Wal-Mart decides to follow the guidance of the courts which support the large menu defense, then its workers will be billions of dollars poorer as a result.

The adverse effects of large menus are most pronounced for the groups who stand the most to lose by not participating in 401(k). The Columbia researchers found that the reduction in participation rates caused by large menus was even greater for older workers, female workers and low-income workers.⁹¹ These are the groups for whom inadequate investing for retirement will have the direst consequences. Older workers have less time to put away funds for retirement, females live longer and therefore have longer retirements to plan for, and low-income workers have the greatest need for each additional dollar of income in retirement. The

⁹⁰ *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 603 n.6 (8th Cir. 2009); see *Ruppert v. Principal Life Ins. Co.*, 796 F. Supp. 2d 959, 963 (S.D. Iowa 2010) (citing argument that limited menu in *Braden*, compared with large menu in *Hecker*, made imprudent management claim more plausible); *Tibble v. Edison Int'l*, 711 F.3d 1061 (9th Cir. 2013).

⁹¹ *Iyengar & Jiang, supra* note 80, at 16.

disproportionate effect of large menus on these groups will impose greater financial burdens on society as well because reduced standards of living in retirement will inevitably place greater pressure on our already strained Social Security system.

B. LARGE MENU EFFECTS – OVERLY CONSERVATIVE ALLOCATIONS

The losses attributable to large menus are by no means limited to lower participation rates. The Columbia study found that large menus also harm participants by causing them to make overly conservative allocations of their assets. This finding is consistent with general research showing that increasing choice suppresses risk-taking. For example, in one study, researchers asked subjects to choose from a series of hypothetical salary options. The researchers found that the subjects' willingness to take risks was inversely correlated with the number of options offered. Similar studies have shown that subjects are more likely to make worse decisions as the number of options increases. For example, a 1995 study found that doctors, when offered the option of prescribing either of two medicines for a medical condition, each of which would have been an improvement over doing nothing, usually chose to do nothing.⁹²

These responses to increasing the number of choices were similarly reflected in plan participants' allocation decisions. The Columbia researchers found that, for every ten-option increase in the size of the menu, participants' allocations to equity funds decreased by 7.1 to 8.9 percentage points, "an amount both economically and statistically significant (at the 2.5% level)."⁹³ This reduction in equity fund allocations is not nearly as striking as the increase in participants who allocated none of their contributions to equities. The researchers found that "the

⁹² See Donald A. Redelmeier & Eldar Shafir, *Medical Decision Making in Situations That Offer Multiple Alternatives*, 273 J. AM. MED. ASS'N. 302 (1995), available at <https://psych.princeton.edu/~psych/psychology/research/shafir/pubs/JAMA.pdf>.

⁹³ See Iyengar & Jiang, *supra* note 80, at 30; see also Sheena S. Iyengar & Emir Kamenica, *Choice Proliferation, Simplicity Seeking, and Asset Allocation*, 94 J. PUB. ECON. 530 (2010) (finding that when a correlation is statistically significant at the 2.5% level, there is a 2.5% chance that a correlation is the result of chance).

probability that an individual contributes anything at all to equity funds also drops by 3.1-4.6%, significantly different from zero at the 5% level.”⁹⁴

Conversely, a ten-option menu increase resulted in “3.9% and 5.4% increases in contribution allocations to, respectively, money market funds alone and both money market and bond funds combined.”⁹⁵ Each ten-option menu increase also produced “nearly a 2% increase in the percentage of choosers who allocated over half their contributions to money market funds alone, and a 3.6% increase in the percentage of choosers who allocated over half their contributions to money markets and bonds combined.”⁹⁶ This shift of assets to less volatile classes would make sense for older workers, but the researchers found that the effects of large menus were uncorrelated with age or job tenure. These effects were greater, however, for female workers and low-income workers,⁹⁷ for whom the adverse effects of inadequate retirement preparedness are also greater.⁹⁸

These large-menu effects impose substantial opportunity costs on plan participants. The expected value of a twenty-year investment in equities, which is an appropriate investment period in light of the increased risk of equity investments, is substantially higher than the expected value of a twenty-year investment in bonds or money market instruments. This problem of overly conservative investment options was a concern for the

⁹⁴ See Iyengar & Jiang, *supra* note 80, at 30. This tendency may be countered if the percentage of equity funds grows with the size of the menu because investors tend to increase their allocations to a particular asset class in proportion to that asset class’s representation in the menu. See Shlomo Benartzi & Richard H. Thaler, *Naive Diversification Strategies in Defined Contribution Saving Plans*, 91 AM. ECON. REV. 79, 87 (2001) (finding that when equity options comprised a larger percentage of hypothetical options, study subjects invested a larger percentage of accounts in equities than when equity options comprised a smaller percentage of options), available at http://www.anderson.ucla.edu/documents/areas/fac/accounting/naive_diversification.pdf; see also Jeffrey Brown et al., *Individual Account Investment Options and Portfolio Choice: Behavioral Lessons from 401(K) Plans* (NBER Working Paper, No. 13169, June 2007) (increasing equity fund representation from 1/3 to 1/2 of menu increased participants’ equity allocations by 7.5%) (“*Behavioral Lessons*”), available at http://www.nber.org/papers/w13169.pdf?new_window=1; Karlsson et al., *supra* note 46 (likelihood of option being chosen increases with its representation in menu), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=888661.

⁹⁵ See Iyengar & Jiang, *supra* note 80, at 33-34. .

⁹⁶ *Id.*

⁹⁷ *Id.* at 31.

⁹⁸ *Id.* at 16.

DOL in 2006, when it was considering the kinds of investment options to which employers should allocate contributions of participants who provided no instructions. Stable value fund sponsors lobbied the DOL to include such funds as “qualified default investment alternatives,” but DOL wisely rejected their entreaties. Its decision to encourage more appropriate risk-taking by participants contrasts with the large menu defense’s effect of arbitrarily reducing risk-taking by encouraging larger menus. The large menu defense similarly undermines the 2006 legislative reform that permitted automatic enrollment of employees in 401(k) plans and has substantially increased plan participation rates. On both fronts, the large menu defense courts are effectively undoing the demonstrated benefits of regulatory reforms.

C. LARGE MENU EFFECTS – INFERIOR INVESTMENT OPTIONS

In addition to reducing participation rates and causing overly conservative asset allocations, large menus reduce the quality of the investment options in 401(k) plans as a group. Researchers have found that the quality of the funds in a plan declines as the number of options increases.⁹⁹ David Goldreich and Hanna Halaburda studied 131 401(k) plans with the number of investment options offered ranging from four to twenty-eight. They evaluated the objective quality of the plans by comparing their respective Sharpe ratios, which measure expected investment return in light of the degree of risk taken by the investor. The data showed a negative correlation between the number of investment options offered and the quality of the plan that was significant at the 1% level. Like the Columbia group, Goldreich and Halaburda concluded “empirically that larger menus are objectively worse than smaller menus, on average, in an important economic context—401(k) pension plans, where a plan is a menu of investment choices.”

Along the same lines, Nina Tang and Olivia Mitchell found that increasing the number of investment options offered in a 401(k) plan did not increase the efficiency of the menu. They evaluated efficiency based on each plan’s Sharpe ratio, degree of nondiversifiable risk, and participants’ potential welfare/utility loss resulting from a less efficient menu.¹⁰⁰ They concluded that, “even with a handful of investment choices,

⁹⁹ See Goldreich & Halaburda, *supra* note 3, at 1.

¹⁰⁰ Ning Tang & Olivia S. Mitchell, *The Efficiency of Pension Plan Investment Menus: Investment Choices in Defined Contribution Pension Plans* (Mich. Ret.

participants will not suffer from menu restriction, as long as the choices offered are sensible ones.”¹⁰¹ They found that it would be “more sensible to add funds that make the menu more efficient, than simply to make the menu longer,”¹⁰² which is precisely the intent of the three-option and broad-range diversification safe harbor requirements.¹⁰³ “The key factor contributing to plan efficiency and performance has to do with the types of funds offered, rather than the total number of investment options provided.”¹⁰⁴

Larger menus are also correlated with higher cost options.¹⁰⁵ Researchers have found that, as the size of a 401(k) plan’s menu increases, the representation of actively-managed funds increases at a greater rate. Actively managed funds charge higher fees than index funds, which means that larger menus correlate with higher costs. The higher fees also mean that large menus have inferior performance. The researchers found that, while the gross performance of index and actively-managed funds was similar, their relative performance net of fees was quite different, with index funds substantially outperforming in terms of both investment returns and percentile ranking.¹⁰⁶ Thus, large menus are correlated with inferior, higher-cost, lower-performing investment options and provide no efficiency benefits.

D. LARGE MENU EFFECTS AND INFORMATION OVERLOAD

The foregoing empirical research demonstrates that rational choice theory fails in the context of large 401(k) menus, notwithstanding the faith that courts in favor of the large menu defense have in the infallible

Res. Ctr., Working Paper 2008-176, No. UM08-20), *available at* <http://www.mrrc.isr.umich.edu/publications/papers/pdf/wp176.pdf>.

¹⁰¹ *Id.* at 7.

¹⁰² *Id.* at 16.

¹⁰³ See 29 C.F.R. § 2550.404c-1(b)(3)(i)(B)(1-4).

¹⁰⁴ Tang & Mitchell., *supra* note 100, at 2.

¹⁰⁵ See Brown et al., *supra* note 47, at 2.

¹⁰⁶ See *id.* at 26 (“while the actively managed and index equity funds offered in our sample of 401(k) plans have similar performance before accounting for expenses (index funds actually slightly outperformed, but the difference is not significant), they differ significantly in their reported annual expenses (on the order of 50 basis points per year), which leads to worse performance after accounting for expenses (both in terms of returns and percentile rankings within its investment objective.)”).

efficiency of “rational” actors and free markets. Large menus cause employees to make worse choices either by making inferior asset allocation decisions or by not participating in 401(k) plans at all. Large menus also result in inferior options being selected by employers. One explanation for investors’ behavioral response to large menus is information overload and complexity, which is particularly ironic in the context of the free market ideology underlying the large menu defense. That ideology assumes that investors are better off with large menus because it is more likely that the menu will include, for example, a low-cost fund. As the *Loomis* court argued, “[a]ny participant who want[ed] a fund with expenses under 0.1% can get it through Exelon’s Plan.”¹⁰⁷ However, the fact that a large menu may be more likely to include such a low-cost fund misses the point. The evidence suggests that an investor would be less likely to actually *find or invest in* the 0.1% fund precisely because it was part of a large menu.

Researchers have found that search costs are a significant factor in the depressing effect of large choice sets on consumers’ willingness to make choices.¹⁰⁸ The additional search costs that a large menu of investment options imposes may lead investors not to search at all (*i.e.*, not participate), or to favor the simplest options, such as money market and bond funds.¹⁰⁹ They may be more likely to follow irrational heuristics, such as making an allocation to equity investments based on the percentage of equity options offered.¹¹⁰ Large menus that impose high search costs make it less likely that investors are actually exercising the “control” that is the basis of the control safe harbor because they will be deterred from exercising control by search costs, yet courts employing the large menu defense assume that larger menus lead to the exercise of greater participant control. In fact, investors may be more likely to avoid an excessive fee fund that is included in a small menu rather than a large one because they are more likely to seek out information about a small number of funds than

¹⁰⁷ *Loomis*, 658 F.3d at 671.

¹⁰⁸ See generally Dmitri Kuksov & J. Miquel Villas-Boas, *When More Alternatives Lead to Less Choice*, 29 MKTG. SCI. 507 (2010), available at <http://groups.haas.berkeley.edu/marketing/PAPERS/VILLAS/Marketing%20Science%202010%20alternatives.pdf>; Julie Agnew & Lisa Szykman, *Asset Allocation and Information Overload: The Influence of Information Display, Asset Choice, and Investor Experience*, 6 J. BEHAV. FIN. 57 (2005) (showing that study subjects reported greater feeling of information overload with more choices) available at http://mason.wm.edu/faculty/agnew_j/documents/assetallocation.pdf.

¹⁰⁹ Kuksov & Villas-Boas, *supra* note 108, at 512.

¹¹⁰ See Brown et al., *supra* note 47, at 18.

when intimidated by a large number. As one research team concluded, “the burgeoning number of actively-managed funds [in large 401(k) menus] makes it harder for investors to find the lower-cost index fund in the plan.”¹¹¹ In other words, investors are less likely to conduct the information search necessary to identify the low-cost needle when included in a large menu haystack.

V. CONCLUSION

The law and economics movement was the most influential jurisprudential development of the 20th century. The application of economic principles to traditional legal concepts has substantially improved our understanding of the relationship between law and practice. In no field has this been truer than in the regulation of commercial activities. Law and economics has improved our ability to apply traditional notions of equity, such as good faith and fair dealing, unconscionability, and fiduciary duties, in ways that better achieve their utility-maximizing purpose.

However, law and economics, especially in the hands of judges, can be an instrument of economic destruction when based on blind adherence to a free market ideology unmoored from any empirical foundation. The large menu defense adopted by some courts applies an axiom of free market adherents—rational choice theory—the social utility of which is disproved by empirical research on the actual effect of large 401(k) menus on workers’ welfare. Large 401(k) menus already cost American workers billions of dollars every year. The effect of the large menu defense, unless promptly repealed by Congress or overturned by the Supreme Court, will exacerbate the problem of large 401(k) menus and cause billions of dollars of additional losses.

¹¹¹ *Id.* at 25.

RETHINKING ERISA'S PROMISE OF INCOME SECURITY IN A WORLD OF 401(K) PLANS

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This article discusses the evolution of retirement income funds from defined benefit packages to 401(k) and IRA accounts and how the changing dynamic has reshaped the way retirees think about post-retirement income. The article outlines the mechanics of 401(k) accounts and rollover IRAs in the post-retirement period and presents questions about the ability of retirees to successfully address the complex issues relating to investment choices including, what entity they entrust their savings to, the volume and source of distributions, and long-term sufficiency planning. The article suggests that an increase in the use of annuities may help to resolve some of the challenges faced by today's retirees.

I. THE DECLINE OF THE DEFINED BENEFIT PLAN.

Over the last twenty years the number of defined benefit plans has steadily declined; as of 2011, fewer than twenty percent of all employees participated in one.¹ Defined benefit plans are being replaced by defined contribution plans: more specifically, 401(k) plans in the private sector, 403(b) plans by tax exempt organizations or public schools, and 457(b) plans for some state and local governmental employees.² (For brevity, these plans will collectively be referred to as 401(k) plans.) Participation in 401(k) plans has steadily risen so that over fifty percent of employees participate in one.³ The dollar amount saved in those accounts is

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¹ U.S. BUREAU OF LABOR STATISTICS, *The Last Private Industry Pension Plans*, (2013), http://stats.bls.gov/opub/ted/2013/ted_20130103.htm.

² The plans take their names from the Internal Revenue Code sections that govern them: I.R.C. § 401(k) (2010), I.R.C. §§ 403(b), 457(b) (2008).

³ William J. Wiatrowski, *Changing Landscape of Employment-Based Retirement Benefits*, U.S. BUREAU OF LABOR STATISTICS (2011), <http://www.bls.gov/opub/cwc/cm20110927ar01p1.htm>.

astounding. As of December 2010, defined contribution plans held \$4.5 trillion.⁴

Employers often cite investment risk as a compelling reason for abandoning defined benefit plans and replacing them with 401(k) plans.⁵ Employers who sponsor a defined benefit plan must annually fund it with the amount due based on several variables, including the probable amount of the defined benefit or pension owed to each retiring employee, the life expectancy of the retired employees and other plan beneficiaries, and the expected investment return on the plan assets. The latter, the return on the plan investments, can cause the greatest year-to-year variance in the employer's required annual plan contribution. The higher the investment return, the fewer dollars that the employer must contribute to the plan. During years of high interest rates on bonds and strong returns on stocks, the employer may need to contribute little or nothing to the plan. But in years of low interest rates on bonds and losses from stock investments, the employer will have to make significant contributions in order to keep the plan actuarially fully funded. Over time, of course, the good investment years and the bad investment years off-set each other, so that over the life of the plan, the pension fund should have an acceptable average return. "Over time," however, provides little comfort to the employer during the years of poor or negative investment returns, which will mandate greater employer contributions to the plan. It is that short-term risk, which may not be all that "short," that employers, or more accurately, the corporate executives, fear.

The swings in the plan investment return and the corresponding changes in the required employer annual contribution affect the employer's annual profit because the plan contributions are expenses that reduce income. Worse, the employer will likely be forced to make greater contributions in years when the economy is doing poorly, causing the investment returns to lag. Moreover, if the economy is performing poorly, the employer's business may also be suffering. Faced with lower revenues and declining profits, the employer will be required to make larger contributions to the plan, thereby further depressing profits.

In response, employers have turned to defined contribution plans, specifically 401(k) accounts, which do not promise a pension or other form

⁴ INV. CO. INST., 2011 INV. CO. FACT BOOK 102 (51st ed. 2011).

⁵ For a detailed discussion on why employers prefer defined contribution plans to defined benefit plans, see Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004).

of assured retirement benefit, but only promise the participating employee that the employer will make contributions to the employee's 401(k) account. The employee is then responsible for investing the funds in the 401(k) account. Because the success of those investments largely determines the value of the account at the time the employee retires, the investment risk is shifted from the employer to the employee. Moreover, the employer has a fixed, predictable cost because its contribution is usually a percentage of the employees' pay for those employees who choose to participate.

This shift of the investment risk to the employee is well understood, as well as the risk of participation, the risk of not participating at the maximum degree allowed by the plan, and the risk of borrowing from the 401(k) account.⁶ Post-retirement risks faced by 401(k) participants has failed to garner much attention.⁷ The realities of the post-retirement world create substantial risks that threaten to lead to the impoverishment of many elderly retirees.

II. THE RISE OF THE ROLLOVER INDIVIDUAL RETIREMENT ACCOUNT

Upon retirement, employees who own a 401(k) account have the option of leaving their account in the employer's 401(k) plan or, as most do, rolling it over, tax-free, into an Individual Retirement Account (IRA).⁸ In 2011 rollover IRAs had a total value of \$4.7 trillion.⁹ (In this paper, retiree defined benefits retirement accounts, whether remaining in the 401(k) or rolled over into an IRA, will be referred to as IRAs.)

⁶ Joellen Leavelle, *Borrowing Against the Future with a 401(k) Loan*, PENSION RIGHTS CTR. (Apr. 12, 2013), www.pensionrights.org/blog/borrowing-against-future-401k-loan; James J. Choi et al., *\$100 Bills on the Sidewalk: Suboptimal Investment in 401(k) Plans*, 93 REV. ECON. & STAT. 748, 748-49 (2011). Most retirees will also have insufficient funds in their 401(k) account to support an adequate income during retirement. See James Kwak, *Improving Retirement Savings Options for Employees*, 15 U. PA. J. BUS. L. 483, 489 (2013).

⁷ But see Lawrence A. Frolik, *Protecting Our Aging Retirees: Converting 401(k) Accounts Into Federally Guaranteed Lifetime Annuities*, 47 SAN DIEGO L. REV. 277 (2010).

⁸ I.R.C. § 402(c)(2) (2005).

⁹ INV. CO. INST., *supra* note 4.

Whether they leave their funds in the 401(k) or roll them over into an IRA, retirees face formidable financial planning hurdles.¹⁰ They must successfully invest the IRA for what is likely to be twenty or more years of their remaining lives, as the average life expectancy at age sixty-five is about nineteen years for men and twenty-one years for women.¹¹ For many, post-retirement will last much longer, as about twenty-five percent of today's sixty-five-year-olds will live past age ninety and ten percent, a majority of whom will be women, will live past age ninety-five.¹² To maintain the value of their retirement fund during their retirement years, retirees must successfully invest it, which at a minimum means earning an investment return at least equal to the rate of inflation. As the financial collapse of the markets in 2001 and 2008 demonstrated, however, even that modest goal may be difficult to achieve. For example, the Dow Jones Industrial average in September 2008, was 13,896. In February 2009, it was 7,069, and in February 2013, it had reached 13,973. Thus, ignoring possible dividends, an investor whose stock portfolio resembled the Dow Jones Industrial Average would have had essentially zero returns for the five-year period from February 2008 to February 2013. Nor would our investor have fared much better by investing in bonds. From 2003 to February 2013, the Vanguard Total Bond fund yielded 5.2 percent, but because inflation from 2002 through 2012 was 2.63 percent, the real annual return on the bonds was less than three percent.¹³

Second, retirees must spend their retirement fund at a rate that will not exhaust it before they die, yet take a sufficient amount out that, when added to their other sources of income such as Social Security, will enable them to live at the level that they deem adequate. Taking money out of a

¹⁰ Even the decision of whether and where to roll over the funds raises difficult choices for retirees. According to the Government Accounting Office, "401(k) plan participants separating from their employers must decide what to do with their plan savings. Many roll over their plan savings to IRAs. As GAO previously reported, there is concern that participants may be encouraged to choose rollovers to IRAs in lieu of options that could be more in their interests." U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-30, 401(K) PLAN: LABOR AND IRS COULD IMPROVE THE ROLLOVER PROCESS FOR PARTICIPANTS (2013).

¹¹ SOC. SEC., *Calculators: Life Expectancy*, available at <http://www.ssa.gov/planners/lifeexpectancy.htm> (last visited Feb. 11, 2014).

¹² *Id.*

¹³ VANGUARD, *Vanguard Total Bond Market Index Fund Admiral Shares*, <https://personal.vanguard.com/us/funds/snapshot?FundId=0584&FundIntExt=INT> (last visited Feb. 11, 2014).

retirement account can be even trickier than being a successful investor. Although the two goals (investment returns that at a minimum keep pace with inflation, and taking distributions at a rate that neither exhausts the fund nor leaves the retiree in poverty) can support each other – good investing means more to spend while tempered withdrawals maintain capital – the two goals are also in conflict. The more the retiree withdraws to live on, the less there will be to invest, which will result in less available income in later years.

The percent of the fund that can be taken out each year without exhausting the fund before death is surprisingly low. The current conventional wisdom is to withdraw no more than four percent of the initial fund plus annual increases for inflation.¹⁴ Following that advice would mean that a retiree with an IRA of \$1,000,000 on the first day of retirement could take out only \$40,000 the first year. Even if the retiree was willing to risk exhaustion of the fund by taking out at a rate of five percent, the IRA would yield only \$50,000 a year.¹⁵

Other factors also diminish the income security of a retiree with a 401(k) account. The right upon retirement to take funds from the 401(k) account creates the potential temptation not to save the funds, but to spend them or use them to pay off existing debts.¹⁶ For many retirees, the right upon retirement to take money out of their 401(k) plan is the first time in

¹⁴ See, e.g., Gregg S. Fisher, *What Portfolio Withdrawal Rate Can You Live With?* (Dec. 5, 2012, 2:13 PM), FORBES, available at <http://www.forbes.com/sites/greggfisher/2012/12/05/what-portfolio-withdrawal-rate-can-you-live-with/> (“Our research points to 4% as being a reasonable starting point for a withdrawal rate. Investors should also consider age, health, and other individual-specific issues in determining whether their own withdrawal rate should in fact be lower than this, or possibly higher. But historically, investors with diversified balanced portfolios who took a total return approach to managing their investments in retirement were able to make this 4% withdrawal rate quite consistently.”).

¹⁵ Taking out at a rate of 4% may be too optimistic. The U.S. Department of Labor provides an income calculator that estimates the amount of income that can safely be taken from a retirement account. The calculator uses a rate of interest equal to the 10-year constant maturity Treasury securities rate, which, as of December 3, 2012 was equal to 1.63%, meaning that \$1,000,000 of retirement savings would produce only \$16,300 per year. See *Lifetime Income Calculator*, U.S. DEP’T OF LABOR, <http://www.dol.gov/ebsa/regs/lifetimeincomecalculator.html> (last visited Feb. 11, 2014).

¹⁶ Colleen E. Medill, *The Retirement Distribution Decision Ten Years Later: Results from an Empirical Study*, 16 ELDER L.J. 295, 316 (2009).

their lives they have access to what seems to them to be significant wealth. The temptation is great to spend some of it and so reward themselves for forty-five years of daily toil. Spending any substantial amount of their lump-sum payout, however, will severely affect their future financial well-being. We do not know how often recently retired employees spend part of their 401(k) accounts, but common sense tells us that many may buy a boat or a car or take a special vacation as they celebrate their retirement. Some undoubtedly spend a significant percentage of their 401(k) accounts by “investing” in a better house or vacation home. Others will have debts that they will need to pay off.¹⁷ Regardless of how much is spent or what it is spent on, however, the result is a diminution in future disposable income.

III. WHY PENSIONS ARE PREFERABLE TO 401(K) ACCOUNTS

The Employee Retirement Income Security Act (ERISA), which was enacted to protect the retirement income of employees, was reasonably successful when defined benefit plans prevailed and when retirement plans paid retirees a lifetime pension. In today’s world, however, where defined contribution plans are in the majority, 401(k) plans prevail, and ERISA “income security” ends at retirement when retired employees roll over their 401(k) accounts into IRAs. Once the retiree funds the IRA, ERISA protection ends.¹⁸ As a result, many of America’s retirees will encounter hard times during their retirement.

Consider the meaning of ERISA’s commitment to “income security.” The purpose of ERISA was to help ensure that retirees would receive the retirement benefits promised to them, which in 1974 typically meant a pension paid by a defined benefit plan. ERISA was not enacted as a means of creating wealth for workers that they could pass on to their descendants as a legacy. ERISA was enacted to help assure that retirees would have a dependable source of retirement income that, along with Social Security retirement benefits, would provide economic security

¹⁷ Deanne Loonin & Elizabeth Renuart, *The Life and Debt Cycle: The Growing Debt Burdens of Older Consumers and Related Policy Recommendations*, 44 HARV. J. ON LEGIS. 167, 168 (2007).

¹⁸ IRAs are not governed by the qualified retirement plan regulation of I.R.C. § 401(c). They are governed by I.R.C. § 408. See I.R.C. § 408 (2005); I.R.C. § 401(c) (2004).

during their retirement.¹⁹ When ERISA was enacted, defined contribution plans, though permitted, were in the minority.²⁰ When workers had a choice, as when negotiating their retirement benefits through collective bargaining, they overwhelmingly bargained for a pension as the best way of creating a financially secure retirement. They preferred a pension because they wanted to replace the loss of income occasioned by retirement, particularly when retirement was often not voluntary but imposed by a mandated retirement age, most commonly age sixty-five.²¹

The concept of the need to replace lost income due to retirement is the foundation of American retirement financial security. The most basic source of income security is the nearly universal Social Security tax on wages, which supports an old age pension.²² Intended as a replacement of income lost due to retirement, its benefits are directly tied to the amount of wages earned during the retiree's working years, with the benefit calculated as a percentage replacement of the highest thirty-five years of earned income that was subject to the Social Security wage tax.²³ Social Security is not a promise of a minimum income for every retiree. That function is performed by the Supplemental Security Income program that pays a modest benefit – in 2013, \$710 a month for a single individual or \$8,520 a year – and is best perceived as an anti-poverty program that provides a very modest degree of financial security.²⁴ In contrast, in 2013, the maximum

¹⁹ James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 1*, 14 J. PENS. BEN. 31, 32 (2006); David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 443–46 (1987) (describing the pension failures that gave rise to the enactment of ERISA).

²⁰ Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 448–49 (2010).

²¹ Until the enactment of the Age Discrimination in Employment Act in 1967 (29 U.S.C. §§ 621–634 (1974)), most employers had the right to terminate employees because of their age.

²² The benefit is payable at age 66 to those eligible. There is no requirement that the recipient retire in order to collect benefits. 42 U.S.C. § 401 (2004).

²³ David Pratt, *Retirement in a Defined Contribution Era: Making the Money Last*, 41 J. MARSHALL L. REV. 1091, 1125 (2008); SOC. SEC. *Frequently Asked Questions*, (Dec. 26, 2013), <https://faq.ssa.gov/ics/support/KBAnswer.asp?questionID=1989&hitOffset=65+36+35+27+23+19+18+13+11+10+8+4+3&docID=4533>.

²⁴ SOC. SEC., *SSI Federal Payment Amounts for 2014*, <http://www.ssa.gov/OACT/cola/SSI.html> (last visited Feb. 17, 2014).

Social Security monthly benefit for a worker retiring at age sixty-six was \$2,533 or \$30,396 a year, which is a replacement percentage of almost twenty-seven percent of the maximum amount of earnings of \$113,700 subject to the Social Security wage tax.²⁵

Employment based pensions, when added to Social Security benefits, were expected to create enough income to permit the retiree to live comfortably. In recognition of the retiree's receipt of Social Security benefits, in calculating the amount of the retiree's pension, the retirement plan can be "integrated" with Social Security; that is, Social Security benefits can be taken into account.²⁶ The right to create a pension benefit formula in light of Social Security benefits only emphasizes how pensions are a means of income replacement. To the extent that Social Security has already replaced lost income, an employer provided pension is relieved of that obligation.

When it became apparent that employer promises of pensions would often not be fulfilled, Congress enacted ERISA. It was meant to strengthen workers' rights by imposing fiduciary obligations on plan administrators and mandate adequate funding to increase the likelihood that pensions would not just be promised, but actually paid. The Pension Benefit Guaranty Corporation (PBGC) was also created to provide assurance that if the plan was unable to meet its pension obligations, at least some of the lost pension income would be replaced.²⁷ With the certain payment of Social Security and the relative security of pension payments, retirees were supposedly assured income for life.

The replacement of defined benefit pensions with 401(k) plans, however, has resulted in an upending of the original goal of income replacement. While 401(k) accounts are often criticized for moving the risk of investment from the employer to the employee, that is only part of the problem arising from the abandonment of pensions. Far more depressing, at least for retirees, has been the end of the national

²⁵ SOC. SEC., *Frequently Asked Questions* (Jan. 7, 2014), <http://faq.ssa.gov/link/portal/34011/34019/Article/What-160-are-160-the-maximum-160-taxable-earnings-amounts-and-the-Social-Security-tax-rate-for-2013>.

²⁶ See generally Patricia E. Dilley, *The Evolution of Entitlement: Retirement Income and the Problem of Integrating Private Pensions and Social Security*, 30 LOY. L.A. L. REV. 1063, 1136-79 (1997).

²⁷ Clare Staub, *Fiduciary Liability Issues in ERISA Pension Plan Terminations*, 11 HOUS. BUS. & TAX. L. J. 427, 430 (2011).

commitment to a guaranteed stream of income secured by ERISA funding requirements, plan administrator fiduciary obligations, and the PBGC.

Rather than promoting retirement income, a 401(k) plan promises the accumulation of a fund that the retiree may draw down and live on during retirement. While in theory a 401(k) plan should be able to serve as a secure source of income in retirement, in reality it will usually not. The difference between a pension – a set amount of annual income for life – and a lump sum that can be converted into a stream of income by annual distributions, is so great that to say that a 401(k) is a replacement for a pension is like saying that an orange is a substitute for an apple because both are fruits. Yes, both a pension and a 401(k) represent a form of wealth, and both can be converted into goods and services in the same way that both oranges and apples can be converted in caloric energy. Other than both providing the opportunity for consumption, however, there is simply no resemblance between a pension and a 401(k) account. The former represents a form of income replacement, while the latter, the 401(k), is a form of wealth accumulation. And while it is true that wealth can be used to replace income, it is not at heart income. Wealth must be managed, invested and husbanded in order for it to produce income during the many years of retirement.

The essence of a pension is its dependable and repetitive nature, so that every dollar received can be used to purchase goods and services, because another dollar, i.e., next month's pension payment, is on the way. That is the good news. The bad news is that the pension benefit is fixed and usually not adjusted to reflect a loss of purchasing power due to inflation, and the death of the pensioner, or the spouse of the pensioner, terminates the benefits. (Though many pensions pay until the last to die of the worker or the worker's spouse, for convenience this paper will refer only to a single pensioner.) Because an ERISA pension is non-assignable and cannot be sold,²⁸ a pension has no present value.

A 401(k) account is the opposite of a pension. Once transferred to an IRA, the funds are assignable, have a present value and maintain that value at the death of the retiree. But the funds, once spent, are forever gone. Every dollar spent is a dollar that will not be replaced. In short, a pension is income, a 401(k) account is wealth. And yes, income can be converted into wealth by not spending it, just as wealth, if spent, can be converted into income. But to save pension income in order to create

²⁸ 29 U.S.C. § 1056(d)(1) (2006).

wealth means the loss of current consumption, which defeats the very reason for the pension – the replacement of income loss due to retirement. And to spend the wealth in a 401(k) plan to create income defeats the core advantage of wealth, the possibility of future consumption either by the current owner of the wealth or by a designated successor.

Pensions, which offer the certainty of income over the life of the retiree or pensioner, meet the challenge of how to pay a fixed level of income for an unknown number of years without assuming any additional funding after the commencement of the pension. There is no risk of running out of income for a retiree because that risk is borne by the payer of the pension, or more correctly the risk is reduced to the risk of the payer not being able to pay the pension because of actuarial miscalculations, lower-than-expected investment returns, or the plan sponsor encountering financial difficulties and so not making required contributions to the plan.

If we conceive of the pension as being a pooling of individual retirement funds by all of the pensioners – albeit contributed by the employer and not the workers – the promise of lifetime income is possible only because of the insurance aspect of the fund. Pensions are a form of pooled risk; the promise of lifetime income to all participants is possible only because of differential dates of death by the participants. Some pensioners will outlive their life expectancy and so receive more value in annual distributions than would be called for based on the dollars that their employer contributed to the pension plan for that individual. Other pensioners will die before their expected life expectancy and so never realize the value of the dollars that were contributed to the fund on their behalf. Those who die before their expected time not only collect a pension for fewer years; they also forfeit what they “paid” to their pension in the form of foregone wages. To the extent their wages were reduced, as the employer shifted their compensation from current wage income to future pension income, pensioners who die early experience an actual loss of lifetime disposable income compared to workers whose employer did not reduce their wages to contribute to a pension plan. In short, a worker enrolled in a pension plan is betting that he or she will live long enough to recapture the loss of current wages in the form of pension income.

A 401(k) account that is rolled over into IRA is the antithesis of the pension plan’s pooled risk; each retiree individually bears the risk of living beyond his or her life expectancy and so exhausting the IRA. The uncertainty of when death may occur and the “risk” of a long life means a retiree cannot spend all of his or her IRA and must hold back some of it in order to guarantee that the fund will not be exhausted before death,

meaning that not all the 401(k) account is available for consumption during retirement.

The uncertainty of when death will occur and the lack of “income insurance” for the long-living retiree results in a pension having a greater worth than an IRA of a similar dollar value. On the first day of retirement, if a pension is discounted back to present value, and that value is equal to the present value of a rollover IRA, the pension will provide more annual income for consumption than the IRA because, unlike the IRA, every dollar of the pension is available for consumption. A pension plan, which has sufficient participants to effectively spread the actuarial risk, can calculate the annual payoff that will exhaust the allocated capital for each participant at the average expected date of death of the plan participants knowing that the “early” deaths of participants and the resultant savings of capital will counterbalance the “late” deaths and so ensure sufficient funds to pay every participant a pension for life. The ability to payout all of the capital is what makes a pension inherently more valuable in terms of consumption to a retiree than a rollover IRA, which the retiree cannot spend down to zero because the retiree does not know when death will occur.

Of course, by not spending all the capital in an account, the IRA owner has funds to pass on after death. The dollar amount of what is passed on will be an actual number, but the value to the IRA owner of passing on funds to another will vary according to the value to the IRA owner of leaving a legacy. Some place a high value on doing so, while others prefer to consume more of the IRA during their life rather than passing that consumption opportunity as a legacy on to another.

The legacy advantage of an IRA is not unique, however, because it can be achieved by a pensioner by the purchase of life insurance. Assuming upon retirement that the pensioner is insurable, he or she can purchase life insurance, whose annual premium will reduce consumption but ensure a legacy. By doing so, a pensioner might end up with a level of annual consumption that is close to the amount of an annual distribution from an IRA that can safely be taken out over the life of the owner. Similarly, an IRA owner can capture the value of a pension by using the IRA to purchase an immediate pay, lifetime annuity, but the transaction costs associated with purchasing an annuity and the conservative future rate of interest assumed by the seller of the annuity will likely result in a lower annual payment than if the same amount in the IRA had been contributed annually to a defined benefit plan and used to finance an annual pension.

It is not the marginally lower return of an individually purchased annuity, however, that accounts for the lack of purchases by IRA owners.²⁹ Scholars of behavioral economics tell us that a variety of psychological traits, such as hyper-discounting of future income, the common reluctance to exchange a very large amount of money for a future stream of income, over-confidence as to the ability to invest, excessive optimism as to rate of return on investments, and underestimating life expectancy, are so deeply inured that it is unlikely that immediate pay annuities will ever find a significant market with IRA owners.³⁰ The result is that most IRA owners do not purchase an annuity and so must manage their accounts during their retirement.

IV. HOW SUCCESSFUL ARE RETIREES IN MANAGING A ROLLOVER IRA?

Upon retirement, the individual can rollover a 401(k) account into a tax-free IRA.³¹ A retiree who decides to rollover a 401(k) account into an IRA must decide where to roll over the funds. There is no shortage of choices; mutual funds, banks, investment advisors, and investment companies all compete for 401(k) accounts dollars, which is hardly a surprise given the opportunity for fees and commissions for the custodian of the IRA. We know very little as to how employees choose the repository of a 401(k) rollover. We do not know if they compare costs in the form of fees and commissions, whether they look closely at the investment return, seek safety from fraud or embezzlement, or search out low or high risk investments. Perhaps they just respond to advertisements or merely follow advice from a friend or relative.

We do know that the choice of the investment vehicle is crucial in terms of the investment return. Retirees who choose unwisely may suffer diminished income in their twenty or thirty years of retirement. We also know that the choice is not “one and done.” Hopefully, over time the retiree gains investment sophistication and invests the account more wisely than at the time of the rollover. Unfortunately, inertia usually wins out

²⁹ Wei-Yin Hu & Jason S. Scott, *Behavioral Obstacles in the Annuity Market*, 63 FIN. ANALYSTS J. 71, 79 (2007).

³⁰ See generally GARY BELSKY & THOMAS GILOVICH, *WHY SMART PEOPLE MAKE BIG MONEY MISTAKES – AND HOW TO CORRECT THEM: LESSONS FROM THE NEW SCIENCE OF BEHAVIORAL ECONOMICS* (2010).

³¹ I.R.C. § 402(c)(2) (2006).

over wisdom (assuming that retirees gain investment skill as they age) so that the initial investment decisions are unlikely to be changed.³²

Of course, the need to make successful investment choices is not new, as the employee faced the same decisions when working. What is new is that the retired employee will be withdrawing funds from the account, or at least the annual minimum distribution that is required after age seventy and a half.³³

The required minimum distribution rules, as well as the practical need to take distributions to provide additional income, raise a number of difficult decisions for the IRA owner. Each year the owner must decide from which assets to take distributions. There are several options, including distributing the most risky assets first, proportional distribution by asset, and either first liquidating equities or the fixed income investments. After each distribution, and in light of past investment returns, the IRA owner faces the choice of whether to adjust the asset allocation. The number and complexity of the choices raised by the need to make annual distributions strongly suggests that many older retirees will not be up to the task.

A retiree who owns an IRA faces confusing choices because the “right” answers are dependent on uncertain variables, including future interest rates, future stock prices, the rate of inflation, future income needs, and the life expectancy of the retiree and the retiree’s spouse. Of course, investors of any age can guess wrong as to the direction of the stock market or future interest rates, but a wrong choice by a retiree may result in a loss of capital: a possibly irreversible choice that may significant lower future distributions.

Given the number of variables that impact retirees’ choices as to how to manage their rollover IRAs, it is unlikely that most are making optimum decisions. Even if they make a wise decision, it is not a final decision. Each year a new retiree can make new mistakes. This repeated need to make difficult investment decisions continues throughout the retiree’s life – stretching from retirement at age sixty-five to age eighty-five, ninety-five or even one hundred. Does anyone really think that most ninety-five-year-olds are up to the task of managing an IRA?

³² See Jeffrey Zwiebel, *Corporate Conservatism and Relative Compensation*, 103 J. POLITICAL ECON. 1, 15–16 (1995).

³³ I.R.C. § 401(a)(9) (2006); see also Treas. Reg. § 1.401(a)(9)-9 (2011) (portraying A-2, Uniform Lifetime Table).

V. DIMINISHED PHYSICAL AND MENTAL CAPACITY

Much has been written about how employees lack the ability to sensibly invest their 401(k) accounts during their working years.³⁴ They also fail to contribute as much as they might, too often borrow from the account, and some even deplete it long before retirement by taking hardship distributions.³⁵ The failure to fully participate, lack of investment acumen, and leakage during working years are all significant drawbacks of 401(k) accounts, yet they fail to capture another inherent fundamental flaw.

Surprisingly, little attention has been paid to the inability of many retirees to successfully manage their rollover retirement IRA funds during the long years of their retirement.³⁶ Retirees typically face twenty to thirty years of retirement. During those many years they must continue to successfully invest and manage an IRA. Unfortunately, during their retirement years most retirees are in physical and mental decline, which erodes their investment skills and diminishes the probability that they will successfully manage their retirement account.

Physical decline is a normal part of aging. The loss of hearing, serious vision impairment, loss of physical energy, and loss of short-term memory are all too common with those aged seventy-five and older.³⁷ The degree of decline varies greatly from individual to individual. Some experience only modest physical decline, such as diminished eyesight or loss of hearing. Others suffer from a general loss of energy and growing frailty. A few will suffer serious declines in short-term memory, others will have significant vision problems, such as macular degeneration, and many will have impaired hearing even if they use a hearing aid. It is difficult to believe that those with serious physical declines can successfully manage an IRA. If, because of failing vision, you have difficulty or cannot read, you cannot effectively review your IRA reports.

³⁴ E.g., James Kwak, *Improving Retirement Savings Options for Employees*, 15 U. PA. J. BUS. L. 483 (2013); Jeff Schwartz, *Rethinking 401(k)s*, 49 HARV. J. ON LEGIS. 53 (2012).

³⁵ Thomas Olson, *401(k) Leakage: Crafting a Solution Consistent with the Shift to Employee-Managed Retirement Accounts*, 20 ELDER L.J. 449, 462–65 (2013).

³⁶ One exception is Pratt, *supra* note 23, at 1137–42.

³⁷ Mary Helen McNeal, *Slow Lawyering: Representing Seniors in Light of Cognitive Changes Accompanying Aging*, 117 PENN ST. L. REV. 1081, 1091–98 (2013); Frolik, *supra* note 7, at 292–97.

Poor hearing may mean you do not hear the advice given to you, mishear it, or avoid meetings with advisors because of your difficulty in hearing. If your short-term memory has severely declined and you have trouble reading because of vision problems, you simply will not be able to make considered decisions. Add to this a general loss of vigor, and it becomes apparent that many very old IRA owners are not capable of active, reasoned management of their account.

Chronic illness is the fate of many elderly. They suffer from conditions such as diabetes, rheumatoid arthritis, and congestive heart failure, which rob them of the energy and concentration needed to be a sophisticated investor. Consider an eighty-year-old woman suffering from end stage renal disease, who travels to the dialysis center three days a week. On the other days of the week, is she really going to devote her limited time and energy to her financial affairs? Will she have the concentration and energy to do so? Other elderly persons experience acute illnesses such as cancer, that leave them in pain, disoriented by drugs or other therapies, and much more concerned about whether they will live than whether their IRA is overloaded with equities or worried about which assets should be sold to provide cash for the annual required minimum distribution.

Even more chilling is the specter of millions of IRA owners who suffer progressive dementia. It is estimated that up to half of those age eighty-five or older suffer from dementia.³⁸ At its most severe, dementia and related illnesses such as Parkinson's leave the victim without the ability to manage even daily expenditures, much less an IRA. It is an odd form of retirement planning indeed to pin the hopes of financial security during retirement on individually managed IRAs, knowing as we do, that a significant percentage of those IRA owners will lose the mental ability to manage those accounts due to dementia. Of course, millions of recipients of pensions will also become demented and lose the ability to handle a monthly pension check. But the risk to a pension recipient is much less. Even if the monthly pension check is lost or misused, another check will arrive next month. But if a demented IRA owner makes investments that result in significant financial losses, there is no additional money coming to the rescue.

³⁸ THE MERCK MANUAL OF GERIATRICS 357 (Mark H. Beers et al. eds., 3rd ed. 2000).

The financial risks to an IRA owner during the early stages of progressive dementia are very great. Dementia or a similar loss of executive functioning can arise from several sources, but the two most prevalent are Alzheimer's and vascular (multi-infarct) dementia. Alzheimer's, the most common form of dementia, is a progressive and irreversible condition that eventually leads to death.³⁹ Vascular dementia, the second most common cause of dementia, is caused by one or more mini-strokes in the brain. While vascular dementia is not necessarily progressive, often the individual experiences additional strokes with a resulting additional loss of mental capacity. The loss of capacity is patchy, as some forms of cognition are unaffected, but the strokes can also cause the loss of physical capability.⁴⁰ The decline in both mental and physical capacity can potentially seriously diminish an individual's ability to effectively manage an IRA.

Whether caused by Alzheimer's or vascular strokes, in its early stages dementia is often not diagnosed. Although some victims of dementia are aware that something is amiss, most do not understand or appreciate that they are losing mental capacity, or they fail to understand the extent of the loss. One of the tragedies of dementia is that it robs its victim of self-awareness and self-judgment. Dementia often waxes and wanes so that the individual may experience times of awareness and realize that they cannot remember some obvious past event or they failed to recognize a good friend on the previous day. But this interval of awareness rarely leads to individuals admitting that they are in mental decline and taking steps to assure that their finances are protected.

Family and friends of individuals with early stages or mild dementia frequently misread it as merely as normal memory loss associated with aging. During the early stages of the disease, the victim can often cover for the deficits; rather than engaging in a conversation, they reply with timeworn clichés or phrases that give the appearance of someone who may be less engaged with the world but is still of sound mind. Some observers perceive the loss of executive functioning as a sign of normal aging or else assume that the older person is merely confused by modern life and new circumstances. Often family members do not want to admit that a parent or spouse is suffering from dementia, and essentially deny the

³⁹ For a detailed discussion of the causes and symptoms of Alzheimer's disease, see JAMES E. SPAR & ASENATH LA RUE, *CLINICAL MANUAL OF GERIATRIC PSYCHIATRY*, 173–220 (2006).

⁴⁰ *Id.* at 242–48.

obvious signs. It seems better to laugh off the confusion and memory loss, which waxes and wanes, and claim that "Mom has good days and bad days," and hope that it is not a progressive condition.

It is during the early stages of dementia that the individual is at particular risk of making misguided decisions about an IRA. Because no one may be aware of the degree of the loss of capacity, the IRA owner will continue to make investment and distribution decisions without anyone raising an objection or intervening. The financial advisor may disagree with IRA owner's decisions, but, absent understanding that the decisions arise from a diminished capacity, the advisor will merely assume that the client has poor judgment. Worse, the individual with early or mild dementia is very vulnerable to financial exploitation and abuse because the loss of capacity leaves the individual less capable of perceiving poor advice or spotting a conflict of interest. The loss of capacity also typically results in the individual being much more susceptible to advice, suggestions and even undue influence from third parties or unreliable sources, such as financial commentators on television or on internet sites. Even family members may take advantage of a confused, forgetful individual suffering from mild dementia by asking for gifts, requesting money for their own investment or business schemes, or even becoming the chief investment advisor (for a fee, of course).

How many IRA owners suffer from some degree of dementia and how much harm that has caused to their accounts is unknown. But statistically we know that millions of older IRA owners have dementia, and we also know that individuals with dementia make poorer decisions and are vulnerable to poor or exploitive advice. So it follows that millions of IRA owners are making poor investment decisions. For an IRA owner not to take steps to assure effective management of the IRA in the event that he or she loses mental capacity reflects a failure to plan for a fairly likely eventuality.

VI. THE LIMITATIONS OF GUARDIANSHIP AND POWERS OF ATTORNEY

The inability of many older individuals to handle their financial affairs has led to the reliance on substituted decision makers: court appointed guardians and agents acting under a power of attorney. Unfortunately, both have serious drawbacks.

A. GUARDIANS

Every state has a guardianship statute that permits a judicial determination that an individual is legally incapacitated and in need of a guardian. Guardianship (called conservatorship in some states) has long been the state response to attempt to protect those who lack mental capacity.⁴¹ At present, the typical statutory test of legal incapacity is the inability of an individual to make reasonable decisions.⁴² If an individual is found to lack mental capacity, the court is empowered to appoint a guardian (or conservator) to act as a substitute decision-maker for the incapacitated individual. The standard of proof of mental incapacity is high because states do not wish to override individuals' autonomy even if they are less mentally capable than they once were or even if they are making questionable financial decisions. Consequently, an IRA owner with diminished capacity might not qualify for the appointment of a guardian even though, because of the loss of mental capacity, his or her investment decisions have been questionable and result in financial losses.

Assuming, however, that a court finds the individual to be mentally incapacitated, the court has the authority to strip the individual of the right to manage an IRA, and all other assets, and appoint a guardian to take over management of the IRA as well as the individual's other assets. The court will grant the guardian sufficient authority to carry out its assigned duties, but usually will not instruct the guardian as to how it should carry out its responsibilities, such as managing an IRA. A guardian is assumed to be capable of protecting the assets of the incapacitated person in an efficient and sensible manner, though a guardian may be subject to some statutory instructions or limitations. Often, for example, a guardian has the authority to spend the income of the incapacitated individual, but must ask the court for authority to spend capital.

Most states expect a guardian to make that decision in accordance with the doctrine of substituted judgment, which requires the guardian to attempt to do what the incapacitated person would have done but for the incapacity.⁴³ The guardian is expected to attempt to ascertain what the

⁴¹ See generally Lawrence A. Frolik, *Plenary Guardianship: An Analysis, A Critique and a Proposal for Reform*, 23 ARIZ. L. REV. 599 (1981).

⁴² E.g., UNIF. PROBATE CODE § 30.1-26-01 (amended 2010).

⁴³ Linda S. Whitton & Lawrence A. Frolik, *Surrogate Decision-Making Standards for Guardians: Theory and Reality*, 2012 UTAH L. REV. 1491, 1494 (2012).

incapacitated person would have done on the basis of his or her prior oral or written statements, any relevant instructions or comments made to financial advisors or others, and by the pattern of prior decisions. For example, if the incapacitated person had invested the IRA exclusively in bonds and eschewed stocks, under substituted judgment, the guardian should continue that investment allocation. Similarly, the guardian should continue to make distributions from the IRA at the same level as in prior years unless the needs of the incapacitated person or his or her spouse suggest larger annual distributions would be appropriate.

The guardian is accountable to the appointing court, perhaps in the form of annual reports, but the level of judicial supervision is usually minimal and largely ineffective because of limited court resources.⁴⁴ It is also not clear how courts expect a guardian to manage an IRA. For example, is a guardian permitted to distribute more than the minimally required annual distribution without prior court approval? The answer likely varies from state to state and may vary from court to court within a state. Guardians, in short, are usually left to their own devices; whether that results in optimal choices about IRA investments and distributions is doubtful.

Guardianship has other drawbacks. The imposition of a guardianship may not be possible even though an individual has diminished capacity, because the appointment of a guardian can only occur if the individual meets the state's statutory test of incapacity. State standards of when a guardian can be appointed are deliberately set fairly high because the state is naturally hesitant to strip an individual of the right to control his or her life. It is thought better to permit individuals with reduced capacity to continue to manage their own affairs so long as they are not putting either themselves or their property at serious risk of harm. Thus, for example, just because an IRA owner puts the funds in more risky investments or comes under the sway of a new financial advisor whose views are out of the mainstream, is not reason enough to impose a guardianship since many IRA owners, who have with no loss of capacity, invest their funds in high risk investments or rely on controversial investment advice.

⁴⁴ Naomi Karp & Erica F. Wood, *Guardianship Monitoring: A National Survey of Court Practices*, 37 STETSON L. REV. 143, 185 (2007).

Even if the court finds the requisite incapacity and approves a guardian, the individual appointed as guardian may lack the knowledge or skill to be an effective manager of an IRA. Typically, the court appoints as guardian the individual nominated in the petition that was filed seeking the imposition of a guardianship. The ability of the individual nominated to wisely manage a retirement IRA undoubtedly varies greatly. Often those nominated are selected more for their willingness and availability to act as guardian rather than for any special financial acumen. Worse, the individual who agrees to act as guardian may agree to do so from a desire to gain some advantage or profit from the assets of the older person rather than using the IRA to promote the interests of the incapacitated person.⁴⁵

B. AGENTS

Because of the costs, complexities, and lack of privacy associated with guardianship, every state has a statute that permits an individual to create a durable power of attorney that appoints an agent to handle financial affairs in the event the principal should be unable to do so. The use of a power of attorney would seem to be the sensible and efficient solution to an older retiree losing the ability to handle a retirement IRA. It is inexpensive because most powers of attorney are based on a form or a standard document, and can be seen as something akin to a private guardianship arrangement, with the agent being comparable to a guardian. The agent takes on his or her duties when the principal is no longer capable of managing his or her financial affairs. There is no judicial involvement involved. The appointment of an agent under a power of attorney is a private solution to a private problem.

Unfortunately, despite the wide use of the durable powers of attorney, no state has succeeded in preventing the misuse of that power by the agent.⁴⁶ Absent requirements in the power that mandate oversight or preapproval of an agent's actions, agents are essentially on their own.⁴⁷ As a result, an agent can manage the financial affairs of the principal as the agent sees fit. Without any on-going oversight, who is to know if the agent

⁴⁵ Alison Barnes, *The Virtues of Corporate and Professional Guardians*, 31 STETSON L. REV. 941, 956 (2002).

⁴⁶ See Linda S. Whitton, *Durable Powers as an Alternative to Guardianship: Lessons We Have Learned*, 37 STETSON L. REV. 8 (2007).

⁴⁷ Nina A. Kohn, *Elder Empowerment as a Strategy for Curbing the Hidden Abuses of Durable Powers of Attorney*, 59 RUTGERS L. REV. 1, 18 (2006).

is dutifully carrying out his or her responsibilities? The agent is, to be sure, a fiduciary and held to the duty of loyalty and the obligation to avoid conflicts of interest and self-dealing, but how the agent is to make decisions is less clear.⁴⁸ Most states require the guardian to act in accord with substituted judgment, that is, to do what the incapacitated person would have done, although some states expect the agent to act in the best interests of the principal.⁴⁹ The latter presumably allows an agent to ignore the expressed wishes of the principal or the previous pattern of decisions by the principal if those decisions do not appear to be the best way to further the principal's financial interest. That has the advantage that an agent acting according to the best interest standard can ignore what the principal might have said or done in the period when the principal might have been suffering from a decline in capacity, though before the loss was sufficient to permit the agent to take control. Even states that insist upon the application of substituted judgment permit an agent to ignore what the principal would have wished if the agent believes that to do so would not be in the principal's best interest.⁵⁰ In the end, how an agent acts may not differ much whether the state standard is one of substituted judgment or best interest; the agent will do what the principal would have done unless it does not seem in the best interest of the principal to do so.

Of course, that is the point of a power of attorney – to create powers in the agent that are very similar to the legal rights of the principal. Unfortunately, that wide grant of authority makes it easy for an agent to perform poorly in managing an IRA even though carrying out his or her duties in a lawful manner.

The initial challenge for the agent is to intelligently invest the IRA assets. Probably, many agents do what is easiest, which is to do nothing and leave the assets invested as they found them. Maintaining the status quo is an attractive option. When faced with whether to act or do nothing, individuals usually prefer to stay the course rather than to make any changes because a lost opportunity is more easily overlooked and forgotten as compared with doing something that proves to be a mistake.⁵¹ The

⁴⁸ Karen E. Boxx, *The Durable Power of Attorney's Place in the Family of Fiduciary Relationships*, 36 GA. L. REV. 1, 27 (2001).

⁴⁹ See Carolyn L. Dessin, *Acting as Agent Under a Financial Durable Power of Attorney: An Unscripted Role*, 75 NEB. L. REV. 574 (1996).

⁵⁰ Whitton & Frolik, *supra* note 43, at 1499.

⁵¹ See Russell Korobkin, *The Status Quo Bias and Contract Default Rules*, 83 CORNELL L. REV. 608, 675 (1998).

preference for the status quo and the desire to avoid losses when faced with uncertain alternatives is well documented in psychological studies.⁵² So it is to be expected that an agent, unless quite confident in his or her investment skills, may choose to leave the asset allocation as is. Changing investments opens the agent to the possibility that the new investments will perform less well than the old investments would have if they had not been abandoned. That underperformance is a natural test to apply to the new investments. In contrast, the wisdom of not changing the investments is difficult to judge because it is unclear as to which possible alternative investment choice the status quo should be measured against. Suppose that when the agent took control from an incapacitated IRA owner, the IRA was invested forty percent in stocks and sixty percent in bonds. An agent, who maintained that asset allocation, could not be criticized because that is a common and defensible allocation of IRA assets. If, however, the agent changed the allocation to eighty percent bonds and twenty percent stocks, it is easy to measure the return of stocks over the next year and observe whether the retreat from stocks was a good decision; that is, the most profitable choice. If stocks had soared in value, it would seem that the agent made a mistake even though, to be fair, the wisdom of the decision to sell stocks and buy bonds should have been judged at the time of the stocks were sold and not in hindsight.

The maintenance of the status quo also fulfills the requirement of substituted judgment by doing what the principal apparently would have done. Doing so, however, assumes that the prior acts of the principal represented decisions made when the principal was fully in command of his or her mental facilities. In many instances, however, that will not be the case. The principal's mental incapacity might have been the result of a swift and dramatic debilitating illness, but it is far more likely that the principal's capacity was a gradual decline and that he or she continued to manage the IRA while suffering from diminished capacity. And during that period of time, the principal may have made investment decisions that did not represent the "true" intent of the principal; that is, the principal at full mental capacity. Obviously, no agent should feel bound by substituted judgment to carry out decisions made by a principal, who suffered from reduced capacity. Given that the agent cannot know when the principal began to lose capacity, and so which past decisions reflect a reduced level

⁵² See, e.g., Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 *ECONOMETRICA* 263 (1979).

of incapacity, an agent should be hesitant to apply substituted judgment to the management of an IRA.

An agent, if not bound by substituted judgment, necessarily must apply the best interest test and manage the IRA in a manner that best promotes the principal's interests, presumably both financial and personal. That dictate, however, presents a number of difficulties for a conscientious agent.

The agent must manage the IRA in a manner that will maximize returns commensurate with an acceptable level of risk. While maintaining a proper return/risk balance is difficult for any investor, an agent managing an IRA, faces the additional obligation of serving the best interest of the principal, which is an almost impossible task because there is no simple metric that tells the agent whether any particular investment strategy meets that obligation. If the agent errs on the side of lower risk, the investment return will suffer, and that in turn will either mean smaller distributions in the future, and so a diminished quality of life for the principal, or an IRA of a lesser value to pass on to the principal's heirs. Of course, the agent has no way of knowing whether the principal is better served by lower investment returns but less risk, or whether the principal would be better off if the agent took greater risks and so achieved greater investment returns. Taking greater risks could either mean greater distributions or a larger IRA to pass on to heirs, but could also mean a loss of capital and so lower returns in the future.

Not only do investment decisions present difficulties for an agent; so do distributions. An agent, when making IRA distributions beyond those mandated by the minimum distribution rules, must look to the quality of life of the principal with an eye towards balancing present and future needs. An increase in distributions today may result in smaller distributions in the future, and also dictates taking greater investment risks in order to support continued large distributions in the future. The agent, who must make decisions in an ever-changing investment climate, must also make distributions with due consideration of the possibility that the principal's financial needs may be increasing as his or her physical and mental condition declines.

It should be apparent, then, that even a dedicated, conscientious agent will find it difficult to manage an IRA. Many individuals, no matter how well intentioned, will not be up to the task. They will lack the investment acumen and sophistication required to successfully handle

investments of a fund from which annual distributions are being made.⁵³ They will also be unable to determine the appropriate amount of distributions in light of the tension between the current and future needs of the principal. The interplay of investment choices, distribution decisions, a fluid investment landscape, and the changing needs of a physically and mentally declining principal will be beyond the ability of most agents.

The inability of the typical agent to effectively manage an IRA is also a result of who the principal is likely to appoint as agent. Usually, in order of priority, principals name their spouse, next an adult child, and finally a more distant relation. None of these individuals are selected because they are financially sophisticated or skilled at managing an IRA; rather, they are named because they are someone the principal trusts and who are willing to serve as an agent. Overwhelmingly, principals name spouses and children as agents, in part because the principal does not realize how difficult it can be for an agent to manage the principal's financial affairs, particularly if the principal owns a rollover IRA.

Additionally, even if the individual who was named agent made sense at the time the power of attorney was executed, that appointment might not be a wise choice by the time the agent actually takes over for the incapacitated principal. For example, at age seventy, the IRA owner named his sixty-nine-year-old wife as agent, but when he became incapacitated at age eighty-six, she was eighty-five and beginning to suffer some mild loss of memory. Will she be mentally sharp enough in the coming years to successfully manage his IRA account? What of the seventy-five-year-old woman who named her fifty-three-year-old daughter as agent, but did not become incapacitated until age ninety when her daughter was sixty-eight and undergoing intensive treatment for lung cancer? Is the daughter really going to be capable of handling her mother's IRA? Or consider a seventy-five-year-old man who names his twenty-five-year-old nephew as his agent. Ten years later, when the principal needs his agent to take over the principal's finances, the now thirty-five-year-old nephew has just filed for bankruptcy after he lost his job, had his house foreclosed and is in the midst of a bitter divorce, not exactly the person the eighty-five-year-old principal would now choose to act as his agent.

⁵³ Financial literacy varies considerably. Some agents may be quite capable; others much less so. One study found that individuals with less education and less wealth have a lower level of financial sophistication and are prone to making more investment errors. Laurent E. Calvet et al., *Measuring the Financial Sophistication of Households*, 99 AM. ECON. REV. (PAPERS & PROC.) 393, 397-98 (2009).

Even if the agent is not suffering from health or financial problems, there is no reason to suppose that most agents will be effective at managing an IRA. When managing an IRA, an agent has incentives and motivations that are not the same as those of the principal, which result in classic “agency costs.”⁵⁴ Unlike the principal, who has a financial stake in the management of the IRA, the agent does not. If the agent is paid, it will be by the hour with little regard to the quality of the agent’s performance. The many agents who are not compensated are motivated by love, concern, and a sense of responsibility; none of which may translate into effective management of the principal’s IRA. Agents may in fact be less capable because they are not dealing with their own money and the quality of their own life is not affected by their decisions. Although the agent may want to make decisions that best promote the interest of the principal, it is unlikely that an agent will devote as much time and energy in managing the IRA as would the principal. That lack of self-interest alone is likely enough to mean less effective management of the IRA by the agent, even assuming the agent has skills comparable to the principal.

In some cases, third parties may bring pressure to bear on the agent. Those who are the beneficiaries of the IRA after the principal’s death may urge greater or lesser risk taking in the IRA investments as a way of protecting their expected future inheritance. Or they may advise the agent to minimize distributions in order to increase their inheritance. For example, if the principal needs daily assistance, the question may arise as to whether to purchase daily attendant care in the principal’s home or elect more economical housing in an assisted living facility. Whether the agent is willing to pay for expensive personal care may depend on the agent’s relation to the principal. An agent, who is the spouse of the principal, may choose to pay for personal care, while an adult child, with an eye to his or her inheritance, may think assisted living is a more sensible choice.

If the agent stands to inherit the IRA, the conflict of interest is obvious and real; yet the selection of an adult child as agent is understandable, though still unfortunate. How an agent responds to a conflict of interest may depend on the agent’s relative financial status and how much the agent is looking forward to inheriting a well-funded IRA.

⁵⁴ See Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305, 308–10 (1976). For an analysis of why a trustee’s relation to a settlor exhibits agency costs, see Robert H. Sitkoff, *An Agency Costs Theory of Trust Law*, 89 CORNELL L. REV. 621, 624 (2004).

The agent is a fiduciary and so should resolve any conflict in favor of the principal or resign as agent. In reality, however, an agent's decisions as to the management of an IRA are likely to be within the zone of the agent's discretion and so are not obvious violations of the agent's fiduciary duty. Even if the agent fails to meet his or her fiduciary obligations, absent a rather obvious transgression and someone who is willing to object, the agent will not be called to account.

Beyond the honest but marginally competent agent are those who misuse, abuse or steal the principal's assets. In the past, agents have made inappropriate gifts to third parties, made inappropriate gifts to themselves, made gifts to charities not favored by the principal, defeated estate plans by creating joint accounts with survivorship interests, changed beneficiaries named in life insurance contracts, revoked trusts, engaged in self-dealing, and used their powers to benefit their spouses, friends or relatives. In short, agents routinely violate their fiduciary obligations and use their authority to advance their own interests at the expense of the principal.⁵⁵

If the agent misuses or wastes the assets in the IRA, the elderly IRA owner will not only be incapacitated but may also be impoverished. Of course, an elderly IRA owner will try to select a trustworthy person to act as agent, and most probably succeed in doing so, but not all will make the right choice.

An aging owner of a retirement IRA who is losing the ability to manage it faces the alternative of accepting guardianship or appointing an agent under a durable power of attorney, neither of which assures proper management of the IRA. This is the world that our nation's retirement system has created for its elderly. The reliance on 401(k) plans has been rightly criticized for leaving retirees with inadequate savings for their retirement. Many have attacked 401(k) accounts for putting the investment risk on employees who in general are not up to the burden.⁵⁶ But even those employees who arrive at retirement having adequately managed their account and have an account with enough money to create a financially secure retirement must still navigate the perilous years of their retirement.

⁵⁵ See generally Jennifer L. Rhein, *No One In Charge: Durable Powers of Attorney and the Failure to Protect Incapacitated Persons*, 17 ELDER L.J. 165 (2009) (describing how agents acting under durable powers of attorney agreements can exploit incapacitated principals).

⁵⁶ Debra A. Davis, *Do-It-Yourself Retirement: Allowing Employees to Direct the Investment of Their Retirement Savings*, 8 U. PA. J. LAB. & EMP. L. 353, 365 (2005).

Like a modern Odysseus, they must successfully navigate a long and difficult voyage.

VII. ANNUITIES

Because of the difficulties of post-retirement management of a rollover IRA, some hope to recreate the advantages of the defined benefit pension by encouraging retirees to convert some or all of their IRA into an immediate pay, lifetime annuity.⁵⁷ Doing so would address the two significant risks created for retirees - financial management and longevity.

A. RECREATING THE ADVANTAGES OF A DEFINED BENEFIT PLAN

The owner of an IRA can capture many of the advantages of the pensions offered by defined benefit plans by converting some or all of the account into an annuity. Merely investing half of the account can dramatically increase the probability that the retiree will not outlive the IRA.⁵⁸ The purchase of a lifetime annuity eliminates the need to manage the investment of those funds, determining which assets should be used to fund distributions, and the fear of zeroing out the fund prior to death. At present, only twenty percent of defined contribution plans offer retirees the option of converting their accounts into an annuity, and only about ten percent of the employees of those plans choose the annuity option. Even if an annuity is available as part of the 401(k) plan, retirees typically prefer a lump-sum distribution to an annuity.⁵⁹ Interestingly, retirees who participate in defined benefit plans often have the option of accepting a pension, which can be thought of as an annuity, or accepting a lump-sum distribution. Although some do elect to take the lump sum, the rate of those who choose the pension do so at a much higher rate than those with defined contribution accounts elect to convert them into an annuity. Apparently, both those expecting pensions and those anticipating the

⁵⁷ See generally Frolik, *supra* note 7 (arguing that federally guaranteed annuities for retirees paid for by 401(k) accounts would provide a more secure method of extending retirement savings).

⁵⁸ Walter Updegrave, *Make Your Dough Last and Last...and Last*, 38 MONEY 92, 94 (Oct. 2009).

⁵⁹ Steven D. Cohen, Note, *Autoenrollment and Annuitization: Enabling 401(k) "DB-ation,"* 5 N.Y.U. J.L. & BUS. 281, 317 (2009).

receipt of a lump sum prefer to stay with the status quo.⁶⁰ For most retirees, exchanging a lifetime of accumulated retirement investment, a very large figure, for periodic annuity benefits, a much smaller figure, is not an appealing tradeoff.⁶¹

A variety of structural reforms are needed to encourage the purchase of annuities. No one reform is going to drastically change the current retiree reluctance to purchase annuities, but in combination, they could begin to change their attitudes. What is needed is a sense by retirees that annuitizing at least part of their rollover IRA is presumptively the intelligent thing to do. We need to reach the point where a retiree feels the need to justify not buying an annuity rather than retirees believing, as they do today, that keeping a lump sum distribution in an IRA is the more sensible approach.

Perhaps many retirees reject annuities because they think of an annuity as an investment rather than the insurance product that it is.⁶² The purchase of an immediate pay, lifetime annuity is the purchase of a stream of income, to be sure, but it is better understood as a “guarantee” of income for life.⁶³ The value of the product is not just the benefits that it pays, but more importantly the assurance of a lifetime of income. An annuity provides a relatively risk-free means of converting capital – the cost of the annuity – into disposable income without fear of exhausting the fund. The insurance value of the annuity is fulfilled no matter when the annuitant dies and the benefit payments cease. Even if an annuitant dies before his or her actuarially projected date of death, he or she does not “lose.” Someone who buys fire insurance has not “lost” if there is no fire and no compensation is paid, because it is avoidance of the risk of loss that was the motivation for the purchase. In the case of an annuity, it is the guarantee of a lifetime of income that justifies its acquisition.

⁶⁰ Shlomo Benartzi et al., *Annuity Puzzles*, 25 J. ECON. PERSP. 143, 156 (2011).

⁶¹ Robert Gazzale et al., *Do Default and Longevity Annuities Improve Annuity Take-Up Rates? Results from an Experiment*, 11 AARP PUB. POL'Y INST. 10, 10–11 (Oct. 2012).

⁶² See Benartzi et al., *supra* note 60, at 156.

⁶³ The “guarantee” of course is only as good as the financial strength of the seller of the annuity. Those who purchase annuities, however, assume that the seller will in fact pay the annuity as promised. It is difficult to believe that any annuitant who had doubts about the certainty of payment would buy an annuity.

Unfortunately, too often those who buy annuities think that they must outlive their expected date of death to avoid “losing” the bet with the seller of the annuity.⁶⁴ To overcome the perceived “gamble” of buying an annuity, an agent, who is selling the annuity, points out that the annuity protects buyers who outlive their life expectancy from outliving their savings. What the agent may not realize is that most individuals underestimate how long they will live. The agent who points out to sixty-five-year-olds that if they live longer than their twenty year life expectancy, they will reap a windfall (actually merely a modestly higher rate of return on the investment, i.e. the cost of the annuity) fails to realize that many potential buyers do not expect to live for another twenty years and so fear that they will never realize that windfall. Moreover, because of the tendency of individuals to hyper-discount future income, even if the potential buyers expect to live long enough to get the windfall, they greatly undervalue it. The combination of underestimating the likelihood of living past their projected life expectancy and undervaluing the payoff if they do, naturally causes many to avoid annuities, which they perceive as very likely resulting in a large “loss” (the cost of the annuity) and a smaller chance of a small gain (the payments continuing on past their life expectancy). Given that many see an annuity as being more likely to result in a perceived, if not a real, loss, and given that most individuals fear losses more than they appreciate gains, it is small wonder that annuities are not attractive to most retirees.⁶⁵

For many, annuities are also unattractive because they limit the ability to leave a financial legacy. They look at the total value of an IRA, and underestimating how long they will live, assume that they will be able to leave most, if not all of that IRA, to their children.⁶⁶ They cannot imagine giving up that legacy by purchasing an annuity regardless of the advantages of doing so. To a remarkable degree, the elderly are willing to

⁶⁴ Most who purchase annuities try to reduce the risk of an early death resulting in a “loss” by purchasing an annuity with a term certain payout period. For example, the annuity might guarantee a minimum payout of ten years. Hu & Scott, *supra* note 29, at 77.

⁶⁵ Jeffery R. Brown et al., *Why Don't People Insure Late-Life Consumption? A Framing Explanation of the Under Annuity Puzzle*, 98 AM. ECON. REV. (PAPERS & PROC.) 304, 304–05 (2008).

⁶⁶ This description holds true whether the IRA owner is single or married. If the latter, then the expectation is that the IRA will be intact at the death of the second to die of the spouses and the IRA owner.

forego consumption in order to preserve their assets so that they can pass them on, usually to their children. While the children and their financial advisors may urge the older person to spend more on themselves, to “live a little,” that advice is often not heeded because many elderly are determined to preserve their capital for their heirs.

Even financially sophisticated retirees who understand the advantages of annuities may not buy them for fear that the seller of the annuity might find itself unable to pay the annuity. Other potential purchasers may be willing to bear the modest risk of possible nonpayment, but may be reluctant to buy annuities because of the fear of rising interest rates. A reasonable fear of the annuity purchaser is that interest rates (as well as investment returns in general) will rise after the annuity has been purchased, leaving the annuitant locked into an annuity whose payments are low because they are based on projected lower interest rates.⁶⁷ Similarly, because sellers of annuities also invest in stocks, a general rise in the stock market after the purchase of an annuity may mean that the purchaser, by waiting a few months and realizing more on the sale of his or her stocks, could have bought a larger annuity.

The possible rise in annuity payment rates is one reason some advocate buying more than one annuity and spacing out the purchases over a few years. Known as “laddering,” the strategy may backfire if future annuity payments decline because of lower interest rates or a decline in the value of stocks, but it does have the advantage of averaging annuity payments over several years and so avoiding extremely low payments, albeit at the potential cost of not locking in higher payments. Laddering also protects against investing a significant portion of assets into a single lifetime annuity that does not have a minimum payout period, and dying soon thereafter. By laddering, or deferring the investment of some funds targeted for the purchase of an annuity, the individual may die before having invested all of the value of the IRA in annuities.

To overcome potential purchasers’ fears that they may die early in the payout period, annuities are often sold with minimum payout periods, with 10 years being common. Of course, a minimum payout period lowers the annual payout, but for many purchasers the trade-off is worth it. Other annuities guarantee a back-pay equal to the initial purchase price. If the

⁶⁷ The seller of the annuity will invest the purchase price. The benefits paid by the annuity will vary based upon the projected investment return anticipated by the seller. If interest rates are low, the seller has to assume a lower rate of investment return.

annuitant dies before that occurs, the annuity continues to pay until it has paid back the purchase price, but of course at the cost of a lower annual payment. Simply put, the more an annuity varies from the “pure product” of a lifetime guarantee without any minimum payment guaranty, the lower the annual payment but the more it appeals to purchasers who are not comfortable with the prospect of dying long before their projected life expectancy.

For those apprehensive about whether the seller of the annuity will be financially secure enough to pay the annuity, one solution is to buy smaller annuities from several annuity sellers, thereby spreading the risk. If one seller should fail, only a portion of the total annuity payments would be lost.

Another possibility is to purchase a deferred annuity with a fixed payout.⁶⁸ For example, a 65-year-old buys an annuity for \$X that will pay \$Y per year for life, but the initial payment will not begin for 10 years (when the purchaser is age 75). Depending on the annuity, it may pay back some, or all, of the purchase price if the annuitant dies before reaching age seventy-five. The advantage to the annuitant is that for \$X purchase price, the annuitant realizes a significantly larger annual payment than by paying the same amount for an immediate pay annuity.⁶⁹ During the intervening ten years, the annuitant can draw down his or her savings knowing that, at age seventy-five, a new stream of income will appear. Some advocate dividing the retirement savings that the retiree expects to spend during retirement – not including savings that are being held back to pass on to heirs – into two equal parts: buying an annuity to begin at age 80, and then spending the other half during the years leading up to age 80. The delay in the start of the annuity will result in a higher annual payment, and the certainty of the forthcoming income permits the annuitant to “self-annuitize” the other half of the savings over the years leading up to age 80.

⁶⁸ Jonathan Barry Forman, *Optimal Distribution Rules for Defined Contribution Plans: What Can the United States and Australia Learn from Other Countries?*, in N.Y.U. REV. OF EMP. BEN. & EXECUTIVE COMPENSATION 3-1, 3-28 (Alvin D. Lurie ed., 2012).

⁶⁹ In February of 2012, the purchase of a deferred annuity for \$100,000 by a sixty-five-year-old male with the first payment to begin at age seventy-five paid about \$11,650 a year. If the annuity was deferred until age eighty-five, the yearly payment was about \$25,450 per year. Calculations are taken from *id.* at 3–29.

B. POSSIBLE REFORMS TO ENCOURAGE THE PURCHASE OF ANNUITIES

The first step is to mandate that all 401(k) plans offer an annuity option and require all rollover IRAs to permit the owner to purchase an annuity without recognition of immediate income.⁷⁰ As a practical matter, the use of IRA funds to purchase an annuity without being taxed on the purchase price should be time limited, perhaps to the first year after the rollover into the IRA. Of course, the entire amount of the annuity is be taxed as ordinary income; the exclusion ratio provided in section seventy-two of the IRC does not apply to annuities purchased with funds that were never subject to the income tax.

Unless the government does something to encourage the use of annuities by IRA owners, the financial security of many retirees will be severely compromised in the years to come. We can expect unacceptable rates of elderly poverty and increasing elderly financial exploitation and abuse. To overcome the reluctance of retirees to purchase annuities, the federal government could create, sell, and likely subsidize new forms of annuities for retirees who have a rollover IRA.⁷¹ No one would be required to purchase an annuity from the government, but if the annuities were attractive enough, many retirees might be inclined to purchase them.

A public entity that sold annuities (fully backed by the federal government) would overcome retiree fears about the financial solvency of the issuer of the annuity. So that government would not compete generally with issuers of annuities, the entity should be limited to selling annuities to retirees who pay for it with funds from their 401(k) or a rollover IRA. Such an entity should be able to sell an attractively priced annuity in part because of savings in the form of lower administrative costs, the lack of the need to advertise, and savings from not paying commissions to sellers of the annuities, as well as not being burdened with the need to create a profit.

To meet the concern of annuity purchasers that they might be buying the annuity when interest rates were too low, the annuities could be tied to a rolling, five-year interest rate based on the interest rate of U.S. Treasury notes. The pension paid to those who participate in a defined benefit plan is not dependent on the prevailing interest rates at the time of the employee's retirement. Similarly, employees who participate in 401(k) plans should have the opportunity to convert their 401(k) accounts into a

⁷⁰ A more radical solution would be to require retirees with 401(k) accounts to purchase annuities. *See id.* at 3–32.

⁷¹ Frolik, *supra* note 7, at 278.

stream of income that is not wholly dependent on the rate of interest prevailing at the time of their retirement. Perhaps some form of post-purchase protection in the form of a higher payout if interest rates rise appreciably might be a solution. The annuities might also offer modest inflation protection. The monthly payout could be increased by a certain percentage in the event that the increase in the consumer price index exceeded a predetermined trigger level. While not offering the complete inflation protection enjoyed by Social Security recipients, whose annual benefit rises with inflation, the partial protection would encourage the purchase of annuities by those who are wary of locking their capital into a fixed income investment.⁷²

Of course, the more protection offered by the annuities, the more they would cost unless some or all of those protections were subsidized by the government. The justification for a subsidy is the public interest in assisting retirees who participated in defined contribution plans to use, enjoy and create lifetime, assured streams of income. For years the nation has promoted employer provided retirement plans by providing generous deferral of income taxes on 401(k) accounts. Modestly extending that subsidy to the post-employment years would not seem excessive.

VIII. CONCLUSION

The assumption that retirees can successfully manage their IRAs during their declining years is a folly. Why any society would willfully create a retirement system that relies on the financial acumen of millions of aging individuals can only be explained as the triumph of hope over common sense and reality. Unless we relieve retirees of the burden of the responsibility for their retirement assets, we can expect growing poverty among the elderly as they mismanage and spend down their retirement funds.

It is time to admit that what most retirees need is a stream of income. Our nation's retirees need and deserve the security of having a check arrive every month that does not depend upon their skill at managing an IRA during their declining years.

⁷² *See id.* at 320-30 (discussing ways the government could encourage the purchase of annuities).

THE SURPRISING EQUALITY OF RETIREMENT TIME: EVIDENCE FROM THE HEALTH AND RETIREMENT SURVEY

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This article discusses the impact changes to the retirement age may have on the distribution of retirement time. The author investigates the length of time men and women are alive between the date of their retirement and their death, finding that the most critical factor in determining length of retirement time is and individual's socio-economic status. As a result, the author opines that because individuals in lower economic classes tend to die earlier, increasing the retirement age will impact these individuals disproportionately and increase retirement time inequality.

I. INTRODUCTION

In 2012, economic inequality in the United States reached its highest level in 100 years.¹ Increasingly, inequality is considered by global

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¹ Every year from 1913 to 2012 (the earliest and latest years for which data is available) the top 10%, 1% and 0.1% of income earners won a greater share of national 2012-value-income than in any previous year (this is true whether one includes or excludes capital gains). See Facundo Alvaredo et al., *The Database, THE WORLD TOP INCOMES DATABASE*, <http://topincomes.gmond.parisschoolofeconomics.eu/> (last visited Feb. 22, 2012) (accessed by selecting the “The Database” link and then selecting the corresponding country and years). Census data for the Gini coefficient (which is negatively related with the degree of equality) has steadily increased since 1967 when records began. In 2012 (and 2011) the Gini coefficient was 0.477 – roughly equal to the Gini measure of inequality for Singapore, Kenya, and the Dominican Republic. See *Historical Income Tables: Households* tbl.H-4, U.S. CENSUS BUREAU, <http://www.census.gov>.

economic and financial leaders to be the principal barrier to economic growth.² However, the disparity of wealth and income do not alone convey the deepening stratification of American society. An equally important dimension of well-being is access to time at the end of a person's working life. We identify "retirement time" as a resource that employees consume after permanently exiting the labor market. Retirement time is simply the time between retiring and dying: the difference between the age at death and the age at the start of retirement. Upper income individuals live longer than lower income workers and the longevity gap has grown wider by socio-economic status (SES) over time.³ We expect the growing inequality of longevity due to SES, coupled with the increasing effort that lower-income older people are making to stay in the labor force, will cause retirement time to become more unequally distributed between SES groups. A growing time-inequality should be avoided because retirement time is one of the only areas where the nation has made significant progress achieving equality among working people.⁴

On average, Americans over age sixty-five are living longer, but longevity gains are unequally distributed between people of different races, between men and women, and among those of different socio-economic status.⁵ For example, white men's longevity at age seventy-five increased 25% between 1980 and 2000, whereas black men's increase in life expectancy at age seventy-five grew by 22.9% over the same time period.⁶

gov/hhes/www/income/data/historical/household/ (follow "Table H-4" hyperlink) (last visited Feb. 17, 2014).

² See Larry Elliot, *Income Gap Poses Biggest Threat to Global Community, Warns WEF*, THE GUARDIAN, Jan. 16, 2014, available at <http://www.theguardian.com/business/2014/jan/16/income-gap-biggest-risk-global-community-world-economic-forum>.

³ That is, not only has income and wealth grown wider, so too has the gap in longevity. See Julian P. Cristia, *Rising Mortality and Life Expectancy Differentials by Lifetime Earnings in the United States*, (Inter-American Dev. Bank, Working Paper No. 665, 2009); Elizabeth Arias, *United States Life Tables, 2007*, U.S. DEP'T OF HEALTH & HUMAN STATISTICS NAT'L VITAL STAT. REP., Sept. 28, 2011, at 48.

⁴ See *infra* App. A.

⁵ NAT'L INST. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., NIH PUBL'N NO. 07-5757, *GROWING OLDER IN AMERICA: THE HEALTH & RET. STUDY 20* (2007).

⁶ Number of years expected to live from age seventy-five onwards is 10.1 and 12.5 years respectively for white males and females, and 11.7 and 14.1 years respectively for black males and females. See *infra* App. A.

But small differences in rates of change compound over time. The white/black gap in age seventy-five life expectancy in 2010 was only nine months. If trends continue however, in twenty years the difference will be over one year and three months. Though longevity is on track to become more unequal, analysis of the Health and Retirement Survey (HRS)⁷ demonstrates that retirement time is still remarkably equal among the last generation of workers – our current retirees – primarily because lower income people tend to retire earlier.

While retirement time had been an equalizing asset between members of different income classes,⁸ there is nascent evidence that the distribution of retirement time may become more unequal.⁹ Income, of course, is not the only factor driving the distribution of retirement time. Not surprisingly, healthier individuals consume more retirement time because they live longer.⁹ Further, although it was not expected, men have more retirement time than women who have retired.¹⁰ Also unexpected is that since lower income workers retire earlier than higher income workers, the lower income groups have, on average, more retirement time.¹¹ However, these results are reversed among middle class elderly persons (i.e., among the group excluding retirees in the top 20% and bottom 20% of the income distribution).¹² When focusing on the middle 60% of the distribution, there is evidence that retirement time inequality may be on the rise.¹³

Retirement time inequality will also likely increase as a result of the continuing weakness of the U.S. labor market as older workers (especially those with less income) work, or search for work, later into life than previous cohorts. We also expect, as the panel grows larger, the bias in the data set (containing a disproportionate share of people who die earlier than normal) will dissipate. The HRS panel data has only a small

⁷ See *infra* note 41.

⁸ Although SES is the key conceptual division, we will avoid the complications of defining precise SES criteria and instead focus simply on full-time labor market income as a rough proxy for SES.

⁹ See NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 56-60.

⁹ *Id.* at 40.

¹⁰ *Id.* at 22, 35, 40.

¹¹ *Id.* at 51-65.

¹² *Id.*

¹³ NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 51-65.

number of respondents who have died after living an average life span,¹⁴ which means the sample is not perfectly representative of the population. However, the large sample currently available is representative in some key dimensions, such as health status. Despite the limitations in the data, we find support for the hypothesis that the distribution of retirement time remains relatively equal because upper-middle class income men work longer and retire at older ages. However, there is nascent evidence that this equity is eroding.

Retirement time inequality should inform policies concerning the appropriate “normal retirement age” in Social Security, Medicare, and other old age programs. If benefits are cut by raising the age participants can collect full benefits, then lower income workers will likely work later into life, eroding their retirement time relative to wealthier and/or healthier individuals. To date, the nation’s old age programs are among the few mechanisms that mitigate the impacts of deepening inequality of wealth, income, opportunity and mortality in the United States.

II. RETIREMENT IN AMERICA – BACKGROUND AND RECENT FINDINGS

Since the 1950s, the labor force participation of men over age fifty declined across all income groups as the expansion of Social Security made retirement income more equally distributed than preretirement income.¹⁵ Defined benefit (DB) pension plans were more prevalent in jobs that were physically taxing, so those with lower than average longevity were able to retire sooner.¹⁶ This recent success in achieving some equity in retirement time stems from the design of the American retirement and disability income system, which has its roots in social systems developed for state and municipal employees at the turn of the last century.¹⁷ These systems were extended to most private sector workers with the adoption of Social

¹⁴ *Id.*

¹⁵ Edward N. Wolff, *Pensions in the 2000s: The Lost Decade?* (Nat’l Bureau of Econ. Research, Working Paper No. 16991, 2011), available at <http://www.nber.org/papers/w16991>.

¹⁶ NAT’L INST. ON AGING, NIH PUBL’N NO. 07-5757, *supra* note 5, at 51.

¹⁷ See ROBERT L. CLARK ET AL., A HISTORY OF PUBLIC SECTOR PENSIONS IN THE UNITED STATES 1, 167-71 (2003).

Security in 1935.¹⁸ More workers were able to retire when Social Security old age benefits and disability programs expanded significantly from the 1950s through to the 1970s.¹⁹ This came with the coincident growth of unions and employer-based DB pension plans in the 1940s and continuing until the 1970s.²⁰ Further, Medicare was established in 1965, providing universal health insurance for those over age sixty-five, which significantly improved the health and longevity of the aged.²¹ As a result of these changes, workers in all socioeconomic groups were able to control some of their own leisure time before they died.

In 2008, Teresa Ghilarducci was the first scholar to measure the distribution of retirement time, finding that the distribution of retirement time was strikingly equal for people who died before age sixty-five.²² Relying on the 2006 HRS sample, Ghilarducci found that the top income-earning quintile of retirees between ages fifty and sixty-five had approximately the same share of retirement time as the other four quintiles in the same age range.²³ The analysis added together retirement times of these retirees before age sixty-five and then found each quintile's relative share of the total sum of retirement time.²⁴ The top quintile accounted for their proportionate share of retirement time consumed before the age of sixty-five. Specifically, retired men in the top 20% of the asset distribution – those with assets worth over \$271,000 – had 5.57 years of retirement time before the age of sixty-five and accounted for 22% of the total amount of retirement time.²⁵ Men in the bottom 20% – those with an average debt of \$6,000 – accounted for 18% of the total retirement time before the age of sixty-five.²⁶ Furthermore, Ghilarducci noted that although the top 20% of the men had 85% of all the wealth and the poorest 20% were in debt, the distribution of retirement time before age sixty-five was almost equal.²⁷ For

¹⁸ See Patricia P. Martin & David A. Weaver, *Social Security: A Program & Policy History*, 66 SOC. SEC. BULL. 1, 1-3 (2005).

¹⁹ *Id.* at 1, 7-9.

²⁰ *Id.*

²¹ *Id.* at 8.

²² See TERESA GHILARDUCCI, WHEN I'M SIXTY-FOUR: THE PLOT AGAINST PENSIONS AND THE PLAN TO SAVE THEM 200-01 (2008).

²³ *Id.*

²⁴ *Id.* at 200.

²⁵ *Id.*

²⁶ *Id.* at 201.

²⁷ Ghilarducci, *supra* note 22, at 201.

women the distribution of pre-sixty-five retirement time was also equal.²⁸ The top and bottom fifths of women accounted for the same share of retirement time – 22.6% for the top and 22.7% for the bottom.²⁹

Furthermore, Ghilarducci found that women and men, blacks and whites, high and low income, have approximately the same amount of retirement time prior to age sixty-five.³⁰ She argued retirement time is distributed relatively equally because in the United States the “retirement date” is flexible.³¹ Many defined benefit plans allow pension collection before age sixty-two, when workers become eligible for early Social Security benefits.³² Similarly, Social Security and workplace disability pensions are available before age sixty-two for eligible workers (albeit at the cost of reduced benefits).³³ In some pension plans, American workers can start collecting a defined benefit pension as early as age fifty.³⁴

Because age discrimination is illegal in the United States,³⁵ many older workers are able to stay in the labor market beyond age sixty-five.³⁶ Since professionals are likely to work later into life than blue-collar workers,³⁷ a retirement system can be more balanced and fair even in the face of longevity differences among social economic classes. In fact, pension systems that allow and encourage people who die sooner than average to retire sooner than average – Social Security and DB pensions have these features³⁸ – are potentially very progressive. If people who die earlier also retire at younger ages they could conceivably have the same amount of retirement time as higher-income people who live longer. In contrast, 401(k)-type pensions (defined contribution (DC) pensions) accumulate significantly as a person ages and pays out lump sums so that retiring earlier is often difficult for lower income individuals.³⁹ Finally, people without employer-based pensions or independent assets would need to work longer, as they can rely only on Social Security benefits. Workers

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 214.

³¹ *Id.* at 215.

³² NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 57-62.

³³ *Id.* at 62.

³⁴ *Id.*

³⁵ 29 U.S.C. § 623 (2008).

³⁶ *Id.*

³⁷ NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757 *supra* note 5, at 43-44.

³⁸ *Id.* at 51.

³⁹ *Id.*

in such situations are predominantly low-income earners with shorter life spans. As DC plans replace traditional DB pensions and as coverage by any employer based retirement plan has stagnated,⁴⁰ one of the key equalizing mechanisms of the American retirement system will be lost.

III. HRS DATA ON RETIREMENT TIME DISTRIBUTION AND METHODOLOGY⁴¹

HRS is administered by the University of Michigan every two years as a series of in-depth interviews with people age fifty and over.⁴² The first cohort began in 1992 and included more than 10,000 respondents.⁴³ The latest available survey is data from 2010.⁴⁴ Our sample comes from each of the ten surveys. Every sixth year (or third survey), the HRS adds approximately 5,000 new participants in order to maintain a sample.⁴⁵ The panel nature of the HRS data is essential to determining individuals' time spent in retirement since we need to know the year and month of both retirement and of death. The key variable, retirement time, is measured as the difference between the respondent's year of death and year of retirement, plus the numeric difference between her or his month of death and the month of retirement where months are coded sequentially, with January equal to one and December equal to twelve.⁴⁶

⁴⁰ Craig Copeland, *Employment-Based Retirement Plan Participation: Geographic Differences and Trends*, 2011, 378 EMP. BEN. RES. INST. ISSUE BRIEF 1, 26, 36 (2012), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_11-2012_No378_RetParticip.pdf.

⁴¹ *Health and Retirement Study*, U. MICHIGAN, <http://hrsonline.isr.umich.edu/> (last visited Mar. 19, 2014).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*; *Sample Sizes and Response Rates*, U. MICHIGAN, <http://hrsonline.isr.umich.edu/sitedocs/sampleresponse.pdf> (last visited Mar. 19, 2014).

⁴⁶ This coding pattern assumes that reported dates occur at the end of the reported month. Alternatively, one could code months as January = 0, February = 1, ... December = 11. The reported result would not differ.

Retirement Time

$$= \left[\text{Death Year} + \frac{\text{Death Month}}{12} \right] - \left[\text{Retirement Year} + \frac{\text{Retirement Month}}{12} \right] \quad (1)$$

Defining the start of retirement can be difficult since many people continue to work, volunteer, or do other activities after they leave a long-term career. Judging what is or is not retirement from work is difficult. We use HRS respondents' own declaration of whether or not they are retired. Specifically, the survey asks respondents if they are retired, disabled or working, and the date of their retirement.⁴⁷ However, if an individual reports she is retired in 1994, working in 1996, and then retired again in 1998, equation (1) uses her most recent statement of retirement year and retirement month (i.e., whatever year and month she states in the 1998 survey wave).

To calculate retirement and death ages, we use a similar formula as (1). We calculate individuals' age of retirement based on their latest answer to their year/month of retirement by subtracting the respondent's year and month of birth.

Retirement Age

$$= \left[\text{Retirement Year} + \frac{\text{Retirement Month}}{12} \right] - \left[\text{Birth Year} + \frac{\text{Birth Month}}{12} \right] \quad (2)$$

Finally we compute age at death with a similar subtraction:

Death Age

$$= \left[\text{Death Year} + \frac{\text{Death Month}}{12} \right] - \left[\text{Birth Year} + \frac{\text{Birth Month}}{12} \right] \quad (3)$$

⁴⁷ *Health and Retirement Study*, *supra* note 41; *2010 Questionnaire*, U. MICHIGAN, <http://hrsonline.isr.umich.edu/modules/meta/2010/core/qnaire/online/10hr10JCore.pdf> (last visited Mar. 19, 2014).

Once these core values are computed, we restrict the data set to respondents who report at least one instance of full-time labor market income.⁴⁸ In addition to dividing the sample of 12,033 respondents by their labor market status, this restriction ensures that we analyze the retirement patterns of workers. Since workers report labor market income in various years, we adjust all values to 2008 dollars according to the Census Bureau's consumer price index (CPI) for the appropriate year.⁴⁹ After adjusting for inflation, we calculate each respondent's mean full-time income. Thus, if a respondent reports full-time income in only one survey year, this amount is his average real income; if a respondent reports full-time income in three separate surveys her average real income is one-third of the sum of the adjusted values.

The sample sizes for retirement time, retirement age and death age are different because more respondents (5,557) consider themselves retired (and provide the interviewer with a valid retirement year and month) than have died. Since the first HRS wave was in 1992, and the latest available data is from 2010, the youngest respondent would be fifty years old (the age one enters the HRS) plus eighteen years, or sixty-eight years old. This limitation leads to a much smaller number of observed death ages (1,418) since these individuals must have reported at least one year of full-time labor market income before retiring and dying. However, since many respondents may have worked and died without ever retiring, the number of those with a retirement time is about half of those with a death age.⁵⁰

A. DOWNWARD LONGEVITY BIAS

Because the survey is only eighteen years old, the majority of respondents are still alive. Due to this, we cannot know living retirees' total retirement time, which creates a bias in our data set because less than 12% ($1,418/12,033 = 11.7\%$) of the eligible sample are deceased. Among

⁴⁸ We define full-time labor market attachment as respondents who described the "usual" working time as at least thirty-five hours per week and "usual" work frequency as forty weeks per year.

⁴⁹ See Minn. Population Ctr., Univ. of Minn., *Note on Adjusting Dollar Amount Variables for Inflation (CPI-U)*, IPUMS-CPS, <https://cps.ipums.org/cps/intro.shtml> (last visited Feb. 12, 2014) ("The IPUMS variable CPI99 provides an easy way to adjust dollar amounts to constant dollars").

⁵⁰ An individual could also have no measured retirement time because not all the necessary data points (year of death, month of death, year of retirement and month of retirement) were recorded, so retirement time was not computed.

the deceased, only half ($725/1,418 = 51.3\%$) have a corresponding retirement date by which retirement time can be calculated. The resulting problem is a downward bias in longevity as shown by the low mean death age of 67.9 in our sample. Therefore, the results reported here must be recognized as representing an unfortunate (early death) subgroup of the population. Key variables are summarized in Table 1.

Table 1: Sample Summary for HRS Respondents with Some Full-Time Income

	Observations	Mean Value	Standard Deviation
Total Number of Respondents	12,033		
<i>Death Age</i>	1,418	67.86	7.57
<i>Retirement Age</i>	5,557	62.10	5.57
<i>Retirement Time</i>	725	8.71	5.68
Average Real Income (Full-Time)	12,033	\$51,173	\$58,550

Employing different techniques or restrictions to correct for the downward bias in death age, however, does not alter the central results of our analysis. One method is restricting the sample to respondents aged sixty or older when they first entered the HRS. To partially mitigate the large reduction in sample size of this approach we drop the *full-time* restriction on labor market income. These two changes generate a sample of approximately 3,100 – about one-quarter the size of our chosen sample. The benefit of this smaller sample is that the downward longevity bias is largely removed as the average age of death increases from 67.9 to 77.4, which is comparable to this generation's expected longevity.⁵¹ However, not only does this approach require an arbitrary age cut off, but the inclusion of part-time income greatly skews the *average real income*

⁵¹ The current longevity estimate for those born in the 1930s is 83.8 years. See generally Arias, *supra* note 3, at 48.

variable downward.⁵² Therefore, correcting for one skew in the sample's distribution introduces another, but at the additional cost of many lost observations.

Yet, in spite of these imposed restrictions, the overall results did not substantially change: men still had more retirement time than women, working men retired earlier than working women, and having a pension continues to appear to have little impact on retirement time. Moreover, retirement time in the restricted sample is still negatively related to income overall, but it is positively correlated among the middle 60% of the distribution. Therefore, given the larger, non-arbitrary and more robust results of the sample presented in Table 1, as well as the importance of full-time labor market income to proxy socio-economic status, we proceed with the analysis acknowledging the downward longevity bias and eagerly await more waves of the HRS.

B. RETIREMENT DISTRIBUTION BY DEMOGRAPHIC AND ECONOMIC CATEGORIES

In our sample, 725 people retired and died with an average retirement time of 8.7 years. This group retired at ages 4.5 months (0.38 of a year) older than the average of all the 5,557 retirees. Table 2 displays retirement age, death age and retirement time by sex, race, pension coverage, and health status. The subgroup sizes are listed below the mean value. The last column reports the retirement age of those who died, which are the individuals for whom we calculate their retirement time.

⁵² Approximately one-third of this sample of persons aged sixty or older had an annual labor market income of under \$4,500 since, in this case, labor market income is not restricted to full-time workers.

Table 2: Retired, Deceased and Retirement Time Averages by Demographics

Subgroups	Retirement Age	Death Age	Retirement Time	Retirement Age (Deceased)
All	62.10	67.86	8.715	62.48
	5,557	1,418	725	
Women	62.05	66.86	8.46	62.75
	2,535	475	216	
Men	62.14	68.37	8.823	62.37
	3,022	943	509	
Nonwhite	61.6	66.61	9.111	61.02
	1,002	285	141	
White	62.2	68.18	8.619	62.83
	4,555	1,133	584	
No Pension in 1992	63.21	68.2	8.325	63.38
	986	342	173	
Has Pension in 1992	62.05	67.93	8.431	61.74
	2,755	627	393	
Health: Good to Poor	62.02	67.30	8.454	62.44
	2,319	800	397	
Health: Excellent to Very Good	62.15	68.59	9.03	62.52
	3,238	618	328	

Although men and women retire at roughly the same age (62.14 and 62.05, respectively), the 509 retired men who died had over four extra months of retirement time than did the 216 deceased women (8.82 versus 8.46, respectively) because the men lived longer than the women who retired. Also surprising, the non-white workers have half a year more of retirement time than white workers (9.11 versus 8.62) because they retired earlier, at age 61.6 compared to 62.2. Since the number of observations differs for each variable, Table 2 lists the subgroup sizes below each group's mean value. The last column reports the retirement age of those who have died, which are the individuals for whom we calculate retirement time.

The difference in retirement age and death age between those with and without pensions was not significant. Those without pensions had, on average, 8.32 years of retirement time compared to 8.43 years for those with access to pensions – a difference of about five weeks.⁵³ Not surprisingly those with self-described ‘excellent’ or ‘very good’ health had a mean 9.03 years in retirement time, whereas those with ‘good’, ‘fair’ or ‘poor’ health had only 8.45 years of retirement time on average.⁵⁴ Since the healthy and less healthy have approximately the same retirement age (62.52 and 62.44, respectively), the difference in retirement time comes entirely from the healthier group’s longer-than-average lifespan (68.59 versus 67.30).

Now that we have presented differences by race, sex and health, we examine two income categories:

- (i) Respondents with income above and below the median full-time labor market income \$40,000, and;
- (ii) Respondents groups by full-time average real income quintiles.⁵⁵

The bottom 50% of income earners had an average retirement time of 9 years, which is significantly greater than the top half’s retirement time of 8.3 years, or 8.4 months more retirement time enjoyed by the lower income half of retired workers, as can be seen in Table 3. Table 3 shows that this negative relation between income and retirement time is driven, to a significant extent, by the top and bottom quintiles which have an average of 7.4 and 10.2 years of retirement, respectively. These extreme differences are not apparent between the second, third and fourth quintiles, which have retirement times of 8.4, 8.2 and 8.9 years, respectively. These stark differences in retirement time are discussed further below, but first we

⁵³ Although restricting this part to individuals in the 1992 HRS reduces our potential sample size, for these rows, only a very few individuals not in the 1992 wave have pensions in later waves *and* have a valid retirement time. Thus, the substantive results are not affected by this restriction.

⁵⁴ The HRS question regarding personal health status is asked of each respondent in each wave. We have relied on an individual’s first reported personal health status – making it perhaps even more surprising that there is such a large division between the self-assessed healthy and unhealthy. We collapse the HRS’s five categories into a binary one for ease of analysis.

⁵⁵ The minimum average annual incomes to be included in each quintile are \$0, \$21,906.64, \$33,362.48, \$47,328.59 and \$69,543.62.

consider the distribution of retirement time among income groups of men and women separately.

Table 3: Retired, Deceased and Retirement Time Averages by Income Groups

Subgroups	Retirement Age	Death Age	Retirement Time	Retirement Age (Deceased)
Lower Half of Incomes	62.55	68.27	9.04	62.86
	2,668	776	384	
Upper Half of Incomes	61.67	67.37	8.348	62.05
	2,889	642	341	
Bottom 20%	62.4	69.04	10.16	62.84
	1,065	340	164	
20-40%	62.52	68.02	8.367	63.22
	1,070	293	145	
40-60%	62.61	67.21	8.229	62.68
	1,106	297	152	
60-80%	61.32	67.41	8.934	61.36
	1,235	279	153	
Top 20%	61.74	67.27	7.393	62.25
	1,081	209	111	

We find lower-income women and men retire at approximately the same age, 62.50 and 62.63, respectively. While there is a larger gap (approximately seven months) between the retirement ages of higher-income women (61.27) and men (61.87), higher earning individuals of both sexes retire at earlier ages than their lower-income counterparts, as shown in Table 4. Yet, this equality between the sexes in retirement age does not carry over into retirement time. Both upper- and lower-income women – for whom we can determine retirement time – have almost identical amounts of retirement time: 8.46 and 8.45 years, respectively.⁵⁶ However,

⁵⁶ It must be noted that at this level of data, parsing our cell counts (i.e., the number of observations per variable type) are approaching the limit of what can be

higher income men have nearly one year less of retirement time than lower income men. The 281 higher-income males have an average of 8.33 years of retirement, whereas the 228 lower-income males have 9.43 years. Thus, in contrast to our initial expectations, among retired workers, retirement time is not positively correlated with labor market income. However, as demonstrated in Table 5, the “reverse inequality” result (i.e., the poor have more) is driven by including the richest and poorest quintiles of retired men.

Table 4: Retirement Age and Time by Sex and Income Group

Income Class	Women		Men	
	Lower Income	Upper Income	Lower Income	Upper Income
No. Retired	1,596	939	1,072	1,950
Mean Retirement Age	62.50	61.27	62.63	61.87
Obs. Retirement Time	156	60	228	281
Mean Retirement Age if Deceased	62.86	62.46	62.86	61.96
Mean Retirement Time	8.464	8.450	9.434	8.327

Restricting the sample to the middle 60% of the income distribution yields a different income and retirement time relationship than in the full sample. Table 5 presents the same data as Table 4, but with the sample restricted to the middle 60% of the income distribution. In the middle class, the lower income women work for a longer period of time: women in the lower half of the middle class retiree distribution retire a full year later than the upper middle-income class women (62.4 years versus 61.4 years). For men, the 1.2 years gap is even larger. Lower-income, middle class men work until nearly age 63 and upper-income middle class men retire at age 61.8 years. Furthermore, the difference in retirement time is positively related to income. Men in the 50th to 80th percentile range

considered useful. The smallest cell counts are 60 and 49, which demand one to extrapolate the results with much caution.

have about 8.8 years of retirement, and their counterparts in the 20th to 50th percentile range have less time in retirement, at an average of 8.5 years. Therefore, the negative relationship between retirement time and income class shown in Table 3 is driven entirely by the top 20% and bottom 20% of male income earners.

Table 5: Middle Income Retirees -- 60% of Distribution -- Retirement Age and Time by Gender and Income Group

Binary Income Class	Women		Men	
	Lower Income	Upper Income	Lower Income	Upper Income
No. Retired	920	716	683	1,092
Mean Retirement Age	62.42	61.41	62.98	61.78
Obs. Retirement Time	85	49	135	181
Mean Retirement Age if Deceased	62.54	62.48	63.08	61.81
Mean Retirement Time	7.727	8.825	8.503	8.805

We conclude that the anomalous results of retirement time – that the lower income fare better – for the full sample is driven in particular by the extreme experiences of men in the top 20% and bottom 20% of the income distribution. As discussed, the top 50% and bottom 50% of females have near-identical retirement time. Yet, Table 5 reveals that this similarity evaporates for the middle 60% of women. The upper-half of middle income women have 8.8 years of retirement time, while the lower-half of middle income women have 7.7 years of retirement time. Note the observations are small – involving eighty-five and forty-nine women, respectively. Nevertheless, these observations are numerically important in calculating average retirement times (insofar as they represent a sizeable portion of the total retirement time sample). Therefore, these data for women reinforce the conclusion that it is the top and bottom quintiles of men, specifically, which account for the entirety of the negative relation between income and retirement time.

Next we consider the income class differences according to the health status of respondents.⁵⁷ When the bottom and top quintiles are included, lower-income individuals, regardless of health, garner more retirement time than their higher-income counterparts (8.7 versus 8.1 for poorer health individuals; 9.4 versus 8.6 for healthier individuals) even though lower income individuals retire later – at ages 62.4 for the less healthy and 62.7 for the healthier – than the higher income individuals, at ages 61.5 and 61.7, respectively. Note that the retirement time benefit from being healthy is larger for of the lower half of retirees (0.72 years) than wealthier retirees (0.52 years). Overall we confirm, in Table 6, that health status is a key driver of retirement time: healthier individuals, regardless of income, enjoy more time in retirement than their unhealthy counterparts.

Table 6: Retirement Age and Time by Health Status and Income Group in the Full Sample

Health	Good, Fair, Poor		Excellent, Very good	
	Lower Income	Upper Income	Lower Income	Upper Income
No. Retired	1,298	1,021	1,370	1,868
Mean Retirement Age	62.42	61.51	62.68	61.76
Obs. Retirement Time	222	175	162	166
Mean Retirement Age if Deceased	62.78	62.02	62.97	62.09
Mean Retirement Time	8.736	8.095	9.456	8.615

Excluding the extreme 20% at the top and bottom of the income distribution, we see, in Table 7, that healthy and/or wealthy individuals share approximately equal retirement times. Among the lower-income middle class, healthier retirees have nearly a full year more of retirement

⁵⁷ The cross tabulation of retirement time by income class and race does not provide further insights beyond what has been discussed above: nonwhites have more retirement time than whites, and in both cases, the relation is negatively associated with income class for the full sample and positively associated with the restricted, middle 60% sample. More importantly, we do not include these results here because the cell counts for nonwhites becomes unjustifiably small in both cases.

time (8.7 years) than the less healthy lower-income middle class (7.8 years). However, the retirement time differential among the upper-income middle class is insignificant at a mere 0.09 years (although this happens to be in favor of the less healthy). Moreover, these retirement time figures for the upper half of income earners are nearly equal to that of the healthy but poor segment of the middle class. Thus, among the middle 60% of the distribution, it is only the unhealthy, lower middle class that is at a significant disadvantage in obtaining retirement time.

Table 7: Retirement Age and Time by Health Status and Income Group Middle 60% of Distribution

Health	Good, Fair or Poor		Excellent/Very good	
	Lower Half	Upper Half	Lower Half	Upper Half
No. Retired	754	704	849	1,104
Mean Retirement Age	62.47	61.66	62.82	61.62
Obs. Retirement Time	124	122	96	108
Mean Retirement Age if Deceased	62.56	61.61	63.28	62.34
Mean Retirement Time	7.79	8.85	8.74	8.76

Before moving to the regression analysis, we provide a brief explanation of the observed biasness of our sample. If an individual entered the HRS in the first survey wave in 1992, they would have been followed for eighteen years (1992 through 2010). Many individuals have simply not been a part of the survey long enough to have died. Those who have died, and for whom we calculate a retirement time, are those from groups with lower-than-average life expectancy. Since it is well documented that longevity is positively correlated with income, the people who died are more likely to be lower income workers. Moreover, since longevity is normally distributed, the HRS data captures a disproportionate share of lower-income individuals' left tail of their death age distribution, relative to the death age distribution of higher income individuals. That is, because the average death age of wealthier individuals is higher, we observed a smaller segment of this distribution's left tail.

This assessment is borne out in the data present in Tables 8 and 9. The middle three quintiles have roughly equivalent rates of death (12.1%, 12.3% and 11.6%), whereas 14.13% of the bottom 20% of the income distribution died compared to a mere 8.69% of the top 20%. Further, far more men (15.2%), than women (8.14%) have died. The sex disparity, in fact, is larger than the difference between the very healthy individuals who died (8.9%) and the proportion of deceased people with worse health (15.6%) as seen in Table 8. Each of the large differences – between women and men, health status and the top and bottom 20% of the income distribution – are associated with unexpected outcomes in the distribution of retirement time. These rates of death support our focus on the middle 60% of the income distribution. Moreover, given the near-equal death rates among the middle three quintiles, this middle class is likely more representative of the true population. In other words, the middle class subset is a reasonable representation of retirement times.

Table 8: Number and Proportion of Deceased Individuals, Plus Death Age, Retirement Age and Time in the Full Sample

		Proportion Dead	Deceased Individuals with a Retirement Time Value			
			No. Deceased	Mean Death Age	Mean Retirement Age	Mean Retirement Time
Gender	Women	8.14%	216	71.21	62.75	8.460
	Men	15.22%	509	71.19	62.37	8.823
Health Status	Good - Poor	15.63%	397	70.90	62.44	8.454
	Excellent - Very Good	8.94%	328	71.56	62.52	9.030
Income Group	Lower Half	12.89%	384	71.90	62.86	9.040
	Upper Half	10.67%	341	70.40	62.05	8.348
Income Quintile	Bottom 20%	14.13%	164	73.00	62.84	10.160
	20-40%	12.17%	145	71.58	63.22	8.367
	40-60%	12.35%	152	70.91	62.68	8.229
	60-80%	11.59%	153	70.30	61.36	8.934
	Top 20%	8.69%	111	69.64	62.25	7.393

However, the final two rows of Table 9 show that the lower death rate variation among the middle class does not hold across gender and health categories. The proportion of deceased men (16.5%) is still far greater than that of women (7.7%), as is the proportion of the deceased who reported poorer health (16.0%) over those who reported being healthy (9.1%). As a result, we are unable to entirely eliminate all biasness in health and gender dimensions, even though we have eliminated the bias for income groups. Therefore, in the regression analysis, we look at both the full sample and the middle 60% subsample to provide some early insights into the state of retirement in America.

Table 9: Number and Proportion of Deceased Individuals, Plus Death Age, Retirement Age and Time in the Middle Class (Middle Three Quintiles)

		Proportion Dead	Deceased Individuals with a Retirement Time Value			
			No. Deceased	Mean Death Age	Mean Retirement Age	Mean Retirement Time
Gender	Women	7.66%	134	70.65	62.52	8.129
	Men	16.52%	316	71.03	62.36	8.676
Health Status	Good - Poor	16.00%	246	70.41	62.09	8.314
	Excellent - Very Good	9.08%	204	71.53	62.78	8.753
Income Group	Lower Half	12.07%	220	71.08	62.87	8.203
	Upper Half	12.00%	230	70.77	61.96	8.809

D. REGRESSION ANALYSIS

Using an ordinary least squares regression on the full sample, we find higher income reduces retirement time, retirement age, and death age. In fact, average full-time labor market income is the only significant variable in each of the three regressions. Note income and retirement age are negatively correlated: higher income people work longer. That higher income individuals remain longer in the workforce explains much of the anomalous results that higher income workers have less retirement time.

After controlling for income and health, men still have more retirement time than women, but the difference is not statistically

significant. Healthier individuals, after controlling for sex and income, die 1.36 years later and the result is highly significant (p-value = 0). The age of death, seen in the final column of Table 10, is negatively correlated with income. Thus, as expected from the cross tabulations, the top 20% of this sample tend to retire older and die a bit sooner.

Table 10: Retirement Time, Age and Death Age by Income, Gender and Health Status

Full Sample	(1)	(2)	(3)
VARIABLES	<i>Retirement Time</i>	<i>Retirement Age</i>	<i>Death Age</i>
Average Full-time Labor Market Income (Thousands of 2008 \$)	-0.0116** (0.00471)	-0.00333** (0.00157)	-0.0109** (0.00488)
Gender (Male = 1; Female = 0)	0.577 (0.468)	0.167 (0.154)	1.721*** (0.433)
Health Status (Excellent/ V. Good = 1; Good to Poor = 0)	0.604 (0.422)	0.168 (0.153)	1.358*** (0.403)
Constant	8.576*** (0.455)	62.07*** (0.151)	66.62*** (0.412)
Observations	725	5,557	1,418
R-squared	0.012	0.001	0.019

Notes: OLS coefficients with standard errors in parentheses
 *** p<0.01, ** p<0.05, * p<0.1

Working past age sixty-five is correlated with higher income and earlier death in the full sample, but not for the middle class sample, represented in Table 11. Labor market income is now associated with more retirement time, which confirms the findings from the simple cross tabulations. For the middle class, every \$10,000 of labor market income increases retirement time by 0.139 years (approximately 6 weeks). Unfortunately, with the reduced sample size, from 725 observations in the full sample in Table 10, to 450 in middle class sample in Table 11, the

coefficient on retirement time is not statistically significant. Nevertheless, the negative relationship between retirement age and labor market income is significant in this sub-sample regression. Therefore, although this second regression loses some of its explanatory power compared to the full sample regression, it supports the hypothesis that, for now, the U.S. retirement system enables lower income individuals to obtain retirement time on an equal basis by enabling them to overcome their shorter life expectancy through earlier retirement.

Table 11: Retirement Time, Age and Death Age by Income, Gender and Health Status

Middle 60% VARIABLES	(1) <i>Retirement Time</i>	(2) <i>Retirement Age</i>	(3) <i>Death Age</i>
Average Full-time Labor Market Income (Thousands of 2008 \$)	0.0139 (0.0184)	-0.0464*** (0.00692)	-0.0344* (0.0192)
Gender (Male = 1; Female = 0)	0.497 (0.521)	0.522*** (0.180)	1.488*** (0.529)
Health Status (Excellent/ V. Good = 1; Good to Poor = 0)	0.441 (0.471)	0.197 (0.179)	1.519*** (0.491)
Constant	7.382*** (0.846)	63.70*** (0.312)	67.31*** (0.857)
Observations	450	3,411	869
R-squared	0.006	0.014	0.020
Notes: OLS coefficients with standard errors in parentheses			
*** p<0.01, ** p<0.05, * p<0.1			

IV. INCOME INEQUALITY AMONG OLDER WORKERS IS GETTING WORSE⁵⁸

Finding that the U.S. retirement system equalizes retirement time is in sharp contrast to the growing inequality of income over the past two decades. Using the same data set, we find the income distribution for full-time workers and their households has become more unequal. In 1992, looking at Table 12, the mean full-time labor market income of middle-income earners (i.e., those in the third quintile – the 40th to 60th percentile) was 31.7% of the average full-time labor market income of those in the top quintile.⁵⁹ By 2010, the middle quintile of workers' average income was only a quarter (25.3%) of the average income of the top 20%. The disparities in median incomes also grew. In 1992, the middle-quintile's median income was 40.7% of that in the top quintile; by 2010, the median middle-income individual had only one-third (33.3%) of the top 20%'s median income.

Table 12: Ratio of Third Quintile (40-60%) to Fifth Quintile (80-100%) of Full-time Labor Market Income

Year of HRS Sample	Quintile's Mean Income	Quintile's Median Income
1992	31.7%	40.7%
1994	31.5%	41.8%
1996	32.1%	40.8%
1998	28.2%	35.9%
2000	29.8%	37.3%
2002	27.9%	33.3%
2004	27.3%	34.7%
2006	26.4%	35.0%
2008	26.8%	34.5%
2010	25.3%	33.3%

⁵⁸ See NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 57.

⁵⁹ Note that these figures for the distribution of full-time income come from the entire full-time workers sample in the HRS and thus are not subject to the sample bias that exists when restricting the sample retirees or the deceased.

V. RETIREMENT TIME EQUALITY AND THE IMPLICATIONS FOR RETIREMENT AGE POLICIES

This study aimed to uncover retirement trends hidden by averages. That the average American man is retiring earlier and living longer hides the potential erosion in a major social accomplishment: Social Security, Medicare, and pension programs allow rich, middle class, and low income workers alike to retire before they die.

The lowest income groups in this sample are retiring early, while others in the middle class are working longer and not enjoying as rapid improvements in longevity. This means retirement time could grow more unequal by social economic class if the age at which Social Security beneficiaries collect full Social Security benefits is raised. It is a mistake to assume that the facts that Americans are living longer and that Americans are retiring earlier are not connected. Retirement improves health, especially for men, so if people work longer, longevity improvements could decrease and access to retirement time could decrease as well.⁶⁰ Reforming policies regarding one aspect of aging (e.g., retirement time) because of changes in the average of another (e.g., death age) is, therefore, ill advised.

It is well documented that the average American's life expectancy has increased markedly since World War II.⁶¹ The average American born in 1950 lived to 68 years old.⁶² By 1980, life expectancy at birth had increased to 73.9 years and to then nearly 78 years by 2007.⁶³ These remarkable increases hide a growing disparity of life expectancies among different socio-economic groups. Longevity has not improved equally for all Americans. Life expectancy for those in the top half of the income distribution has improved much more than for those in the bottom half.⁶⁴ Stunningly, this increasing inequality of outcomes has occurred with remarkable speed. For example, the Inter-American Development Bank

⁶⁰ See Kevin Neuman, *Quit Your Job and Get Healthier? The Effect of Retirement on Health*, 29 J. LAB. RES., 177-201 (2008).

⁶¹ *Life Expectancy at Birth by Race and Sex, 1930-2010*, NAT'L CTR. FOR HEALTH STATISTICS, available at <http://www.infoplease.com/ipa/A0005148.html>.

⁶² *Id.*

⁶³ Arias, *supra* note 3, at 48.

⁶⁴ See Cristia, *supra* note 3.

estimates that from the 1983-1997 period to the 1998-2003 period,⁶⁵ The differences in life expectancy between the highest 20% and lowest earning 20% of Americans (for those ages 35-76) grew from 0.7 to 1.5 years among women, and from 2.7 years to 3.6 years among men.⁶⁶

To explain the growing disparities in longevity, other studies have sought to isolate a broader range of socio-economic variables. Education is a driving force behind longevity and mortality differentials.⁶⁷ Waldron, an economist, finds income is the driving force, though she did not have data on education.⁶⁸ Specifically, differentials in life expectancy among race-sex groups (at age twenty-five) remained constant from 1990 to 2000, but that differences significantly increase between high- and low-education groups.⁶⁹ Lower-educated women (both white and black) had a statistically significant lower average life expectancy in 2000, compared to better-educated women than they did in 1990.⁷⁰

What are the implications for retirement policy? The evidence suggests that raising the retirement age and implementing other policies that encourage longer working lives may actually reverse longevity gains, so that higher labor incomes may result in a decrease in retirement time. Raising the normal retirement age in Social Security, which is equivalent to cutting benefits for workers, will reduce income for any person in a group that tends to leave the labor force early to compensate for a lower life expectancy. Higher income people also obtain more years of life, but the inequality of life expectancy can be counterbalanced by a well-designed pension system that allows lower income and lower educated workers to collect pensions or disability benefits earlier than higher income and higher educated individuals. On the other hand, pension systems that encourage lower-income, lower-educated people to work longer will create unequal distributions of retirement time.

In sum, sex and health are important factors in predicting who will have more or less retirement time, but economic class is a key factor. If

⁶⁵ These periods were chosen so that the sizes of the two groups considered were approximately equal.

⁶⁶ Cristia, *supra* note 3, at 20, 29-30.

⁶⁷ See Ellen R. Meara et al., *The Gap gets Bigger: Changes in Mortality and Life Expectancy, by Education, 1981-2000*, 27 HEALTH AFFAIRS 350 (2008).

⁶⁸ See Hilary Waldron, *Trends in Mortality Differentials and Life Expectancy for Male Social Security-Covered Workers by Socioeconomic Status*, 67 SOC. SEC. BULL., no. 3, 2007.

⁶⁹ *Id.*

⁷⁰ *Id.*

lower socio-economic status individuals are forced to delay retirement because private and/or public pension payments shrink, then retirement time is bound to become more unequal.

Appendix A: Longevity at various ages, by race⁷¹

Table A: Longevity at Various Ages from 1980-2010, by Race

	White Male	White Female	Black Male	Black Female
At birth	8.2%	4.1%	12.5%	7.6%
At 65 years	25.4%	10.3%	22.3%	14.9%
At 75 years	25.0%	11.3%	22.9%	16.8%

⁷¹ See ROBERT D. GROVE & ALICE M. HETZEL, U.S. DEP'T OF HEALTH, EDUC., & WELFARE, VITAL STATISTICS RATES IN THE UNITED STATES 1940-1960 (1968), available at http://www.cdc.gov/nchs/data/vsus/vsrates1940_60.pdf; ELIZABETH ARIAS, U.S. DEP'T OF HEALTH & HUMAN SERV., UNITED STATES LIFE TABLES BY HISPANIC ORIGIN (2010), available at http://www.cdc.gov/nchs/data/series/sr_02/sr02_152.pdf; Sherry L. Murphy, et al., *Deaths: Final Data for 2010*, U.S. DEP'T OF HEALTH & HUMAN STATISTICS NAT'L VITAL STAT. REP., May 8, 2013, at 1, 3, 18-21, available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf.

Appendix B: Definition Variables

Variable Name	Stata code	Explanation	Other Notes
Entry Age	Y_age	Age of respondent when he/she first enters the HRS survey.	Here 'age' is simply the difference between year of birth and survey year
Death Age	death_age	Difference between year/month of death and year/month of birth. Month's (1=January; 12 = December) are divided by 12 and added/subtracted from the difference in years	HRS 2010 Tracker data. HRS records year of death and then verifies with CDC mortality tables.
Retirement Age	ret_age	Difference between year/month of stated date of retirement and year/month of birth	Year and month of retirement is asked if retired 'year' == 1 (see below)
Disabled Age	dis_age	Difference between year/month of stated date of when a disability (keeping one from work) began and year/month of birth	
Time in Retirement	ret_time	Difference between retirement or disabled age and death age. If respondent has both a retirement and disability age, retirement age is used.	
Retired	retired{'year' } or retired (0 = not retired; 1 = retired)	Based on the respondents labor force status (reported in each survey), he/she is considered retired only if the first/primary response is "retired". Therefore a respondent may be coded as 1 for several survey years – and may switch to and from retirement.	Each respondent with retired 'year' == 1 also states a year and month of retirement. For the calculations of retirement time and age we take the mostly recently reported retirement year and month.

Individual Income	inc{`year`}	Annual income from wages, salaries and business. Positive values only.	RAND income and wealth files, 1992 through 2010. (e.g., rlearn)
Average Real Income	avg_inc_r	Constructed by adjusting individual incomes by CPI to 2010 US dollars. Average is constructed as the mean for each individuals across the survey years they report an individual income	CPI adjustment figures are taken from IPUMS CPS (CPI99) The variable is restricted to full-time income only (35+ hr/wk; 40+ wk/yr)
Top Half / Bottom Half	avg_topbottom (0 = bottom; 1 = top)	Binary value assigned to each respondent based on whether their average real income is above or below of the median income	The median average income is the median
Income Quintile	avg_quint (1 = poorest 20%; 5 = richest 20%)	Same as Top / Bottom, but dividing individuals into 5 income groups rather than 2.	Cut off points are based on average real income
Sex/Gender	GENDER (0 = Woman; 1 = Man)		HRS 2010 Tracker data
White/Non-White	white (0 = not white; 1 = white)		HRS 2010 Tracker data
Covered by a Pension Plan, 1992	inplan1992 (1 covered by a plan; 0 = not covered)	Whether employed persons in 1992 are or are not covered by a pension plan at work that year.	
Health Status	health1 (0 = not great; 1= great)	Health status is a self-reported 5-level variable with responses: 'Poor', 'Fair', 'Good', 'Very Good' and 'Excellent'. The latter two are coded as 0, the former three are coded as 1.	Health status is asked in each survey year. health1 takes the first reported status

DESPERATE RETIREES: THE PERPLEXING CHALLENGE OF COVERING RETIREMENT HEALTH CARE COSTS IN A YOYO WORLD

RICHARD L. KAPLAN*

This article explores the challenges that retirees face when it comes to selecting and paying for the proper healthcare coverage post retirement. The author examines the rising cost of healthcare as well as the complexities of Medicare plans that often make up a retiree's healthcare coverage package. The author concludes that most retirees are not prepared to pay for healthcare in their retirement years.

I. INTRODUCTION

That retirement formulas and templates of earlier times have little relevance to today's retirees is a vast understatement. In virtually every significant aspect of retirement planning, it is a brand new ball game, and almost every change has spawned increasing uncertainty, unpredictability, and anxiety for persons affected by these changes. To encapsulate the direction of these massive changes, I have resorted to a four-letter acronym, YOYO, which stands for You're On Your Own.¹ Quite bluntly, retirees and prospective retirees are now the locus of increasing risks relating to retirement security,² and the foreseeable trends suggest that this situation will only exacerbate in the future.

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¹ To be sure, there is a whole sub-industry of advice-providers seeking to assist individuals with the financial aspects of retirement. *See, e.g., WALL ST. J.*, May 13, 2013, at C7 (full-page advertisement showcasing twenty-five "best selling authors" on this topic from a single publisher).

² *See* Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53 (2004). *See generally* EDWARD A. ZELINSKY,

Rather than try to consider all of these changes, I will explore instead just one very important, but largely neglected, component of the increasingly desperate condition in which today's retirees find themselves – namely, covering the cost of health care during their retirement. The significance of this issue is captured by the most recent Health Confidence Survey that was reported this past January.³ An analysis of that Survey by the Employee Benefit Research Institute concluded that “[t]he percentage of Americans reporting that health expenses are an important consideration when planning for retirement has always been relatively high, and it has recently increased.”⁴ The survey results for the most recent three years are summarized in the following table:⁵

Percent of Respondents Citing Medical Expenses as Extremely or Very Important in Planning for Retirement			
	<u>2010</u>	<u>2011</u>	<u>2012</u>
Extremely Important	38	37	45
Very Important	<u>31</u>	<u>33</u>	<u>26</u>
Total	<u>69</u>	<u>70</u>	<u>71</u>

Paying for one's health care is, of course, a major issue throughout a person's life, but many people were able to ignore the fundamental necessity of securing health insurance until they retire, because their employers typically provided health insurance as part of their compensation package.⁶ While the specific components of such coverage undoubtedly

THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA (2007).

³ Paul Fronstin, *Views on Health Coverage and Retirement: Findings from the 2012 Health Confidence Survey*, EMP. BENEFITS RES. INST. NOTES, Jan. 2013 at 2, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_01_Jan-13_HCS-TxExps3.pdf.

⁴ *Id.*

⁵ See *id.* at 5, fig.3.

⁶ See Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 537–40 (2005).

changed over the years, the essential availability and general contours of such coverage were generally not a major concern. Employers negotiated with health care providers or insurers, designing one or more packages of benefits that they thought their employees might want, handled much of the attendant paperwork in administering the plan, and facilitated enrollment via their payroll systems.⁷ Such employer involvement, if not beneficence, basically disappears once a person retires. As a result, the financial context of health care coverage that retirees confront is fundamentally different than what they had when they were working.

The nature of this contrast can be described in overview as follows: wage earners received periodic income, increased irregularly for reasons of inflation or career advancement, with income taxes withheld from each payment,⁸ along with health insurance for themselves and their dependents. Classic pension schemes based on defined benefit plans⁹ self-consciously sought to mimic this basic pattern, though usually without any scheduled increases in payment amounts. That is, traditional pensions and retirement annuities provide periodic income, with income taxes withheld from each payment,¹⁰ but no increases for inflation once they commence. But the bigger difference is that most retirees cannot look to their former employer for coverage of their health care expenses. As I have noted elsewhere,¹¹ retiree health benefits are provided by fewer employers every year, and the benefits that are provided are diminished regularly. Accordingly, employees who had been largely sheltered from the chore of securing coverage for unexpected health care costs must become their own human resources counselors upon retirement. They must learn how to navigate a very different health care system, one that was assembled over several decades with no coherent vision and with precious little regard to consumer friendliness.

Fidelity Investments, the major financial services provider, has estimated that a retired couple aged sixty-five years is likely to need nearly

⁷ See *id.* at 540–41; see also David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001).

⁸ I.R.C. § 3402(a)(1) (Supp. IV 2007–2011).

⁹ See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 361–64 (5th ed. 2010).

¹⁰ I.R.C. § 3405(a)(1) (Supp. V 2007–2012).

¹¹ See generally Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287 (2009).

a quarter of a million dollars to pay for their health care costs in retirement.¹² This estimate is necessarily an average figure, and many retirees will need substantially more funds for this essential retirement outlay. Much depends upon how long a specific individual lives, that person's health status, the nature and extent of health care that that person receives, and the rate of health care cost inflation, among other factors. A careful simulation by the Employee Benefit Research Institute determined that a sixty-five year old man would need savings of \$135,000 to \$185,000,¹³ depending on the extent of his prescription drug usage, and a sixty-five year old female would require \$154,000 to \$210,000.¹⁴ These projections cover anticipated Medicare premiums, deductibles, and co-payment or cost-sharing obligations as well as the cost of certain supplementary arrangements. They do not, however, include the cost of long-term care.¹⁵ But the basic point is that retirees face a large and unpredictable liability in retirement for their health care expenses. That such a prospect is foisted on retirees in a "You're On Your Own" world makes retirement security – the theme of this Symposium – especially problematic.

II. MEDICARE ELIGIBILITY

Many workers, and much of the public as well, have the mistaken impression that upon retirement, their health care cost concerns are over because they can now access the federal government's Medicare program. But Medicare is no walk in the park in terms of understandability or internal consistency, and it is not generally available to retirees who have not yet reached the statutory eligibility age of sixty-five years.¹⁶ This is a very important point because many Americans retire before that age, not always as a matter of choice. In fact, most retirees begin collecting Social

¹² FIDELITY BROKERAGE SERVICES LLC, *THE INCREASING COST OF HEALTH CARE UPON RETIREMENT* (2012), available at http://workplace.fidelity.com/sites/default/files/FF_TBO_IncreasingCostofHC.pdf (projecting required savings at \$240,000).

¹³ Paul Fronstin et al., *Savings Needed for Health Expenses for People Eligible for Medicare: Some Rare Good News*, EMP. BENEFIT RES. INST. NOTES, Oct. 2012, at 2, 4, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_10_Oct-12.HlthSvg-IRAs.pdf.

¹⁴ *Id.*

¹⁵ *Id.* at 5.

¹⁶ 42 U.S.C. § 1395c(1) (2006).

Security retirement benefits before reaching age sixty-five, and a majority do so as early as age sixty-two.¹⁷ These “early” retirees cannot, however, access Medicare before age sixty-five unless they satisfy the Social Security program’s functionality-based criteria for being “disabled” namely, that they are unable to perform “any substantial gainful activity by reason of a medically determinable physical or mental impairment.”¹⁸ Moreover, they must have received disability payments under this standard for twenty-four months before they become eligible for Medicare coverage.¹⁹ If they cannot qualify under these requirements, they must wait until their sixty-fifth birthday to enroll in Medicare and therefore must secure health insurance from some other source before then.²⁰

Proposals were made near the end of the Clinton Administration to allow retirees who were not yet sixty-five years old to buy into Medicare at actuarially fair prices, but those proposals were soon eclipsed by the Monica Lewinsky scandal and the ensuing presidential impeachment battle.²¹ The last time this issue was seriously considered was in the context of the major health care reform legislation enacted during President Obama’s first term,²² known variously as the Affordable Care Act or ObamaCare.²³ That legislation actually jettisoned the prospect of early-access Medicare in favor of universally available health insurance exchanges that are scheduled to begin next year.²⁴ Although the new law did include a very modest program to subsidize employers that maintained

¹⁷ See Dan Muldoon & Richard W. Kopcke, *Are People Claiming Social Security Benefits Later?*, CTR. FOR RETIREMENT RES., JUNE 2008 at 1, 2, available at http://crr.bc.edu/wp-content/uploads/2008/05/ib_8-7.pdf.

¹⁸ 42 U.S.C. § 416(i)(1)(A) (Supp. IV 2007–2011).

¹⁹ *Id.* §§ 426(b)(2)(A)(i), 1395c(2).

²⁰ See Kaplan et al., *supra* note 11, at 336–37 (explaining the possible availability of “continuation” coverage from a former employer under certain specified circumstances).

²¹ See *id.* at 343.

²² Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

²³ See Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 213–14 (2011).

²⁴ See 42 U.S.C. § 18031(b) (Supp. V 2007–2012) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 1311(b), 124 Stat. 119, 173 (2010)).

their existing health insurance programs for pre-Medicare retirees,²⁵ that program disappears entirely in 2014²⁶ when the state-organized health insurance exchanges will presumably be operational.²⁷

In any case, if Medicare's eligibility age is reconsidered amidst the current efforts to tackle America's long-term fiscal dilemma, it is more likely that this age will be *raised* then lowered. Indeed, coordinating Medicare's eligibility age with Social Security's age for full retirement benefits has been seriously considered for some time.²⁸ That change would boost Medicare's eligibility age to sixty-six currently and eventually to sixty-seven.²⁹ For what it's worth, if Medicare's eligibility age of sixty-five were adjusted for changes in life expectancy that have occurred since the program was enacted, it would be seventy-three years.³⁰ The bottom line is that retirees who are not yet sixty-five years old cannot enroll in Medicare, presently or in the foreseeable future.

III. MEDICARE'S COVERAGE COMPONENTS

Retirees who can enroll in Medicare confront an uncoordinated "system" of separate coverages and confusing options that does not correspond even remotely to what they had during their working lives. The elemental separation of Medicare's disparate coverages into hospital costs (Part A), physicians' charges (Part B), and prescription drug expenses (Part D) is unfathomable to new retirees who are accustomed to the all-inclusive

²⁵ Under this program, the federal government paid eighty percent of claims for medical services costing between \$15,000 and \$90,000 that were incurred between June 22, 2010 and December 31, 2013. 42 U.S.C. § 18002(c)(2), (3) (Supp. IV 2007-2011) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1102(c)(2), (3), 124 Stat. 119, 145 (2010)). The maximum benefit per claim, in other words, was \$60,000 (maximum claim of \$75,000 × 80%). Among other limitations, this program had a global budget cap of \$5 billion, after which no further claims were payable. 42 U.S.C. § 18002(e).

²⁶ 42 U.S.C. § 18002(a)(1).

²⁷ 42 U.S.C. § 18031(b).

²⁸ See Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 791-92.

²⁹ See 42 U.S.C. § 416(l)(1) (2006).

³⁰ Life expectancy when Medicare was created (1965) was 70.2 years and was 78.7 years in 2010. *Life Expectancy at Birth by Race and Sex, 1930-2010*, INFO. PLEASE (2011), <http://www.infoplease.com/ipa/A0005148.html>. Therefore, $78.7 \div 70.2 = 1.12108 \times 65 = 72.9$ years.

health care plans that characterize the modern workplace. To be fair, when Medicare was created in 1965, its designers self-consciously mimicked the “major medical” plans that private health insurance companies were then offering.³¹ But those plans evolved over time, while Medicare’s fundamental organizational components have not. As a result, a newly retired person faces a program that seems designed for a time long ago and in fact was.

Perhaps the most egregious aspect of this programmatic ossification involves prescription drugs. When Medicare was created in 1965, such medications were few and relatively inexpensive and were used primarily to treat specific maladies over very short time courses. In the ensuing decades, however, pharmacological innovations have brought forth a veritable cornucopia of amazing treatments that control and ameliorate a wide range of common chronic conditions including heart disease, hypertension, diabetes, arthritis, asthma, osteoporosis, and the like. These drug regimens are not cheap and generally must be followed for the rest of a patient’s life, but they extend people’s lives and improve the quality of the lives they live. Yet, by the time that Medicare was changed to cover outpatient prescription drugs, it was the only health care insurance program in the country that lacked such coverage – a situation that typifies the anachronistic nature of Medicare’s basic structure.

IV. MEDICARE’S COST EXPOSURES

Unbeknownst to most pre-retirees, Medicare is not a comprehensive health care plan.³² It exposes its beneficiaries to a dizzying array of deductibles and co-payments that can be understood only as historical accidents lacking any sense of medical coherence.

A. HOSPITALS

Medicare Part A covers most of a retiree’s hospital costs for up to sixty days in a single “spell of illness” after payment of a per-admission deductible.³³ A “spell of illness” for this purpose begins with the admission

³¹ See THE CENTURY FOUND., *MEDICARE TOMORROW: THE REPORT OF THE CENTURY FOUNDATION TASK FORCE ON MEDICARE REFORM* 47 (2001).

³² See Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 *ELDER L.J.* 1, 10–11 (2012).

³³ 42 U.S.C. § 1395x(b) (2006).

and ends sixty days after the patient has been discharged.³⁴ Although a per-admission deductible is a fairly common feature in health care plans, it usually is much lower; e.g., \$250. That is not the case with Medicare. The per-admission deductible in 2014 is \$1,216,³⁵ and it increases every year based on increases in health care costs generally. Moreover, retirees tend to use more health care services than the general population and could conceivably face two or even three hospitalizations in the same calendar year.

For example, a retiree might be hospitalized on January 14, discharged two weeks later, and then readmitted in May and perhaps in October as well. If that happened, this retiree would be liable for the per-admission deductible twice or even three times that year. In this context, it is extremely important to note that Medicare has *no annual stop-loss provisions that cap an enrollee's out-of-pocket costs* once that person's expenditures reach some pre-determined amount³⁶ – again unlike many, if not most, health care plans that are available today to the pre-Medicare population.

Medicare Part A also has a durational limitation on hospital stays that reflects its generally out-of-date orientation. Medicare covers virtually all costs for up to sixty days and then covers costs in excess of a daily deductible for an additional thirty days within the same “spell of illness.”³⁷ That per-day deductible is adjusted annually and in 2014 is \$304.³⁸ The resulting cost exposure, however, is fairly inconsequential because a hospital stay exceeding sixty days is very uncommon, especially after the Diagnostic Range Groupings were implemented in 1987.³⁹ These groupings limit how many hospital days Medicare will pay for specific treatments and as a result, the average hospital stay of a person age sixty-five and older is less than six days, according to the most recent data available.⁴⁰

³⁴ 42 U.S.C. § 1395x(a) (2006).

³⁵ *Medicare 2014 Costs at a Glance*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4811> (last visited Mar. 22, 2014).

³⁶ Katherine Baicker & Helen Levy, *The Insurance Value of Medicare*, 367 *NEW ENG. J. MED.* 1773, 1773 (2012).

³⁷ 42 U.S.C. § 1395x(a) (2006).

³⁸ *Medicare 2014 Costs at a Glance*, *supra* note 35.

³⁹ See generally RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?*, 162–64 (1997).

⁴⁰ See ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., *A PROFILE OF OLDER AMERICANS: 2012 13* (2013), available at

B. NURSING HOMES

Medicare Part A's coverage of nursing home care is far more restrictive than its coverage of hospital charges but is similarly time-warped. Nursing home costs are covered by Medicare for the first twenty days within a "spell of illness,"⁴¹ and Medicare then pays all costs beyond a per-day deductible,⁴² which in 2014 is \$152.⁴³ This extended coverage, however, cannot exceed eighty days,⁴⁴ so Medicare's coverage stops after one hundred days in a nursing home. This coverage design may have been appropriate when Medicare was created in 1965, when most people did not live long enough to develop conditions like Alzheimer's Disease, which can require care in a nursing facility for three to five years or longer. But today, the majority of older residents in nursing homes have such conditions, and a result, Medicare's one-hundred-day coverage limitation seems archaic, if not downright cruel.

Moreover, even this limited coverage of nursing home costs is subject to a major and poorly understood overarching restriction – namely, that the patient requires and receives "skilled nursing care" on a daily basis⁴⁵ for the same or a medically related condition that was treated previously in a hospital.⁴⁶ Most retirees and their families do not realize that much of the care these facilities provide is actually lower-level "custodial care" rather than "skilled nursing care," which typically entails injections, gastronomy feedings, catheters, administration of medical gases, and the like.⁴⁷ Consequently, Medicare does not cover the cost of such care.

Moreover, the prior hospitalization must have lasted at least three days⁴⁸ and must have occurred within the thirty days preceding admission

http://www.aoa.gov/aoaroot/aging_statistics/Profile/2012/docs/2012profile.pdf (reporting that persons aged sixty-five to seventy-four averaged stays of 5.4 days, persons aged seventy-five to eighty-four averaged 5.7 days, and persons aged eighty-five and over averaged 5.6 days).

⁴¹ 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3) (Supp. III 2007–2010).

⁴² *Id.* § 1395e(a)(3).

⁴³ *Medicare 2014 Costs at a Glance*, *supra* note 35.

⁴⁴ 42 U.S.C. § 1395e(a)(3).

⁴⁵ 42 U.S.C. § 1395f(a)(2)(B) (Supp. III 2007-2010); 42 C.F.R. § 409.31(b)(1) (2012).

⁴⁶ 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

⁴⁷ 42 C.F.R. § 409.33(a)-(c) (2012).

⁴⁸ 42 U.S.C. § 1395x(i) (2006).

to the nursing home.⁴⁹ So, if a retiree enters a nursing home directly from her home, for example, Medicare does not cover any of the ensuing expenses.

Adding insult to injury, the Diagnostic Range Groupings that reduced the number of days that Medicare would pay for hospital care effectively eliminated Medicare's coverage of many nursing home stays. That is, when a hospital stay for a particular medical condition is shortened from three days to two days, a subsequent nursing home stay will not be covered by Medicare because of that program's three-day minimum.⁵⁰ The bottom line is that Medicare's coverage of nursing home care is much more limited than it first appears, which means that retirees who require such facilities face considerable financial exposure for the cost of care they receive there. In this context, it should be noted that Medicare provides no coverage whatsoever for care in assisted living facilities, largely because those institutions did not exist when Medicare was created.

C. DOCTORS' FEES

Physicians' charges are another source of major expense for retirees and are covered by Medicare Part B. Medicare pays eighty percent of a participating physician's "approved charge,"⁵¹ and the patient then owes the remaining twenty percent. Nonparticipating physicians can charge patients up to an additional fifteen percent of the "approved charge,"⁵² and increasing numbers of health care providers are switching from participating to nonparticipating provider status⁵³ in response to repeated reductions in Medicare's "approved charge" schedules – the most recent being the two percent reduction mandated by the Budget Control

⁴⁹ *Id.* § 1395x(i)(A).

⁵⁰ Exacerbating this problem is the practice of many hospitals to keep patients for several days in "observation" status. See Christopher W. Baugh & Jeremiah D. Schur, *Observation Care-High-Value Care or a Cost-Shifting Loophole?*, 369 NEW ENG. J. MED. 302, 303 (2013). Such patients are not treated as being admitted into the hospital, so the days they spend in "observation" do not count toward the three-day minimum. See *id.*

⁵¹ 42 U.S.C. § 1395l(a)(1) (2006).

⁵² *Id.* § 1395w-4(g)(2)(C).

⁵³ See Melinda Beck, *More Doctors Steer Clear of Medicare*, WALL ST. J., July 29, 2013, at A1, A4, available at <http://online.wsj.com/news/articles/SB10001424127887323971204578626151017241898> (reporting a 2.9% increase in nonparticipating providers from 2010 to 2012).

Act's sequestration provisions.⁵⁴ In effect, such payment reductions can indirectly increase retirees' health care costs as more physicians change their status to nonparticipating provider, a phenomenon that is likely to increase as federal budgetary pressures worsen.

Moreover, it should be emphasized that doctors' bills are not occasional expenditures for most Medicare beneficiaries. Fully forty percent of Medicare's population has three or more so-called "chronic conditions," such as heart disease, asthma, osteoporosis, hypertension, arthritis, diabetes, and chronic obstructive pulmonary disease.⁵⁵ These conditions typically require regular appointments with various medical specialists to control the patient's health and to forestall expensive complications and hospitalizations. Doctors' visits, in other words, are far more frequent and less episodic for retirees than for pre-retirees as a general matter.

V. MEDICARE PART B OPTIONS

As noted previously in passing, the coverage for physicians' charges just described is provided under Medicare Part B rather than Part A, a distinction that has significant financial implications for retirees. Medicare Part A is financed by a payroll tax of 1.45 percent imposed on an employee's wages and salaries,⁵⁶ with a comparable amount paid by that person's employer.⁵⁷ After that worker (or the worker's spouse)⁵⁸ has earned forty "quarters of coverage,"⁵⁹ Medicare Part A is provided without any further premiums being charged.⁶⁰ In contrast, Medicare Part B is a

⁵⁴ 2 U.S.C. § 901a(8) (Supp. V 2007-2012) (enacted as part of the Budget Control Act of 2011, Pub. L. No. 112-25, § 302(a), 125 Stat. 240, 258 (2011)).

⁵⁵ KAISER FAMILY FOUND., *MEDICARE AT A GLANCE* 1 fig. 1 (2012), available at <http://www.kff.org/medicare/upload/1066-15.pdf>.

⁵⁶ I.R.C. § 3101(b)(6) (Supp. V 2007-2012).

⁵⁷ *Id.* § 3111(b)(6).

⁵⁸ 42 C.F.R. § 406.10(a) (2012); 42 U.S.C. § 402(b)(1), (c)(1) (2006). The divorced spouse of a Medicare-eligible worker is also entitled to Medicare Part A if the divorced spouse is at least sixty-five years old and if this person was married to the Medicare-eligible worker for at least ten years. 42 C.F.R. § 406.10(a)(1) (2012); 42 U.S.C. §§ 402(b)(1), (c)(1), 416(d)(1) (2006).

⁵⁹ 42 U.S.C. § 414(a)(2) (2006).

⁶⁰ Persons who have not earned the requisite forty "quarters of coverage" may purchase Medicare Part A if they have lawfully lived in the United States at least five years. 42 U.S.C. § 1395i-2(a)(3) (2006). The monthly premium for such

separate program that requires annual enrollment and monthly premiums paid by the retirees themselves.⁶¹ In 2014, this monthly premium is \$104.90,⁶² which is calculated to cover approximately twenty-five percent of the program's projected expenditures.⁶³ This monthly outlay, in other words, represents a seventy-five percent subsidy from general tax revenues.

Since 2006, higher-income enrollees have been required to pay surcharges to reduce the extent of the subsidy that they receive.⁶⁴ The amount of these so-called "means-tested" surcharges is based on an enrollee's taxable income as determined for the second-preceding calendar year.⁶⁵ Thus, the following table⁶⁶ displays the monthly cost of Medicare Part B in 2014 as a function of a retiree's income for federal income tax purposes in 2011:

Income (if unmarried)	Monthly Payment
\$85,000 or less	\$104.90
\$85,001 - \$107,000	\$146.90
\$107,001 - \$160,000	\$209.80
\$160,001 - \$214,000	\$272.70
Over \$214,000	\$335.70

coverage is adjusted annually and in 2013 was \$441. *Medicare 2014 Costs at a Glance*, *supra* note 35.

⁶¹ 42 U.S.C. § 1395j (2006). *See generally* FROLIK & KAPLAN, *supra* note 9, at 76–83.

⁶² *Medicare 2014 Costs at a Glance*, *supra* note 35.

⁶³ 42 U.S.C. § 1395r(a)(1), (3) (Supp. V 2007–2012); *see* MEDICARE HANDBOOK § 6.02[C][1], at 6–11 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2013).

⁶⁴ 42 U.S.C. § 1395r(i)(1), (4)(B)(i) (2006).

⁶⁵ *See generally* Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLANNING, May-June 2006, at 22.

⁶⁶ *See Part B Costs*, MEDICARE.GOV, <http://medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html> (last visited Jan. 27, 2014).

Note that the applicable income thresholds are doubled for married couples.⁶⁷ Moreover, these thresholds were frozen through the year 2019, rather than being adjusted for inflation, by the Affordable Care Act.⁶⁸ Accordingly, increasing numbers of retirees are likely to face income-based surcharges for Medicare Part B in the future.

The principal point, however, is that Medicare Part B is optional coverage. Thus, retirees must decide as an initial matter whether they want such coverage at all. Retirees who do not anticipate having many physician encounters might forego such coverage, but they will then be subject to a delayed enrollment penalty if they subsequently enroll in this program.⁶⁹ This penalty is ten percent of the regular Medicare Part B monthly premium for every twelve-month period in which the retiree did not enroll in the program when she was first eligible.⁷⁰

Assume, for example, that Denise delayed enrolling in Medicare Part B for forty months, so there are three twelve-month periods within that delayed enrollment period. She will therefore owe a penalty of thirty percent (ten percent for each twelve-month delayed enrollment period) of the monthly Medicare Part B premium. Most importantly, this penalty provision never ceases! That is, Denise will owe thirty percent more for her Medicare Part B benefits as long as she is enrolled in Medicare Part B.

VI. “MEDIGAP” COVERAGE

As noted previously, the various deductibles and co-payment obligations in Medicare Part A and Medicare Part B represent an open-ended liability. That is, there is no annual cap on the amount of such costs. For that reason, many Medicare beneficiaries decide to supplement their Medicare coverage with private insurance that is usually called “Medigap” insurance.⁷¹ Some retirees are able to purchase such supplemental coverage from their former employer or from their union, while others obtain such

⁶⁷ 42 U.S.C. § 1395r(i)(3)(C)(ii), (iii) (2006).

⁶⁸ 42 U.S.C. § 1395r(i)(6) (Supp. V 2007-2012) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3402(4), 124 Stat. 119, 489 (2010)).

⁶⁹ 42 U.S.C. § 1395r(b) (Supp. V 2007-2012).

⁷⁰ *Id.*

⁷¹ See generally FROLIK & KAPLAN, *supra* note 9, at 97–103.

coverage individually.⁷² In any case, the question of supplemental insurance presents retirees with further choices, each of which has financial implications.

First, retirees must decide whether to purchase Medigap insurance at all. Such policies are not inexpensive and their cost is usually borne by the retirees. The federal government does not provide any financial subsidies for Medigap insurance, although it does regulate its content⁷³ and mandates that retirees cannot be denied Medigap insurance because of pre-existing medical conditions if they purchase this insurance within the first six months of their enrolling in Medicare Part B.⁷⁴

Second, retirees must then select among the eleven different but standardized Medigap insurance packages that include various benefits.⁷⁵ Medigap insurers can determine what they will charge for particular policies, but the scope of any specific “plan” does not vary from one insurer to another. Thus, a retiree must first determine which combination of specific benefits most closely fits his or her needs and then look for the best price from the insurers that offer that plan. For example, a prospective retiree may choose Medigap coverage for the per-hospital-admission deductible under Part A or decide instead to self-insure for that liability by not obtaining such coverage. Similarly, a retiree who expects to travel outside the United States might want to add the “foreign travel emergency” benefit. In general, the more extensive the coverages included, the higher the plan’s cost. But the point is that Medigap itself presents a series of distinct choices that a retiree must consider.

To summarize, a retiree must decide first whether to enroll in Medicare Part B presently, whether to enroll at some later time and pay the corresponding delayed enrollment penalty, or whether to forego Medicare Part B entirely. This retiree must then decide whether to buy a Medigap policy to cover the unlimited cost exposure of Medicare Parts A and B presently or to wait until some later time and lose the guaranteed

⁷² See JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., MEDICARE CHARTBOOK 60 (4th ed. 2010), available at <http://www.collaborationhealthcare.com/11-9-10KFFMedicareChartBook2010.pdf> (stating that ninety percent of Medicare beneficiaries have some supplemental health insurance).

⁷³ 42 U.S.C. § 1395ss(o), (p), (w), (y) (2006 & Supp. IV 2007–2011).

⁷⁴ *Id.* § 1395ss(s)(2)(A) (2006).

⁷⁵ See CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., MEDICARE & YOU 67–72 (2014), available at <http://www.medicare.gov/Pubs/pdf/10050.pdf>.

insurability that is available within the first six months of Medicare Part B enrollment. Finally, the retiree must decide which specific Medigap policy to buy.

VII. PRESCRIPTION DRUG COVERAGE OPTIONS

The level of complexity and cost exposure described above actually pales in comparison to what is involved regarding Medicare's coverage of prescription drugs. Once again, the threshold decision is whether to buy prescription drug coverage at all, or whether to pay for prescribed drugs as the need for them arises. While the private companies that provide Medicare Part D coverage cannot deny coverage because of a retiree's pre-existing medical conditions, there is a delayed enrollment penalty in Part D that is structured similarly to the delayed enrollment penalty in Medicare Part B that was considered previously.⁷⁶ To some extent, the decision to forego Medicare Part D coverage presently is a bet that one will not need such coverage any time soon – even though new medications are being developed every year to treat existing maladies and one never knows whether he or she might be diagnosed with such conditions in the future.

If a retiree does decide to obtain prescription drug coverage under Medicare Part D, the next step is determining which plan to buy. This is no easy decision, because there is no single Medicare Part D plan or even standardized Medicare Part D plans comparable to the federally standardized Medigap plans described above.⁷⁷ Instead, private insurers offer different plans in different states that cover some medications and not others, and some dosage amounts and frequencies but not others. Thus, a given plan might cover 20 milligrams of Lipitor® twice a day, another plan will cover 40 milligrams of that drug once a day, and still another plan will not cover Lipitor® at all. In essence, a retiree must gather the various medications that he or she is taking currently and then enter their names, dosage amounts, and dosage frequencies into Medicare's website to find the available plans that cover these medications.⁷⁸ Additional

⁷⁶ 42 U.S.C. § 1395w-113(b)(1) (2006). For the mechanics of how this penalty is calculated, see FROLIK & KAPLAN, *supra* note 9, at 88.

⁷⁷ See *supra* text accompanying note 75.

⁷⁸ See *Medicare Plan Finder*, MEDICARE.GOV, <https://www.medicare.gov/find-a-plan/questions/home.aspx> (last visited Jan. 27, 2014). (follow "General Search" hyperlink (entering zip code); enter basic information on next page (step 1

differentiating variables among the offered plans might include convenience of pharmacy locations and availability of mail order renewals.

Most Medicare Part D plans impose an annual deductible that is fairly modest. In 2013, for example, fifty-five percent of Medicare Part D plans had an annual deductible, usually \$325.⁷⁹ Such plans typically provide several distinct “tiers” of cost coverage. That is, a plan might require a low or no co-payment for certain generic medications while charging a higher co-payment for a preferred brand-name drug and an even higher co-payment for a nonpreferred brand-name drug. Most plans also have a coverage gap that is generally denominated the “donut hole” in which annual drug expenditures above a specified amount are covered to a lesser extent.⁸⁰ In 2013, two out of three Medicare Part D plans had coverage gaps that began at \$2,970 in annual drug costs.⁸¹ The Affordable Care Act purports to close this “donut hole,” but the closing process phases in over ten years and will still leave enrollees with a co-payment obligation of twenty-five percent when it is complete.⁸² Thus, retirees in 2014 are responsible for seventy-two percent of the cost of generic drugs and forty-seven and a half percent of the cost of brand-name drugs for costs incurred within the “donut hole.”⁸³

In any case, the procedure for finding a Medicare Part D prescription drug plan must be repeated *every year*, because plan providers regularly change their formularies in advance of the annual enrollment process. Thus, a Humana plan that reasonably met a retiree’s needs one year may not meet those needs the next year, may be much more expensive, or may not even be offered. I am not making this up!

of 4), then see step 2 of 4 “Enter your Drugs” (plan selection and estimate can be generated by completing questionnaire)).

⁷⁹ JACK HOADLEY ET AL., MEDICARE PART D: A FIRST LOOK AT PART D PLAN OFFERINGS IN 2013 3 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8375.pdf>.

⁸⁰ For an explanation of how this curious provision came about, see Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAELA J. 167, 170–74 (2005).

⁸¹ See HOADLEY ET AL., *supra* note 79, at 3.

⁸² 42 U.S.C. § 1395w-102(b)(2)(C)(ii) (Supp. V 2007-2012) (generic drugs); *id.* § 1395w-102(b)(2)(D)(i)(I), (ii)(VI) (brand-name drugs). For a graphic representation of the phase-in process, see Kaplan, *supra* note 23, at 219–220.

⁸³ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 75, at 91.

VIII. THE MANAGED CARE ALTERNATIVE

As the preceding discussion has demonstrated, retirees seeking to pay for their health care expenses in retirement confront a bewildering if not overwhelming array of disjointed coverages under Medicare, each with its own programmatic limitations and cost-sharing provisions. There is an alternative approach, however, in the form of Medicare's managed care component, which is legally designated as Medicare Part C, but is more popularly styled Medicare Advantage.⁸⁴ For a single monthly premium and nominal co-payment obligations, one organization provides the sort of all-inclusive health insurance arrangement that many retirees had when they were still working. Such arrangements typically limit an enrollee's access to specific hospitals, doctors, pharmacies, and other health care providers, while services obtained from "out-of network" providers are covered at substantially higher cost to the enrollee, or not at all.⁸⁵ While such restrictions are endemic to managed care plans generally, the prospect of losing access to favored specialists is often very troubling to retirees who have established relationships with particular health care providers. In fact, only twenty-eight percent of Medicare's population was enrolled in a Medicare Advantage plan in 2013.⁸⁶

If a retiree is comfortable with the basic concept of managed care, that person must then select from among the Medicare Advantage plans that are available in that person's geographic area. This decision, moreover, will probably need to be revisited annually, because Medicare Advantage plans regularly change the array of health care providers that they include, adding some and dropping others, as well as the scope of benefits they provide and the monthly cost they charge to enrollees. This process is generally undertaken during the annual "re-enrollment period" that runs from October 15 to December 7,⁸⁷ but certain changes can be made at other times as well, such as when an enrollee moves out of the geographic area that his or her current Medicare Advantage plan covers.⁸⁸

⁸⁴ 42 U.S.C. § 1395w-21 (2006).

⁸⁵ See generally FROLIK & KAPLAN, *supra* note 9, at 104–06 (describing Medicare's managed care component).

⁸⁶ KAISER FAMILY FOUND., MEDICARE ADVANTAGE FACT SHEET 1 (2013), available at <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

⁸⁷ 42 U.S.C. § 1395w-21(e)(3)(B)(v) (Supp. V 2007–2012).

⁸⁸ *Id.* § 1395w-21(e)(4)(B) (2006).

Near term, such plans may become less available or less appealing due to the Affordable Care Act. The drafters of that legislation believed that Medicare managed care plans were overpaid by the federal government, so payments to these plans are to be reduced beginning in 2014.⁸⁹ In fact, more than a quarter of the cost savings in Medicare from ObamaCare come from cuts in payments to Medicare Advantage plans.⁹⁰ These plans, therefore, are likely to curtail some of the nonmandatory benefits that they provide currently, such as vision care and hearing aids, and some plans may terminate their participation in Medicare entirely. Little wonder, therefore, that Medicare's Chief Actuary when the Affordable Care Act was being considered predicted that enrollment in Medicare Advantage would drop by half when the projected cuts are "fully phased in."⁹¹ As even more retirees opt for the disjointed Medicare components examined previously instead of Medicare managed care, this population will likely face greater health care cost exposure and fiscal uncertainty.

IX. THE PREMIUM SUPPORT ALTERNATIVE?

The relatively recent and highly controversial enactment of health care reform in 2010 suggests that any serious effort to rethink how health care for older Americans should be financed is unlikely any time soon. In fact, ObamaCare is a staggering testament to the power of path dependency. Despite all the heated rhetoric that accompanied its gestation and the impassioned allegations of a government "takeover" of the health care system, rampant socialism, and even death panels, the Affordable Care Act left the basic structure of the Medicare program intact. The noncoordinated components of Medicare Parts A, B, and D, though largely accidents of history, were not reformed or rationalized in any meaningful

⁸⁹ See Kaplan, *supra* note 23, at 239–40.

⁹⁰ See Memorandum of Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended 2, 8 (Apr. 22, 2010), available at <http://graphics8.nytimes.com/packages/pdf/health/oactmemo1.pdf>; see also Letter from Douglas W. Elmendorf, Director, Cong. Budget Office to John Boehner, Speaker of the House 5 (July 24, 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf> (showing that twenty-one percent of the projected Medicare savings in the Affordable Care Act derive from cuts to the Medicare Advantage program).

⁹¹ Memorandum of Richard S. Foster, *supra* note 90, at 11.

way. In fact, the only paradigmatic alternative to this basic structure – namely, Medicare managed care – was actually the focus of significant budget cuts.

In 2011, the chair of the House Budget Committee, Congressman Paul Ryan, proposed transforming the Medicare program into a marketplace where beneficiaries could select from various comprehensive offerings, with the federal government providing premium support or “vouchers” for these offerings.⁹² Instead of the present one-size-fits-all approach, the retirement health care universe would look more like what Americans under age sixty-five typically have. Congressman Ryan’s plan included very few details, but the basic vision it propounded would look fairly familiar to persons who have never enrolled in Medicare. Be that as it may, the 2012 elections effectively sidelined that effort for the foreseeable future, and President Obama’s full-throated defense of entitlement programs such as Medicare in his Second Inaugural Address⁹³ makes major systemic change unlikely.

From the perspective of current and near-retirees, however, the Ryan proposal would have been irrelevant by its very terms. His original proposal would have applied only to persons who first became eligible for Medicare in the year 2022.⁹⁴ That provision essentially exempts the current Medicare population, as well as a significant portion of the vaunted Baby Boom generation that is gaining access to Medicare with each passing day. Even more to the point, Ryan subsequently adopted a feature suggested by Senator Ron Wyden that would retain the existing Medicare program as one of the alternatives in the marketplace that he intends to create.⁹⁵ In

⁹² See H. COMM. ON THE BUDGET, 112TH CONG., THE PATH TO PROSPERITY RESTORING AMERICA’S PROMISE 46–47 (Comm. Print 2011), available at <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf> (primarily the work of Chairman Paul Ryan).

⁹³ See Barack H. Obama, *Full Text of President Barack Obama’s Second Presidential Inaugural Address*, U.S. NEWS & WORLD REP. 2 (Jan. 21, 2013), http://www.usnews.com/news/articles/2013/01/21/full-text-of-president-barack-obamas-second-inaugural-address_print.html (“The commitments we make to each other: through Medicare, and Medicaid, and Social Security, these things do not sap our initiative; they strengthen us. They do not make us a nation of takers; they free us to take the risks that make this country great.”).

⁹⁴ H. COMM. ON THE BUDGET, *supra* note 92, at 46.

⁹⁵ See SEN. RON WYDEN & REP. PAUL RYAN, GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL 7 (2011), available at <http://budget.house.gov/uploadedfiles/wydenryan.pdf>. Senator Wyden

other words, the latest iteration of Ryan's proposal would actually keep the existing discombobulated Medicare program in place as long as any Medicare-eligible retiree, now or in the future, selects it.

X. IMPLICATIONS FOR RETIREES

As retirees contemplate the accumulated balances in their defined contribution retirement plans, they must consider how much of those balances they will need to spend on health care in retirement, which is likely to be one of their largest budget items. Current cost projections are undoubtedly understated if past trends are indicative. The history of medical, and especially pharmacological, progress makes conditions that were previously untreatable newly treatable if not curable. Newly concocted drug regimens may be much less expensive than hospitalizations and their medically intensive therapies, but such drug regimens are not cheap either. Even though the cost of pharmaceutical interventions is shared by retirees and the Medicare program, a significant portion of those costs is paid by the retirees themselves, so increasing drug costs represent a rising cost burden to retirees generally.

By contrast, most of the money saved by fewer hospitalizations would have been paid by the Medicare program itself. After the per-admission deductible is paid, most other hospital costs are paid by Medicare, as noted previously. And if future medical innovations translate into more nursing home stays instead of hospitalizations, the resulting nursing home care may not be the "skilled nursing care" that Medicare pays for.⁹⁶ Even if it is, Medicare's liability for such costs is limited to one hundred days, so any additional days in the nursing home is an expense of the retiree rather than of Medicare. As a consequence, Medicare's hospital expenditures may decrease, but retirees' outlays for nursing home care will likely increase. That phenomenon explains, in part, this graph from the *New England Journal of Medicine*,⁹⁷ which shows that the cumulative cost of a person's health care expenditures (solid line) increases the longer that

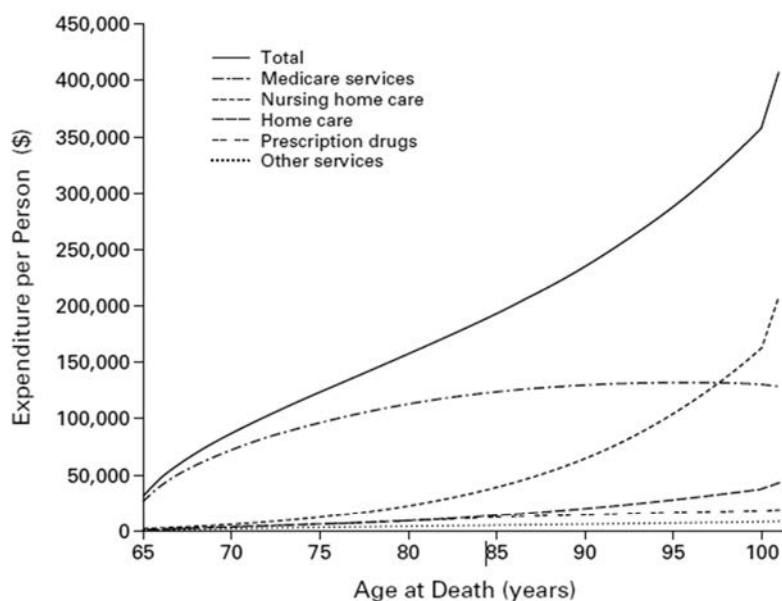
subsequently distanced himself from this proposal. *Sen. Wyden Distances Himself from Medicare Plan He Crafted with Ryan*, THE HILL (Aug. 13, 2012, 04:43PM), <http://thehill.com/blogs/healthwatch/politics-elections/243387-wyden-downplays-medicare-plan-he-crafted-with-ryan>.

⁹⁶ See *supra* text accompanying notes 45–47.

⁹⁷ Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. MED. 1409, 1411 (2000).

person lives, but the cumulative cost paid by Medicare (long dash/short dash line) does not.

Figure 1. Cumulative Health Care Expenditures from the Age of 65 Years until Death, According to the Type of Health Service and the Age of Death:



In other words, extended longevity may increase per capita medical expenditures, but much of that increase will not burden the Medicare program. To put the matter bluntly, the additional medical costs associated with increased longevity will largely be on the retiree's dime.

XI. FUNDING LONG-TERM CARE

Retirees' responsibility for their own long-term care costs is a major and largely unrecognized variable in assessing retirement funding adequacy. This is a huge point, as I explained in my article entitled "Retirement Planning's Greatest Gap: Funding Long-Term Care."⁹⁸ Not

⁹⁸ See generally Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407 (2007) (examining the

only is Medicare Part A's coverage of nursing homes severely limited,⁹⁹ its coverage of home health care is limited to no more than twenty-eight hours per week¹⁰⁰ of specified types of care¹⁰¹ that are provided by Medicare-certified home health agencies¹⁰² pursuant to a physician's plan of care.¹⁰³ Moreover, only someone who cannot leave his or her home without assistance is eligible for this care.¹⁰⁴ A joint federal and state government program called Medicaid¹⁰⁵ does cover many forms of long-term care, but Medicaid has severe assets and income qualification standards¹⁰⁶ and as a result, few retirees plan to avail themselves of its provisions. Moreover, budgetary pressures on state governments result in ever-tightening eligibility standards, making Medicaid an increasingly unreliable source for funding future long-term care needs.¹⁰⁷ From the perspective of retirement security, in other words, the cost of long-term care is essentially a private expense.

And a considerable expense it can be. According to the most recent survey of long-term care costs in the United States,¹⁰⁸ the median costs of long-term care are as follows:

- licensed home health aide – \$19 per hour
- adult day care – \$65 per day
- assisted living facility – \$3,450 per month, and
- nursing home (private room) – \$230 per day.

major missing component of retirement planning: how to finance the potentially explosive cost of long-term care).

⁹⁹ See *supra* text accompanying notes 41–50.

¹⁰⁰ 42 U.S.C. § 1395x(m) (2006).

¹⁰¹ *Id.* § 1395x(m)(1), (2).

¹⁰² *Id.* § 1395x(m), (o).

¹⁰³ *Id.* § 1395x(m).

¹⁰⁴ *Id.* §§ 1395f(a)(2)(C), 1395n(a)(2).

¹⁰⁵ See generally FROLIK & KAPLAN, *supra* note 9, at 110–38.

¹⁰⁶ See Kaplan, *supra* note 98, at 423–25. In addition, the value of the benefits received from Medicaid must be recovered when the Medicaid recipient dies. See *id.* at 429–30.

¹⁰⁷ See, e.g., Save Medicaid Access and Resources Together Act, 2012 Ill. Legis. Serv. 120 (enacting tightened restrictions on eligibility for Medicaid benefits).

¹⁰⁸ GENWORTH, GENWORTH 2013 COST OF CARE SURVEY 4 (10th ed. 2013), available at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf.

This last amount translates into an annual cost of \$83,950. These figures, moreover, represent *national* medians, and the cost differentials among states and within states are considerable.¹⁰⁹

A. LONG-TERM CARE INSURANCE

Private long-term care insurance has been developed to respond to this need, but its problems are legion. The cost of such insurance is high and premiums of current policyholders are regularly increased by fifty percent or more a year.¹¹⁰ Policy options are unstandardized and confusing,¹¹¹ and insurer solvency is a major concern¹¹² – especially as more long-term care insurance companies exit this marketplace.¹¹³ Moreover, nearly a quarter of sixty-five-year-olds are medically ineligible to buy such insurance,¹¹⁴ even if they were willing to bear the associated expense.

Just the briefest overview of what is involved in acquiring long-term care insurance can be discerned from the following table¹¹⁵ of policy choices and premiums offered by one prominent insurer:

¹⁰⁹ See *id.* at 14–72 (compilations by cities and states for each care category).

¹¹⁰ See *Do You Need Long-Term-Care Insurance?*, CONSUMER REP., Nov. 2003, at 20, 22; see also Jennifer Levitz & Kelly Greene, *States Draw Fire for Pitching Citizens on Private Long-Term Care Insurance*, WALL ST. J., Feb. 26, 2008, at A1 (reporting a 260% increase in premiums in only three years); Kelly Greene & Leslie Scism, *Long-Term-Care Insurance Leaves Customers Groping*, WALL ST. J., July 2, 2013, at A1 (reporting a 77% increase in one year); see generally Kaplan, *supra* note 98, at 440–41.

¹¹¹ See Kaplan, *supra* note 98, at 438–39.

¹¹² See *id.* at 441–42; M.P. McQueen, *Insurer Casts Off Long-Term-Care Policies*, WALL ST. J., Dec. 3, 2008, at D1.

¹¹³ See Kelly Greene, *Long-Term Care: What Now?*, WALL ST. J., Mar. 10, 2012 (noting that ten of the top twenty long-term care insurers by sales volume have left this market within the past five years).

¹¹⁴ See Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 INQUIRY 271, 277 (1995).

¹¹⁵ See Nancy Ann Jeffrey, *Your Needs, Plus Your Budget, Equals What to Pay on Long-Term Care Policy*, WALL ST. J., Mar. 21, 1997, at C1 (rates for John Hancock Life Insurance Co.).

ANNUAL COST OF AN INDIVIDUAL POLICY			
Age at Issue	55	65	75
\$100 daily benefit for nursing-home; home-health coverage; 4 years coverage; 100-day deductible period	\$510	\$990	\$2,830
Shorter coverage period: 2 years	380	720	2,010
Lower home-health-care benefit: \$50 daily	410	810	2,350
Shorter deductible period: 20 days	643	1,247	3,566
Richer benefits: \$200 daily for nursing home and home-health care	1,020	1,980	5,660
Inflation-indexed benefits: annual increases at 5% compounded rate	1,090	1,740	4,230

The premiums quoted above are over a decade old, and premiums are undoubtedly higher today, but the long-term care insurance industry does not generally make price information available outside of a personalized – read, pressurized – presentation by a sales agent.¹¹⁶ Even so, this table can convey some of the complex choices that a prospective buyer of long-term care insurance must confront:

- Whether to buy a long-term care insurance policy at all, or plan instead to fund long-term care needs as they arise by accessing the equity in one’s residence via a “reverse mortgage.”¹¹⁷
- If an insurance policy is desired, how much should the daily benefit be?
- How long should these benefits last?

¹¹⁶ *But see Long-Term Care Sample Rates*, CAL. DEP’T OF INS., <https://interactive.web.insurance.ca.gov/survey/survey?type=longTermCareSurvey&event=longTermCareSearch> (last visited Jan. 22, 2014) (making rates available online for certain specified insurance packages in California); *Long-Term Care Insurance Rate Guide Sample Policy 1*, TEX. DEP’T OF INS., http://www.tdi.texas.gov/pubs/consumer/lrg_policy1.html (last visited Jan. 22, 2014) (making rates available in Texas).

¹¹⁷ *See generally* FROLIK & KAPLAN, *supra* note 9, at 212–22. Another possible funding source might be “accelerated benefits” on an existing life insurance policy that can be accessed for long-term care. *See id.* at 156–58.

- How long should the deductible or “elimination period” be?
- Should home health care be covered and if so, at what daily rate?
- Should the daily benefit be increased for inflation and if so, what metric (consumer price index, five percent simple, five percent compounded) should apply?

There are other policy decisions as well that are not captured by the preceding chart, such as whether to have premiums waived when benefits begin, whether to have the premiums refunded if no benefits are ever paid, and so forth.¹¹⁸ But the main point is that securing insurance to cover possible long-term care expenses is not a simple or straightforward process.

B. GOVERNMENTAL COVERAGE OF LONG-TERM CARE COSTS

In this context, it is notable that the Affordable Care Act included a voluntary long-term care insurance program called Community Living Assistance Services and Supports, or CLASS.¹¹⁹ This program would have covered some – but not all – long-term care costs in various settings, but its benefits were targeted to less costly care environments, such as home health care and community-based services, rather than assisted living facilities and nursing homes.¹²⁰ In any case, the enabling legislation mandated that the CLASS program be fiscally self-sustaining,¹²¹ a requirement that the Obama Administration’s Department of Health and Human Services determined was impossible to satisfy. In October 2011, the Secretary of that Department declared that the CLASS program would not be implemented,¹²² and these now-moribund provisions were then

¹¹⁸ See Kaplan, *supra* note 98, at 439.

¹¹⁹ 42 U.S.C. §§ 300ll–300ll-9 (Supp. IV 2007–2011) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 8002, 124 Stat. 119, 828–47 (2010)).

¹²⁰ 42 U.S.C. §§ 300ll-1, 300ll-2, 300ll-4 (Supp. IV 2007–2011); see generally Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform*, J. RETIREMENT PLAN., July–Aug. 2010, at 7.

¹²¹ 42 U.S.C. § 300ll-7(a), (b) (Supp. IV 2007–2011).

¹²² See Letter from Kathleen Sebelius, Sec’y Dep’t of Health & Human Servs., to Congress (Oct. 14, 2011), available at <http://www.hhs.gov/healthcare/facts/blog/2011/10/class10142011.html>.

repealed by the legislation that forestalled the “fiscal cliff” at the very beginning of 2013.¹²³ In its place, Congress created that most quintessentially worthless alternative, a commission to study how long-term care should be financed.¹²⁴ The bottom line is that the federal government will probably not be increasing its role in financing long-term care outside the poverty-based space that is presently occupied by Medicaid any time soon.

XII. CONCLUSION

Retirees are never more “on their own” than when they try to cover their retirement health care expenses. In fact, a comprehensive analysis of twelve prominent online retirement calculators found that all but two did not even consider health and long-term care expenses.¹²⁵ Yet, seniors who consulted a professional regarding retirement planning indicated that their number one concern was “the future of Medicare,” followed closely by “paying for long-term care” and “paying for healthcare.”¹²⁶ With health care constituting one of the largest and the least predictable of all retirement expenses,¹²⁷ retirees with defined contribution plans will be increasingly desperate as they contemplate the daunting challenge of covering these critical costs.

¹²³ American Taxpayer Relief Act of 2012, Pub. L. No. 112–240, § 642(a), 126 Stat. 2313, 2358.

¹²⁴ American Taxpayer Relief Act of 2012, Pub. L. No. 112–240, § 643, 126 Stat. 2313, 2358–62.

¹²⁵ BRYAN DOWD ET AL., AARP PUB. POL. INST., PLANNING FOR RETIREMENT? WEB CALCULATORS WEAK ON HEALTH COSTS 7–8 (2008), available at http://assets.aarp.org/rgcenter/health/2008_12_savings.pdf.

¹²⁶ ALLSUP, ALLSUP MEDICARE ADVISOR® SENIORS SURVEY: MEDICARE PLANNING AND TRENDS AMONG SENIORS WITH FINANCIAL PLANNERS 7 (2012), available at <http://www.allsup.com/portals/4/AMA-Seniors-Survey-Financial-Planners-Oct2012.pdf>.

¹²⁷ See Allison K. Hoffman & Howell E. Jackson, *Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications*, 39 AM. J.L. & MED. 62, 83–85 (2013) (comparing estimates of future health care spending of 1,700 near and current retirees with experts’ estimates).

AN AFFORDABLE CARE ACT FOR RETIREMENT PLANS?

AMY B. MONAHAN*

In the United States, the availability of tax subsidies for retirement savings is largely based on an individual's employment status and whether such individual's employer has voluntarily chosen to offer a tax-favored savings vehicle. Even where an individual has access to an employer-sponsored retirement plan, such plans are too often suboptimally designed. This article proposes an incremental reform that ensures universal access to tax-favored retirement savings irrespective of employment status or employer decisions. Borrowing from the model of the Affordable Care Act, the article calls for the creation of an optional, universally available retirement plan, which would be designed according to both retirement savings and behavioral best practices. Such a plan would be designed to increase the number of Americans saving for retirement, as well as the likelihood that individuals will accumulate sufficient savings to maintain their standard of living throughout retirement. After discussing the design details for such a plan, the article concludes by examining the legal and practical challenges of implementing a universal retirement plan at either the federal or state level.

I. INTRODUCTION

Given the current challenges of implementing the Affordable Care Act (ACA), it is perhaps unwise to suggest that the ACA's model should be replicated in the retirement plan context, as the title of this article suggests. However, the basic structure of the ACA, which provides all Americans with access to health insurance regardless of their employment status or their employer's choices, provides a promising model for enhancing retirement savings and security.

Many Americans are ill equipped for their retirement, having failed to save a sufficient amount to maintain their standard of living in

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retirement.¹ Much blame for this failure has been placed on the widespread shift in the design of employer-sponsored retirement plans.² Instead of being offered traditional, defined benefit pension plans that offer a set level of lifetime income, most employees are now offered only a defined contribution plan, usually in the form of a 401(k) plan.³ These defined contribution plans depend for their success on individual participants making rational decisions and executing them in a timely manner. Yet, there is significant evidence suggesting that many individuals fail to make rational decisions and implement them in a timely manner. As one prominent scholar succinctly put it, “It’s crazy that we ended up with this as our retirement system.”⁴ The popular 401(k) plans, she explained, were meant to supplement traditional forms of lifetime income, such as social security and defined benefit pension plans.⁵ “It was supposed to be money that you could use to go to Paris. Instead, it’s become our basic system.”⁶

¹ See, e.g., Jack VanDerhei & Craig Copeland, *The EBRI Retirement Readiness Rating: Retirement Income Preparation and Future Prospects*, 334 EMP. BENEFIT RES. INST. ISSUE BRIEF 1 (2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1645412 (estimating that 47.2% of early baby boomers are at risk of not having sufficient resources to pay for basic retirement expenditures and uninsured health costs). One large administrator of 401(k) plans recently reported that average 401(k) plan balances for those age 65-69 were \$136,800. Jill Schlesinger, *The Latest on America’s 401(k)s*, CHI. TRIB., Feb. 27, 2013, available at http://articles.chicagotribune.com/2013-02-27/business/sns-201302271600--tms--retiresmctnrs-a20130227-20130227_1_retirement-savings-fidelity-plans-fidelity-investments.

² See, e.g., Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004); James M. Poterba, *Individual Decision Making and Risk in Defined Contribution Plans*, 13 ELDER L.J. 285 (2005); Susan J. Stabile, *Is It Time to Admit the Failure of an Employer-Based Pension System?*, 11 LEWIS & CLARK L. REV. 305 (2007).

³ Craig Copeland, *Retirement Plan Participation and Asset Allocation, 2010*, 34 EMP. BENEFIT RES. INST. NOTES 9, 11 (2013), available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_04_Apr-13_CDHPs-RetPart1.pdf (finding that among working heads of households who participated in an employer-sponsored retirement plan, 18.9% participated only in a defined benefit plan, 65% participated only in a defined contribution plan, and 16.1% participated in both).

⁴ Jeff Sommer, *Suddenly, Many Nest Eggs Look Fragile*, N.Y. TIMES, June 15, 2013, <http://www.nytimes.com/2013/06/16/your-money/suddenly-retiree-nest-eggs-look-more-fragile.html?pagewanted=all&r=0>.

⁵ *Id.*

⁶ *Id.*

While the problems associated with individual retirement savings decisions are well documented, this article seeks to highlight another weakness of our current reliance on 401(k) plans to deliver retirement security – suboptimal *employer* decision-making. Our retirement savings system relies on employers voluntarily offering retirement plans. Some employees do not have access to tax-favored retirement savings plans simply because their employer does not offer one. And even when employers do offer a plan, they often offer a plan that is not well-designed to help participants accumulate sufficient retirement savings. These plans often minimize employer costs while failing to take into account the abundant literature on 401(k) plan designs that can help overcome some of the well-known weaknesses in individual retirement savings decisions. To address the potential problems with employer decision-making in the 401(k) plan context, this article suggests both federal and state solutions that borrow from the ACA model for health insurance to ensure that all Americans who wish to save for retirement have a well-designed option available to them in the event their employer either fails to offer a plan or offers a plan that is suboptimally designed. The goal of this proposal is to minimize both suboptimal participant-level decisions regarding retirement saving and also suboptimal employer-level decisions regarding plan design.

II. WEAKNESSES IN THE CURRENT MODEL OF RETIREMENT SAVINGS

The weaknesses in individual decision-making within participant-directed 401(k) plans are well documented. Individuals struggle to begin saving at an early enough age to meet their retirement goals, they often fail to contribute sufficient amounts, and have difficulty navigating investment and distribution options. Less appreciated is the fact that many employers make poor decisions when they design their 401(k) plans. This Part will review the weaknesses in the 401(k) plan model that might explain why so few Americans appear to be able to achieve financial security through such plans.

A. INDIVIDUAL DECISION-MAKING

Section 401(k) plans are premised on classic economic theory, which posits that welfare will be optimized where each individual makes his or her own rational savings and consumption decisions within a fully

functioning market.⁷ The success of a 401(k) plan in providing adequate retirement income depends on an individual making several important decisions: whether and when to participate in the plan, what amount of salary to defer to the plan, where to invest plan contributions, when (if at all) to access retirement savings prior to retirement, and the rate at which to withdraw savings once retirement age has been reached. If an individual is perfectly rational, this type of retirement plan should work very well, as it can be customized to match the individual's preferences.⁸

We have good reason to believe, however, that most individuals are not perfectly rational and do not make optimal decisions within the 401(k) plan context.⁹ These problems with participant-level decision-making have been well documented elsewhere,¹⁰ and therefore this article provides only a high-level overview of the key findings. For plans that require an individual to take affirmative action to enroll in the plan, participants often procrastinate in implementing the decision to participate, thereby shortening the period of time they are saving for retirement.¹¹ In addition, many studies have shown that once individuals elect to participate they are overwhelmed by the decisions they are required to make, such as selecting a contribution level and making investment decisions, and therefore stick to the defaults or allow the plan's framing of choices to

⁷ See Amy B. Monahan, *Addressing the Problem of Impatients, Impulsives and Other Imperfect Actors in 401(k) Plans*, 23 VA. TAX REV. 471, 480–81 (2004).

⁸ See *id.*

⁹ See, e.g., James J. Choi et al., *For Better or for Worse: Default Effects and 401(k) Savings Behavior*, in PERSPECTIVES ON THE ECONOMICS OF AGING (David A. Wise ed., 2004); Julie R. Agnew & Lisa R. Szykman, *Asset Allocation and Information Overload: The Influence of Information Display, Asset Choice, and Investor Experience*, 6 J. BEHAV. FIN. 57 (2005); Shlomo Benartzi & Richard H. Thaler, *Heuristics and Biases in Retirement Savings Behavior*, 21 J. ECON. PERSPECTIVES 81 (2007); Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116 Q.J. ECON. 1149 (2001); Olivia S. Mitchell & Stephen P. Utkus, *Lessons from Behavioral Finance for Retirement Plan Design* (Pension Research Council, Working Paper No. 2003-6, 2003). For a helpful overview of the literature on retirement savings decisions, see Melissa A. Z. Knoll, *The Role of Behavioral Economics and Behavioral Decision Making in Americans' Retirement Savings Decisions*, 70 SOC. SEC. BULL. 1 (2010).

¹⁰ See sources cited *supra* note 9.

¹¹ Knoll, *supra* note 9, at 8–9.

impact their decisions.¹² There is also strong evidence that hyperbolic discounting affects retirement savings decisions causing individuals to give more weight to current consumption than to future needs, thereby under-saving for retirement.¹³ Many studies have shown that simply changing plan defaults results in dramatic changes in behavior – which would not be predicted under standard economic theory.¹⁴ According to standard economic theory, a rational decision-maker will simply opt out of any defaults that do not maximize her preferences.¹⁵ Yet, the evidence on the impact of defaults in the retirement savings context suggests that cognitive biases are impacting many individuals' decision-making.¹⁶

B. EMPLOYER DECISION-MAKING

A less explored weakness inherent in relying on 401(k) plans to provide retirement security is the fact that they depend on sound employer decision-making.¹⁷ In theory, employers should act as effective agents for their employees and offer retirement plans that maximize their employees' preferences.¹⁸ But there are various reasons why employers may not, in fact, offer plans designed to produce adequate retirement income. The subparts below illustrate the ways in which employer decision-making can negatively impact employees' retirement security.

1. Failing to Offer a Plan

Employers are not required to offer any type of retirement plan to their workers. It is a completely voluntary decision, driven by labor market

¹² See, e.g., Agnew & Szykman, *supra* note 9, at 66; Choi et al., *supra* note 9, at 125.

¹³ See, e.g., David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q.J. ECON. 443 (1997).

¹⁴ See, e.g., Choi et al., *supra* note 9.

¹⁵ See *id.* at 81.

¹⁶ See *id.* See also Madrian & Shea, *supra* note 9.

¹⁷ For an examination of the role of employers in employees' health and retirement security, see Amy B. Monahan, *Employers as Risks*, 89 CHI. KENT L. REV. 751 (2014).

¹⁸ See Gregory Acs & Eugene Steuerle, *The Corporation as Dispenser of Welfare and Security*, in *THE AMERICAN CORPORATION TODAY: EXAMINING THE QUESTIONS OF POWER AND EFFICIENCY AT THE CENTURY'S END* 360, 361 (Carl Kaysen, ed. 1996).

pressures.¹⁹ We would expect an employer to voluntarily offer a retirement plan in lieu of other forms of compensation where it believes that doing so will help it attract and retain workers.²⁰ Indeed, pension formation is typically explained as a contract driven by worker demand to provide workers with security and income protection.²¹ But it is widely acknowledged that pensions also offer other benefits to employers, in addition to simply helping them attract and retain employees. For example, pensions can help employers control their employees' tenure and turnover by designing plans to encourage retirement at certain ages.²²

But allowing labor market pressures to determine whether a retirement plan is offered has shortcomings. It aggregates the preferences of employees. If the majority of employees of a given employer do not value retirement benefits, the employer is unlikely to offer a plan. For those minority employees that would value a retirement plan, their only option would be to find a different employer that offers the desired benefits. Because many factors enter into a decision to work at one firm over another, it may be that many who desire a retirement plan are not offered one. And bear in mind that a job switch is in fact the only complete solution if an employee's current employer fails to offer a retirement plan. While there are individual tax-favored retirement accounts available outside of the employment context, none can duplicate the extent of the tax benefits available to employer plans. An employee can currently defer up to \$17,500 of her salary tax-free per year to a 401(k) plan,²³ but can only contribute \$5,500 annually to an Individual Retirement Account (IRA).²⁴

Prior to health care reform, we saw the same dynamic at play in an employer's decision to offer a health plan to employees. Employers

¹⁹ See TERESA GHILARDUCCI, LABOR'S CAPITAL: THE ECONOMICS AND POLITICS OF PRIVATE PENSIONS 2 (1992).

²⁰ See Alan L. Gustman et al., *The Role of Pensions in the Labor Market: A Survey of the Literature*, 47 INDUS. & LABOR REL. REV. 417, 426 (1994).

²¹ GHILARDUCCI, *supra* note 19. For alternative explanations of pension formation, see *id.* at 2-7.

²² *Id.* at 2-3.

²³ I.R.S. News Release IR-2013-86 (Oct. 31, 2013), [http://www.irs.gov/uac/IRS-Announces-2014-Pension-Plan-Limitations;-Taxpayers-May-Contribute-up-to-\\$17,500-to-their-401\(k\)-plans-in-2014](http://www.irs.gov/uac/IRS-Announces-2014-Pension-Plan-Limitations;-Taxpayers-May-Contribute-up-to-$17,500-to-their-401(k)-plans-in-2014). Participants who are age fifty or older are permitted to contribute an addition \$5,500 each year, for a total of \$23,000 per year. *Id.*

²⁴ *Id.* Participants who are age fifty or older may contribute an additional \$1,000 per year to an IRA, for a total annual contribution of \$6,500. *Id.*

decided to offer a health plan based on labor market pressures,²⁵ and employees had little ability to replicate the benefits of an employer plan by seeking individual level coverage.²⁶ Health care reform will change this reliance on employers, as discussed in more detail in Part II.

2. Offering a Suboptimal Plan

Even if an employer offers a retirement plan, it may nevertheless be the case that an employer offers a plan that, from an employee's perspective, is suboptimally designed. Employers offer retirement plans in order to recruit and retain valued workers. Retirement plans help recruit and retain workers when workers find them to be a positive addition to their compensation package. Employers should therefore structure their retirement plans in a way that employees find attractive.²⁷ In other words, we would expect employers to be effective agents for their employees when they design their retirement plans.²⁸ Employees, however, are unlikely to be familiar with all of the features of their retirement plan, and are likely, when evaluating an employer plan, to focus on only a few features that are highly salient to employees.²⁹ For example, it seems plausible that employees would focus on whether a plan is offered at all, and the amount and structure of any employer contributions to the plan, such as matching or profit sharing contributions. Most employees, when deciding whether to accept or retain an offer of employment from a firm, probably do not examine plan details such as plan defaults, the quality of plan investments, investment fees, or forms of distribution. If employers believe or discover that employees focus only on a handful of highly salient features, employers are likely to respond by structuring their plans only around those features and otherwise acting to minimize their costs. For example, an employer might offer a 401(k) plan with a matching

²⁵ See, e.g., Michael Chernew et al., *Quality and Employers' Choice of Health Plans*, 23 J. HEALTH ECON. 471, 472 (2004).

²⁶ See Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1944 (2013).

²⁷ For an overview of pension theories, see GHILARDUCCI, *supra* note 19, at 1–7.

²⁸ See Chernew et al., *supra* note 24, at 472.

²⁹ See James R. Bettman et al., *Constructive Consumer Choice Processes*, 25 J. CONSUMER RES. 187, 199 (1998) (discussing that increased numbers of alternatives facing the consumer when choosing retirement products lead to a greater use of non-compensatory strategies which eliminate alternatives).

contribution that equals or exceeds that offered by its competitor firms, but in order to reduce its costs associated with the plan might select a plan provider that offers high fee investments, defaults that do not address participants' likely cognitive biases, and distribution forms that do not help participants manage income in retirement. The end result may be that even where employers offer plans, they offer plans that are not designed to maximize participants' retirement security.

Again, much the same dynamic is at play in how employers approach health plan design. Employees are likely to focus only on highly salient features when evaluating a health plan – in this case on premium levels, copays, and whether their current doctor is in-network.³⁰ And employers are likely to respond to this employee focus by designing plans around the highly salient features, potentially at the expense of other important plan design features such as the quality of the plan or providers.³¹

If this hypothesis regarding employer plan design is correct, the implications for retirement and health security are significant. In the retirement plan context, it would mean that even if every employer made a 401(k) plan available to its workers, the problem of insufficient retirement savings would not be solved. While we know relatively little regarding how employer plan design decisions are made and the factors that motivate those design decisions, data regarding plan features provide support for the hypothesis that the majority of employers do not offer plans that are optimally designed. Plans often have defaults that work against retirement savings. Individuals that desire to participate must take active steps to enroll in the plan, instead of being defaulted into participation.³² Even where participants are automatically enrolled in a plan, default contribution

³⁰ See Amy B. Monahan, *Why Tax High-Cost Employer Health Plans?*, 65 TAX L. REV. 749, 764–765 (2012).

³¹ See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 58–59 (1999) (explaining how health insurance companies are likely to structure health plans given consumers' focus on only a handful of highly salient features).

³² See Alicia H. Munnell, *401(k) Plans in 2010: An Update from the SCF*, ISSUE IN BRIEF (Ctr. for Ret. Research at Bos. C., Boston, MA), July 2012, at 1, 4, available at http://crr.bc.edu/wp-content/uploads/2012/07/IB_12-13-508.pdf (finding that fewer than half of all 401(k) plans offered automatic enrollment in 2010).

rates are often too low to provide adequate savings.³³ Many plans allow easy access to savings prior to retirement,³⁴ and nearly all have a lump sum distribution as either the default or the only form of distribution available.³⁵

In addition, plans sometimes work against participants' savings goals by offering poor investment choices and little investment advice.³⁶ As we have seen through countless class action lawsuits, many employers allegedly offer a menu of investments that charge excessive fees.³⁷

³³ See *id.* See also DELOITTE, ANNUAL 401(K) BENCHMARKING SURVEY 9 (2012), available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Consulting/us_cons_hc_401ksbecnchm_arkingsurvey2012.pdf (finding that the average default contribution rate was 3%, an amount unlikely “to support a comfortable retirement”).

³⁴ For example, approximately 90% of 401(k) plan participants participate in a plan that offers plan loans. John Beshears et al., *The Availability and Utilization of 401(k) Loans* 2 (John. F. Kennedy Sch. of Gov't, Working Paper No. 11-023, 2011), available at <https://research.hks.harvard.edu/publications/getFile.aspx?Id=693>. Sixty-six percent of all 401(k) plans permit participants to take hardship distributions prior to retirement. INTERNAL REVENUE SERV., SECTION 401(K) COMPLIANCE CHECK QUESTIONNAIRE FINAL REPORT 6 (2013), available at http://www.irs.gov/pub/irs-tege/401k_final_report.pdf. Studies are, however, mixed on the extent to which such pre-retirement access threatens retirement security. See generally sources cited *infra* note 64.

³⁵ See INTERNAL REVENUE SERV., *supra* note 34, at 59 (finding that 99% of 401(k) plans offer a lump sum distribution, while only 19% offer a qualified joint and survivor annuity). See also HEWITT ASSOC., TRENDS AND EXPERIENCES IN 401(K) PLANS 7 (2009) available at http://www.retirementmadesimpler.org/Library/Hewitt_Research_Trends_in_401k_Highlights.pdf (finding that all 401(k) plans offered a lump sum option, while 14% offered annuities).

³⁶ See, e.g., James Kwak, *Improving Retirement Savings Options for Employees*, 15 U. PA. J. BUS. L. 483, 511–12 (2013) (examining the weaknesses of 401(k) investment options); Karen Blumenthal, *Thanks but No Thanks on 401(k) Advice*, WALL ST. J., Nov. 7, 2011, <http://online.wsj.com/news/articles/SB10001424052970204346104576638933476020932> (finding that while a majority of 401(k) plans offer investment advice, only around a quarter of participants offered some form of investment advice utilize the service).

³⁷ For a detailed examination of this litigation and its effects, see Mercer Bullard, *The Social Costs of Choice, Free Market Ideology and the Empirical Consequences of the 401(k) Plan Large Menu Defense*, 20 CONN. INS. L.J. 335 (2014) and Ian Ayres & Quinn Curtis, *Beyond Diversification: The Pervasive Problem of Excessive Fees and “Dominated Funds” in 401(k) Plans* 13-20 (Feb. 21, 2014 (unpublished manuscript) available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2399531). See also Kelly

Employers often offer employer stock as an investment option, even though in many cases it is unwise for a participant who depends on an employer for her current income to invest in that employer's stock for her long-term savings.³⁸ And finally, plans are permitted to, and often do, pass along to participants nearly all of the administrative costs of running the plan, further reducing participants' rate of return.³⁹

There has been one area of plan design that has improved significantly over the last decade. Beginning in the 1990s, several 401(k) plan sponsors began experimenting with automatic enrollment provisions, which provide that an eligible participant will automatically participate in the employer's plan unless he or she takes affirmative action to opt out.⁴⁰ The number of employers utilizing automatic enrollment grew following the passage of the Pension Protection Act of 2006, which offered employers various incentives for putting such procedures in place. However, a well-known potential weakness of automatic enrollment provisions is that plan sponsors can choose default contribution levels and investment options that are too low and too conservative to produce adequate retirement savings. When automatic enrollment provisions first gained traction in the late 1990s and early 2000s, default investment options were primarily conservative, capital-preserving investments.⁴¹ However, a recent survey found that 82% of plans with automatic enrollment now had as their default investment option a lifecycle or target-date fund, designed to invest appropriately given the participant's years to

Greene, *Letters About 401(k) Plan Costs Stir Tempest*, WALL ST. J., July 24, 2013, <http://online.wsj.com/news/articles/SB10001424127887323971204578626103409341648> (describing Yale Law Professor Ian Ayres' letter writing campaign to 401(k) plan sponsors regarding their fee levels, and the reaction such letters have provoked).

³⁸ See generally Ning Tang et al., *The Efficiency of Sponsor and Participant Portfolio Choices in 401(k) Plans*, 94 J. PUB. ECON. 1073 (2010).

³⁹ See DELOITTE, *supra* note 33, at 19 (finding that 51% of plans paid all administrative and recordkeeping fees through investment revenue).

⁴⁰ See Jack VanDerhei & Craig Copeland, *The Impact of PPA on Retirement Savings for 401(k) Participants*, 318 EMP. BENEFIT RES. INST. ISSUE BRIEF 1, 4 (2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_06-20087.pdf.

⁴¹ See PROFIT SHARING/401(K) COUNCIL OF AMERICA, *AUTOMATIC ENROLLMENT 2001: A STUDY OF AUTOMATIC ENROLLMENT PRACTICES IN 401(K) PLANS* available at <http://www.pcsa.org/data/autoenroll2001.asp> (finding that among plans with automatic enrollment, 66% had a conservative default investment option such as a stable value or money market fund).

retirement.⁴² Note, however, that this change was likely brought about by a change in Department of Labor regulations that protected plan fiduciaries from liability where they offered a “qualified investment” as the default investment option.⁴³ This change does not appear to have been the result of employers independently making a decision to improve the quality of the plan’s default investment option. As a result, this improvement does not provide significant evidence against the hypothesis that employers often lack motivation to design optimal retirement plans. Indeed, when the state of 401(k) plan design is viewed as a whole, it seems reasonable to conclude that even when participants are lucky enough to be offered an employer-sponsored retirement plan, that plan in many cases will not be designed to maximize retirement security.

III. THE ACA MODEL

While there is reason to be less than confident in our current retirement savings system, the structure of federal health care reform provides an interesting model of how dependence on employers can be reduced, and portions of its structure might successfully be borrowed to improve retirement savings. As noted above, there are important similarities between employer-sponsored health and retirement plans. Both types of plans depend on employer decision-making for their success. An employer must decide to offer a plan if an employee is to have access to the benefit at all, since neither type of plan can be duplicated outside of the employment context.⁴⁴ And the quality of the benefit provided depends in large part on how employers decide to structure the benefit plan. If an employer makes suboptimal choices in a health plan, an individual’s health

⁴² See DELOITTE, *supra* note 33, at 11.

⁴³ Default Investment Alternatives Under Participant Directed Individual Account Plans, 29 C.F.R. § 2550.404c-5 (2008). Each of the three qualified default investment options is diversified in order to minimize the risk of large losses but also to provide long-term growth potential.

⁴⁴ Health plans, like retirement plans, depend on employer sponsorship for the individual to receive the most favorable tax treatment. If an employee buys health insurance on her own, she must pay for the coverage with after-tax dollars, whereas an employee who participates in an employer plan may pay premiums with pre-tax dollars. This tax advantage did not change with the passage of the ACA. In addition, purchasing coverage through an employer gives the employee access to group coverage, which tends to be more affordable than individual coverage. See Monahan & Schwarcz, *supra* note 26, at 1942–44.

security can be jeopardized, much the same way an individual's retirement security can be compromised if an employer designs a suboptimal retirement plan.

For health plans, however, this should begin to change as the major reforms of the ACA take effect.⁴⁵ Once the ACA's provisions are fully effective, individuals who are not offered health coverage through an employer, or are offered a plan that does not satisfy their preferences, should have a meaningful coverage alternative. Such individuals can freely purchase any individual coverage available on their state's health insurance exchange⁴⁶ and, assuming these markets function well post-reform, should have a broad variety of plan designs and premium levels from which to choose.⁴⁷ The ACA requires all plans sold on the state exchanges (referred to as "qualified health plans") to satisfy various plan design, content and quality requirements in order to ensure that the options available meet minimum standards.⁴⁸ In other words, one underappreciated function of the ACA is to act as a backstop for *employer* choices that might be suboptimal from an employee's perspective. While not perfect (an employee purchasing health insurance on an exchange would have to purchase coverage with after-tax instead of pre-tax dollars), the ACA should give an individual a much greater ability to secure desired health care coverage without regard to his or her employer's choices.⁴⁹ For example, if an employee is offered health insurance coverage by her employer that has a deductible too high for the employee to afford, or that fails to offer a broad network of providers, that employee is no longer effectively stuck with what the employer offers, but will instead have the option of going to her state's health insurance exchange and buying coverage that satisfies her preferences.

The ACA's provision of a universal option available to all individuals without regard to employment status or employer decision-making provides an interesting model that might be of use in improving retirement security in the United States. Part IV below explores ways in

⁴⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

⁴⁶ See 42 U.S.C. 18031(b) (Supp. V 2012).

⁴⁷ See 42 U.S.C. 18022 (Supp. V 2012).

⁴⁸ See *id.*

⁴⁹ For a discussion of some of the implications of these choices, see Brendan S. Maher, *Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected*, 44 CONN. L. REV. 1099 (2012).

which both the federal and state governments could borrow from the ACA to provide a meaningful alternative to suboptimal employer-sponsored retirement plans.

IV. A UNIVERSAL BACKSTOP RETIREMENT PLAN

Both the federal and state governments have the ability to use law to improve retirement security for many Americans. This Part begins by exploring the use of a universal “backstop” retirement plan, similar to the concept of a qualified health plan under the ACA, which could help to address the problem of flawed employer decision-making. It then discusses the possibilities and impediments associated with establishing such a backstop at either the federal or state level.

A. BACKSTOP RETIREMENT PLAN DESIGN

There are myriad problems in our current retirement savings system. Employer plans provide the greatest tax benefit for retirement savings, but are far from universal.⁵⁰ Even when employer plans are available, they are often not designed to address the well-documented mistakes that individuals make in their retirement savings decisions.⁵¹ While there are Individual Retirement Accounts universally available, these savings vehicles have much lower contribution limits than employer-sponsored plans,⁵² involve even more complex participant decision-making

⁵⁰ See EMP. BENEFIT RESEARCH INST. & MATHEW GREENWALD & ASSOCS., 2013 RCS FACT SHEET #3, at 5 (2013), available at http://ebri.org/pdf/surveys/rcs/2013/Final-FS.RCS-13.FS_3.Saving.FINAL.pdf. (reporting that only 72% of workers are offered a retirement plan by their employer); See Emp. Benefit Research Inst., *Pension Plan Participation*, FAST FACTS (Emp. Benefit Research Inst., Washington, D.C.), March 28, 2013, available at <http://www.ebri.org/pdf/FF.225.DB-DC.28Mar13.pdf>. (finding that in 2011, 3% of private sector workers participated in a defined benefit plan, 11% participated in both a defined benefit and defined contribution plan, and 31% participated only in a defined contribution plan).

⁵¹ See *supra* Part II.B.2.

⁵² See I.R.S. Notice 2012-67, 2012-50 I.R.B. 671 (stating that in 2013, individuals can contribute \$17,500 to an employer-sponsored 401(k) plan, but can contribute only \$5,500 to an IRA).

than employer plans,⁵³ and are not designed to counteract cognitive biases in retirement savings decisions.⁵⁴

There are many ways to address the perceived shortcomings of our current system. We could reform Social Security so that it provided more complete income replacement in retirement. We could implement a government-sponsored, universal pension plan. We could raise contribution limits on IRAs. The proposal offered in this article is an incremental reform that is based on the premise that 401(k) plans, and defined contribution retirement plans in general, are here to stay and that a wholesale shift away from either defined contribution plans or employer-provided plans is unlikely to be politically viable. Instead, the universal backstop retirement plan is designed to work within the existing employer-based system to ensure that all individuals have access to a quality retirement plan designed to maximize the likelihood that a participant will have adequate income in retirement. The goal is, as best we can, to minimize both suboptimal participant-level decisions regarding saving and investing *and* suboptimal employer-level decisions regarding plan design.

As the ACA will do for health plans, the idea of a backstop retirement plan is to have a plan available to all individuals, regardless of whether they are employed or have access to other retirement plans through an employer. It is offering a new option, not supplanting the existing system. One significant advantage of this type of reform is that it lets the backstop plan compete against employer offerings. It lets participants choose the plan that best meets their needs. In this way, a backstop retirement plan is superior to direct regulation of employer plan offerings. Employers remain free to design a plan that best meets the needs of their

⁵³ The decision-making process to establish and fund an IRA is more complicated than participation in a 401(k) plan because there are a greater number of options. An IRA can be established with numerous investment firms, in contrast to an employer that would offer only a single plan. And once an IRA provider is selected, an individual can essentially invest her contributions in any publicly traded security – making the investment decision more complex compared with a 401(k) plan that often offers a limited menu of investment options.

⁵⁴ Because IRAs must be initiated and established by an individual, design features such as automatic enrollment, automatically increasing contribution rates, and default investment options typically cannot be utilized. This could change if the law required the establishment of so-called payroll IRAs or automatic IRAs, recently proposed by President Obama. *See Retirement Security for American Families*, WHITEHOUSE.GOV 3, http://www.whitehouse.gov/assets/documents/Retirement_Savings_Fact_Sheet.pdf (last visited Feb. 16, 2014).

employees, or even forgo a plan, but employees will not bear any ill consequences of the employer's decision. In fact, the backstop retirement plan may incent some employers to improve their plan offerings. It is possible, of course, that employers may drop their retirement plans if a backstop retirement plan becomes available. It is important to note that this is not necessarily a bad outcome, if the backstop plan is appropriately designed. Employers dropping retirement plans is only problematic if their doing so leaves employees worse off with respect to retirement savings. An appropriately designed backstop plan, as discussed in more detail below, should prevent such an outcome.

While in reality designing a backstop plan would be a difficult process relying on input from many experts and stakeholders, I offer here some initial thoughts on basic approaches to the backstop plan and issues to be considered. Some of the design features mentioned would require changes to either federal or state law, an issue I discuss in the next subpart.

The first issue to tackle would be designing the plan to encourage participation. The evidence seems clear that automatic participation, with the ability to opt-out, would be preferable to requiring affirmative action to begin saving.⁵⁵ But given that this is a backstop plan, and not merely the plan of a single employer, implementing automatic enrollment is complicated. We have three potential categories of participants: employees who have access to an employer-sponsored plan, employees without an employer plan, and self-employed individuals. It would be easiest to implement automatic enrollment for employed individuals without access to an employer plan. Those individuals could simply be defaulted into the backstop plan through required payroll deduction. For those employees who are offered an employer plan, the question becomes *which* plan they should be automatically enrolled in – the backstop plan or the employer plan? The best approach for an employee would depend on how the employer plan compares to the backstop plan, so that is of little help in determining the default. One simple solution would be to default the employee into the backstop plan only if the employer plan does not provide for automatic enrollment. For self-employed individuals, automatic

⁵⁵ See, e.g., Richard H. Thaler & Shlomo Benartzi, *Save More Tomorrow: Using Behavioral Economics to Increase Employee Saving*, 112 J. POL. ECON. S164, S169 (2004); John Beshears et al., *The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States*, in SOCIAL SECURITY POLICY IN A CHANGING ENVIRONMENT 167–95 (Jeffrey Brown et al. eds., 2009).

enrollment is impossible to implement because payroll deduction is not practical. But there are other methods to encourage participation. Self-employed individuals could face a small fee for failing to participate in the plan (or an equivalent retirement savings vehicle), or they could be required to state when filing their federal tax return whether they wish to participate in the plan, and be given the ability to direct any tax refund to the backstop plan. These are not ideal, of course, but illustrations of how participation can be encouraged without the ease of payroll deduction.

After tackling the issue of getting individuals into the backstop plan, the next design issue is contributions, both participant and employer. Ideally, the default contribution level for participants would be a percentage of wages which, if contributed over an average working life, and taking into account an appropriate investment return assumption, would result in a level of income replacement at retirement that would be sufficient to provide seventy to eighty percent of pre-retirement income for the average life expectancy.⁵⁶ Obviously, such a contribution level would not be ideal for everyone, and in fact may be so large as to result in participants either dropping out of the plan entirely or lowering their contribution rate.⁵⁷ Further study would be necessary to select a contribution rate that would maximize plan participation and contribution rates. One possibility would be to adjust the contribution rate based on a

⁵⁶ Financial planners often suggest that, for most individuals, retirement savings should aim to replace 70% to 80% of pre-retirement income, although this is at best a rough guide. See, e.g., Jason Jenkins, *The New Rule of Thumb for Retirement Savings*, INVESTMENT U (2012), available at <http://www.investmentu.com/2012/October/new-rule-of-thumb-for-retirement-savings.html>. For a more sophisticated analysis of retirement savings needs, see Jonathan Skinner, *Are You Sure You're Saving Enough for Retirement?* (Nat'l Bureau Econ. Research, Working Paper No. 12981, 2007), available at http://www.nber.org/papers/w12981.pdf?new_window=1.

⁵⁷ See Thaler & Benartzi, *supra* note 55, at S169–72 (citing behavioral analysis which indicates that many individuals who perceive themselves as unable to meet current expenditures will not be interested in increasing their participation in savings plans if a rate above their perceived ability to save is suggested); See Beshears et al., *supra* note 55, at 171 (noting that employers often set automatic enrollment contribution levels low due to the commonly held belief that high contribution levels will encourage employees to opt out).

participant's income.⁵⁸ Another well-tested plan design would be to start participants at a low initial contribution rate, and increase that contribution rate automatically at specified intervals to gradually bring a participant to an adequate savings level.⁵⁹

It is important that employers be able to contribute to an employee's account in the backstop plan. It is easy to imagine that many employers would, if a backstop retirement plan were in place, no longer sponsor their own 401(k) plan. But without the ability of employers to contribute directly to their employees' retirement, an important source of savings would be lost. Therefore, making it easy (and tax advantaged) for an employer to contribute to an employee's retirement savings, whether through an employer-sponsored plan or the backstop plan, would be an important design feature.

Assuming that participation is encouraged at an adequate savings rate, the next design issue, and potentially the most difficult one, is to determine both the default and alternative investment options. The ideal default investment is likely a passive fund that offers the appropriate mix of risk and return characteristics appropriate for the individual's savings horizon.⁶⁰ Target date funds, which are designed to automatically shift the fund's asset allocation as the target retirement date nears, are attractive because they are designed around the participant's investment time horizon, and they offer one-stop shopping.⁶¹ Theoretically, a participant could put all of their savings in a single target date fund. These funds are not without risks,⁶² but they may provide a better default option than others readily available.⁶³

⁵⁸ Varying contribution rates by income level may be more palatable to low-income individuals, and could also be designed to reflect the fact that social security replaces a larger percentage of income for low-income individuals.

⁵⁹ A plan design with automatically increasing contribution rates was pioneered by economists Richard Thaler and Shlomo Benartzi. See Thaler & Benartzi, *supra* note 55.

⁶⁰ See Kwak, *supra* note 36.

⁶¹ Julie R. Agnew et al., *What People Know About Target-Date Funds: Survey and Focus Group Evidence* 4 (Fin. Sec. Project at B.C., Working Paper 2011-2), available at <http://crr.bc.edu/wp-content/uploads/2011/05/FSP-WP-2011-2.pdf>.

⁶² See Zvi Bodie et al., *Unsafe at Any Speed? The Designed-in Risks of Target-Date Glide Paths*, J. FIN. PLAN. (March 15, 2010), available at <http://www.fpanet.org/journal/CurrentIssue/TableofContents/UnsafeatAnySpeed/>.

⁶³ Zvi Bodie et al., *Life Cycle Finance and the Design of Pension Plans*, 1 ANN. REV. OF FIN. ECON. 249, available at <http://papers.ssrn.com/sol3/papers.cfm?>

An important issue worth considering is whether the backstop plan should *not* have participant-directed investment, but should instead operate as a cash balance plan, where participants are guaranteed a rate of return on their contributions.⁶⁴ If a cash balance approach is taken, participants would not face significant investment risk, a distinct advantage over current 401(k) plans.⁶⁵ The price, of course, is that such plans typically have conservative rates of return, which may be insufficient to provide adequate retirement income given reasonable contribution rates.⁶⁶ Another option would be to default participants into the cash balance plan and allow individuals to opt out of the cash balance plan and into a participant-directed 401(k) plan if desired. Doing so would allow more sophisticated investors to seek higher rates of return than the cash balance plan offers, while still offering unsophisticated or risk-adverse investors a guaranteed rate of return.

Another approach to participant investments would be to invest contributions in deferred life annuities, similar to a recent proposal by Senator Hatch for public pension plans.⁶⁷ Investing contributions in annuities would both protect employees against investment risk and provide them with a guaranteed income stream at retirement. However, like the cash balance option described above, such a structure would not necessarily guarantee that the amount of the income stream would be adequate.

abstract_id=1396835. For an interesting example of an investment option that utilizes both target date funds and annuities that provide a guaranteed level of lifetime income, see Tara Seigel Bernard, *A 401(k) That Promises Never to Run Dry: [Your Money]*, N.Y. TIMES Nov. 14, 2012, at F.4, available at <http://www.nytimes.com/2012/11/14/your-money/a-401-k-that-promises-income-for-life.html?r=0>.

⁶⁴ Kevin E. Cahill & Mauricio Soto, *How Do Cash Balance Plans Affect the Pension Landscape?*, AN ISSUE IN BRIEF (Ctr. For Ret. Research. Bos. Coll., Boston, MA), Dec. 2003, at 1, 1.

⁶⁵ See *id.* at 3; Richard W. Johnson & Cori E. Uccello, *Cash Balance Plans: What Do They Mean For Retirement Security?*, 57 NAT'L TAX J. 315, 316–18 (2004).

⁶⁶ See Cahill & Soto, *supra* note 64 at 3 (noting that cash balance plans on average offer a 5.6% rate of return, compared to a market-average rate of return of 7.6%).

⁶⁷ See The Secure Annuities for Employees Retirement Act, S. 1270, 113th Cong. (2013).

The final major design decision concerns plan distributions, both before and during retirement. Allowing easy access to retirement savings prior to retirement may significantly endanger retirement security.⁶⁸ However, individuals may be more likely to participate in the first place if they know that they can access their savings in the event of a financial hardship.⁶⁹ To balance these competing concerns, the plan could offer pre-retirement distributions only for specific financial hardships,⁷⁰ instead of offering relatively unrestricted pre-retirement access as many employer 401(k) plans do currently.⁷¹ Consideration should be given to whether pre-retirement access should only be the form of plan loans,⁷² or whether an outright distribution will be permitted, and in what circumstances.

The other major design decision with respect to distributions will be the form of retirement distributions. Most participants in 401(k) plans receive lump sum distributions.⁷³ However, what most individuals require

⁶⁸ See Alicia H. Munnell & Annika Sundén, *401(k) Plans Are Still Coming Up Short*, ISSUE IN BRIEF (Ctr. for Ret. Research Bos. C., Boston, MA), Mar. 2006, at 1, 5, available at http://crr.bc.edu/wp-content/uploads/2006/03/ib_43.pdf.

⁶⁹ The evidence regarding whether or to what extent access to funds pre-retirement increases participation are mixed. Compare Alicia H. Munnell et al., *What Determines 401(k) Participation and Contributions?* 16 (Ctr. for Ret. Research Bos. Coll., Working Paper No. 2000-12, 2000), available at http://crr.bc.edu/wp-content/uploads/2000/12/wp_2000-12.pdf (“the ability to borrow increases the contribution rate by about 1 percentage point”), with U.S. GEN. ACCOUNTING OFFICE, *401(K) PENSION PLANS: LOAN PROVISIONS ENHANCE PARTICIPATION BUT MAY AFFECT INCOME SECURITY FOR SOME* 5 (1997), available at <http://www.gao.gov/archive/1998/he98005.pdf> (“[p]articipation rates in plans with loan provisions are about 6 percentage points higher than plans with no loan provisions”).

⁷⁰ The IRS publishes a list of “safe harbor” reasons for hardship distributions, which could be used in the loan context as well. See Treas. Reg. § 1.401(k)-1(d)(3)(iii) (2011).

⁷¹ PROFIT SHARING/401(K) COUNCIL OF AM., *PLAN LOAN RESTRICTION STUDY* (1999), available at <http://www.pasca.org/RESEARCHDATA/PlanLoanRestrictionStudy/tabid/176/Default.aspx> (reporting that 82% of plans did not place restrictions on the purposes for which a plan loan would be granted).

⁷² Loans have the advantage of allowing the participant to return the retirement savings to the plan with interest, but loan repayment may not be possible in some financial circumstances.

⁷³ See U.S. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, BULL. NO. 2749, *NATIONAL COMPENSATION SURVEY: HEALTH AND RETIREMENT PLAN PROVISIONS IN PRIVATE INDUSTRY IN THE UNITED STATES, 2009*, at 125 (2010),

in retirement is lifetime *income*.⁷⁴ For this reason, having a life annuity as the default form of retirement distribution likely makes the most sense, with notice and consent required for other forms of distributions such as lump sum or installments.⁷⁵

1. A Federal Backstop?

With the design basics in place, the next issue to consider is whether a backstop plan is best offered at the federal or state level. A backstop retirement plan created at the federal level has some advantages over state-based plans. Assuming there is political will to put such a plan in place, the federal government could easily pass a law establishing the backstop plan that has the basic design features described above. States, on the other hand, would have to work around existing federal law to put such a plan in place, as is discussed in more detail below. A federal plan may also make sense given that retirement savings goals and related plan design likely do not vary significantly by state, as some other types of programs might, and there are also likely to be economies of scale associated with a single backstop plan, versus fifty individual plans.

The biggest impediment to establishing a federal backstop plan, in addition to political will, is the cost. Assuming that the backstop plan would involve extending the tax benefits of employer-sponsored plans to

available at <http://www.bls.gov/ncs/ebs/detailedprovisions/2009/ebb10045.pdf> (finding that 90% of plan participants had a lump sum distribution option, while 27% were offered installments and 15% were offered an annuity); VANGUARD, DISTRIBUTION DECISIONS AMONG RETIREMENT-AGE DEFINED CONTRIBUTION PLAN PARTICIPANTS 6 (2010), *available at* <https://institutional.vanguard.com/iam/pdf/CRRDDP.pdf> (finding that only 2% of retirement-aged participants elected installments, whereas 47% took a lump sum distribution and the remainder left their account in the plan).

⁷⁴ See Lawrence A. Frolik, *Protecting Our Aging Retirees: Converting 401(k) Accounts into Federally Guaranteed Lifetime Annuities*, 47 SAN DIEGO L. REV. 277, 285–86 (2010) (explaining the process of managing retirement wealth to produce an income stream in retirement).

⁷⁵ While legislative action to require annuities does not seem imminent, the Department of Labor has recently proposed regulations that would require defined contribution plans to provide on participant's benefit statements an estimated lifetime income stream based on current retirement savings. Pension Benefit Statements, 78 Fed. Reg. 26727, 26737–38 (proposed May 8, 2013) (to be codified at 29 C.F.R. pt. 2520).

the backstop plan, the cost of an already expensive tax expenditure would increase.⁷⁶ Given our current fiscal realities, it may be difficult to persuade Congress to spend money now in order to save money on supporting retirees in the future.

One potentially revenue-neutral way to expand tax benefits to the backstop plan would be to lower the current 401(k) deferral limits. In other words, to shift some of the current tax benefits available exclusively to employer-provided plans to a wider population. While there are sound equity-based arguments for lowering the tax benefit but extending it to a wider population, objections might be raised that doing so would have the perverse effect of lowering existing rates of retirement savings by those in employer plans. Further study would be necessary to better understand the effects of shifting the tax benefit. The maximum salary deferral in 2014 is \$17,500, but historical data shows that few participants contribute the maximum amount.⁷⁷ Not surprisingly, the number of participants contributing the maximum amount to a 401(k) plan is closely correlated to income level.⁷⁸ While twenty-eight percent of those earning \$100,000 or more contribute the maximum amount to a 401(k) plan, only one percent of those earning between \$40,000 and \$60,000 do so.⁷⁹ On average, participants contribute between 7.5 and 8% of their income.⁸⁰ These data suggest that the maximum pre-tax deferral to 401(k) plans could be lowered without adversely affecting the majority of participants, and the minority that would be affected would be relatively high-income

⁷⁶ The tax expenditure for employer-sponsored defined contribution plans is estimated to be \$57 billion in 2013. JOINT COMM. ON TAXATION, 113TH CONG., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2012–2017, at 39 (Comm. Print 2013), available at <https://www.jct.gov/publications.html?func=startdown&id=4503>.

⁷⁷ See Munnell, *supra* note 32, at 5.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ See Craig Copeland, *401(k)-Type Plans and Individual Retirement Accounts (IRAs)*, EBRI NOTES (Emp. Benefit Research Inst., Washington, D.C.), Oct. 2007, at 1, 6, available at http://www.ebri.org/pdf/EBRI_Notes_10a-2007.pdf (reporting average deferral rate of 7.5%); *Fidelity Average 401(k) Balance Climbs to Record High at End of 2012*, FIDELITY.COM (Feb. 14, 2013), <http://www.fidelity.com/inside-fidelity/employer-services/fidelity-analysis-finds-record-high-average-401k-balance> (reporting 8% average annual deferral rate among Fidelity 401(k) plan participants).

participants (who are likely to save for retirement even in the absence of a tax benefit).⁸¹

Another way to address the tax issue would be to structure the plan as an after-tax plan. One way to do so, which would require no change to tax laws, would be to have contributions to the plan be made on an after-tax basis and have participants subject to capital gains taxation when gains or losses are realized.⁸² Another option would be for Congress to make the plan operate like a Roth IRA, where contributions are after-tax, but distributions are tax-free.⁸³

2. A State Backstop?

Theoretically, states could take legislative action to do much the same thing as the federal solutions described above. States could create their own state-based retirement plan available to all workers, designed to produce adequate income replacement for the average worker. But implementing a state-based solution is difficult because of current federal limitations. First, the federal Employee Retirement Income Security Act of 1974 (ERISA), preempts any state law that “relates to” an employee benefit plan.⁸⁴ Without getting into the complex details of ERISA preemption, suffice it to say that a state law that required employer participation in a retirement plan or significantly penalized an employer for failing to participate in a retirement plan would be preempted by ERISA.⁸⁵ As a

⁸¹ See generally Eric M. Engen et al., *The Illusory Effects of Saving Incentives on Saving*, 10 J. ECON. PERSP. 113 (1996) (examining whether and to what extent tax incentives increase the level of retirement savings).

⁸² Depending on the investment strategy pursued, conventional savings accounts without tax deferral can be just as tax efficient as tax-favored accounts that tax gains at ordinary rather than capital gains rates. See generally, John B. Shoven & Clemens Sialm, *Asset Location in Tax-Deferred and Conventional Savings Accounts*, 88 J. PUB. ECON. 23 (2003) (describing how locating assets optimally can significantly improve the risk-adjusted performance of retirement saving).

⁸³ For an overview of the relative tax advantages of Roth IRAs, see Leonard E. Burman et al., *The Taxation of Retirement Saving: Choosing Between Front-Loaded and Back-Loaded Options*, 54 NAT'L TAX J. 689 (2001).

⁸⁴ 29 U.S.C. § 1144(a) (2006).

⁸⁵ For a more detailed overview of ERISA preemption in this context, see Edward A. Zelinsky, *California Dreaming: The California Secure Choice Retirement Savings Trust Act*, 20 CONN. INS. L.J. 547 (2014).

result, states would be unable to require employer contributions to a state retirement plan, although they should be able to require employers to facilitate payroll deduction contributions to a state retirement plan.

In addition, the federal tax code currently grants tax benefits for retirement savings in limited circumstances – either when an employer plan is utilized, or when a qualified individual retirement account is used. As a result, if a state were to adopt a state-based retirement plan, it may not be able to take advantage of federal income tax preferences. A state backstop retirement plan would not be an employer-provided plan, and therefore would be ineligible for existing federal tax benefits for employer plans. And while the state plan might be able to qualify as an IRA, structuring the plan in such a way would likely prohibit the use of a cash balance design,⁸⁶ and would only provide the lower tax benefits available to IRA holders.⁸⁷

Still, there is some reason to believe that this is an area where states may be more interested and nimble than the federal government. Indeed, California has passed a law requiring employers to either sponsor a retirement plan or participate in a state-based retirement plan.⁸⁸ That law, however, is effectively on hold until the state can get favorable ruling from the federal government on the tax and ERISA issues noted briefly above and described in more detail in Professor Zelinsky's article in this issue.⁸⁹

States could, of course, design a plan that avoids ERISA preemption and does not depend on federal tax benefits for its success. As mentioned in the previous section regarding a federal backstop plan, a state plan could allow individuals to invest on a post-tax basis, with any gains then being taxed at capital gains rates when realized. Alternatively, the state could offer state-tax benefits to attempt to offset, at least in part, the absent federal tax benefits. For example, a state could exempt from its income tax retirement savings contributions regardless of whether such contributions were made to an employer-based or state-based plan.⁹⁰ While this would help improve the tax advantage of the state plan, it would not

⁸⁶ *See id.*

⁸⁷ *See* I.R.S. Notice 2012-67, 2012-50 I.R.B. 671.

⁸⁸ *See* CAL. GOV'T CODE § 20139 (2013).

⁸⁹ *See* generally Zelinsky, *supra* note 85.

⁹⁰ While states often adhere to the federal definition of income for tax purposes, they are of course free to define income for state income tax purposes in any manner they see fit. For an in-depth discussion of federal-state tax conformity, see Ruth Mason, *Delegating Up: State Conformity to the Federal Tax Base*, 62 DUKE L.J. 1267 (2013).

put participants in the same tax position they would be in if they participated in an employer plan. A state could, however, offer a state matching contribution equal to the estimated value of the federal income tax benefit if the contribution had been made to an employer-plan. Doing so could put the individual in the same position as she would have been in if federal income tax law treated employer and individual retirement savings equally, but it would obviously do so at a cost to state governments. If a state were to expend money on a retirement plan through the use of state tax benefits it would likely want to address how to treat participants in the state plan who move to a different state either before or during retirement. One possibility would be to have a claw back provision that would require repayment of the tax benefit upon losing state residency. On the whole, while states may be good laboratories for experiments in this area, existing federal law may make it difficult for states to meaningfully pursue retirement savings improvements.

3. Which Plan Provider?

Regardless of whether the backstop retirement plan was established at the federal or state level, thought would need to be given to which entity would most appropriately administer the plan and any investment options. One approach would be to designate either a governmental agency or an independent agency to administer the plan. For example, the California law establishing a state retirement plan for all workers allows the state to designate CALPERS (the California Public Employee Retirement System) as the plan administrator.⁹¹ Another approach would be to take a free market approach, and allow any licensed investment firm to offer a retirement plan structured around legal design and investment requirements. Providers could also be made subject to basic fiduciary duties with respect to participants' accounts. While this option involves less direct government action than the first proposal, it would also be in many ways harder to implement, and may cost participants more if fees are not very closely regulated. If there were numerous providers for these plans, it would be difficult to auto-enroll participants, unless some entity wanted to take responsibility of assigning individuals to certain providers. In addition, it would complicate payroll deduction significantly, given that employers would be responsible for transferring contributions to many different providers instead of a single entity.

⁹¹ See CAL. GOV'T CODE Sec. 20139 (2013).

B. CONGRESSIONAL ACTION TO ALLOW STATE INNOVATION

There may not be political will at the federal level to implement a backstop retirement plan, and states may be hampered in their reform efforts by existing federal laws that constrain their options. One available compromise would be for Congress to amend ERISA to allow state governments to require automatic enrollment in state retirement plans and allow employer contributions to such plans without triggering ERISA preemption. Doing so would significantly broaden states' reform options. If this reform is perused, careful thought should be given to whether ERISA should apply to such state plans and, if so, whether any of its requirements should be modified.⁹²

In addition to addressing the ERISA barriers to state action, Congress could also amend the tax code to provide tax benefits for state-based plans that are equivalent to those afforded to private-employer plans. There would again be the issue of increased cost, but perhaps Congress would be willing to do so in order to see the results of state-based retirement plan experiments.

V. CONCLUSION

The system of retirement savings on which many Americans currently rely does not generate sufficient capital for most individuals to adequately replace their income in retirement. While a widespread shift to 401(k) plans has likely contributed to this outcome, this article has suggested that it is not 401(k) plans per se that are to blame, but rather a bad combination of flawed individual decision-making and poor employer plan design. The federal government could take a lesson from the ACA and create a universally available retirement plan designed to reflect the many lessons learned from behavioral economics about encouraging retirement savings. If it is unwilling to do so, it could at the very least make it possible for states to meaningfully experiment with universal retirement savings options.

⁹² Historically there has been little political interest in subjecting state retirement plans to ERISA regulation. See Amy B. Monahan & Renita K. Thukral, *Federal Regulation of State Pension Plans: The Governmental Plan Exemption Revisited*, 28 ABA J. LAB. & EMP. L. 291, 297 (2013).

REVENUE SHARING IN 401(K) PLANS: EMPLOYERS AS MONITORS?

DANA M. MUIR*

This article presents a discussion of the use of revenue sharing by mutual funds and 401(k) plan service providers. The author engages in a historical exploration of how revenue sharing has been used in 401(k) plans and highlights how regulators have taken an increased interest in ensuring disclosure of fund monies diverted for revenue sharing purposes. In addition, the article discusses how the current federal regulatory framework for employee benefits has not adapted to the increased use of 401(k) plans. The author challenges how ERISA places the burden of monitoring compensation to service providers on the employers who make the 401(k) plan available to their employees and instead, presents several alternative frameworks that would decrease employer responsibility and liability for investment selection.

Employees have maligned the use of revenue sharing¹ in 401(k) plans² as a burden on investment returns and a hidden source of wealth for plan service providers.³ A few commentators have been shrill in their

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¹ For a discussion of the nuances of the definition of revenue sharing, *see infra* text accompanying notes 23–27.

² 401(k) plans are employer-sponsored benefit plans that permit employees to contribute a portion of their future earnings to the plan. EMPLOYEE BENEFITS LAW 6–15 (Jeffrey Lewis et al. eds., 3rd ed. 2012).

³ *See, e.g.,* Healthcare Strategies, Inc. v. ING Life Ins. & Annuity Co., No. 3:11-CV-282, 2012 U.S. Dist. LEXIS 184544, at *3–4 (D. Conn. Sept. 27, 2012) (ruling on various motions in a case where plaintiffs alleged that revenue sharing in a 401(k) plan violated federal law); *see also* Matthew D. Hutcheson, *Uncovering and Understanding Hidden Fees in Qualified Retirement Plans*, 15 ELDER L.J. 323,

criticism of revenue sharing.⁴ Service providers have responded that traditionally they did not have any obligation to report or limit the amount of revenue sharing they received and that revenue sharing has supported growth and innovation in 401(k) plans.⁵ Policy groups have concluded that the use of revenue sharing in 401(k) plans is widespread and not necessarily pernicious.⁶ Given the varying perspectives of the parties, none of that is surprising or particularly troubling.

What is troubling, however, is the extent to which responsibility for alleged misuse of or failure to monitor revenue sharing in 401(k) plans is laid at the feet of employers who voluntarily sponsor those plans. In my view, this assignment of responsibility for decision making and oversight is just one example of a larger issue – an antiquated regulatory model of employer responsibility in 401(k) plans.⁷ To maximize the opportunity of employees to build lifelong financial security through the United States paradigm of voluntary plan sponsorship, it is imperative that the regulatory system properly allocate responsibility and liability. My goal in this Article is modest; I will evaluate the way in which the federal law that

328 (2007) (“Revenue sharing’ is a euphemism for kickbacks from one financial services firm to another and is a common economic driver of conflicts of interest.”).

⁴ See Hutcheson, *supra* note 3, at 328 (“Revenue sharing’ is a euphemism for kickbacks from one financial service firm to another”); Cris de la Torre & Rutilio Martinez, *Mutual Fund Revenue Sharing: A Case of Pay to Play*, 4 J. PERS. FIN. 47, 48 (2005) (“[R]evenue sharing’ . . . looks very much like a ‘pay to play’ practice associated with the supermarkets and shelf space . . .”).

⁵ See, e.g., *Leimkuehler v. Am. United Life Ins. Co.*, 713 F.3d 905, 914 (7th Cir. 2013) (finding that plan administrator was not a fiduciary with respect to revenue sharing it received).

⁶ ERISA ADVISORY COUNCIL, REPORT OF THE WORKING GROUP ON FIDUCIARY RESPONSIBILITIES AND REVENUE SHARING PRACTICES (2007), available at <http://www.dol.gov/ebsa/publications/AC-1107b.html> (“[R]evenue-sharing in a broad sense allows the market ‘to develop efficiencies and innovations that have enhanced the quality of services of products available to [defined contribution] and 401(k) plans.’”).

⁷ See Dana M. Muir, *Choice Architecture and the Locus of Fiduciary Obligation in Defined Contribution Plans*, 99 IOWA L. REV. 1 (2013) (criticizing assignment of responsibility to employers for selection and oversight of plan investment options).

regulates benefit plans, the Employee Retirement Income Security Act (ERISA),⁸ applies to the use of revenue sharing in 401(k) plans.

I begin this Article with a discussion of the history of revenue sharing in 401(k) plans and how that history relates to the use of revenue sharing outside plans. The discussion shows that revenue sharing has become an integral part of 401(k) plan history. In Part II, I assess the limited information that has been available on the prevalence of revenue sharing in 401(k) plans. Until the early-to-mid 2000s, little attention appears to have been paid to revenue sharing except by those who pay and receive it. That Part also considers innovations in 401(k) plans, which may have been supported by the use of revenue sharing.

In Part III, I briefly explain the extent to which federal employee benefits regulation applies to the use of revenue sharing in 401(k) plans. In contrast to federal disclosure requirements, the governing fiduciary framework has not adapted to the increased importance and complexity of 401(k) plans. ERISA's fiduciary standards do not impose any responsibility or liability regarding revenue sharing on the mutual funds that pay it or the plan service providers that receive it. Instead, employers bear the burden of assessing the practice. The potential liability of employers regarding revenue sharing is comprised of two primary responsibilities: employers must (1) ensure that compensation to plan service providers is reasonable and (2) act loyally and prudently when choosing and monitoring the investments that employees may make through the 401(k) plan. In Part IV, I raise the question of whether employers are the best-positioned actors among the constellation of plan-related actors to monitor revenue sharing. I end by briefly outlining alternative regulatory structures that would reallocate responsibility away from employers.

I. HISTORY OF REVENUE SHARING IN 401(K) PLANS

The development and expansion of 401(k) plans supported growth in the mutual fund industry and has been linked from the relatively early days of those plans with the use of revenue sharing. The addition of

⁸ Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.).

subsection (k)⁹ to Section 401¹⁰ of the Internal Revenue Code (Code) in 1978 first permitted what have come to be known as 401(k) plans. At that time, defined benefit (DB) plans, which typically provide guaranteed lifetime incomes, were the paradigmatic type of retirement plan in the United States.¹¹ The original purpose of the 1978 amendment was to clarify that employees could contribute to benefit plans through salary reductions, not to remake the U.S. system of private sector retirement plans.¹²

The number of 401(k) plans grew after the Internal Revenue Service (IRS) issued explanatory regulations in 1981.¹³ As of 1996, 401(k) plan accounts held \$1 trillion in assets. By the end of 2005, 401(k) plans had surpassed DB plans in terms of numbers of participants (employees and their beneficiaries who are entitled to plan benefits) and assets. 401(k) plans continue to be the most prevalent type of retirement plan sponsored by private sector employers. 401(k) plan assets grew from \$2.4 trillion in 2005 to almost \$3.8 trillion as of March 31, 2013.¹⁴

According to one report, in the early days of 401(k) plans, some employers were reluctant to handle plan administration services such as: (a) communications,; (b) acting as the liaison between participants, mutual

⁹ Revenue Act of 1978, Pub. L. No. 95-600, §135(a), 92 Stat. 2763, 2785 (Nov. 6, 1978).

¹⁰ I.R.C. § 401(k) (2006).

¹¹ Other types of retirement plans were so insignificant at that time that they were not even included in the National Compensation Survey. See EMP. BENEFIT RESEARCH INST., EBRI DATABOOK ON EMPLOYEE BENEFITS Table 10.1(a) (2005), available at <http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2010.pdf>.

¹² See EMP. BENEFIT RESEARCH INST., HISTORY OF 401(K) PLANS: AN UPDATE (2005), available at <http://www.ebri.org/pdf/publications/facts/0205fact.a.pdf>.

¹³ Dana M. Muir, *The Dichotomy Between Investment Advice and Investment Education: Is No Advice Really the Best Advice?*, 23 BERKELEY J. EMP. & LAB. L. 1, 6 (2002).

¹⁴ SARAH HOLDEN ET AL., 401(K) PLANS: A 25-YEAR RETROSPECTIVE 3 (2006), available at <http://www.ici.org/pdf/per12-02.pdf>; SARAH HOLDEN & DANIEL SCHRASS, DEFINED CONTRIBUTION PLAN PARTICIPANTS' ACTIVITIES, FIRST QUARTER 2013 2 (July 2013), available at http://www.ici.org/pdf/ppr_13_rec_survey_q1.pdf. Comparatively, in 2005, DB plans held \$1.9 trillion in assets and \$2.7 trillion as of March 31, 2013. Holden et al., *supra*; Robert Steyer, *ICI: Retirement Assets Total \$20.8 Trillion in First Quarter 2013*, PENSIONS & INVESTMENTS, June 26, 2013, <http://www.pionline.com/article/20130626/ONLINE/130629908/ici-us-retirement-assets-hit-record-208-trillion>.

funds; and (c) trading. While there is no data on why employers decided not to handle these functions themselves, the administration of investment accounts is not among the core competencies of most employers. It makes sense that third parties could perform the functions more efficiently than if each employer had to develop and maintain its own staff and capabilities. Consulting firms apparently spotted the business opportunity and began to perform the necessary administrative plan functions. Perhaps to compete on the direct costs that were most visible to employers choosing among service providers, in the early 1990s, those service providers began to seek payments – revenue sharing -- from the mutual funds that were offered as investments in 401(k) plans.¹⁵

In theory, instead of making payments to consulting firms, the mutual funds themselves could have developed the expertise to provide administrative services to 401(k) plans. Eventually, as the industry and 401(k) plans grew, large fund families developed the capabilities needed to offer plan administrative services.¹⁶ During the 1990s, however, it appears that at least some mutual funds concentrated on their investment expertise and chose not to deal directly with investors or employers that sponsored 401(k) plans. For sales to investors who were not 401(k) plan participants, mutual funds relied on brokers and personal investment advisers to handle the interactions with investors, including communications, customer service, and trading. The mutual funds compensated the brokers and investment advisers for those services by paying them a portion of the funds' revenue (an early form of revenue sharing).¹⁷ The revenue sharing to the service providers that fulfilled parallel functions in 401(k) plans mirrored the practice used by the funds outside 401(k) plans.

Modern mutual funds pre-date 1940, when the Investment Company Act of 1940¹⁸ was enacted to regulate the industry. In 1981,

¹⁵ McHenry Consulting Group, *Revenue Sharing in the 401(k) Marketplace: Whose Money Is It?*, 3 (2001), available at http://www.plansponsor.com/pdfs/White%20Papers/McHenry_Rev_Share_Report.pdf.

¹⁶ See, e.g., *Tussey v. ABB, Inc.*, No. 2:06-CV-04305-NKL, 2012 U.S. Dist. LEXIS 45240, at *7 (W.D. Mo. Mar. 31, 2012) (discussing the various plan-related roles played by affiliates of Fidelity Investments).

¹⁷ John Howat & Linda Reid, *Compensation Practices for Retail Sale of Mutual Funds: The Need for Transparency and Disclosure*, 12 *FORDHAM J. CORP. & FIN. L.* 685, 687-94 (2007).

¹⁸ Investment Company Act of 1940, ch. 686, 54 Stat. 789 (codified as amended at 15 U.S.C. §§ 80a-1-64 (2006)).

when the IRS issued the first 401(k) regulations, U.S. mutual funds held assets of just over \$241 billion.¹⁹ As 401(k) plans grew in assets and popularity, so did mutual funds. The fate of the two is linked because a significant percentage of the assets invested in mutual fund assets are typically held in retirement plan accounts. By the end of 2005, mutual funds held almost \$8.1 trillion in assets, and that number grew to more than \$13 trillion at the end of 2012.²⁰ At that time, \$2.7 trillion of those assets were held in defined contribution plans.²¹

In 1980, the Securities and Exchange Commission (SEC) promulgated Rule 12b-1,²² which formalized the ability of mutual funds to use fund assets to pay for marketing and distribution costs. Here, a brief detour into terminology is warranted. The securities industry and its commentators typically break payments made from mutual funds into more categories than is typical of the employee benefits industry and its commentators. For example, in an article focused on securities law, Professors Howat and Reid discussed a variety of “enhanced compensation arrangements”²³ used by mutual funds. They explained revenue sharing as “occur[ring] when a fund manager agrees to pay a brokerage firm cash compensation not otherwise disclosed in the prospectus fee table to promote the mutual fund to the broker’s clients.”²⁴ They separately define 12b-1 fees, which are paid by mutual funds out of fund assets rather than by the fund manager, as a separate category of fees.²⁵ As for other categories of enhanced compensation practices they discuss “directed brokerage,” “soft dollar practices,” and “differential cash compensation.”²⁶ Often, the employee benefits community includes any payments made from mutual funds or their managers in its use of the term revenue sharing.²⁷ In

¹⁹ INVESTMENT COMPANY INSTITUTE, *2013 Investment Company Fact Book* 142 (2013), available at http://www.ici.org/pdf/2013_factbook.pdf.

²⁰ *Id.*

²¹ *Id.* at 132. The report does not break out 401(k) account holdings from the more inclusive category of defined contribution accounts. *Id.*

²² *Bearing of Distribution Expenses by Mutual Funds*, Investment Company Act Release No. 11,414, 45 Fed. Reg. 73,898 (Nov. 7, 1980).

²³ Howat & Reid, *supra* note 17, at 687.

²⁴ *Id.* at 689–90.

²⁵ *See id.* at 694 (stating that the expense ratio of a fund typically includes an advisory fee, administrative fee and 12b-1 fees).

²⁶ *Id.* at 688–91.

²⁷ *See, e.g.*, U.S. GOV’T ACCOUNTABILITY OFFICE (GAO), GAO-12-325, 401(K) PLANS: INCREASED EDUCATIONAL OUTREACH AND BROADER OVERSIGHT

employee benefits parlance, revenue sharing includes both its narrow securities law definition and other amounts paid by mutual funds, such as 12b-1 fees. Unless otherwise specifically noted, in this Article, I use the term “revenue sharing” in this broad sense, as defined by the employee benefits community.

The now well-known brokerage company, Charles Schwab Corporation (Schwab), is credited with using the concept of revenue sharing to establish a 401(k) plan paradigm that remains in widespread use today. In 1992, it first offered what it described as an “innovative service,” which allowed investors to choose among multiple mutual funds from a variety of fund families rather than being limited to a single fund family and to do so without paying any direct fees to Schwab for administering their accounts.²⁸ As with other mutual fund practices, such as revenue sharing where mutual funds used parallel approaches for individual investors and 401(k) plans,²⁹ Schwab offered its new innovation to 401(k) plan sponsors as well as to individual investors. In the 401(k) offering, Schwab provided record keeping services, including a single statement for participants showing their investments in all funds. Schwab originally referred to this as a “no transaction fee” (NTF) program. Reportedly, “Schwab eliminated transactions costs, supporting the platform on revenue generated by fund distribution commissions and servicing fees.”³⁰ In simple terms, Schwab’s NTF model relied on revenue sharing to pay for all of the services that Schwab provided to 401(k) plans or to individual investors. As discussed below, the use of revenue sharing to offset plan costs continues to be in widespread use to this day.

MAY HELP REDUCE PLAN FEES 10 (2012), available at <http://www.gao.gov/assets/600/590359.pdf> (defining revenue sharing “in the 401(k) plan industry, [as] generally referr[ing] to indirect payments made from one service provider, such as the investment fund provider, to another service provider in connection with services provided to the plan, rather than payments made directly by the plan sponsor for plan services.”).

²⁸ Charles Schwab, *Schwab’s Mutual Fund OneSource® at 20: How a Single Idea Transformed the Way America Invests* at 4 (2012), available at <http://www.aboutschwab.com/images/press/071612MFOSWhitePaper.pdf>.

²⁹ See *supra* notes 15–17 and accompanying text.

³⁰ McHenry Consulting Group, *supra* note 15, at 3.

II. REVENUE SHARING IN 401(K) PLANS – SCOPE AND EFFECT

Little reliable historical data exists on the growth and amount of revenue sharing that has been paid within 401(k) plans. However, as the first subsection below discusses, the available evidence indicates that the dollar volume of revenue sharing is substantial and the practice is widely used. To provide some context for the way revenue sharing may redound to the benefit of 401(k) plan participants, the following subsection discusses the complexity of plan administration and services.

A. SCOPE OF REVENUE SHARING IN 401(K) PLANS

Plans were not required to report revenue sharing until 2009, when the Department of Labor (DOL) began requiring reporting of those payments as part of large plans' annual reporting.³¹ To this day, securities law requires reporting of 12b-1 fees, but not those fees paid by fund managers that are known as revenue sharing in the securities law community.³² As one data point in 2006, 12b-1 fees paid by all mutual funds, not just those held in 401(k) accounts and excluding revenue sharing as used in the securities context, totaled \$11.8 billion.³³

It appears that plan fees and employer responsibilities for understanding those fees started to become of interest to regulators in the late 1990s. The DOL commissioned a study of 401(k) fees which culminated in a report entitled "Study of 401(k) Plan Fees and Expenses."³⁴ That report explicitly discussed 12b-1 and other types of fees³⁵ but did not use the term "revenue sharing." However, it recognizes the general concept that "[i]n the case of mutual fund expense ratios or where the investment management fees are otherwise incorporated in net asset

³¹ See Michele A. Rivas, *Fee Disclosures by Service Providers to Benefit Plans: How to Protect Your Clients*, 34 MI. TAX L. 11, 12-13 (2008). Plans do not always need to report revenue sharing separately from other types of compensation paid to plan service providers. *Id.* at 13.

³² See Howat & Reid, *supra* note 17, at 689-96.

³³ John P. Freeman, *The Mutual Fund Distribution Expense Mess*, 32 IOWA J. CORP. L. 739, 744 (2007).

³⁴ PENSION & WELFARE BENEFITS ADMIN., ECONOMIC SYSTEMS, INC., STUDY OF 401(K) PLAN FEES AND EXPENSES (1998), available at <http://www.dol.gov/ebsa/pdf/401kRept.pdf>.

³⁵ See *id.* at 3.3.5.

valuation computations, participants pay all of the fees.”³⁶ In addition to the study, in 1997, the DOL held hearings on the transparency of fees in 401(k) plans. The extent to which employers and participants would benefit from increased transparency was somewhat controversial.³⁷

In spite of the amount of revenue sharing changing hands and its role in 401(k) plan innovation, the first report I have found that explicitly refers to revenue sharing as such in the context of 401(k) plans was issued by the McHenry Consulting Group in 2001.³⁸ That report, titled “Revenue-Sharing in the 401(k) Marketplace,” explained that U.S. securities laws permit mutual fund companies to share their revenues with service providers to 401(k) plans. According to the report, “Almost every investment and administration service provider engages in this activity to some degree. It is virtually impossible to compete in the 401(k) marketplace without subsidies to help offset service costs, as provided by asset-based revenues.”³⁹ It also provides some general information about the costs of plan services and the kinds of services that affect costs.⁴⁰

A policy advisory group to the DOL, known as the ERISA Advisory Council,⁴¹ of which I was a member at the time, studied revenue sharing in 2004. In my experience, each year, the ERISA Advisory Council members choose approximately three issues to consider. Working groups are constituted to study those issues. ERISA Advisory Council members then volunteer to serve on any or all of the working groups, according to interest and expertise.

The 2004 working group on plan fees and reporting on Form 5500 (Fees and Reporting Working Group) heard testimony over multiple days from a number of industry participants about plan fees, and some of those

³⁶ *Id.* at 5.3.2.

³⁷ *See id.* at 5.3.3 (reporting that the disclosure to sponsors and participants of fees and expenses imposed on 401(k) plans is often not complete and that this lack of information may affect the costs to the plans).

³⁸ McHenry Consulting Group, *supra* note 15.

³⁹ *Id.* at 4.

⁴⁰ *Id.* at 5–6.

⁴¹ ERISA Advisory Councils are comprised of fifteen member groups of citizens appointed for staggered three-year terms by the Secretary of Labor. Pub. L. 93-406, tit. I, § 512, 88 Stat. 895 (1974) (codified at 29 U.S.C. § 1142 (2006)). I was a member of the ERISA Advisory Council from 2002–2004, and was a member of both the working group that studied plan fees and reporting and the one that studied fee and related disclosures to participants.

witnesses discussed revenue sharing.⁴² As is typical, the working group's final report includes summaries of the testimony of each witness and the group's overall findings based on the testimony. The report confirms that the data available to the employee benefit plans community on revenue sharing were limited. A number of the witnesses discussed the lack of transparency of plan fees and revenue-sharing arrangements.⁴³ None of the witnesses that I remember advanced a legal theory under which service providers had any obligation to disclose revenue sharing unless asked by an employer. Nor were revenue-sharing disclosures required as part of plans' annual reporting to the DOL.

In spite of the lack of specific data, the working group's conclusions reflect the testimony that 401(k) plan service providers often relied on revenue sharing to compensate them in full or part for the services they provided to the plan.⁴⁴ In its findings, the Fees and Reporting Working Group wrote: "[t]he testimony established that explicit charges in many plans have been substantially reduced or nearly completely eliminated and the majority of costs associated with administering many retirement plans are now embedded in the form of asset-based fees and borne by the plan participants."⁴⁵ The report recommended that the DOL study regarding the reporting of plan fees, including the use of revenue sharing, should be required.⁴⁶

At least two other direct or indirect references to revenue sharing and 401(k) plans date to 2004. A second working group of the 2004 ERISA Advisory Council focused on the somewhat different issue of how fee disclosures related to participant investment elections.⁴⁷ That group's final report did not directly discuss revenue sharing, except to the extent that specific witnesses used the term and it became part of the summaries

⁴² See ADVISORY COUNCIL ON EMP. WELFARE & PENSION BENEFIT PLANS, REPORT OF THE WORKING GROUP ON PLAN FEES AND REPORTING ON FORM 5500 (2004), available at http://www.dol.gov/ebsa/publications/AC_111804_report.html.

⁴³ See, e.g., *id.* at 10.

⁴⁴ *Id.* at 2.

⁴⁵ *Id.* at 5.

⁴⁶ *Id.* at 3.

⁴⁷ See ADVISORY COUNCIL ON EMP. WELFARE & PENSION BENEFITS PLANS, REPORT OF THE WORKING GROUP ON FEE AND RELATED DISCLOSURES TO PARTICIPANTS (2004), available at http://www.dol.gov/ebsa/publications/AC_111704_report.html.

of the individual testimony.⁴⁸ In addition, the *New York Times* quoted an employee of a prominent benefits consulting firm as stating that “90% of 401(k) plans engage in revenue sharing.”⁴⁹

Interest in and discussion about the prevalence of revenue sharing in 401(k) plans has continued. In 2007, another working group of the ERISA Advisory Council studied fiduciary responsibilities and revenue-sharing practices. In introducing its findings on revenue sharing, the report states, “[t]he Working Group recognized that there was a considerable amount of consensus with respect to the concept of revenue sharing, how it can benefit plan sponsors and their participants.”⁵⁰ The first of its four consensus thoughts was that “[r]evenue sharing is an acceptable practice.”⁵¹ The prevalence of revenue sharing is implicit in those statements and throughout the report. The report also reflects a belief that revenue sharing pays for plan services that would have to be paid for in some other way in the absence of revenue sharing. “[T]he Working Group recognized that revenue sharing was a common and considerable practice used to offset plan expenses with respect to [defined contribution] plans.”⁵²

Today, revenue sharing continues to be widely used in 401(k) plans and to attract the attention of commentators and policy makers. In a 2011 report on fees in the 401(k) plan marketplace, Deloitte reported survey results showing that 55 percent of the responding plan sponsors reported that “all of the record-keeping and administrative fees are paid through investment revenue.”⁵³ In 2012, the Government Accountability Office (GAO) released the results of its study of 401(k) plan fees, which is discussed in more detail below.⁵⁴ The DOL has also imposed a variety of mandatory reporting requirements regarding plan fees and the use of revenue sharing.⁵⁵

⁴⁸ *Id.* at 13, 18.

⁴⁹ Jill E. Fisch, *Rethinking the Regulation of Securities Intermediaries*, 158 U. PA. L. REV. 1961, 2004 n.269 (2010) (quoting Lynn O’Shaughnessy, *A 401(k) Picks a Mutual Fund. Who Gets a Perk?*, N.Y. TIMES, Feb. 15, 2004, at BU5).

⁵⁰ ERISA Advisory Council, *supra* note 6, at 3.

⁵¹ *Id.*

⁵² *Id.* at 1-2.

⁵³ DELOITTE ET AL., ANNUAL 401(K) BENCHMARKING SURVEY 24 (2011), available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_consulting_Deloitte%20401k%20Survey_2011%20edition_12082011.pdf.

⁵⁴ GAO, *supra* note 27; see also *infra* text accompanying notes 114-17.

⁵⁵ See *infra* text accompanying notes Part III.A.

B. EFFECT OF REVENUE SHARING IN 401(K) PLANS

Since Schwab created the NTF model in 1992, 401(k) plans have added services to participants, increased the average number of investment options they offer participants, and complied with increasing regulatory obligations. Plans now face far more extensive regulatory requirements than at the time 401(k) plans began.⁵⁶

The costs of these elaborate and extensive services may be shared between employers and employees, but employees usually pay the largest share. One survey shows that 83 percent of all fees associated with 401(k) plans are paid by plan participants. Most of those payments are made through revenue sharing. The survey also notes that some of the revenue sharing may pay for plan administration, including recordkeeping.⁵⁷

The main concern that seems to be expressed about the effect of revenue sharing on 401(k) plan participants is the lack of transparency associated with revenue sharing. According to one commentator, Matthew Hutcheson,⁵⁸ “[r]evenue sharing is the ‘big secret’ of the retirement

⁵⁶ See, e.g., DEP’T OF LABOR, FINAL REGULATION RELATING TO SERVICE PROVIDER DISCLOSURES UNDER SECTION 408 (B)(2): FACT SHEET (2012), available at <http://www.dol.gov/ebsa/newsroom/fs408b2finalreg.html> (explaining the obligation of service providers to disclose compensation to plan fiduciaries, which implies the obligation of plan fiduciaries to evaluate those disclosures); DEP’T OF LABOR, FINAL RULE TO IMPROVE TRANSPARENCY OF FEES AND EXPENSES TO WORKERS IN 401(K)-TYPE RETIREMENT PLANS: FACT SHEET (2012), available at <http://www.dol.gov/ebsa/newsroom/fsparticipantfeerule.html> (explaining final regulations requiring plans to disclose plan fees to participants); DEP’T OF LABOR, REGULATION RELATING TO QUALIFIED DEFAULT INVESTMENT ALTERNATIVES IN PARTICIPANT-DIRECTED INDIVIDUAL ACCOUNT PLANS (2008), available at <http://www.dol.gov/ebsa/newsroom/fsQDIA.html> (explaining the effect of and requirements for a 401(k) plan offering a "qualified default investment alternative.").

⁵⁷ DELOITTE, INSIDE THE STRUCTURE OF DEFINED CONTRIBUTION/401(K) PLAN FEES: A STUDY ASSESSING THE MECHANICS OF THE ‘ALL-IN’ FEE 5 (2011), available at https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_consulting_StructureofDefineContribution_112411.pdf.

⁵⁸ In 2013, Mr. Hutcheson was sentenced to prison after being convicted of wire fraud in connection with his service as a retirement plan fiduciary. See U.S. DEP’T OF JUSTICE, *Eagle Man Sentenced to Over 17 Years in Prison for Theft from Retirement Plans* (July 31, 2013), <http://www.justice.gov/usao/id/news/2013/jul/hutcheson07312013.html>.

industry.”⁵⁹ Some witnesses to the ERISA Advisory Council’s 2004 Fees and Reporting Working Group expressed the view that neither participants nor plan sponsors had a good understanding of revenue sharing.⁶⁰ Mr. Hutcheson feared that revenue sharing “impair[s] the retirement income security of participants,”⁶¹ and could result in fiduciary liability for plan sponsors who fail to consider these costs when making decisions regarding plan service providers.⁶²

However, to the extent that sponsors with that plan face fiduciary liability because of the lack of transparency in revenue sharing, one response – and the one I advocate later in this Article – is that the system has it wrong when it allocates fiduciary responsibility for revenue sharing-related decision making to plan sponsors.⁶³ If, as the 2007 ERISA Working Group found, revenue sharing has encouraged the development of important services to participants and enhanced the popularity of 401(k) plans, then it would seem to have accomplished the opposite of impairing retirement security.

It is important to recognize that the array of functions provided by 401(k) plan service providers is very broad. Those functions include account statements, educational programs and materials, investment transactions, call centers, web sites, etc., that provide information and receive transaction orders, process plan loans, distributions, roll-overs, contributions, and court orders to divide 401(k) plan accounts upon a participant’s divorce, etc. Some of these services, such as account statements, are required by law.⁶⁴ Others, such as call centers and websites, are not required but provide participants with enhanced access to information about their accounts and efficient methods of implementing investment decisions. Service providers may perform a variety of other services, such as preparing annual reports the plan must file with the DOL⁶⁵

⁵⁹ Hutcheson, *supra* note 3, at 328.

⁶⁰ ERISA Advisory Council, *supra* note 42, at 9-10, 12.

⁶¹ Hutcheson, *supra* note 3, at 328.

⁶² *Id.*

⁶³ See *infra* text accompanying notes 146-48.

⁶⁴ See, e.g., ERISA § 105(a)(1)(A)(i), 29 U.S.C. § 1025(a)(1)(A)(i) (2006) (requiring plans that permit participants to choose their investments to provide a benefits statement at least quarterly).

⁶⁵ See, e.g., ERISA § 103, 29 U.S.C. § 1023 (2006) (requiring plans to file annual reports). Filing Form 5500 with the DOL fulfills this reporting requirement. See Fisch, *supra* note 49, at 1986 (briefly discussing Form 5500 filing obligations).

and holding account assets in trust⁶⁶ to enable plans to comply with legal requirements. Finally, 401(k) service providers may undertake functions such as investment recordkeeping and serving as the interface between participants and investment providers such as mutual funds. One commentator identified fourteen different entities or people that may receive payments from 401(k) plan assets for services provided to those plans.⁶⁷

The complexity of plan recordkeeping, participant communications, and similar services may also be affected by the investment choices offered to plan participants. The investment options from which participants may choose, often referred to as the investment menu, have increased from an average of six in 1995 to fourteen in 2005.⁶⁸ When new financial products are developed, that can raise the question of whether those products are suitable for 401(k) plans.⁶⁹

The services provided by 401(k) plans redound to the benefit of plan participants and enable them to build wealth in those plans. Providers of those 401(k) plan services must be compensated in some way for their services. As explained above, the norm has become to pay for some or all of the costs through revenue sharing. One prominent scholar explained it this way: “the employees bear the costs of running the plan but pay those

⁶⁶ ERISA § 403(a), 29 U.S.C. §1103 (2006).

⁶⁷ Hutcheson, *supra* note 3, at 344-47; *see also* GAO, *supra* note 27, at 7-9 (discussing the variety of plan service providers and how services may be combined, which is referred to in the industry as bundled services).

⁶⁸ Holden et al., *supra* note 14, at 17. It is useful to note, however, that work by behavioral economists indicates that it is better for retirement participants to have only a small number of investment options because too large a set of options may discourage participants from participating in the plan. Sheena S. Iyengar et al., *How Much Choice Is Too Much?: Contributions to 401(k) Retirement Plans*, in PENSION DESIGN AND STRUCTURE: NEW LESSONS FROM BEHAVIORAL FINANCE, 83-95 (Olivia S. Mitchell & Stephen P. Utkus eds., 2004). One important strategy that has been successful in increasing plan participation is to automatically enroll participants in plans while also providing them the opportunity to actively opt out. *See* Dana M. Muir, *Default Settings in Defined Contribution Plans: A Comparative Approach to Fiduciary Obligation and the Role of Markets*, 28 A.B.A. J. LAB. & EMP. L. 59, 60-61 (2012) (outlining the use of defaults in 401(k) plans).

⁶⁹ *See, e.g.*, William A. Birdthistle, *The Fortunes and Foibles of Exchange-Traded Funds: A Positive Market Response to the Problems of Mutual Funds*, 33 DEL. J. CORP. L. 69, 74 (2008) (discussing the possibility that 401(k) plan menus might include exchange-traded funds (ETFs)).

costs indirectly through the fees charged to them by the participating mutual funds.”⁷⁰

Arguably, revenue sharing has had a positive effect on the popularity of 401(k) plans and on the breadth of services the plans provide to participants. This was the view of the 2007 ERISA Working Group, which wrote: “revenue-sharing in a broad sense allows the market ‘to develop efficiencies and innovations that have enhanced the quality of services of products available to [defined contribution] and 401(k) plans.’”⁷¹ The report also states: “[t]he witnesses generally testified, and the Working Group recognizes that revenue sharing supports a wide variety of distribution and shareholder servicing activities, including administrative record keeping and sub-transfer agent services that were traditionally viewed as investment fund responsibilities.”⁷²

III. THE ROLE OF EMPLOYERS IN MONITORING REVENUE SHARING

Federal pension regulation applies a two-prong approach to revenue-sharing. One component relies on disclosure and the other on substantive fiduciary obligation. This Part addresses each of those in turn. The analysis shows that employers bear the primary fiduciary burden vis-à-vis the use of revenue sharing in 401(k) plans. It further reveals that employers’ fiduciary obligation with respect to revenue sharing is comprised of two main components: (i) the obligation to ensure that compensation to plan service providers is reasonable; and (ii) the need to act loyally and prudently when choosing and monitoring products for the plan’s investment menu.

A. DISCLOSURE OF REVENUE SHARING IN 401(K) PLANS

During the past five years, the DOL has overhauled the reporting of the compensation received by employee benefit plan service providers, including their receipt of revenue-sharing. The first disclosure obligation became effective in 2009 when large plans⁷³ were required to identify in

⁷⁰ Fisch, *supra* note 49, at 2004-05.

⁷¹ ERISA ADVISORY COUNCIL, *supra* note 6.

⁷² *Id.*

⁷³ Large plans typically are those with at least one hundred participants. As of 2005, approximately 86 percent of those participating in a 401(k) plan were in a

the annual reports they file with the DOL all service providers who directly or indirectly receive more than \$5,000 compensation during the plan year covered by the reporting.⁷⁴ Although this increased the transparency of service provider compensation, gaps remained. The definition of compensation was broad enough to include revenue sharing.⁷⁵ However, in certain situations, revenue sharing can be included with other types of compensation rather than being separately reported.⁷⁶ Second, nothing in this annual reporting requirement required service providers to disclose their compensation to plan sponsors.⁷⁷ When plan sponsors did not have compensation information from the service providers, the plan sponsors could meet their disclosure obligation by identifying service providers and noting the lack of information.⁷⁸

The next prong of the DOL's effort to increase the transparency of 401(k) fees became effective in 2012 when it issued final regulations requiring plan service providers that receive at least \$1,000 annually in plan-related compensation to disclose their total compensation to plan fiduciaries.⁷⁹ In turn, the plan now must disclose administrative fees and expenses to plan participants.⁸⁰ Guidance issued by the DOL makes clear that both sets of disclosure requirements include revenue sharing.⁸¹

In addition to providing information to plan sponsors and participants, disclosures of plan administrative fees and expenses may be of

large plan. See Debra A. Davis, *How Much is Enough? Giving Fiduciaries and Participants Adequate Information About Plan Expenses*, 41 J. MARSHALL L. REV. 1005, 1022 (2008).

⁷⁴ *Id.* at 1023.

⁷⁵ See DEP'T OF LABOR, *Frequently Asked Questions: The 2009 Form 5500 Schedule C, Q14*, http://www.dol.gov/ebsa/faqs/faq_scheduleC.html.

⁷⁶ See *id.*

⁷⁷ Davis, *supra* note 73, at 1023.

⁷⁸ See *id.*

⁷⁹ DEP'T OF LABOR, FINAL REGULATION RELATING TO SERVICE PROVIDER DISCLOSURES UNDER SECTION 408(B)(2): FACT SHEET 2 (2012), available at <http://www.dol.gov/ebsa/newsroom/fs408b2finalreg.html>.

⁸⁰ DEP'T OF LABOR, FINAL RULE TO IMPROVE TRANSPARENCY OF THE FEES AND EXPENSES TO WORKERS IN 401(K)-TYPE RETIREMENT PLANS: FACT SHEET 2 (2012), available at <http://www.dol.gov/ebsa/newsroom/fsparticipantfeerule.html>.

⁸¹ See DEP'T OF LABOR, FEE DISCLOSURE GUIDANCE, FIELD ASSISTANCE BULLETIN 2012 – 02 (2012), available at <http://www.dol.gov/ebsa/regs/fab2012-2.html>.

value to other interested parties. The tax-advantaged nature of 401(k) plans means that a variety of government agencies, including the Internal Revenue Service, may have an interest in the information. Securities analysts, independent researchers, and competitors of both plan sponsors and plan service providers may also find the information useful.

It is too early to tell whether the benefits of increased disclosure outweigh its costs. The reporting is complex⁸² and commentators question the extent to which it is understood by either employers or employees.⁸³ As described below, plan service providers have an interest in making it difficult for employers to compare fees across plan providers.⁸⁴ The GAO's 2012 report discusses the extent to which employers have been comparing fees and, even after 2009, remain confused about plan fees and the role that revenue sharing plays in compensating plan service providers.⁸⁵

B. FIDUCIARY RESPONSIBILITY AND REVENUE SHARING IN 401(K) PLANS

In addition to the relatively recent disclosure obligations just discussed, ERISA's fiduciary standards apply to revenue-sharing. This subsection explains ERISA's basic fiduciary requirements and how those requirements apply to the various parties involved in the use of revenue-sharing in 401(k) plans. It then explains the extent to which employers bear the primary fiduciary obligation in authorizing and monitoring the use of revenue-sharing in those plans.

When functioning as an ERISA fiduciary, individuals and entities must act loyally⁸⁶ and in accordance with a standard of care defined as that of a prudent person familiar with the benefit plan matters at issue.⁸⁷ To

⁸² See, e.g., Reasonable Contract or Arrangement Under Section 408(b)(2) – Fee Disclosure, 77 C.F.R. § 5632 (containing a preamble in excess of 18 pages before the regulatory impact analysis).

⁸³ See Mark Mensack, *The Moral Hazard of Too Big to Jail*, J. COMP. & BENEFITS 42, 45 (2013) (discussing the frustration of some plan sponsors in trying to evaluate the fee disclosures).

⁸⁴ See *infra* text accompanying notes 118-20.

⁸⁵ GAO, *supra* note 27, at 24-28.

⁸⁶ ERISA § 404(a)(1)(A)(i), 29 U.S.C. § 1104(a)(1)(A)(i) (2006) ("solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries.").

⁸⁷ See ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B) (2006); see also 29 C.F.R. § 2550.404a-1 (1997) (explaining the application of the prudence standard

supplement these trust law-based, general fiduciary standards, ERISA contains what are known as prohibited transactions provisions. One set of those provisions bars transactions between a plan and certain specified parties that have relationships with plans, including plan service providers, unless an exemption applies.⁸⁸

ERISA utilizes a functional definition of fiduciary, which means that any person or entity that engages in actions involving discretionary plan administration, asset or plan management, or investment advice acts as a fiduciary.⁸⁹ This broad definition could lead a reasonable person to think that the mutual funds that pay revenue sharing, the service providers that administer plans and receive revenue sharing from account assets, and the employers who sponsor plans all act as ERISA fiduciaries. ERISA has a way, however, of confounding the expectations of reasonable people.

ERISA's fiduciary definition explicitly excludes from its scope the mutual funds that pay revenue sharing. Although the functional definition of fiduciary includes persons or entities that engage in discretionary asset management, the definition clarifies that investments of plan assets in mutual funds do not cause the mutual fund or its advisor to become an ERISA fiduciary.⁹⁰ It appears that Congress' rationale for the exclusion when it enacted ERISA, which was well before the existence of 401(k) plans, was that existing federal regulation of mutual funds was sufficient.⁹¹

Plan service providers, including those that receive revenue-sharing, typically avoid ERISA fiduciary status in one of two ways. First, they may not exercise the discretion that is required by the statute for fiduciary status. For example, entities that provide recordkeeping and similar services may successfully argue that they merely administer the

to investment duties). ERISA's other fiduciary standards require benefit plan fiduciaries to minimize the risk of large losses by diversifying plan investments, ERISA § 404(a)(1)(C), 29 U.S.C. § 1104(a)(1)(C) (2006), and to act in accordance with plan documents, ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (2006).

⁸⁸ ERISA § 406(a)(1), 29 U.S.C. § 1106(a)(1) (2006).

⁸⁹ ERISA § 3(21)(a)(ii), 29 U.S.C. § 1002(21)(a)(ii) (2006).

⁹⁰ See ERISA § 3(21)(b), 29 U.S.C. § 1002(21)(b) (2006).

⁹¹ See U.S. Dep't of Labor Adv. Op. 2009-04A (Dec. 4, 2009) (stating that "Congress concluded that it did not need to apply ERISA's fiduciary rules to the operation of mutual funds in addition to the Investment Company Act's regulatory scheme.").

terms of the plan and that does not constitute the fiduciary exercise of discretion.⁹²

Second, some providers of investment advice to plans and participants may rely on an early DOL regulation that narrowly defined the provision of fiduciary investment advice. Under that regulation, issued in 1975 when DB plans were typical, an investment adviser is not a fiduciary when giving advice regarding benefit plan assets or an Individual Retirement Account (IRA) unless the adviser (1) advises on securities valuation or makes recommendations on the purchase or sale of securities, (2) on a regular basis, (3) according to a mutual agreement with the plan or a plan fiduciary, (4) that provides the advice will serve as the primary basis for decisions on investments, and (5) the advice is individualized to the plan's needs.⁹³ For example, entities that provide advice to employers on the selection of plan investments can avoid fiduciary status by providing the advice on a one time, rather than ongoing, basis.

The DOL recognizes that this narrow definition of fiduciary investment advice no longer has currency in the 401(k) plan environment. In 2010, the agency proposed regulations that would have dramatically increased the scope of financial advisory activities that result in a provider becoming a fiduciary when giving investment advice regarding benefit plan or IRA assets. The proposed regulatory definition tracked the general statutory definition and specifically stated that investment advice or recommendations given to a plan participant or beneficiary or to an investor regarding an IRA are a fiduciary act.⁹⁴ After widespread objection from the financial services sector, the DOL withdrew the proposed regulations.⁹⁵ Current indications are that the agency plans to revise and repropose the regulations.⁹⁶

⁹² See e.g., *Hecker v. Deere*, 556 F.3d 575, 584 (7th Cir. 2009) (holding that the plan's service provider was not a fiduciary because it did not exercise discretion in plan administration or with respect to plan management); cf. *Tussey v. ABB, Inc.*, No. 2:06-CV-04305-NKL, 2012 U.S. Dist. LEXIS 45240, at *100-01 (W.D. Mo. Mar. 31, 2012).

⁹³ Definition of the Term 'Fiduciary', 75 Fed. Reg. 65,263, 65,265 (proposed Oct. 22, 2010).

⁹⁴ *Id.* at 65,277.

⁹⁵ *Labor Department's EBSA to repropose rule on definition of a fiduciary*, U.S. DEP'T OF LABOR (Sept. 19, 2011), <http://www.dol.gov/opa/media/press/ebsa/EBSA20111382.htm>.

⁹⁶ U.S. Dep't of Labor, *Conflict of Interest Rule – Investment Advice*, FEDERAL REGISTER (2013), available at <http://www.federalregister.gov/regulations/1210->

ERISA's exclusion of mutual funds from fiduciary status and de facto exclusion of nearly any service provider that wants to be excluded leaves employers holding the fiduciary bag for 401(k) plans. Jurisprudence and DOL authority make clear that ERISA's fiduciary definition encompasses certain acts of employers that sponsor a benefit plan, including the selection and monitoring of plan investments.⁹⁷ Employers may form a committee of employees to select and monitor plan investments or otherwise delegate those functions. In such an instance the employer remains a fiduciary for the appointment and monitoring of its agents and the agents are ERISA fiduciaries for the discretionary functions delegated to them.⁹⁸

In September 2006, employees began alleging that fiduciary violations by employers resulted in inappropriately high 401(k) plan fees that in turn negatively affected the employees' account balances.⁹⁹ A complete analysis of the litigation involving plan fees is beyond the scope of this Article. It is useful, though, to consider one of the more prominent cases in order to categorize the types of responsibility employers face with respect to the use of revenue sharing in their 401(k) plans.

AB32/conflict-of-interest-rule-investment-advice (targeting October 2013 for reproposal).

⁹⁷ See, e.g., *Quan v. Computer Sci. Corp.*, 623 F.3d 870, 880-81 (9th Cir. 2010) (finding that employer-fiduciary's choice of investments was entitled to deference); Final Regulation Regarding Participant Directed Individual Account Plans (ERISA Section 404(c) Plans), 57 Fed. Reg. 46,906, 46,924 n.27 (Oct. 16, 1991) ("Thus . . . the plan fiduciary has a fiduciary obligation to prudently select such [investment options], as well as a residual fiduciary obligation to periodically evaluate the performance of such [investment options]."); see also 29 C.F.R. § 2550.404c-5(b)(2) (2012) ("Nothing in this [regulation] shall relieve a fiduciary from his or her duties under . . . ERISA to prudently select and monitor any qualified default investment alternative under the plan or from any liability that results from a failure to satisfy these duties, including liability for any resulting losses."). But see *Hecker*, 556 F.3d at 586 (leaving open the issue of "whether [the plan sponsor's] decision to restrict the direct investment choices in its Plans . . . is even a decision within [the plan sponsor's] fiduciary responsibilities."), *order denying rehearing en banc*, 569 F.3d 708 (7th Cir. 2009).

⁹⁸ See Mark Casciari & Ian Morrison, *Should the Securities Exchange Act be the Sole Federal Remedy for an ERISA Fiduciary Misrepresentation of the Value of Public Employer Stock?*, 39 J. MARSHALL L. REV. 637, 643 (2006).

⁹⁹ See Chris Thixton, *A 401(k) Fee Lawsuit First*, PENSION CONSULTANTS INC. (Nov. 17, 2009), <http://pension-consultants.com/2009/11/fee-lawsuit/>.

In *Tussey v. ABB, Inc.*, 401(k) plan participants alleged, among other things, that their employer, ABB, Inc. (ABB), violated its fiduciary duties when making decisions on matters that involved revenue sharing.¹⁰⁰ First, ABB allegedly permitted Fidelity Trust, the 401(k) plan's recordkeeper, to receive such extensive revenue sharing payments that Fidelity Trust's compensation became excessive.¹⁰¹ The excessive compensation allegedly subsidized work on non-401(k) plans that Fidelity Trust did for ABB. ABB failed to convince the court that it appropriately monitored the fees Fidelity Trust received.¹⁰² According to the court, ABB was primarily concerned with minimizing its own costs rather than with ensuring the plan participants did not overpay Fidelity Trust.¹⁰³

Second, the participants argued that ABB had violated its fiduciary obligations when it deleted one mutual fund offering and selected or kept other funds as part of the plan's investment menu.¹⁰⁴ The court determined that ABB inappropriately considered the "effect of the fund selected on recordkeeping fees, and what changes to the fee structure were in [ABB's] best interest" when replacing one fund with another.¹⁰⁵ ABB also decided to offer some share classes in the plan that charged higher fees to participants, and thus paid more in revenue sharing, than paid by other lower-fee share classes of the same funds that were available to the plan.¹⁰⁶ The court held the ABB fiduciaries jointly and severally liable for \$34.2 million as a result of these fiduciary breaches.¹⁰⁷

The *Tussey* decision illustrates that employers have two primary responsibilities when considering the use and scope of revenue sharing. First, the duties of loyalty and care require employers to ensure that any compensation paid by the plan, directly or indirectly, to its service providers is reasonable. Second, employers must act loyally and prudently when choosing and designating the investments offered to employees.

¹⁰⁰ *Tussey v. ABB, Inc.*, No. 2:06-CV-04305-NKL, 2012 U.S. Dist. LEXIS 45240, at *100-01 (Mar. 31, 2012).

¹⁰¹ *See id.* at *28.

¹⁰² *Id.* at *29.

¹⁰³ *Id.* at *31.

¹⁰⁴ *See id.* at *47-48.

¹⁰⁵ *Id.* at *57.

¹⁰⁶ *See id.* at *79.

¹⁰⁷ *Id.* at *116. The court awarded the plaintiffs an additional \$1.7 million due to ABB's failure to monitor the way a Fidelity entity administered float income. *Id.*

In sum, ERISA's fiduciary framework, which was developed during an era of DB plan dominance, imposes significant responsibility on employers who sponsor 401(k) plans. Among those responsibilities is an obligation to select both plan service providers and the investments offered in the plan in accordance with fiduciary standards of loyalty and prudence. In contrast, ERISA generally does not impose fiduciary duties on either plan service providers or the providers of mutual funds offered as plan investments. Revenue sharing, which is frequently used to pay some or all of the costs of 401(k) plan administration, illustrates the challenges and burdens this regulatory approach poses for employers.

IV. EMPLOYERS AND 401(K) FIDUCIARY DUTIES

In this Part, I briefly explain the way employers' roles have changed as a result of the transition from a DB pension system to one that primarily relies on DC plans such as 401(k) plans. The basic alignment of interests that supported the choice of an employer-centric fiduciary framework for DB plan investments no longer exists. Furthermore, employers do not inherently have the expertise to select and monitor financial products targeted to individual investors or the way in which the product providers interact with other actors in the financial and 401(k) systems. Contributing to the task for employers are information asymmetries between employers and providers of 401(k) services and investment products. The Part concludes with a brief discussion of alternative regulatory approaches.

A. EMPLOYER INTERESTS AND EXPERTISE IN THE 401(K) PLAN SYSTEM

The role employers play in the retirement plans that they voluntarily sponsor has shifted significantly since ERISA's fiduciary provisions were enacted in 1974. ERISA requires employers to fund DB plans they sponsor to whatever degree necessary to enable the plans to pay promised benefits.¹⁰⁸ That means that employers with DB plans have a direct interest in plan investments and in the fees charged to the plans.

¹⁰⁸ See Dana M. Muir, *Counting the Cash: Disclosure and Cash Balance Plans*, 37 J. MARSHALL L. REV. 849, 869 (2004) (“[E]mployers retain the obligation to fully fund a DB plan should investment returns not meet expectations . . .”).

Positive investment returns reduce an employer's funding obligation, and every dollar of cost the plan pays in fees is a dollar that the employer must contribute to the plan. In addition, employers have full control over DB plan investment decision-making. The alignment of the employer's interests with the plan beneficiaries' interests favors treating the employers as plan fiduciaries.

In the 401(k) paradigm, employers' interests are less closely aligned with the retirement plan policy goal of maximizing employee opportunity to achieve lifelong financial security. Most 401(k) plans delegate to employees the decision on how to invest their account assets.¹⁰⁹ As a result, employers no longer control how plan assets are invested. Nor do employers have any direct interest in the investment returns. The investment vehicles used in 401(k) plans may be significantly different from those in DB plans. 401(k) investments must be suitable for the varied needs of participants, which depend on demographic and risk factors as well as plan scale. Since the plan service provider fees are typically paid either directly or indirectly by the participants, employers may be largely indifferent to the amount of those fees or the way in which they are charged to participants.

The change in the alignment of interests is not the only factor that favors reallocation of the fiduciary obligations in 401(k) plans. Employers, especially small ones, may not have the expertise to evaluate the financial products offered on their 401(k) plan menu. There is nothing in the business model of non-financial sector employers to lead a reasonable observer to believe that employers have the professional proficiency in financial planning necessary to decide on the appropriate set of investment choices to be offered to employees. Nor are employers necessarily knowledgeable about the increasing complexities of financial products and how those products operate within the larger 401(k) system that encompasses a range of service providers such as broker-dealers, financial planners, and record keepers.

A variety of factors contribute to the complexity involved in 401(k) plans. One is the number of different services and providers that the plan may need.¹¹⁰ The size of a 401(k) plan can cut both ways in terms of complexity. The problem for small plans is that they need many of the

¹⁰⁹ See Davis, *supra* note 73, at 1028 (explaining that approximately 96% of all individuals actively participating in 401(k) plans have both the right and the responsibility to choose how to invest their account assets).

¹¹⁰ See Hutcheson, *supra* note 3, at 344-47.

same services and must meet many of the same compliance requirements as large plans but have fewer participants and lower levels of plan assets to bear those costs.¹¹¹ Larger plans tend to have lower per-participant fees because of the economies of scale those plans can achieve.¹¹² Large plans may be challenged, though, to meet the diversity of interests that naturally occurs among a large participant population. Finally, as employers examine their plan costs and compare those costs with those of other plans, the employers must consider the qualitative differences among the plans. An employer's fiduciary obligation does not require it to offer a low-cost plan. Instead, it requires the employer to act prudently and to ensure the plan service providers are not overcompensated for the services that they render.¹¹³

A concern related to complexity and limited employer expertise is that employers suffer from information asymmetry on revenue sharing and other compensation and fees in the investment industry as compared to plan service providers and mutual funds. The 2012 GAO report found that some plan sponsors were not aware of financial arrangements among service providers and investment products or, if generally aware, did not understand the amount or use of those fees.¹¹⁴ Some of the GAO's findings are astonishing in the extent to which employers are unaware of or do not consider revenue-sharing when making plan-related decisions. Almost half of the surveyed plan sponsors did not know if revenue-sharing occurred in their 401(k) plan.¹¹⁵ And a number of employers that knew revenue sharing occurred within their plan admitted they did not consider the revenue sharing compensation when selecting plan service providers.¹¹⁶ In some instances, the GAO cross-checked the fee data reported by the employers who participated in its study. One example the GAO gave is that of a large plan that paid 16 times more in fees for administrative services and record-keeping during one year than the employer had reported.¹¹⁷ Presumably,

¹¹¹ See GAO, *supra* note 27, at 15.

¹¹² See *id.*

¹¹³ See DEP'T OF LABOR, *Meeting Your Fiduciary Responsibilities* 5 (2012) (“[F]iduciaries will want to understand the fees and expenses charged and the services provided”), available at <http://www.dol.gov/ebsa/pdf/meetingyourfiduciaryresponsibilities.pdf>.

¹¹⁴ See GAO, *supra* note 27, at 13-14, 16-21.

¹¹⁵ *Id.* at 25.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 27.

the employer did not understand the extent of the fees being paid within its plan.

One might assume that the disclosure obligations imposed by the DOL on plan service providers beginning in 2012 would eliminate this asymmetry. However, experts in retirement system fees and the new disclosures explain that service providers are going to considerable lengths to make the mandated fee disclosures difficult for employers to comprehend and analyze.¹¹⁸ One commentator refers to the disclosures as “*dizzily complex*.”¹¹⁹ Discussing plan sponsor obligations in evaluating the disclosures, one plan consultant said “[t]he time it takes – and the attention to detail it takes – is more than sponsors can handle.”¹²⁰

Fewer than 60% of full time U.S. workers in the private sector have any access to a retirement plan.¹²¹ A well-functioning regulatory system would encourage employers to increase their sponsorship of retirement plans. Assigning fiduciary obligation and liability for investment selection and monitoring to employers who voluntarily sponsor 401(k) plans does not take advantage of a strong alignment between the interests of employers and employees because no such alignment exists. Nor does designating employers as fiduciaries utilize expertise that they naturally have in running their businesses because few employers naturally develop expertise in the complexities of investment products intended for individuals. It appears that even extensive disclosure requirements may not entirely eliminate information asymmetries that increase the challenges participants face in meeting their ERISA fiduciary obligations.

The observation that employers may not be the best-placed of the entire constellation of actors in the 401(k) plan system to bear the responsibility and liability associated with approval and monitoring of the

¹¹⁸ See Mark Mensack, *The Moral Hazard of Too Big to Jail*, J. COMPENSATION & BENEFITS, May/June 2013, at 42, 44-45. The DOL did not mandate a particular format for these disclosures although it did provide a sample guide for preparation of the initial disclosures. See generally Reasonable Contract or Arrangement under Section 408(b)(2) – Fee Disclosure, 77 Fed. Reg. 5632, 5658-59 (Feb. 3, 2012) (to be codified at 29 C.F.R. pt. 2550).

¹¹⁹ Mensack, *supra* note 118, at 45.

¹²⁰ Lee Barney, *The Moment of Truth*, PLANADVISER (Feb. 2013), available at <http://www.planadviser.com/MagazineArticle.aspx?id=10737418889&magazine=10737418887>.

¹²¹ Alicia Munnell et al., *The Pension Coverage Problem in the Private Sector*, CTR. FOR RETIREMENT RES. AT B.C. (Sept. 2012), available at http://crr.bc.edu/wp-content/uploads/2012/09/IB_12-16.pdf.

use of revenue sharing is not incompatible with a regulatory system that appropriately protects employees. Instead the observation provides a rationale for a careful examination of that constellation of actors and the various roles they should play in a properly performing 401(k) system.

B. PROPOSALS TO REALLOCATE FIDUCIARY RESPONSIBILITY

Numerous commentators and policy makers have offered proposals intended to improve the 401(k) system. Some of those suggestions are incremental and would have little or no effect on employer responsibility for the use of revenue sharing.¹²² Other suggestions, some of which I categorize below based on their approach to investments and briefly discuss, would dramatically change the DC plan landscape. All of the proposals discussed below address broad, systemic problems in the U.S. DC system. However, I only discuss their implications for employer fiduciary responsibility for plan investments.

In one category of proposals the federal government, or a committee appointed by the government, would assume total or primary responsibility for selection of the investments to be held in DC accounts. Professor Theresa Ghilarducci has offered a schematic for a system that would entirely replace the current DC system, which she calls Guaranteed Retirement Accounts (GRAs).¹²³ The board of the Thrift Savings Plan (TSP), which administers and invests the DC accounts of federal employees, would invest GRA assets.¹²⁴ Professor Ghilarducci's plan would guarantee a three percent investment return in GRAs.¹²⁵ During periods of economic stress, GRA assets and the three percent return would

¹²² See, e.g., Colleen E. Medill, *Targeted Pension Reform*, 27 J. LEGIS. 1, 3 (2001) (proposing closure of loopholes in the tax system that result in benefits being lower than they otherwise would be for lower wage workers); Michael W. Melton, *Making the Nondiscrimination Rules of Tax-Qualified Retirement Plans More Effective*, 71 B.U. L. REV. 47, 50 (1991) (arguing that tax incentives are not sufficient to induce low-income workers to save for retirement); see also Paul M. Secunda, *401(k) Follies: A Proposal to Reinvigorate the United States Annuity Market*, 30 A.B.A. SEC. TAX'N NEWSQUARTERLY, Fall 2010, at 13, 14-15 (arguing for tax law changes to require 401(k) plans to offer annuitized distribution options).

¹²³ TERESA GHILARDUCCI, *WHEN I'M SIXTY-FOUR: THE PLOT AGAINST PENSIONS AND THE PLAN TO SAVE THEM* 262 (2008).

¹²⁴ *Id.* at 264-65.

¹²⁵ *Id.* at 265.

be protected. On the other hand, the accounts would receive only limited returns during robust financial market periods. Employers would have no responsibility or liability for the investments held in GRAs.

Professor Jeff Schwartz has proposed a government-run system of individual accounts that, like Professor Ghilarducci's, would replace 401(k) plans.¹²⁶ One role of the government would be to designate a private sector fund manager to invest account assets, although Professor Schwartz allows that the system may provide some opportunity for employees to select their own investments.¹²⁷ The default investment product to be managed by the government-appointed manager would consist of a portfolio made up of a U.S. equity index fund and treasury-inflation protected securities (TIPS).¹²⁸ While not formally promising a guaranteed minimum investment return, the use of TIPS is intended to provide a "guarantee[d] return of principal in real terms at retirement."¹²⁹ The allocation between the equity index fund and TIPS, and thus the effective guarantee, would vary according to employee age.¹³⁰ As with Professor Ghilarducci's plan, employers would not have any role or liability in the selection of account investments.

A second category of reform proposal would retain many of the contours of the existing 401(k) plan system but would make changes to the investment component of the system. One plan receiving significant attention is sponsored by Senator Tom Harkin.¹³¹ If adopted, his proposal would require any employer not offering a DB or DC plan that meets minimum criteria to enroll employees into a newly-created type of private sector pension plan, a Universal, Secure, and Adaptable (USA) Retirement Fund.¹³² Senator Harkin's proposal only provides the broad details of how USA Retirement Funds would work. There are indications that employees would have individual accounts because the proposal states that "[t]he amount of a person's monthly benefit would be determined based on the total amount of contributions made by, or on behalf of, the participant and

¹²⁶ Jeff Schwartz, *Rethinking 401(k)s*, 49 HARV. J. ON LEGIS. 53, 74-78 (2012).

¹²⁷ *See id.* at 85.

¹²⁸ *Id.* at 83.

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *See generally* TOM HARKIN, U.S. SENATE COMM. ON HEALTH, EDUC., LABOR & PENSIONS, THE RETIREMENT CRISIS AND A PLAN TO SOLVE IT (2012), available at <http://www.harkin.senate.gov/documents/pdf/5011b69191eb4.pdf>.

¹³² *Id.* at 1, 6-7.

investment performance over time.”¹³³ However, the proposal also contemplates risk sharing, the type and amount of which is ambiguous. The risk sharing delegates to the trustees of each fund the flexibility to gradually increase or decrease benefits depending on investment performance.¹³⁴ Such sharing of risks is incompatible with a system that calculates individual benefits based purely on account balances.

The fiduciary responsibility for USA Retirement Funds would lie with the fund trustees charged with plan management.¹³⁵ Trustees would represent various constituencies: employees, retirees and employers.¹³⁶ USA Retirement Funds would be licensed by an unspecified entity.¹³⁷ Employers would not have any fiduciary liability for the selection of a USA Retirement Fund for their employees and, in fact, would be permitted to “use the ‘default’ fund identified for the region, industry, or through collective bargaining.”¹³⁸ Presumably a federal agency would determine the default fund for various regions and industries. Senator Harkin’s plan does not seem to address the responsibility and liability for investments of employers that choose to offer their own DC plan rather than enrolling their employees in a USA retirement fund.

Elsewhere, I have proposed a system that is similar to Senator Harkin’s in that it would leave intact much of the present 401(k) framework.¹³⁹ It would decrease employer liability for investment selection and provide added incentives for plan sponsorship by offering additional liability protections for small employers.¹⁴⁰ My proposal is centered on a new type of investment product, Safe Harbor Automated Retirement Product (SHARPs).¹⁴¹ In lieu of employer fiduciary obligation for SHARPs, I propose a two-part mechanism consisting of: (1) assigning fiduciary responsibility to the investment managers and fund directors that determine and implement a SHARP’s investment strategy; and (2) licensing by and reporting to a federal regulatory agency. Disclosure

¹³³ *Id.* at 6.

¹³⁴ *Id.* at 7.

¹³⁵ *Id.* at 6.

¹³⁶ *Id.*

¹³⁷ *Id.* at 7.

¹³⁸ *Id.*

¹³⁹ Muir, *supra* note 7, at 49.

¹⁴⁰ *Id.* at 50.

¹⁴¹ *Id.* at 7.

requirements would promote the ability to make competitive comparisons among SHARPs.¹⁴²

The investment strategy of SHARPs is critical to employees' wealth accumulation. SHARPs would be permitted to use any investment strategy that would currently meet the Qualified Default Investment Alternative requirements imposed by the DOL as part of a safe harbor for default plan investments in automatic enrollment 401(k) plans.¹⁴³ To drive investor-focused performance and low fees, the investment managers of SHARPs would have fiduciary liability to act in the best interest of the participants, including determination, disclosure, and implementation of an appropriate asset allocation strategy.¹⁴⁴ As a final check, the board members of a SHARP would be responsible for its compliance with regulatory standards and its disclosed strategy.¹⁴⁵

My SHARPs proposal is based, with appropriate adaptations for the U.S. system, on Australia's implementation of MySuper investment products. Elsewhere, I have described Australia's approach to private sector pension provision in greater detail.¹⁴⁶ Relevant here is that after the global financial crisis Australia undertook a review of its retirement system.¹⁴⁷ The final reform recommendations were extensive.¹⁴⁸ One component addressed the default investment vehicles used for the accounts of employees who do not designate their investment choices. Default investment products are in extensive use in Australia because many Australians are passive with respect to their investments, do not make active plan choices, and have limited financial literacy.¹⁴⁹ In the reformed system, MySuper products will be the only permitted type of default investment product. In addition, employees who wish to make explicit

¹⁴² *Id.* at 51.

¹⁴³ For an explanation of both QDIAs and automatic enrollment 401(k)s, see *id.* at 53.

¹⁴⁴ *Id.* at 51.

¹⁴⁵ *Id.*

¹⁴⁶ For a discussion of the system and the values it represents, see Dana M. Muir, *Building Value in the Australian Defined Contribution System: A Values Perspective*, 33 COMP. LAB. L. & POL'Y J. 93 (2011).

¹⁴⁷ SUPER SYS. REVIEW PANEL, SUPER SYSTEM REVIEW FINAL REPORT pt. 1 (2010), available at http://www.supersystemreview.gov.au/content/downloads/final_report/part_one/Final_Report_Part_1_Consolidated.pdf.

¹⁴⁸ *Id.* at 24–60.

¹⁴⁹ *Id.* at 8–9.

investment decisions may designate a MySuper product to receive their retirement plan contributions.¹⁵⁰

The regulatory framework is relatively simple. The Australian Prudential Regulatory Authority (APRA) will gather and make public data on MySuper product performance and fees to facilitate competition among the offerings.¹⁵¹ The regulatory approach to MySuper default products imposes an enhanced set of duties on MySuper fund entity trustees (sometimes referred to as corporate trustees)¹⁵² and on the boards that govern the entity trustees.¹⁵³ Employers play no significant role and have no significant liability in this system. The enhanced obligations of MySuper entity and individual trustees essentially will operate as an additional layer of duties on top of the basic set of requirements that applies to all entity trustees of funds that hold retirement assets.¹⁵⁴ In addition, trustees must be licensed and meet specific standards with respect to the operation of a MySuper product.¹⁵⁵

Unlike the employer-based retirement system in Australia, the U.S. regulatory system currently relies on employers as the primary gatekeepers and decisionmakers for 401(k) plan investments. This approach is a relic of the period when DB plans were the predominant type of retirement plan. In the context of the current DC system, employers' interests do not

¹⁵⁰ *Id.* at 10.

¹⁵¹ See TREASURY, COMMONWEALTH OF AUSTL., STRONGER SUPER: INFORMATION PACK 4 (2011), available at http://strongersuper.treasury.gov.au/content/publications/information_pack/downloads/information_pack.pdf.

¹⁵² See Mark Blair & Ian Ramsay, *Collective Investment Schemes: The Role of the Trustee*, 1 AUSTL. ACCT. REV. 10, 17 (1992) (noting that a trustee is required in order to receive certain tax benefits); Jeremy Cooper, *Super for Members: A New Paradigm for Australia's Retirement Income System*, 3 ROTMAN INT'L J. PENSION MGMT. 8, 13 (2010).

¹⁵³ See SUPER SYS. REVIEW PANEL, SUPER SYSTEM REVIEW FINAL REPORT pt. 2, at 12–14 (2010), available at http://www.supersystemreview.gov.au/content/downloads/final_report/part_two/Final_Report_Part_2_Consolidated.pdf; TREASURY, COMMONWEALTH OF AUSTL., *supra* note 151, at 19–20.

¹⁵⁴ MySuper entity trustees will be required to: promote the financial interests of MySuper members, in particular net returns; annually assess sufficiency of scale; and include in their investment strategy an investment return target and level of risk for MySuper members. *Superannuation Legislation Amendment (Trustee Obligations and Prudential Standards) Act 2012* (Cth) div 6 (Austl.).

¹⁵⁵ See Superannuation Legislation Amendment (MySuper Core Provisions) Bill 2011 (Cth) (Austl.), available at <http://www.comlaw.gov.au/Details/C2011B00234>.

strongly align with the interests of employees who invest through those plans, typically do not have specialized expertise in investment products targeted to individual investors, and suffer from information asymmetry as compared to 401(k) plan service providers and entities such as mutual funds that invest account assets.

A number of the proposals for reform of the U.S. 401(k) system advocate decreasing the responsibility and liability employers face in offering their employees the opportunity to use DC plans as a component of the employees' pursuit of lifelong financial security. Revenue-sharing is a good example of the challenges employers confront in establishing 401(k) plan investment menus, monitoring those menus, and overseeing the compensation of plan service providers. None of the proposals discussed here would leave plan participants unprotected. Instead, the proposals divide responsibility for investment oversight in various ways among the federal government and the providers of investment products and 401(k) services.

V. CONCLUSION

Revenue sharing in 401(k) plans dates at least to the early 1990s. It took some time, though, before revenue-sharing began to receive significant attention from others than those who paid or received it. The DOL recently has increased disclosure obligations to provide more transparency on the compensation, including from revenue-sharing, which service providers derive from 401(k) plans.

In addition to the disclosure obligations, ERISA imposes fiduciary obligations and liability on employers for the selection and monitoring of 401(k) plan investments and service providers. Cases brought by participants alleging excessive investment fees and service provider compensation have highlighted these obligations, including the role played by revenue sharing. But workers struggling to meet their survival needs and save for the future deserve a better system. The current fiduciary structure serves to discourage employers, particularly small employers, who have neither the expertise nor the time to understand financial products targeted at individual investors and the compensation practices, including revenue-sharing, used in the financial sector, from establishing a 401(k) plan. In today's competitive business environment, even large employers may be reluctant to develop the expertise necessary to meet ERISA's substantive fiduciary standards. In short, revenue-sharing is but one example, albeit an important one, of why the US needs to carefully evaluate its approach to building retirement wealth for its workers.

RETIREMENT POLICIES AND RELATED SOCIAL CHANGES IN THE LIFECYCLE

RUSSELL K. OSGOOD*

This Essay argues that retirement policies, including retirement income and healthcare sufficiency, should be crafted in light of demographic and lifestyle changes rather than as a means to solve a larger fiscal problem. The author studies work force demographics and life expectancy in the decades following WWII as compared to today and discusses how other nations have attempted to solve the same problems currently facing the United States. As a means of addressing the increasing fiscal demands of paying for retirement, the article proposes an “omnibus” plan that extends the retirement age, introduces “means testing” for certain benefits as well as cutbacks and proposes changes to the taxable wage base.

I. INTRODUCTION

This Essay¹ is an effort to establish a framework for action in dealing with the issues in a great debate that is not happening, but should be, about retirement, retirement policy and retirement income, and health care sufficiency. Lots of ideas have been floated and much ink and paper, and many cyber impulses, expended, discussing various aspects of this set of issues but those ideas have typically been generated by reference to a single policy perspective, including most frequently national fiscal necessity, health care adequacy, or social security solvency. This is

* Distinguished Visiting Professor of Law, Washington University School of Law. The author thanks Merton Bernstein, Jonathan M. Brand, Lucas Deppermann '15, Carol A. Fichtelman, Richard L. Kaplan, Fred C. Little, Kathryn Moore, Robert Pollak, Spencer Reynolds '14, Liz Sepper, and Peter Wiedenbeck for reading drafts of this paper and the participants in the spring 2013 Insurance Law Journal Symposium at the University of Connecticut School of Law for listening to a speech setting forth the proposals made here.

¹ The word “Essay” is used intentionally to connote a looser style of argumentation and also fewer footnotes than conventional law review articles. Almost every sentence in this Essay could be footnoted to the mountain of technical material and the reams of commentary on this set of complex subjects.

essentially how the retirement proposals by the well-known Bowles-Simpson Commission² were generated as part of a larger proposal aimed at solving problems of national fiscal policy. That set of proposals has languished for lots of reasons and this Essay will argue that the set of related retirement issues cannot be “solved” by reference to a set of proposals focused only on fiscal needs. It is said that these retirement issues cannot be solved at all because they are too “political.” The matters are obviously political (and politicians have difficulty solving big problems), but these matters also reflect deep changes in the underlying social order and in longevity that make changes in the relevant policies exceptionally difficult to resolve when looked at in a short-term political framework.

This Essay will review the following: 1) the shape of the various component retirement and health policies (and demographic facts) in the late 1950s and early 1960s as a reference point, 2) the policies in place right now (with imminent changes), and 3) a brief summary of related policies in Germany, Britain, Canada, and Singapore. The Essay will then make an omnibus proposal *not aimed primarily at solving the fiscal problem*, but developed by reference largely to the changes in longevity and labor force participation. This omnibus proposal would, however, if implemented, contribute to an amelioration of the fiscal problem.

A. A NOTE ON STATISTICS AND PROJECTIONS

The arena of retirement and healthcare policies has a huge statistical component, but I will start with several cautionary notes about statistics in this area. *First*, statistical projections that go very far into the future, say twenty years or more, are extraordinarily unreliable. Mortality statistics are an exception, but projections of costs, etc. turn out frequently to be overstated. When Medicare Part D was added during the presidency of George W. Bush, virtually all statistical projections were wrong on the high side.³ This was the case because no one was sure how adding drug

² NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM, REPORT OF THE NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM: THE MOMENT OF TRUTH, (Dec. 2010) [hereinafter BOWLES-SIMPSON].

³ See Edwin Park, *Refuting, Once Again, the Medicare Part D Myth*, OFF THE CHARTS BLOG: POLICY INSIGHT BEYOND THE NUMBERS, CENTER ON BUDGET AND POLICY PRIORITIES (March 11, 2013, 11:04 AM), <http://www.offthechartsblog.org/refuting-once-again-the-medicare-part-d-myth-2/>.

benefits would affect hospitalization and other costs. In retrospect it seems to have reduced them (this is logical). *Second*, human, social and economic behavior is dynamic and hard to predict. For instance, many people believe that there will be (or is) a significant increase in delayed retirements due to the rise of retirement living costs (and longevity) and the failure of private savings and employer provided retirement income to increase commensurately (or at all). Current data fails to show this because the current data can, due to exogenous factors, mask what is going on. For instance, just as many people may wish to work longer, but we have had a major employment contraction with many attendant “early” retirements. These people are not retiring early because they wish to but because it was forced on them individually or in large groups. *Third*, health care cost projections continue to be based on what has been a norm created during a period of sustained healthcare inflation (1965 to the present). This inflation was fueled by massive resource infusions by employer plans and government transfer payments. No one is predicting an end to this inflation in part because the Affordable Care Act (“ACA”) is slowly coming into effect and it will increase the demand for healthcare services. But the rate of inflation has to change. There literally will not be resources available to provide for health care at the quantities projected if the inflation continues at a very elevated level. How it will come to an end is not yet understood, but it is beyond doubt going to end.

I. A LOOK BACK

One of the problems in thinking about how to resolve the many pending “crises” in the areas of retirement and related retirement healthcare has been a failure to study methodically what has changed or led to our present situation. Typically, it is assumed that the problems have sprung from: 1) increases in longevity and/or 2) government intervention in the health care market. But the story is more complicated and multifaceted than these two phenomena, and in the next few paragraphs I will sketch our situation as of 1960, and then in the following section describe our situation today.

A. OASDI⁴

The Social Security system is comprised of various benefits and it is widely assumed that these have not changed much and that the threat of insufficiency of funds today is a function of an aging workforce, lower birthrate, and increased longevity. This is not true. The primary insurance benefit (of OASDI) has changed in a number of ways since 1960. First, the minimum benefits were much lower then. Second, there were no automatic, only episodic, COLA (“Cost of Living Adjustment”) adjustments to benefits until 1972. Third, there was no Social Security Disability Insurance scheme until 1956 and the number of participants had not ballooned as it did in the 1970s and 1990s.⁵ Fourth, since the wage base was lower the amount of higher end and maximum benefits were relatively smaller. Fifth, a significant number of workers, including governmental, charitable, farm and ecclesiastical organization workers, were not included in the system. The system was funded, as it is today, by a dual employer/employee tax on “wages and salaries” (without any offset for the various income tax deductions) that was intelligently premised on the notion that all people should at all times and all income levels put aside a portion of wages (matched by the employer) for support during old age.

B. HEALTHCARE “SYSTEM”

In 1960 there was no Medicare and no ACA. A significant number of workers had employer- or union-provided health insurance but many did not. A few people (usually wealthy) bought individual policies. Healthcare inflation had begun to increase as medicine modernized and began to add procedures and medications and machines that prolonged life or tested for sickness. Healthcare insurance was a state matter.

⁴ This discussion of Social Security was informed by a recent, comprehensible and careful description of the system’s current provisions and its origins. Kathryn L. Moore, *An Overview of the U.S. Retirement Income Security System and the Principles and Values it Reflects*, 33 COMP. LAB. L. & POL’Y J. 5 (2011).

⁵ See *Disability Policy & History: Statement Before the H. Subcomm. on Soc. Security of the Comm. on Ways and Means* (July 13, 2000) (statement of Edward D. Berkowitz).

C. LONGEVITY

Longevity for males in 1960 was 66.6 years and for females was 73.1 years.⁶ It was higher in developed European countries, but it had been creeping up in all developed nations during the post-World War II epoch, particularly for women.

D. PRIVATE PENSIONS

Private employer and union plans covered approximately forty-one percent of the full time workforce in 1960.⁷ This group was largely male and had shorter life expectancies. The pensions were generally defined benefit plans paying annuity type benefits that were set at retirement and generally did not increase automatically with inflation. Defined contribution plans had become popular in the private (non-union) sector, but not in the case of public plans. The rate of coverage of employees had increased from 1945 until 1960 significantly. Private pension plans sometimes had disability insurance features that covered a disabled worker until he or she attained age sixty-five.

E. LABOR MARKET PARTICIPATION AND THE STRUCTURE OF EMPLOYMENT

In 1960 83.3% of males aged sixteen to sixty-five participated in the labor force with females at 37.7%.⁸ Labor market participation immediately after age sixty-five by males was 35%.⁹ Employment was concentrated in full-time forty hour a week jobs reflecting the norms of the Federal Fair Labor Standards Act, (supervisors, overtime, etc. etc.) devised to regulate industrial and other large employment employers. To be sure, there were large numbers of small employers, and many rural employers, including

⁶ *Health Data Interactive: Life Expectancy at Birth, 65 and 85 Years of Age, US, Selected Years 1900-2010*, NAT'L CTR. FOR HEALTH STATISTICS (Jun. 25, 2013), <http://205.207.175.93/HDI/TableViewer/tableView.aspx?ReportId=169>.

⁷ S.A. SASS, *THE PROMISE OF PRIVATE PENSIONS* 139 (1997).

⁸ *Current Population Survey Database*, BUREAU OF LABOR STATISTICS (2013) available at <http://www.bls.gov/opub/ted/2007/jan/wk2/art03.txt>.

⁹ Robert S. Szafran, *Age-Adjusted Labor Force Participation Rates, 1960-2045*, 123 MONTHLY LAB. REV. 25, 30 (2002).

farms, that existed outside the industrial model, but they were not a focus of federal regulation.

F. MANDATORY RETIREMENT

For employees or most employers there was a mandatory retirement age, generally age sixty-five. There was no Age Discrimination in Employment Act (“ADEA”) and, as mentioned above, not a large number of disabled workers. Some employers, including police, fire, and the military provided for retirements typically before age sixty-five. Colleges and universities typically had a mandatory retirement age for faculty, but occasionally it was somewhat higher than sixty-five.

As we shall see shortly, the world shown by these facts is different, in significant ways, from the world our retirement programs now confronts. Most of the changes have added costs to these programs, so part of what this excursus into the past shows is that there are multiple contributing factors to our now heavy costs of retirement. This suggests that no single change will alter the cost “crisis.”

II. THE CURRENT SITUATION

A. OASDI

Today the primary insurance benefit is significantly higher than projected in 1960. This is attributable to indexed increases, increases in minimum benefits, and increases in wages and salaries and the social security wage base. The Social Security Trust Fund reserves, which are entirely composed of IOUs from the United States Treasury because all past and current FICA payments have been or will be expended by the Trustees, are being depleted, and the most recent data suggests that only about seventy-five percent of projected benefits are funded (counting future FICA taxes) and that the Social Security Trust Fund reserves will be exhausted in 2035.¹⁰ Early retirement (with reduced benefits) continues to

¹⁰ SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES, STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2013 ANNUAL REPORTS 2 (2013) [hereinafter 2013 SUMMARY TRUSTEES REPORTS]. The exhaustion of the reserves does not mean there will be nothing to pay benefits for there will be a continuing accrual of future employment taxes and these taxes are

be available at age sixty-two, and normal retirement (depending on one's birth date) is at sixty-six or sixty-seven. Participants may elect to defer the regular commencement of benefits at this age, and if they do, their later benefits are increased by a set percentage. The Social Security Disability Insurance Trust Fund is projected to be exhausted in 2016, and there has been a large increase¹¹ both in those claiming and securing disability benefits, due in part to the employment contraction of the recent recession.¹² There has been active discussion of this "crisis" and no action on a solution. There seems to be consensus on a modest recalibration of the COLA (using a "chained" CPI versus the current CPI¹³) measuring point for the primary insurance amount but, even that has not yet been approved by Congress and the President.

B. HEALTHCARE SYSTEM

Medicare participants are eligible to enter at age sixty-five, whether retired or not. (Disabled Social Security annuitants may qualify early in

projected to cover seventy-five percent of the projected future benefits if no changes are made.

¹¹ From 1998 to 2012 the number of disabled individuals receiving benefits increased from 4,698,319 to 8,853,614. *Selected Data from Social Security's Disability Program*, SOC. SEC. ADMIN. (Dec. 2013), <http://www.ssa.gov/OACT/STATS/dibStat.html>.

¹² 2013 SUMMARY TRUSTEES REPORTS, *supra* note 10. The Bowles-Simpson Commission made a suggestion that people "unable to work" but not disabled be permitted to receive an actuarially reduced payment of their primary insurance benefit at age sixty-two (augmented to 100% at their regular retirement date). One would be more sanguine about this proposal except for the history of difficulty in policing the definition of "disabled" under the current system. "Unable to work" is apparently a lower standard. BOWLES-SIMPSON *supra* note 2, at 51. It is worth noting that the Social Security Administration has been concerned, from the beginning of this benefit, about the administrability of the concept of disability. See Berkowitz, *supra* note 5. The parallel Railroad Retirement System has had similar, or even more difficulty, in assessing correctly disability status. See William K. Rashbaum, *600 Long Island Railroad Retirees Lose Disability Pay in U.S. Inquiry*, N.Y. TIMES, July 1, 2013, at A18.

¹³ BOWLES-SIMPSON, *supra* note 2, at 51-2. Yale Sterling Professor of Economics, Robert J. Shiller, has recently proposed that social security benefits be indexed to GDP changes to align retirees' interests with society's as a whole. Robert J. Shiller, *Want to Fix Social Security? Use the Right Wrench*, N.Y. TIMES, June 8, 2013, at 4.

certain circumstances for Medicare.¹⁴) The costs of participation include: 1) substantial premium payments for Part B (physician and related services) and 2) in connection with the newer Part D certain payments. Individuals commonly obtain wrap-around policies that in turn do not cover all of these costs.¹⁵ The Medicare Trust Fund's (which technically only relates to Part A (hospitalization) of Medicare) reserves are projected to be exhausted sooner than the Social Security Trust Fund. The wage base for this system is unlimited, unlike the one for OASDI, but the foreseeable tax revenues leave this system even more underfunded.¹⁶ Some Medicare eligible individuals are, due to their low income, also eligible for Medicaid.¹⁷

Many employees are (before Medicare eligibility) covered by employer or union provided health insurance and a smaller number also have post-retirement, employer-provided wrap-around (Medicare) coverage. The passage of ACA in 2010 portends significant changes in (and an augmentation of) this, but at this time all of this seems dicey at best.¹⁸ The core feature of the augmentation, a series of state exchanges, seems in doubt. The related expansion of Medicaid¹⁹ is on track in many states but has been rejected in other states. The theory of a fully implemented ACA was that affordable near universal coverage would be obtained by collecting premiums from many young and relatively healthy people, but this theory has yet to be tested in the United States except in Massachusetts, Vermont, and Hawaii. There are predictions that many employers will drop their employer plans as ACA Exchange policies

¹⁴ *Disability Planner: Medicare Coverage if You're Disabled*, SOC. SEC. ADMIN. (2013), <http://www.ssa.gov/dibplan/dapproval4.htm>.

¹⁵ The relatively high costs and confusing structure of Medicare is well described in the companion piece to this article by Richard Kaplan. YOYO of course means, "you're on your own," an appropriate acronym for the current financial aspects of Medicare. Richard Kaplan, *Desperate Retirees: The Perplexing Challenge of Covering Retirement Health Care Costs in a YOYO World*, 20 CONN. INS. L.J. 433 (2014).

¹⁶ 2013 SUMMARY TRUSTEES REPORTS, *supra* note 10, at 3.

¹⁷ *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending and Existing Policies*, CONG. BUDGET OFF. (June 6, 2013), <http://www.cbo.gov/publication/44308>.

¹⁸ Susan E. Cancelosi, *What to do, What to do: Employer Health Benefit Plans During and After 2012's Uncertainty*, 51 U. LOUISVILLE L. REV. 569 (2013).

¹⁹ Medicaid is a joint federal-state system that provides healthcare for individuals and families below a certain level of income. It has been steadily expanded but the states vary significantly in what is covered.

become available, and it is even clearer that many employers are already dropping employer provided wrap-around post-retirement plans (even though Medicare coverage and costs are not directly changed by the ACA).²⁰ Finally, the CLASS (“Community Living Assistance Services and Support Act”) (or long term care) feature of ACA has been declared dead by the Secretary of Health and Human Services.²¹

One of the major changes in the healthcare environment since 1960 is the widespread social perception that health care is a “right,” or an “entitlement,” and “someone” else should pay for it. This perception extends to the feeling that insurers and employers, or Medicare, is, or are, greedy if they deny coverage for a therapy or an additional test or other medical procedures. In the campaign around ACA the supporters never confronted this but in fact traded on it and the opponents only obliquely hinted that not all health care can, or will, be available under any system.

Finally, healthcare inflation, while bending slightly down, remains high from almost any reference point. New technology and insistent demands for, and provision of, experimental and other high-cost, or arguably duplicative procedures, continue to drive up cost.

C. LONGEVITY

In 2010, male life expectancy was seventy-six years and female was 80.9 years.²² Many serious illnesses that were quickly fatal in 1960 are now managed over long periods of time, including cancer, heart disease, and dementia. At the same time there is no reliable data that shows individuals are not “wearing out,” or physically declining, at a rate consistent with the recent past. Finally, the CLASS ACT (a long term care program that proved fiscally unsound) of ACA, and its recent abandonment, reflects concern about what is thought to be a tsunami of baby boomers needing to be nursed for long periods of declining health in long term care facilities. This last prediction is one of the statistical projections that is hard to feel certain about.

²⁰ See generally Cancelosi, *supra* note 18.

²¹ The Bowles-Simpson Commission had previously recommended its abandonment. BOWLES-SIMPSON, *supra* note 2, at 37.

²² *Health Data Interactive*, *supra* note 6.

D. PRIVATE PENSIONS

In 2012 fifty-four percent of the civilian workforce participated in a public (non-Social Security), private, or union pension or other deferred compensation plan or plans.²³ See Table I inset. Compared to 1960 there has been a large scale change²⁴ from guaranteed, defined benefit plans to §401(k) defined contribution plans which are likely to produce lower levels of lifetime contributions for retirement income purposes and ultimately lower benefits.²⁵ See Figure 1 inset. Amounts accumulated in defined contribution plans can be rolled over into Individual Retirement Accounts (“IRAs”) which permit withdrawals for non-retirement purposes before retirement.²⁶ Many §401(k) plans and IRAs have employee direction of investments which adds risk in many cases and also has produced high maintenance and investment advisor fees (which have produced litigation and some corrective rule-making).²⁷

About midway in the period from 1960 to the present the United States considered, but did not adopt, a minimum universal (employer paid for) pension (“MUPs”)²⁸ designed to produce a higher level of private pension

²³ *Retirement Benefits: Access, participation, and take-up rate, civilian workers, National Compensation Survey*, U.S. BUREAU OF LABOR STATISTICS (Mar. 2012), http://bls.gov/ncs/ebs/benefits/2012/ownership/civ_all.pdf (last visited June 25, 2013).

²⁴ This change has many causes but one of the leading ones has been the inflexible funding obligations and the massive funding deficiencies in many defined benefit plans. See, e.g., Mary Williams Walsh, *Ratings Service Finds Pension Shortfall*, N.Y. TIMES, June 27, 2013, at B1 (Moody’s recomputes state and local pension liabilities showing larger deficiencies in a number of states).

²⁵ There is no good data for 1960 because the Labor Department was not yet charged with regulating deferred compensation plans but data from the passage of ERISA in 1974 to the present shows the dramatic move to §401(k) plans. See, e.g., Bureau of Labor Statistics, *Defined Contribution Plans: Method of Contribution*, BUREAU OF LABOR STATISTICS, <http://bls.gov/ncs/eba/detailedprovisions/2010/ownership/private/table20a.txt> (viewed on June 25, 2013). Currently eighty-six percent of those who participate in a defined contribution plan participate in a §401(k) (perhaps alongside another defined contribution plan in some cases).

²⁶ 26 U.S.C.A. §§72 (t)(6), (7), (8) and 408 (d).

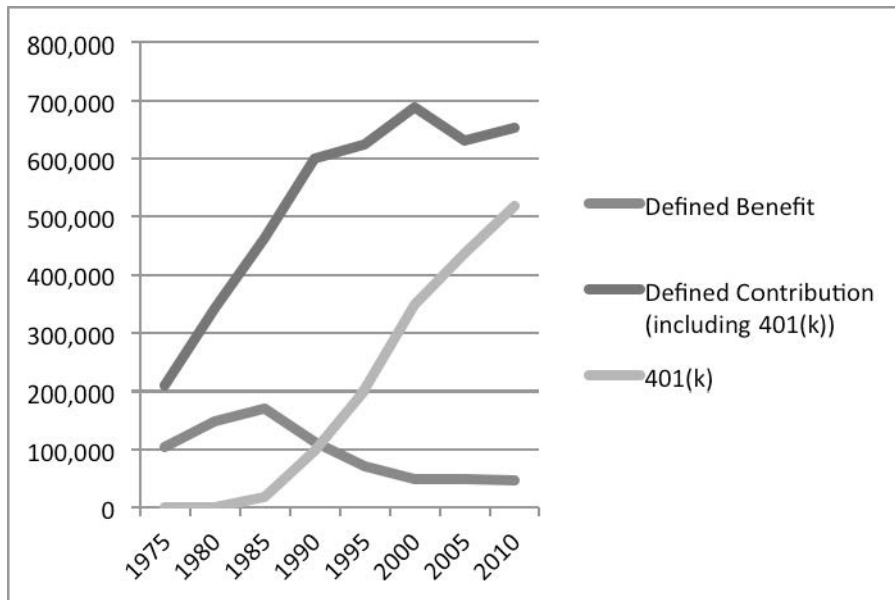
²⁷ See Tara Siegel Bernard, *Limiting the 401(k) Finder’s Fee*, N.Y. TIMES, June 21, 2013, at B1.

²⁸ See P. WIEDENBECK & R. OSGOOD, *CASES AND MATERIALS ON EMPLOYEE BENEFITS* 84 (2d ed. 2013). MUPs were recommended by the President’s Commission on Pension Policy in 1981.

plan benefits to a larger number of workers, particularly the low paid. While a few other developed countries have done this, there was no political support for this expensive idea that would have loaded another expense on employment.

The confluence of the decline of regular pension plans and the rise of the highly discretionary §401(k) plans will likely cause private pensions to recede as a percentage contributor to retirement income. This can be attributed to a number of factors, including the ferocious legal complexity of this area of the law and the need on the part of employer to reduce employment related costs as the social insurance costs of social security and health care have risen dramatically. Private plans are voluntary and inflexible and in the environment of oscillating economic growth they are disfavored.

FIGURE 1:²⁹



Y axis = number of plans

²⁹ U.S. DEP'T OF LABOR, *Private Pension Plan Bulletin Historical Tables and Graphs 25* (Nov. 2012), available at http://www.dol.gov/ebsa/pdf/historical_tables.pdf.

Table 1. Retirement Benefits: Access, participation, and take-up rates, civilian workers, National Compensation Survey, March 2012³⁰

(All workers = 100 percent)

Characteristics	All retirement benefits ³			Defined benefit			Defined contribution		
	Access	Participation	Take-up rate	Access	Participation	Take-up rate	Access	Participation	Take-up rate
All workers	68	54	79	29	26	91	55	37	68
Worker characteristics									
Management, professional, and related	83	74	89	43	40	92	63	48	76
Management, business, and financial	84	76	91	39	36	92	74	61	82
Professional and related	82	72	88	45	41	92	59	43	73
Teachers	88	83	94	74	70	94	35	19	55
Primary, secondary, and special education school teachers	97	93	96	91	88	97	27	11	41
Registered nurses	82	69	84	39	35	91	71	50	71
Service	47	29	63	17	16	94	35	16	45
Protective service	76	60	78	52	49	95	41	17	41
Sales and office	71	54	76	23	19	84	62	43	70
Sales and related	67	42	63	12	8	68	62	38	61
Office and administrative support	73	61	83	29	26	88	62	46	75
Natural resources, construction, and maintenance	68	55	81	30	29	96	56	40	72
Construction, extraction, farming, fishing, and forestry	65	52	80	31	30	97	50	35	70
Installation, maintenance, and repair	71	58	81	29	27	95	61	44	73
Production, transportation, and material moving	67	52	77	26	24	92	55	37	66
Production	69	54	78	22	21	93	64	45	70
Transportation and material moving	65	49	75	29	27	92	47	29	61
Full time	78	65	83	34	32	92	63	45	72
Part time	38	21	54	12	9	79	30	13	44
Union	95	88	93	81	77	95	45	29	85
Nonunion	64	48	75	20	17	88	57	39	68
Average wage within the following categories:⁴									
Lowest 25 percent	41	21	51	9	7	77	35	16	44
Lowest 10 percent	30	10	33	5	3	61	26	7	28
Second 25 percent	70	52	75	24	21	90	58	38	65
Third 25 percent	79	67	85	35	32	92	62	46	75
Highest 25 percent	88	80	91	50	47	93	68	53	79
Highest 10 percent	90	83	92	51	48	93	71	56	79
Establishment characteristics									
Goods-producing industries	75	61	82	27	26	93	68	51	75
Service-providing industries	67	53	79	29	26	91	53	35	67
Education and health services	77	66	85	43	40	92	51	33	65
Educational services	86	80	93	72	67	93	35	20	57
Elementary and secondary schools	91	86	95	85	82	96	24	9	38
Junior colleges, colleges, and universities	87	78	90	53	44	83	62	45	72
Healthcare and social assistance	70	55	78	23	21	90	62	43	69
Hospitals	90	77	86	48	44	90	75	54	72
Public administration	90	86	95	85	80	95	33	17	50

See footnotes at end of table.

E. LABOR MARKET PARTICIPATION AND THE STRUCTURE OF EMPLOYMENT

Women have tremendously increased their participation in the labor force (37.7% to 58.6%)³¹ while male participation remains at historic

³⁰ *Retirement Benefits*, *supra* note 23.

levels. Participation by the elderly (sixty-five or older) is rising significantly (currently 18.5%) after a drop to an all-time low in the mid-1980s (11%) but due to the employment contraction of the recent recession it is hard to be sure how much of the current rise is permanent,³² (see Figure 2 inset).³³ Labor force participation by younger people has dropped recently to 54.9% in 2012 due to high levels of post-high school educational enrollment and also the depth of the recession of 2007-09.³⁴

An equally significant set of changes seems to be occurring in the structure of employment. The industrial (and FLSA) model of full work weeks, a single employer, supervisors, and overtime is changing. As in the 18th century,³⁵ it now looks like more people are working at home, holding multiple jobs simultaneously, not working forty hours a week for any single employer, and changing employers more frequently. See Figure 3 inset on the rise of regular part-time employment. Some of these changes may reflect profit-maximizing employers shifting to short-term contract labor (to avoid regulatory and health care costs), but they also reflect the effect of new technologies on the place and nature of employment. These trends seem likely to continue and perhaps even to accelerate.

F. MANDATORY RETIREMENT

In 1986 Congress passed and President Reagan signed an amendment to the Age Discrimination in Employment Act (“ADEA”) banning mandatory retirement for virtually all employees.³⁶ This change, when added to the increased costs of retirement and changes in labor force participation by women and heavy immigration, have added significantly to

³¹ See Howard N. Fullerton, Jr., *Labor Force Participation: 75 years of change, 1950-98 and 1998-2025*, MONTHLY LAB. REV. 3, 4 (Dec. 1999).

³² *Id.* at 4.

³³ See *id.*

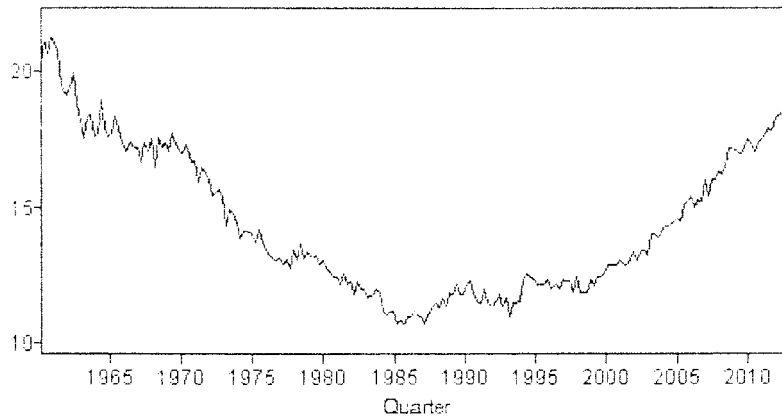
³⁴ Bureau of Labor Statistics, *Labor Force Projections to 2022: The Labor Force Participation Rate Continues to Fall*, MONTHLY LAB. REV. 1, 12, 18 (Dec. 2013).

³⁵ See generally ROY PORTER, *ENGLISH SOCIETY IN THE 18TH CENTURY* 185-213 (Rev. ed. 1991); T.C.W. BLANNING, *THE EIGHTEENTH CENTURY: EUROPE 1688-1815*, 91-130 (2000) (Europe). As to our current situation, see Editorial, *Part-Time America*, WALL STREET J., July 7, 2013, at A12.

³⁶ Age Discrimination in Employment Amendments of 1986, Pub. L. No. 99-592, 100 Stat. 3342 (1986).

the labor force³⁷ and created a significant downdraft on wages and salaries.³⁸

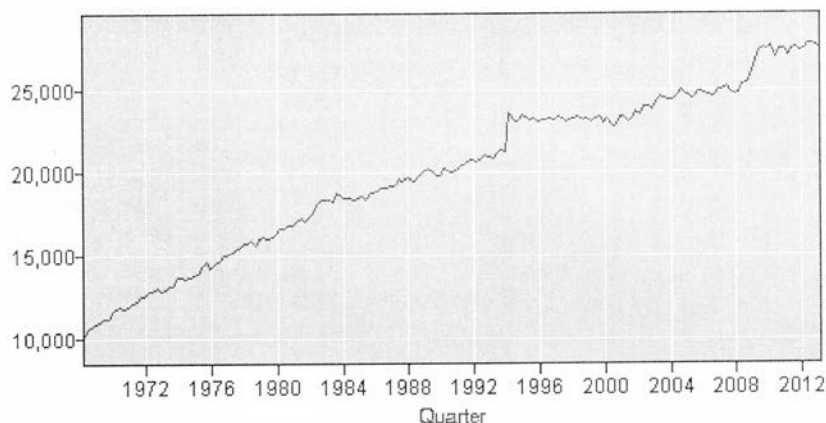
FIGURE 2: Labor Force Participation Rate – 65 years and over³⁹



³⁷ Mitra Toossi, *A Century of Change: The U.S. Labor Force, 1950-2050*, MONTHLY LAB. REV. 15, 20, 25-27 (May 2002).

³⁸ Lawrence Mishel & Heidi Shierholz, *A Decade of Flat Wages: The Key Barrier to Shared Prosperity and a Rising Middle Class*, ECON. POL'Y INST. BRIEFING PAPER 365, Aug. 21, 2013, at 3, available at <http://s1.epi.org/files/2013/BP365.pdf>.

³⁹ Fullerton, *supra* note 31, at 3-4.

FIGURE 3: Employed part time⁴⁰

III. COMPARATIVE RETIREMENT AND HEALTH SYSTEMS

Table II⁴¹ inset in the text, compares the health and retirement policies of the United States, the United Kingdom, Canada, Germany, and

⁴⁰ BUREAU OF LABOR STATISTICS, ISSUES IN LABOR STATISTICS: SUMMARY 08-08 (2008), available at <http://www.bls.gov/opub/ils/pdf/opbils71.pdf>.

⁴¹ This chart is constructed from information gleaned from a number of law review articles about the foreign nations' systems. See Steven Ney, *Pension Reform in Germany* (ICCR Vienna/PEN-REF Project, Feb. 2001); Lillian Liu, *Retirement Income Security in the United Kingdom*, 62 SOC. SEC. BULL., no.1, at 24, 26, 27, 29 (1999); Donald W. Light, *Universal Health Care: Lessons From the British Experience*, 93 AM. J. PUB. HEALTH, no.1, at 25, 29 (2003) (United Kingdom's universal health care program); United Kingdom, *Retirement Age*, GOV.UK (last updated Nov. 8, 2013), <https://www.gov.uk/retirement-age>; Michael Wiseman & Martynas Yčas, *The Canadian Safety Net for the Elderly*, 68 SOC. SEC. BULL, no. 2, at 55, 56, 64 (2008); DAVID MCCARTHY ET AL., ASSET RICH AND CASH POOR: RETIREMENT PROVISION AND HOUSING POLICY IN SINGAPORE 3, 4, 5, 9, 28 (2001), available at <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN018299.pdf>. It is worth noting that the rates and the base of taxation for social insurance benefits are and have been quite variable among these and other countries. (United States: employee (7.3%), employer (7.3%); Germany: employee (17.3%), employer (17.3%); Canada: employee (6.2%), employer (10.5%)). *International Comparisons of Charitable Giving November 2006*, CAF BRIEFING PAPER (CAF), 9 (2006). <http://www.cafonline.org/>

Singapore. Canada, Germany, and the United Kingdom, like the United States, have an aging workforce and face significant fiscal challenges in paying for the obligations of their health and retirement benefits. At the same time each of the foreign nations is funding supplemental retirement income (in various ways) at higher levels than the United States. They have not experienced such high health care inflation and all cap or ration health coverage in ways that has led to significant use by citizens who are using private alternative systems while employed or after retirement. Germany alone retains a mandatory retirement age of sixty-seven. Germany's primary social security retirement benefits are more variable than the United States, and depending on income and other factors, but all of these nations use general revenues to support the basic social security system at least in part. In sum, these systems will likely produce, if solvent, a higher level of retirement income and lower health care costs for retirees.

The comparative chart shows, however, that there is no quick, unitary or easy solution to the United States' multiple "crises" for it demonstrates the significant parallels in the approaches of the five nations. To the extent that there are parallels, the chart also fails to demonstrate the major challenges that they face in common which is that as life expectancy increases, the likelihood that a national economy will generate enough "surplus" labor income to fund thirty years of retirement (and all health costs for a lifetime) after only forty-plus years of covered employment is low. More workers will need to work beyond age sixty-five to ensure the solvency of these promises. Finally, the increase in longevity when coupled with the fracturing of employment into smaller and less stable components requires a re-conceptualization of how to amass sufficient retirement resources for the population.

TABLE II: Pension, Retirement Age & Health Coverage Comparison

	<u>United States</u>	<u>United Kingdom</u>	<u>Canada</u>	<u>Germany</u>	<u>Singapore</u>
<u>Basic S/S Retirement System</u>	Yes Employer/Employee Contribution	National Insurance Fund (Based on years of contribution) Employer/Employee/ State Funded	Old Age Support (OAS) Employer/Employee/ State Funded, Flat Rate	GRV Employer/Employee/ State Funded	Central Pension Fund (CPF) Multiple Distinct Accounts Employer/Employee Funded
<u>Mandatory Supplemental Retirement System</u>	No	Second State Pension (SSP or S2P) Earnings-related Redistributive Mandatory	CPP/QPP Earnings-related Employer/Employee Contributions	Not Mandatory Supplemental Employer-run, Defined-benefit	Not Mandatory
<u>Voluntary Supplemental Retirement Option (Employer)</u>	Yes Moving to 401(k) Employer/Employee	Yes Tax Incentives	Yes Tax Incentives	Yes Employer-funded More Emphasis on this as GRV weakens	Yes Voluntary SRS Tax Incentives
<u>Mandatory Retirement Age</u>	No	No after 2011	No 65 Can Be NRA under OAS and CPP/QPP	Yes, age 67 (Rest of EU is 65)	No Minimum Age: 62
<u>Health Coverage</u>	Before Age 65: Private Employer Ins. & ACA—2014 Age 65+: Medicare	State Provided	State Mandated	State Insurance Mandate	Yes Under CPF

IV. AN OMNIBUS PROPOSAL

All recent efforts to reform or alter the various retirement and healthcare provisions relating to older Americans have failed. The last

successful set of changes occurred during Ronald Reagan's presidency when in 1983, on a bipartisan basis, Congress and the President agreed to move the OASDI full retirement eligibility age from sixty-five to sixty-six and finally to sixty-seven.⁴² No change was made in the early retirement age (sixty-two) or in the year of Medicare eligibility. During George W. Bush's presidency he proposed making a portion of a person's OASDI contributions be eligible to be invested in actual external (to the Government) investment vehicles.⁴³ Politicians derided and rejected this idea, but a number of our developed peers, including the United Kingdom and Singapore, have adopted a feature like this or are actively considering it.

In the following paragraphs, labeled as in the discussion above, I will make a set of linked proposals that are designed to deal with an aging and expanded workforce, fiscal deterioration of both OASDI and Medicare, the absence of a norm of retirement, changes in the structure of work, and health care developments. The overall theory of the proposals is that individuals and the governments are not able to amass enough resources to pay for elongated retirements and people should work beyond the conventional retirement age of sixty-five to contribute to the labor force and for continuing professional stimulation.

A. OASDI

The year for retirement eligibility with full benefits should be moved gradually to age seventy. Bowles-Simpson also proposed an increase in the regular and early retirement ages for the primary benefit eligibility, but this was couched in terms of making that system, and the entire federal government, more solvent.⁴⁴ This was not an adequate reason for most

⁴² Janice M. Gregory et al., *Strengthening Social Security for the Long Run*, NAT'L ACAD. OF SOC. INS.: SOC. SEC. BRIEF, no. 35, Nov. 2010, at 3,4.

⁴³ Elizabeth D. Tedrow, *Social Security Privatization In Other Countries – What Lessons Can Be Learned For the United States?*, 14 ELDER L.J. 35, 36, 39 (2006); see also Kathryn L. Moore, *Privatization of Social Security: Misguided Reform*, 71 TEMP. L. REV. 131, 148-50 (privatization entails investing funds in non-governmental entities).

⁴⁴ BOWLES-SIMPSON, *supra* note 2, at 50. A commission chaired by then Sen. Kerrey of Nebraska recommended in 1995 delaying further the full retirement eligibility age but not the early retirement age. J. ROBERT KERREY & JOHN C. DANFORTH, *Reform Proposal of Commissioners*, in BIPARTISAN COMMISSION ON

people. Why? A primary cause of the parlousness of the Social Security, Disability and Medicare Trust Funds has been Congress's penchant for liberalizing benefits without paying for them. The payroll taxes and the wage base have increased but in each case not enough to finance the addition of COLAs, larger minimum benefits, and the disability income feature and program. It is true that the aging of the workforce and the drop in the birthrate⁴⁵ have also contributed to this situation, but the trust funds (except the Disability Insurance Trust Fund) would have years of solvency ahead of them without the congressional giveaways.

The only convincing reason to delay for three years (to age seventy) the year for full retirement eligibility is that the population is living longer and is healthier. These changes mean that if the average person goes to work at, say, age twenty and retires at sixty-four, he or she has forty-five years to accumulate resources (in government solution and in various qualified and non-qualified savings vehicles) for a likely retirement period of twenty five years (or more if the couple is married). The elongated period of retirement requires more working and productive years to save adequately and also to contribute to the mandatory government plans (OASDI and Medicare).

Four additional changes should also be considered. *First*, the early retirement age of sixty-two should be raised (probably to age sixty-five) because the pre-retirement age should parallel the full retirement age and also the discounted (from age seventy to age sixty-two) primary retirement benefit would be too small. *Second*, for retirees in the top income⁴⁶ quartiles (say \$250,000 or more) the portion of the primary retirement benefit attributable to employer contributions and the income on them (logically fifty percent) should be means tested. Some resist this on the ground that it is a breach of the OASDI "social contract" but Congress' many liberalizations of that system eliminated any implied promise of noninterference with the equilibrium (which never existed) of sufficiency. If the breach argument was convincing, then the change could be

ENTITLEMENT AND TAX REFORM: FINAL REPORT TO THE PRESIDENT 7, 16 (Dec. 1994).

⁴⁵ Mark Mather, *World Population Data Sheet 2012: Fact Sheet: The Decline in U.S. Fertility*, POPULATION REFERENCE BUREAU (July 2012), <http://www.prb.org/Publications/Datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁴⁶ The figure used for these purposes should not be federal taxable income but a more robust computation of income including exempt municipal bond interest.

prospective in effect, but intellectually it is not convincing because the employer contributions are mandated and could be applied logically to anyone's primary retirement benefit. *Third*, the previously eliminated earnings test set at a high level for workers who work beyond the age of primary retirement benefit eligibility (to be age seventy) and are receiving benefits should be reinstated.⁴⁷ *Fourth*, the cutback of benefits (currently 5/9% for each month before full retirement eligibility that one retires early) applicable to those who commence benefits between ages sixty-five and seventy should be modestly reduced.⁴⁸ Delayed retirement increases the monthly retirement pension, when taken, by eight percent for a year's delay or 2/3% per month of delay (for those with birthdays in or after 1943) up to retirement at age seventy. The eight percent figure should be reduced modestly as part of the system-wide belt-tightening proposed here.⁴⁹ This reflects the fact that the labor market is less stable than before and older workers will likely find it harder to find new employment during this period. Such a modification of the cutback should also take some pressure off of the disability income fund. This reduction in the cutback is obviously something that will "add" cost but the fact that it is part of a further pushing back of the age of full retirement eligibility indicates that it

⁴⁷ This test was eliminated in 2000 for individuals who have attained their normal retirement age. Senior Citizens' Freedom to Work Act of 2000, Pub. L. No. 106-182, 114 Stat. 198 (2000); see Office of the Chief Actuary, Soc. Sec. Admin., *Automatic Determinations: Exempt Amounts, 1975-1999*, SOC. SEC. ADMIN., <http://www.ssa.gov/oact/cola/rteahistory.html> (last modified Oct. 16, 2008).

⁴⁸ The current actuarial reduction (5/9% per month) is said to be actuarially "fair" and my proposal would depart from that standard (at some cost to the trust fund) by reducing it to say 5/12% per month. This is justifiable taking into account the various equities of this delay in benefit commencement and the variability of the health of people over age sixty-five.

⁴⁹ See SOC. SEC. ADMIN., *Retirement Planner: Delayed Retirement Credits* <http://www.ssa.gov/retire2/delayret.htm> (last visited Jan. 25, 2014) ("social security benefits are increased by a certain percentage (depending on date of birth) if you delay your retirement beyond full retirement age"); SOC. SEC. ADMIN., *Summary of P.L. 98-21, (H.R. 1900) Social Security Administration Amendments of 1983 – Signed on April 20, 1983*, LEGISLATIVE HISTORY, IN-DEPTH RESEARCH, <http://www.ssa.gov/history/1983amend.html> (last visited Jan. 25, 2014) (Act increases delayed retirement credit).

is really a softening of that decision.⁵⁰ *Fifth*, there are a plethora of proposals to increase the taxable wage base to include up to ninety percent of all wages and salaries or even investment or capital gains income.⁵¹ The historic reason for limited social security taxation of wages or salaries is that the primary insurance benefit is intended as a jointly funded employee pension. However, since some people, in effect, earn investment income as their self-employment income, it seems appropriate to include an amount of investment income above say \$30,000 and below the current social security wage base as analogous to salary or wage income.

There will be some who will condemn any further delaying of primary retirement eligibility. In an editorial⁵² entitled “What’s Next for Social Security?” published on June 9, 2013 the *New York Times* lambasted the “cuts” already taking place in Social Security. It specifically referred to the delay from age sixty-five to sixty-seven as a “cut”. The *Times* opined that Social Security “benefit cuts...cannot go much further.” Putting aside the *Times*’ current tendency for rhetorical excess, the editorial is an example of how difficult it is to discuss social security when *ad hominen* statements that ignore the many changes that have liberalized benefits decry other changes that slow or defer benefits. The full truth as to whether any “cuts” are taking place would have to take into account that if the social security regime of the fairly recent past was in effect, many of the people (who are now working beyond age sixty-five) would have lost (due to the very low earnings test) their entire benefit without having the option of deferring commencement and increasing it. A further system-wide

⁵⁰ This would also be consistent with the Bowles-Simpson proposal to allow greater benefits to those who are unable to work after age sixty-five but not disabled within the meaning of the law. BOWLES-SIMPSON, *supra* note 2, at 50-51.

⁵¹ In 2005 (due to growth in income equality) only eighty-five percent of wages and salaries, were taxable for FICA purposes. Proposals to tax one hundred percent of wages and salaries would, if implemented, significantly delay the exhaustion of the Social Security trust fund (for up to forty more years if benefits are not similarly increased) but they have not been legislatively feasible due to a disagreement over whether the benefits of the high-income earners should be increased in a parallel fashion. An increase of both taxable wages and benefits would retain the historic character of the system but be less fiscally positive. See JANEMARIE MULVEY, CONG. RESEARCH SERV., RL32896, SOCIAL SECURITY: RAISING OR ELIMINATING THE TAXABLE EARNINGS BASE, at 1-3 (Sept. 24, 2010).

⁵² Editorial, *What’s Next for Social Security?*, N.Y. TIMES, June 9, 2013, available at http://www.nytimes.com/2013/06/10/opinion/whats-next-for-social-security.html?_r=0.

deferral of benefits is obviously a serious move that should not be undertaken lightly, but the increase in longevity coupled with past benefit liberalizations since 1960 justifies a revision of the current rules contrary to the Times editorial.

It is possible that one might see the proposal to establish a mandatory retirement age of seventy as in tension with the overall conclusion that people can, and should, for societal and for individual reasons, work beyond age sixty-five. This perception misses the fact that the change in the social security eligibility age for primary retirement benefits from sixty-five to seventy will constitute a powerful incentive to work until age seventy for most people in the workforce. That incentive is appropriately limited to working until age seventy. After age seventy individual health considerations and society's interest in accommodating young labor force entrants suggests the advisability of a mandatory retirement option for employers. As mentioned above, no employer would be required to adopt such a mandatory retirement rule but many would, particularly if the demographic trend of people seeking to work beyond age sixty-five continues or increases.

Under current labor title pension and federal income tax law, a qualified plan may, in some cases, set a normal retirement date under the age of sixty-five.⁵³ Such a plan provision does not mean that a participant must retire at age sixty-five but it does trigger (usually) possible benefit distribution eligibility, vests any unvested benefits, and a few other things.

It is possible that this private pension age sixty-five option should be rethought in light of the other proposals made here, if adopted. At the same time it is not necessary to change this now and in view of the increase in instability of employment particularly for older workers, it should not be changed simultaneously but it should be looked at again after a period of time has passed for the other changes to settle in.

B. HEALTHCARE SYSTEM

In line with the proposal on moving full primary retirement benefit eligibility to age seventy, it would seem logical to gradually, and over time, move full Medicare eligibility to age seventy also. Those between ages sixty-five and seventy would be covered, if they come into effect fully, by the provisions of ACA including in some cases continuing employer-provided healthcare. This ACA coverage begins to address the large issues

⁵³ See, e.g., 26 U.S.C. § 411(a)(8) (2006).

coming to the fore as a result of the change in the structure of employment and also the difficulties of those losing coverage employed later in life due to industrial dislocations and/or a significant recession. The changes in eligibility will bring extra revenues to the Trust funds but likely increase ACA costs (when they are honestly calculated). It would almost certainly increase the cost of Medicaid. It is not clear, given the prior commitment to ACA, as febrile as it is, that this change will affect healthcare inflation. It might, in fact, increase it a bit by taking five years out of the Medicare (low fee) system and putting it in the higher fee insurance and less high fee (Medicaid) system.

This change in the Medicare eligibility age will help retirees in that it delays for five years entry into the confusing, multiple fee, and compartmentalized Medicare system, a system that provides low payments to providers, few incentives to economize, and absurdly pays the most to the highest cost providers without regard to outcomes. But all of these problems with Medicare would better be handled by moving it either to be a unified state-controlled system *or* to a system in which providers and insurers have to compete to win contracts to provide services to beneficiaries. The beneficiaries currently have no motive to diminish expenses and the government has devised a Rube Goldberg system comprised of components only fit to be understood as a rolling steel ball sculpture in an airport waiting room.

C. PRIVATE PENSIONS

It is not clear that this omnibus proposal will lead to any increase in the costs (or change the viability) of private or other governmental pension or §401(k) plans. At the same time Congress should reconsider the ease of making early withdrawals from all such plans for any but the most worthy purposes.⁵⁴ Why should the assets of a §401(k) account, if rolled over into an IRA, be withdrawable to buy a new or larger home or to send a child to college when, in general, people are not saving adequately for retirement? Other related changes could be made to refocus qualified plan treatment on

⁵⁴ Dan Halperin, among others, has endorsed limitations on the allowable reasons for distributions. *See infra* note 54-58 and accompanying text. *See, e.g.*, Richard L. Kaplan, *Retirement Funding and the Curious Evolution of Individual Retirement Accounts*, 7 ELDER L.J. 283, 283, 293-303 (1999).

retirement needs. Why should Roth IRA's even exist?⁵⁵ Why should roll-over distributions from IRAs to charities permanently escape income tax?⁵⁶

Daniel Halperin has made a series of thoughtful proposals (divided into "ideal" and "possible" categories) to improve the retirement income of lower paid⁵⁷ people participating in qualified plans.⁵⁸ He proposes changes in the coverage and substantiality of benefits of the low paid, including full and immediate eligibility and vesting.⁵⁹ He also suggests that employees should be protected against market declines in their accounts in defined contribution plans.⁶⁰ He admits that all or most of his "ideal" proposals would discourage adoption or even trigger terminations of such qualified plans.⁶¹ In sum, his proposals resemble the MUPs⁶² proposal which never was adopted or even widely supported.

Halperin's proposals are particularly unlikely to be adopted when the social security system itself is underfunded in the longer term. The most sensible set of changes to the qualified plan rules would be those which facilitate less complex alternatives like the SEP-IRA option or a Simplified Retirement Plan ("SIMPLE" Plan) which allows employers to adopt a plan composed of linked IRAs for each employee and then perhaps to add a governmental match contribution for certain low paid workers.⁶³

⁵⁵ See *id.* at 303-04 (a Roth IRA does not require lifetime distributions, which "undercuts the very notion that it is a retirement funding vehicle at all.").

⁵⁶ 26 U.S.C. § 408(d)(8)(E) denies a charitable deduction of any such amount if excluded from the income of the participant. See generally 26 U.S.C. § 408(d)(8) for this extraordinary loophole from the tax base.

⁵⁷ It is important to note that these changes could potentially advantage very wealthy people who have never earned wages or salaries and hence have low or even the minimum social security primary insurance benefit.

⁵⁸ Daniel Halperin, *Employer-Based Retirement Income – The Ideal, the Possible and the Reality*, 11 ELDER L. J. 37 (2003).

⁵⁹ See also Russell K. Osgood, *Qualified Pension and Profit-Sharing Plan Vesting: Revolution Not Reform*, 59 B.U. L. Rev. 452 (1978) (calling for full and immediate vesting for all private pension plan participants).

⁶⁰ Halperin, *supra* note 58, at 45.

⁶¹ *Id.* at 67.

⁶² MUPs ("Minimum Universal [Private] Pension") were proposed by the President Commission on Pension Policy in 1981 as a way to increase for all people retirement income by mandating universal private pension coverage. See WIEDENBECK & OSGOOD, *supra* note 28, at 84.

⁶³ In 1983 Congress added SEPs ("Simplified Employee Pensions" which are company-wide employee linked IRAs) in I.R.C. § 408(k) (2006). SEPs have not been widely adopted perhaps because of Congress' nearly simultaneous creation

This alternative would also create a vehicle (each IRA) that would be fully portable and that would permit contribution during periods of unstable, part-time employment or for several part-time employers, a trend that is occurring.

D. MANDATORY RETIREMENT AGE

To help employers deal with increased costs of some of this proposal, Congress should amend ADEA to permit an employer (including the government) to impose a mandatory retirement age of seventy. Many employers, particularly colleges and universities, struggle with the propensity of some faculty and other highly paid workers to stay on beyond seventy. Many of these people are capable of performing their jobs but some are not, and a majority has experienced some diminution of productivity.

Allowing a mandatory retirement age of seventy helps address the problem of the lack of skilled jobs for new entrants to the labor force. It also would remove, for electing employers, the cost and anguish of dealing with the weakening but not yet fully debilitated employee. Finally, allowing an employer to do this would not coerce them to do it (consistent with pre-ADEA law and practice).

The only significant objection to allowing a mandatory retirement age is that most people already retire at or before age seventy⁶⁴ and it is not clear whether this change will save employers much or do much for labor market flexibility. But, going back to the unreliability of statistical projections, we are only at the beginning of the changes (in employee behavior at age sixty-five) that might come as economic needs grow and the propensity to retire after sixty-five changes dramatically.

and favoring (in many ways) of the even more flexible § 401(k) alternative. I.R.C. § 401(k). Most recently the Simplified Retirement Plan (SIMPLE plan) was added in 1996 and can be in the form of a SEP or a § 401(k) plan. *See* WIEDENBECK & OSGOOD, *supra* note 28, at 382–91.

⁶⁴ It is hard to establish this, but it can be shown by looking at the Bureau of Labor Statistics Data on Labor Force Participation at age 70 and beyond; for instance, labor force participation, while growing for those aged 70 to 74 is about 19%. BUREAU OF LABOR STATISTICS, DEP'T OF LABOR, LABOR FORCE STATISTICS FROM THE CURRENT POPULATION SURVEY (2013), *available at* <http://www.bls.gov/cps/cpsaat03.htm>.

Some will object to the notion that there is no human right to work beyond age seventy but the European Court of Justice has held that the Union's Human Rights Convention and related directives of the European Council validly permit mandatory retirement at age sixty-five and the Germans still permit it, but at age sixty-seven.⁶⁵ Reinstatement of the possibility of a mandatory retirement age would not prohibit anyone from working beyond age seventy but it would permit electing employers to end employment in those enterprises or entities at age seventy. If an employer thinks that is not justifiable then it does not have to elect to impose a mandatory retirement age. It would be important in crafting the repeal of the current ADEA rule to ensure that employers could be given flexibility to phase down on a non-discriminatory basis an employee's employment starting at age seventy (or perhaps a little sooner) as long as employment continues for a reasonably short period of time after age seventy, say, no more than a five-year phase down. This would also fit with the changes occurring in the structure of employment and not require employers to forfeit suddenly all of the accrued experience of employees attaining age seventy.

Finally, this change in mandatory retirement contributes to the creation of a coherent and sensible set of policies for employees, employers, and the government. Age seventy would be the target for retirement for all purposes. One possible addition to this proposal might be to impose an additional employer payroll tax of say one percent on the wages of any employee who works beyond age seventy. This tax would be collected and split between the Medicare and Social Security trust funds. Why impose it on the wages of those who work over age seventy? Because this reinforces the goal of retirement at seventy. Alternatively or perhaps additionally, employers who impose a mandatory retirement age of age seventy could be required to contribute an additional amount to a mandated private pension fund for all of its qualifying employees (a form of MUPs) for the privilege of mandatory retirement.

⁶⁵ See Case C-388/07, *The Queen v. Sec'y of State*, 2009 E.C.R. I-01569, available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62007CJ0388:EN:HTML>; Case C-411/05, *Palacios de la Villa v. Cortifiel Servicios SA*, 2007 E.C.R. I-8531, available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:62005CJ0411:EN:HTML>.

E. LABOR MARKET AND STRUCTURE OF EMPLOYMENT

I have argued that the changes we are seeing in the structure of employment may well accelerate and certainly will continue. This should be watched closely for it would seem that the employment tax model, relying on taxes on wages and salaries for both Medicare and OASDI, may need to be reconsidered in light of these changes. Wages and salaries, the current wage base, presuppose conventional, industrial model employment, not piece work or independent employment based in the home. They were conceived in a world in which an employee had only one employer. The entire structure of the employment tax trust funds are derivative of the federal Fair Labor Standards Act (“FLSA”) which again is premised on an employee having only one employer. In a world in which people might work for a number of employers on a part-time basis, the FLSA rules about over-time, supervision, etc., are outmoded and may, in fact, encourage unrelated employers to use even more part-time workers.⁶⁶

There has been a fair amount of anguish, by commentators⁶⁷ and the Labor Department⁶⁸, about the move to episodic, multiple part-time employment. It certainly has a negative financial impact for many workers, but the old norm of sustained very long-term employment by a single large employer did not frequently produce long-term satisfaction on the part of workers. Very long-term employment can produce stagnation on the part

⁶⁶ In recent years the Labor Department has fought valiantly to police the line between true “independent” contractors and part-time employees called independent contractors. See Susan N. Houseman, *A Report on Temporary Help, On-Call, Direct-Hire, Temporary, Leased, Contract Company, and Independent Contractor Employment in the United States*, U.S. DEP’T OF LABOR (Aug. 1999), http://www.dol.gov/oasam/programs/history/herman/reports/futurework/conference/staffing/exec_s.htm.

⁶⁷ See generally Julia J. Bartkowiak, *Trends Toward Part-Time Employment: Ethical Issues*, 12 J. BUS. ETHICS 811 (1993). ACA creates another Incentive to limit workers to “part-time” status (30 hours of work a week or less). This was one of the reasons that the Obama Administration recently deferred the implementation of the employer mandate for a full year. Avik Roy, *White House to Delay Obamacare’s Employer Mandate until 2015; Far-Reaching Implications for the Private Health Insurance Market*, FORBES (July 2, 2013, 6:21 PM), <http://www.forbes.com/sites/theapothecary/2013/07/02/white-house-to-delay-obamacare’s-employer-mandate-until-2015-far-reaching-implications-for-the-private-health-insurance-market/>.

⁶⁸ See *supra* note 62 and accompanying text.

of the employer and its cadre of employees. Of course, this was not always the case but economic changes beginning in the 1980s are not reversible and those changes require enterprises to be more nimble in hiring employees (and in making major capital investments) and require employees to be more aggressive in seeking out multiple, sometimes simultaneous work opportunities.

V. SUMMATION AND FEASIBILITY

I have argued in this Essay that the problems with our retirement and health policies for the aging are so deep and the politics so heavy, that the only solution that might succeed is an omnibus solution devised in light of the long-term trends in employment, longevity, and the nature of employment or work. The proposals that I have made require contributions by employees in the form of more work and possibly diminished benefits *and* by employers of potentially additional years of healthcare premiums and retirement plan contributions all aimed at creating a retirement norm of age seventy. This is a reasonable proposal and one that will help both the OASDI and the Medicare trust funds.

A great uncertainty in the foregoing is the future of ACA. It certainly rests on a foundation of sand that the ocean of events is eroding. On the other hand, the changes in the structure of employment suggest that healthcare coverage needs to be decoupled from the model of the large employer providing employees (and their families) healthcare coverage. ACA is a move in that direction, but it may not survive after coming out of the regulatory incubator it was placed in when it was crafted legislatively. If it does not survive, however, the combination of the social sense of healthcare entitlement along with the changes in the structure of employment will dictate some way to provide additional, affordable health care coverage that eliminates exclusions based on age, pre-existing conditions, or employment status.

In sum, I propose that in light of major demographic changes, including increased labor force participation, increased longevity, and the absence of adequate retirement saving, we should gradually move primary social security retirement to age seventy, increase the age of Medicare entry also to age seventy, permit optional (with the employer) mandatory retirement at age seventy, and make a number of smaller changes designed to soften the effects of these changes. Workers now seem to wish (or feel the need) to work beyond age sixty-five and this additional period of work will improve the financial viability of the two trust funds. In the longer run additional retirement savings are needed either in the form of additional

non-social security employer retirement plan contributions *or* amounts in other tax-favored retirement vehicles external to the employment relationship. Finally, these changes do not address in a systematic way the developments in the structure and nature of employment. Perhaps the current range of tax favored structures, modified by moving to more portable and employee focused retirement savings accounts rather than qualified plans, can accommodate this change but that is not at all sure.

CALIFORNIA DREAMING: THE CALIFORNIA SECURE CHOICE RETIREMENT SAVINGS TRUST ACT

EDWARD A. ZELINSKY*

Half of American workers are not covered by employer-sponsored retirement arrangements. The recently passed California Secure Choice Retirement Savings Trust Act seeks to solve this problem by mandating retirement savings arrangements for California employers, coupled with a public investment vehicle for investing these private retirement savings. The Act is important because of California's size and status as a trendsetter for other states.

This Article is the first to examine the important legal questions the Act raises under the Internal Revenue Code and ERISA. Contrary to the drafters' intent, the savings accounts authorized under the Act do not qualify as individual retirement accounts under the Code. Hence, employees participating in savings arrangements established under the Act will not receive the income tax benefits associated with individual retirement accounts.

If the Act were to be amended to make its accounts individual retirement accounts, the Act would survive ERISA preemption under New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995), though not under Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). Since Travelers is the Court's more recent and more compelling construction of ERISA preemption, the Act should survive ERISA preemption if the Act is amended to have true individual retirement accounts.

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A final section of this article addresses the choices other state legislatures, as well as Congress, confront if they elect to follow part or all of the path on which California has embarked to encourage private retirement savings. President Obama has recently proposed a federal mandate under which employers with more than ten employees would be required to maintain either retirement plans or IRA coverage. The President's proposal ensures public debate about the appropriate function of government in encouraging retirement savings. The Golden State's Act will play an important role in that debate. In that debate, I favor state-by-state experimentation rather than any single approach to the task of encouraging greater retirement savings.

I. INTRODUCTION

By signing the California Secure Choice Retirement Savings Trust Act (“the Act”), Governor Edmund (“Jerry”) Brown, Jr. took an important step toward establishing a retirement savings mandate for Golden State employers, coupled with a public investment vehicle for private retirement savings.¹ By simultaneously signing S.B. 923,² Governor Brown guaranteed further debate about the Act and its provisions since S.B. 923 requires an additional vote of the California legislature before the Act can be implemented.³ The Act represents the first tentative success of nationwide efforts to create state-sponsored private retirement programs.⁴

¹ S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012); see Laura Mahoney, *California Governor Signs Bills to Create Pension Mandate for Private Employers*, DAILY TAX REP. (BNA) No. 190, at H-2 (Oct. 2, 2012).

² S.B. 923, 2012 Leg., Reg. Sess. (Cal. 2012); Mahoney, *supra* note 1.

³ See S.B. 9232012 Leg., Reg. Sess. § 2 (Cal. 2012) (adding § 100043.5 to the CAL. GOV'T CODE (2013)).

⁴ See Florence Olsen, *California Leads, No State Has Green Light For State-Based Private Retirement Accounts*, PENSION & BENEFITS DAILY (BNA) (Aug. 7, 2013). For examples of other states' efforts, see Brent Hunsberger, *Oregon House Passes Bill to Examine Statewide Retirement Savings Plan*, OREGON LIVE (June 24, 2013), http://www.oregonlive.com/finance/index.ssf/2013/06/oregon_house_passes_bill_to_ex.html; National Conference of State Legislatures, *State Sponsored Retirement Savings Plans for Non-Public Employees*, <http://www.ncsl.org/issues-research/labor/state-sponsored-retirement-plans-for-nonpublic.aspx> (last visited Jan. 24, 2014).

The Act is important, not only because of California's size and status as a trendsetter, but because the task the Act addresses is pressing: increasing the retirement savings of the half of American workers not currently covered by employer-sponsored retirement arrangements.⁵

I write to explore the legal status of the Act, in particular the Act's standing under the Employee Retirement Income Security Act of 1974 (ERISA)⁶ and the Internal Revenue Code (Code).⁷ The Act raises three important questions under ERISA and the Code: Are the accounts established by the Act individual retirement accounts for purposes of the Code? Does ERISA preempt the employer mandate established by the Act? Does ERISA preempt the Act's provisions authorizing supplemental employer contributions to employees' accounts established under the Act? The drafters of the Act were acutely sensitive to all three of these questions.⁸

The accounts created by the Act do not qualify as individual retirement accounts under the Code. The hallmark of an individual

⁵ DEP'T OF THE TREASURY, GENERAL EXPLANATIONS OF THE ADMINISTRATION'S FISCAL YEAR 2014 REVENUE PROPOSALS 124 (Apr. 2013) ("Tens of millions of U.S. households have not placed themselves on a path to become financially prepared for retirement. In addition, the proportion of U.S. workers participating in employer-sponsored plans has remained stagnant for decades at no more than about half the total work force . . .").

⁶ ERISA was originally adopted as the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) and has repeatedly been amended. Many provisions of ERISA were adopted twice, once as tax law additions to the Internal Revenue Code and once as additions to Title 29 of the United States Code, enforced by the Department of Labor. It is today customary to refer to the labor provisions codified in Title 29 as "ERISA" and to refer to the tax provisions of ERISA by their respective designations in the Internal Revenue Code. This article follows this convention. On the dual tax/labor structure of ERISA, see JOHN H. LANGBEIN ET AL., PENSION AND EMPLOYEE BENEFIT LAW 97 (5th ed. 2010).

⁷ 26 U.S.C. § 1 (2006).

⁸ See S.B. 1234, 2012 Leg., Reg. Sess. § 3 (Cal. 2012) (adding § 100043 to the CAL. GOV'T CODE (2012) (program not to be implemented "if it is determined that the program is an employee benefit plan under" ERISA or if the employees' accounts under the program "fail to qualify" as IRAs) and §§ 100004(e) and 100012(k) (supplementary employer contributions to be permitted only if such contributions "would not cause the program to be treated as an employee benefit plan under" ERISA)).

account for retirement planning purposes is the direct and unmediated assignment to the account holder of the rewards of good investment performance and the costs of investment loss. In contrast, the accounts created under the Act are notional in nature, formula-based cash balance-style defined benefit claims against a collective trust fund. These notional accounts are credited with an assumed rate of return determined before the beginning of the year, regardless of the Trust's actual investment experience during the year. The Trust established by the California Act (not the individual employee/account holder) bears investment risk and is liable for underfunding. The formula-based, cash balance-style accounts created by the Act do not qualify under the Code as individual retirement accounts as these accounts will not be decreased to reflect investment losses and will not directly benefit from current investment gains.

Suppose, however, that the Act is amended to make its accounts individual retirement accounts for purposes of Code § 408 by shifting investment reward and downside to the account holder. In this case, the ERISA preemption status of the Act's employer mandate reflects the Court's contradictory guidance on ERISA preemption: ERISA § 514(a)⁹ preempts the Act's employer mandate under *Shaw v. Delta Air Lines, Inc.*¹⁰ but not under the Court's later decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹¹ Since *Travelers* is the Court's more recent and more persuasive approach to ERISA preemption, *Travelers* should control. Thus, assuming amendment of the Act to convert the Act's accounts into individual retirement accounts, the Act's employer mandate should not be ERISA-preempted.

My conclusion is similar as to the third legal issue raised by the Act, whether ERISA preempts the provisions of the Act which authorize supplementary employer contributions to employees' accounts established under the Act: this provision of the Act is ERISA-preempted under *Shaw* but survives § 514(a) scrutiny under *Travelers*' more recent, more flexible, and more compelling approach to ERISA preemption.

In light of the foregoing, if *Travelers* controls (as it should), the Act could, as a legal matter, be salvaged by recasting the Act's accounts as individual retirement accounts under which the employee/individual account holders bear investment risk and thus benefit directly from

⁹ 29 U.S.C. § 1144(a) (2006).

¹⁰ See 463 U.S. 85, 91 (1983).

¹¹ See 514 U.S. 645, 701 (1995).

investment gains and incur the costs of investment losses. However, as the Act is currently structured, the Act fails muster under the Code because the notional accounts created by the Act do not qualify as individual retirement accounts.

There is, thus, a road map for amending the Act to make it Code and ERISA-compliant under *Travelers*: reformulate the accounts established under the Act as individual retirement accounts with investment reward and investment loss assigned to the account holder, rather than the current notional, formula-based design of the Act's accounts. However, under *Shaw*, there is no equivalent road map. Since *Travelers* is the Supreme Court's more recent and more convincing approach to ERISA preemption, the Act should be salvageable by converting its accounts to individual retirement accounts that allocate investment gain and loss to the account holders.

This Article first outlines the Act and then identifies five noteworthy features of the Act including the Act's linkage of its employer mandate for retirement savings with a public investment vehicle for those savings as well as the Act's characterization of the interests it creates as "accounts" rather than as annuities. Part IV then discusses ERISA preemption, focusing upon the tension between *Shaw* and *Travelers*, and next introduces payroll deduction IRA arrangements. In Part VI, this article explains its conclusions as to the three major issues raised by the Act under ERISA and the Code: the notional cash balance-style accounts created by the Act do not qualify as individual retirement accounts since the accounts established by the Act create a defined benefit-type, formula-based claim against a collectively-managed fund. Individual retirement accounts instead allocate investment gain and loss directly to the individual account holder. If the Act were amended to recast its accounts as individual retirement accounts, the Act's employer withholding mandate and the Act's authorization of voluntary employer contributions should survive ERISA preemption under *Travelers*.

Legality, of course, is not the same as wisdom. Thus, the final section addresses the choices other state legislatures, as well as Congress, confront if they elect to follow part or the entire path on which California has embarked to encourage private retirement savings. Among these choices are an employer mandate without a state-sponsored savings vehicle like the California Trust, the augmentation of the federal tax credits for retirement plans and retirement savings with supplementary state tax credits, and the promotion of retirement savings through public education. Other legislatures may reasonably conclude that there is no role for the

states to play in light of both the robust market for retirement savings products and the federal government's support for such savings.

President Obama has recently proposed a federal mandate under which employers with more than ten employees would be required to maintain either retirement plans or IRA coverage.¹² However, the Obama proposal would not create the kind of public investment vehicle established under the California Act. The President's proposal ensures public debate about the appropriate function of government in encouraging retirement savings. The Golden State's Act will play an important role in that debate. In that debate, I favor state-by-state experimentation rather than any single approach to the task of encouraging greater retirement savings.

II. THE ACT, THE TRUST AND THE PROGRAM DESCRIBED

The Act¹³ creates a nine-member board¹⁴ ("the board") to administer the California Secure Choice Retirement Savings Trust¹⁵ ("the Trust"). The Trust will "offer . . . a retirement savings program" to be known as the California Secure Choice Retirement Savings Program¹⁶ ("the program"). Integral to the program is an employer mandate, requiring California employers to maintain for their employees a "payroll deposit retirement savings arrangement."¹⁷ Under these mandated arrangements, employees in the Golden State otherwise without employment-based retirement savings options will be able to contribute to

¹² See DEP'T OF THE TREASURY, *supra* note 5, at 125.

¹³ S.B. 1234 (Cal. 2012).

¹⁴ *Id.* at § 3 (adding § 100002 to the CAL. GOV'T CODE (2012)). In its original incarnation, the Act established a seven member board consisting of the Treasurer of California, California's Director of Finance "or his or her designee," the Controller of California, "[a]n individual with retirement savings and investment expertise appointed by the Senate Committee on Rules," two gubernatorial appointees (one "[a] small business representative," the other "[a] public member") and "[a]n employee representative appointed by the Speaker of the Assembly." *Id.* Senate Bill 923 then amended the Act to add two additional members to the board appointed by the Governor with no restrictions. See S.B. 923, 2012 Leg., Reg. Sess. § 1 (Cal. 2012) (adding § 100002(a)(1)(H) to the CAL. GOV'T CODE (2013)).

¹⁵ S.B. 1234 § 3 (Cal. 2012) (adding § 100004(a) to the CAL. GOV'T CODE (2013)).

¹⁶ *Id.* (adding § 100000(b) to the CAL. GOV'T CODE (2012)).

¹⁷ *Id.* (adding §§ 100000(g) and 100032(d) to the CAL. GOV'T CODE (2012)).

accounts managed by the Trust through employer withholding from employees' paychecks.¹⁸

Within nine months "after the board opens the program for enrollment,"¹⁹ private and nonprofit employers²⁰ in the Golden State must have such a payroll "arrangement to allow employee participation in the program"²¹ through payroll deductions unless one of several statutory exemptions applies. Under one of these exemptions, an employer need not maintain a state-sponsored payroll deduction arrangement if the employer has fewer than five employees.²² Moreover, employees cannot participate in the California program if they are covered by the Railway Labor Act²³ or by a multiemployer pension plan.²⁴ In addition, a California employer need not enroll employees in the state-run program established by the Act if the employer sponsors its own retirement program for its employees²⁵ or if the employer has in place an IRA payroll deduction plan for its employees.²⁶

Thus, when it takes effect, the Act will promulgate an employer retirement savings mandate for California employers. Under the Act's mandate, Golden State employers with five or more employees will be required to have one of three forms of retirement savings arrangements for their employees, i.e., an employer-sponsored plan (including a multiemployer or railroad pension), a payroll IRA deduction plan or, as the default option, a state-sponsored "payroll deposit retirement savings arrangement"²⁷ under the California program established by the Act.²⁸

¹⁸ *Id.* (adding § 100012(j) to the CAL. GOV'T CODE (2012)).

¹⁹ *Id.* (adding § 100032(d) to the CAL. GOV'T CODE (2012)). During this nine-month period, larger employers must offer payroll deposit retirement savings arrangements. *Id.* (adding §§ 100032(b) and 100032(c) to the CAL. GOV'T CODE (2012)).

²⁰ *Id.* (adding § 100000(d) to the CAL. GOV'T CODE (2012)). Public employers are specifically exempted from the requirements of the Act. *Id.*

²¹ *Id.* (adding § 100032(d) to the CAL. GOV'T CODE (2012)).

²² *See id.* (adding § 100000(d) to the CL. GOV'T CODE (2012)).

²³ *Id.* (adding § 100000(c)(2)(A-B) to the CAL. GOV'T CODE (2012)).

²⁴ *Id.* (adding § 100000(c)(2)(B) to the CAL. GOV'T CODE (2012)).

²⁵ *Id.* (adding §§ 100032(d) and 100032(f) to the CAL. GOV'T CODE (2012)).

²⁶ *Id.*

²⁷ *Id.* (adding § 100000(f) to the CAL. GOV'T CODE (2012)).

²⁸ Employers employing four or fewer employees can participate in the program, though they are not required to do so. *Id.* (adding § 100032(a) to the CAL. GOV'T CODE (2012) ("[A]ny employer may choose to have a payroll deposit

When a California employer maintains a payroll savings deposit arrangement pursuant to the state-sponsored program, any of the employer's employees will be able to affirmatively elect against participation in such arrangement.²⁹ Absent such an election of nonparticipation, each California employee covered by the state-run program will "contribute 3 percent of the employee's annual salary or wages to the program"³⁰ through employer withholding. However, the Act provides that an employee may specify a contribution rate other than 3%.³¹ The Act also provides that the board "may adjust the contribution" rate under the program to as little as 2% of an employee's compensation and as much as 4% of an employee's compensation,³² and may "vary" the program's contribution rate between 2% and 4% "according to the length of time the employee has contributed to the program."³³

Employee contributions pursuant to the program will be withheld by employers and remitted to the Trust.³⁴ The Act also permits employers to make supplementary contributions from their own funds to employees' accounts under the program as long as such employer contributions "would not cause the program to be treated as an employee benefit plan under" ERISA.³⁵

The Trust will provide a public vehicle for the investment of employees' retirement savings. The Trust and the program, governed by a public board,³⁶ will collect and provide for the investment of those

retirement savings arrangement to allow employee participation in the program.")).

²⁹ *Id.* (adding §§ 100032(e)(1) and 100032(g) to the CAL. GOV'T CODE (2012)).

³⁰ *Id.* (adding § 100032(h) to the CAL. GOV'T CODE (2012)).

³¹ *Id.*

³² *Id.* (adding § 100032(i) to the CAL. GOV'T CODE (2012)).

³³ *Id.*

³⁴ *Id.* (adding §§ 100000(g) and 100012(j) to the CAL. GOV'T CODE (2012)).

³⁵ *Id.* (adding §§ 100004(e) and 100012(k) to the CAL. GOV'T CODE (2012)).

Employer contributions cause the California program to become an employee benefit plan for ERISA purposes since such employer contributions transform a payroll deposit IRA arrangement limited to employees' contributions into an employee benefit plan with employer contributions. However, such employer contributions do not trigger preemption under ERISA § 514(a) as explicated by *Travelers*. See *infra* notes 104-24 and accompanying text

³⁶ *Id.* (adding § 100002 to the CAL. GOV'T CODE (2012), as subsequently amended by S.B. 923, 2012 Leg., Reg. Sess. § 1 (Cal. 2012)).

savings.³⁷ The monies held in the Trust may, at the board's election, be invested by the treasurer of California.³⁸ Alternatively, the board can arrange for the Trust's funds to be invested by the board of the California state pension plan³⁹ (commonly known as CalPERS)⁴⁰ or by "private money managers,"⁴¹ or by some combination of CalPERS and private managers.⁴² Among the board's other powers in its "capacity of trustee"⁴³ of the Trust, the board can "[p]rocur[e] insurance against any loss in connection with the property, assets, or activities of the trust, and secure private underwriting and reinsurance to manage risk and insure the retirement savings rate of return."⁴⁴

If the board does not purchase such insurance to protect against losses, the board must instead provide an "annuity, or other funding mechanism . . . at all times that protects the value of individuals' accounts."⁴⁵

Withholding by participating employers under the program is intended to qualify as "payroll deposit IRA arrangements."⁴⁶ Each employee contributing to the Trust through employer withholding will have a notional account in the Trust.⁴⁷ These notional accounts are intended to qualify as individual retirement accounts under Code § 408.⁴⁸ The Act specifically prohibits the board from implementing "the program if the IRA arrangements" offered under the program "fail to qualify for the favorable federal income tax treatment ordinarily accorded to IRAs under the Internal Revenue Code"⁴⁹ This favorable treatment includes the

³⁷ According to the Act, the Trust is intended to be financially self-sustaining, paying its administrative costs from the assets contributed to the Trust. *See id.* (adding §§ 100004(c) and 100042 to the CAL. GOV'T CODE (2012)).

³⁸ *Id.* (adding § 100004(c) to the CAL. GOV'T CODE (2012)).

³⁹ *Id.*

⁴⁰ *See* CALPERS, www.calpers.ca.gov (last visited Jan. 25, 2014).

⁴¹ S.B. 1234 § 3 (Cal. 2012) (adding § 100004(c) to the CAL. GOV'T CODE (2012)).

⁴² *Id.*

⁴³ *Id.* (adding § 100010(a) introductory language to the CAL. GOV'T CODE (2012)).

⁴⁴ *Id.*

⁴⁵ *Id.* (adding § 1000013 to the CAL. GOV'T CODE (2012)).

⁴⁶ *Id.* (adding § 100008(a) to the CAL. GOV'T CODE (2012)).

⁴⁷ *Id.* (adding § 100008(b) to the CAL. GOV'T CODE (2012)).

⁴⁸ *Id.* (adding § 100043 to the CAL. GOV'T CODE (2012)).

⁴⁹ *Id.* An interesting issue that need not be addressed today is whether the Trust

tax-free growth of investments held within individual retirement accounts,⁵⁰ the deductibility of contributions to traditional individual retirement accounts,⁵¹ and the exclusion from income taxation of qualified distributions from Roth individual retirement accounts.⁵²

Each employee's account under the program is notional in nature.⁵³ Each such account will be credited with the employee's contributions⁵⁴ through the employer's payroll withholding as well as with the "[S]tated interest rate"⁵⁵ selected annually and prospectively by the board and with the Trust's "excess earnings"⁵⁶ which the board may, but not need, allocate to employees' accounts. During each year, the board is "to declare the stated rate at which interest shall be allocated to program accounts for the following program year."⁵⁷

There is no provision in the Act for allocating investment losses to employees' accounts or otherwise adjusting such accounts downward to reflect such losses. The employee's "retirement savings benefit under the program"⁵⁸ will be a claim against the Trust in "an amount equal to the balance in the [employee's] program account."⁵⁹

As I discuss *infra*,⁶⁰ since the Trust's investment gains will not directly pass through to the notional accounts created under the Act, those accounts will not qualify as individual retirement accounts under the Code. The Trust, when it sets "the stated interest rate," can pass through some, all, or none of the Trust's prior investment earnings. Similarly, the board can retroactively credit accounts with some, all or none of the Trust's "excess" earnings above the stated rate of return. The board has no

would be tax exempt under I.R.C. § 115 (2006) as a governmental agency if the accounts established by the Act do not qualify as IRAs. Since the Act will not go into effect unless the accounts created by the Act are IRAs, this issue need not be confronted, at least for now.

⁵⁰ I.R.C. § 408(e)(1) (2011).

⁵¹ I.R.C. § 219 (2011).

⁵² I.R.C. § 408A(d)(1) (2011).

⁵³ S.B. 1234 § 3 (Cal. 2012) (adding § 100008(c) to the CAL. GOV'T CODE (2012)).

⁵⁴ *Id.* (adding § 100008(a) to the CAL. GOV'T CODE (2012)).

⁵⁵ *Id.* (adding §§ 100000(h) and 100008(b) to the CAL. GOV'T CODE (2012)).

⁵⁶ *Id.* (adding § 100006(a-c) to the CAL. GOV'T CODE (2012)).

⁵⁷ *Id.* (adding § 100008(b) to the CAL. GOV'T CODE (2012)).

⁵⁸ *Id.* (adding § 100008(c) to the CAL. GOV'T CODE (2012)).

⁵⁹ *Id.*

⁶⁰ See *infra* notes 134-35.

authority to reduce account balances to reflect the Trust's investment losses. These features of the accounts created under the Act preclude those accounts from constituting individual retirement accounts under the Code since the Trust's investment gains and losses do not pass directly to accounts, but are instead mediated through the decisions of the board and through the formulas the board determines.

The Act provides that the State of California has no "liability in connection with funding retirement benefits pursuant to" the program.⁶¹

The board is not to implement the program if employees' accounts under the program "fail to qualify" as IRAs under the Internal Revenue Code⁶² or "if it is determined that the program is an employee benefit plan under" ERISA.⁶³ Moreover, under S.B. 923, the provisions of the Act will go into effect only if another vote of the California legislature approves the program and the Trust.⁶⁴

III. FIVE NOTEWORTHY FEATURES OF THE ACT, THE TRUST AND THE PROGRAM

Five features of the Act, the Trust and the program are noteworthy. First, the Act links its employer mandate to withhold and remit employees' retirement contributions to the state-created (but not state-guaranteed) Trust holding and investing such contributions. However, an employer mandate need not be adopted together with a public investment vehicle like the Trust.

A state legislature determined to mandate employee retirement saving could instead require all employers to maintain a qualified plan or an IRA payroll deduction arrangement without establishing the kind of

⁶¹ S.B. 1234 § 3 (Cal. 2012) (adding §§ 100013, 100014(c)(3), and 100036 to the CAL. GOV'T CODE (2012)).

⁶² *Id.* (adding §§ 100043 and 100010(a)(11) to the CAL. GOV'T CODE (2012), authorizing the board "in the capacity of trustee" to "[s]et minimum and maximum investment levels in accordance with contribution limits set for IRAs by the Internal Revenue Code."). Presumably, the individual employee will be given the choice between conventional IRA tax treatment under I.R.C. § 408 or Roth IRA treatment under I.R.C. § 408A – if the Act's accounts are modified to qualify as individual retirement accounts.

⁶³ *Id.*

⁶⁴ S.B. 923, 2012 Leg. Reg. Sess. at § 2 (Cal. 2012) (adding § 100043.5 to the CAL. GOV'T CODE (2012)).

state-sponsored accounts to be managed by the California Trust. This is the approach embodied in President Obama's proposal to establish a national employer mandate requiring retirement savings opportunities in the workplace without establishing any public investment vehicle for such savings.⁶⁵

One could also envision a legislature creating a voluntary state-sponsored investment trust for retirement savings (like current section 529 college savings programs)⁶⁶ without the legislature simultaneously enacting an employer mandate requiring workplace savings arrangements. However, the California Act links its employer mandate to a public investment vehicle by sending to the Trust all employee contributions withheld by employers pursuant to the program established under the Act.

A second notable feature of the California Act is the Act's attempt to qualify employees' accounts under the Act as individual retirement accounts. Individual retirement accounts are today ubiquitous instruments for holding employees' retirement wealth.⁶⁷ However, as I discuss *infra*,⁶⁸ employees' accounts under the California program are not individual retirement accounts, defined contribution devices under which account owners benefit directly from the gains earned by those assets while bearing the losses incurred by those assets. Instead, the employees' interests in their notional accounts in the California Trust resemble participants' entitlements under cash balance pension plans. Cash balance plans are defined benefit arrangements. An employee covered by a cash balance pension has a notional account to which is credited contributions and an assumed rate of interest.⁶⁹

On retirement, the cash balance participant is entitled to receive the balance in his notional account, rather than an amount which reflects

⁶⁵ See *supra* note 5.

⁶⁶ See EDWARD A. ZELINSKY, THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA 64-70 (2007) (discussing Section 529 plans).

⁶⁷ See *id.* at 39-42 (discussing IRAs).

⁶⁸ See *infra* notes 134-35.

⁶⁹ See generally Edward A. Zelinsky, *Cooper v. IBM Personal Pension Plan: A Critique*, in NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION 1-1—1-19 (Alvin D. Lurie ed., 2007); Alvin D. Lurie, *Murphy's Law Strikes Again: Twilight For Cash Balance Design?*, 101 TAX NOTES 393 (Oct. 20, 2003); Edward A. Zelinsky, *The Cash Balance Controversy*, 19 VA. TAX REV. 683 (2000).

the value of the underlying assets held by the plan. If the employees' cash balance accounts aggregate to more than the assets in the plan, the sponsoring employer is obligated to fund this difference. Conversely, if the assets held by a cash balance pension exceed the total of the employees' notional accounts, those extra assets may revert to the employer.⁷⁰ Thus, as a defined benefit plan, a cash balance pension assigns the benefits and downsides of investment performance to the sponsoring employer.

The accounts created by the Act resemble this kind of cash balance arrangement rather than an individual retirement account under which investment risk is, for better or worse, assigned to the account holder. The Act does not authorize the allocation of investment losses to the accounts authorized by the Act. Under the Act, there is no direct connection between the Trust's investment gains and the balances of such accounts. Rather, the Trust's investment gains will be mediated through the board's selection of a stated rate of return for employees' accounts and by the board's decisions to allocate (or not) some or all of the Trust's "excess" investment gains above the stated rate of return. That stated return, to be picked before the year begins, may prove higher, the same or lower than the Trust's actual investment performance. As I discuss *infra*,⁷¹ because the cash balance-style accounts established under the Act do not assign investment risk to the employee/account holders, such accounts do not qualify as individual retirement accounts under the Code.

Third, the Act repeatedly and specifically characterizes participants' interests under the programs as "accounts" rather than as annuities.⁷² The Act does not subject the Trust to California's regulation of insurance companies⁷³ or purport to characterize the Trust as an insurance company. Thus, as I discuss further *infra*,⁷⁴ the notional accounts established by the Act not only fail to qualify as individual retirement accounts under the Code, but they also are not individual retirement annuities for purposes of Code § 408(b).⁷⁵

A fourth notable feature of the Golden State's program is its

⁷⁰ Such a reversion is subject to an excise tax. 26 I.R.C. § 4980(a) (2010).

⁷¹ See *supra* text accompanying notes 68-69.

⁷² See generally S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (adding § 100008(b) to the CAL. GOV'T CODE).

⁷³ See generally CAL. INS. CODE.

⁷⁴ See discussion *infra* 166-176 and accompanying text.

⁷⁵ See 26 U.S.C. § 408(b) (2006).

automatic enrollment of eligible employees, subject to each employee's ability to opt out of the program if the employee so chooses. The program's automatic enrollment feature reflects the influential observations of behavioral economists that individuals are often subject to inertia and procrastination in making important decisions like the decision to save for retirement.⁷⁶ From the premise of inertia and procrastination, many commentators conclude that higher participation rates can be achieved in 401(k) and similar retirement savings arrangements if employees are presumptively included in such arrangements and required to elect out, rather than being obligated to affirmatively elect coverage under such arrangements.⁷⁷ Just as procrastination and inertia discourage employees from electing to save for retirement, procrastination and inertia discourage employees from electing against such saving when saving is presumptive and must be affirmatively rejected.

This insight of behavioral economics led Congress to amend Code § 401(k) to authorize sponsoring employers to adopt automatic enrollment provisions.⁷⁸ Under these provisions, employees contribute from their salaries to their retirement accounts unless such employees choose not to contribute. Initial "[s]tudies have shown that automatically enrolling people into 401(k) plans can achieve higher levels of participation."⁷⁹ In this spirit, the Patient Protection and Affordable Care Act mandates that large employers must automatically enroll their covered employees into employer-sponsored health plans, subject to the employees' ability to opt out.⁸⁰ The California Act and the program the Act creates embrace this

⁷⁶ Hanming Fang and Dan Silverman, *Distinguishing Between Cognitive Biases*, in BEHAVIORAL PUBLIC FINANCE 51, 55-56 (Edward J. McCaffery and Joel Slemrod eds., 2006).

⁷⁷ *See id.*; WILLIAM J. CONGDON ET AL., POLICY AND CHOICE 77-79 (2011); James J. Choi et al., *Saving for Retirement on the Path of Least Resistance*, in BEHAVIORAL PUBLIC FINANCE, *supra* note 76, at 304; Annie Lowrey, *Tax Breaks and Savings Play Role in Budget Talks*, N.Y. TIMES, Nov. 26, 2012, at A19 ("policies that automatically saved a portion of a worker's income increased total savings by a substantial amount.").

⁷⁸ 26 I.R.C. § 401(k)(13) (2006). *See also* Fran Hawthorne, *Heading for Retirement on Autopilot*, N.Y. TIMES, Feb. 11, 2013.

⁷⁹ Jonathan Barry Forman & Gordon D. Mackenzie, *Optimal Rules for Defined Contribution Plans: What Can We Learn from the U.S. and Australian Pension Systems* 36 (Austl. Sch. of Bus., Working Paper No. 2013), available at <http://ssrn.com/abstract=1954879>.

⁸⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1511,

increasingly fashionable pattern of automatic enrollment under which eligible employees presumptively contribute to their respective program accounts unless they affirmatively reject such contributions.⁸¹

A fifth notable feature of the Act is the acknowledgment of the problem of implicit government guarantees and the Act's explicit repudiation of any such guarantees. Recent discussion about implicit government guarantees has occurred in the context of banks and other financial institutions deemed "too big to fail," as well as government-sponsored entities such as Fannie Mae and Freddie Mac.⁸² Important commentators suggest that these large institutions and entities benefit from an unstated but widely-accepted understanding that the federal government could not permit any of these institutions or entities to become insolvent.⁸³ From this vantage, there is an implicit guarantee that the federal government will again bail out many of these institutions and entities, as the federal government did during the Great Recession.

The Act explicitly and repeatedly warns that the State of California is not liable to the employees who participate in the program.⁸⁴ According to the Act, participating employees must be paid from the assets of the Trust including any private insurance coverage the Trust may purchase to guarantee the program's promises to such employees.⁸⁵ While the Act reiterates that the treasury of the Golden State does not stand behind the Trust or the program, some critics suggest that, despite the Act's disclaimer of state liability to the employees who participate in the program, in a crunch, no future governor or legislature of California could in fact stand by idly if the Trust lacked the financial ability to pay the

124 Stat. 119, 252 (2010) (amending the Fair Labor Standards Act of 1938 by adding § 18A, codified as amended at 29 U.S.C. § 218A (2010)).

⁸¹ President Obama takes a similar approach in his proposal for a federal employer mandate for workplace retirement savings. *See supra* text accompanying notes 4-5.

⁸² *See, e.g.,* SHEILA BAIR, *BULL BY THE HORNS* (2012); ANDREW ROSS SORKIN, *TOO BIG TO FAIL: THE INSIDE STORY OF HOW WALL STREET AND WASHINGTON FOUGHT TO SAVE THE FINANCIAL SYSTEM FROM CRISIS – AND THEMSELVES* (2009); Gretchen Morgenson, *One Safety Net That Needs to Shrink*, N.Y. TIMES, Nov. 4, 2012, at BU1.

⁸³ *See, e.g.,* Bair, *supra* note 82, at 28 ("The moral hazard problem is worse for very large institutions that the market perceives as being too big to fail.").

⁸⁴ *See* S.B. 1234, 2012 Leg., Reg. Sess. § 3 (Cal. 2012) (adding §§ 100013, 100014(c)(3) and 100036 to the CAL. GOV'T CODE (2012)).

⁸⁵ *Id.* (adding § 100010(a)(9) to the CAL. GOV'T CODE (2012)).

account balances of such employees.⁸⁶ In discussion of S.B. 1234, the California Department of Finance expressed this concern that California's treasury might ultimately wind up responsible for the program's commitments.⁸⁷ However, the text of the Act is explicit that the Golden State's public treasury does not stand behind the Trust.

IV. ERISA PREEMPTION: *Shaw v. Travelers*

ERISA's preemption clause, ERISA § 514(a),⁸⁸ is extremely broad: ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" regulated by ERISA. Starting with its decision in *Shaw v. Delta Air Lines, Inc.*⁸⁹ through *District of Columbia v. Greater Washington Board of Trade*,⁹⁰ the U.S. Supreme Court interpreted § 514(a) expansively.⁹¹ Under the case law developed during this period, § 514(a) preempts any state law which "has a connection with or reference to" an employee benefit plan.⁹² Under this

⁸⁶ See, e.g., Frank Keegan, *Private Pension Plan Would Raid Taxpayers to Fill Public Pension Gap*, SACRAMENTO BEE, Sept. 29, 2012, at A13 ("But the overriding question left answered on the issue of 'guaranteed' retirement income is: guaranteed by whom? Answer: taxpayers, the same people now stuck with the insurmountable debt of a retirement system in an accelerating death spiral."); Rich Danker, *California Doubles Down on Pension Promising*, CONTRA COSTA TIMES, Nov. 11, 2012, at A13 (The Act "confuses retirement as an expectation, rather than an objective."); Judy Lin, *The Problems with SB1234*, ASSOC. OF CAL. LIFE & HEALTH INS. CO., May 30, 2012 ("Funding shortfalls and huge taxpayer liabilities.").

⁸⁷ See Kevin DeLeon, Department of Finance Bill Analysis (May 2, 2012) (on file with the California Department of Finance) ("Despite the bill's stated intent to shield the state from financial liability, the state ultimately could be responsible for benefit payments under federal law, putting the state at serious risk of billions of dollars in unfunded liabilities if investment performance falters under the Program.").

⁸⁸ 29 U.S.C. § 1144(a) (2006).

⁸⁹ See *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

⁹⁰ See *D.C. v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

⁹¹ For a detailed discussion of this initial stage of the Court's interpretation of ERISA § 514(a), see Edward A. Zelinsky, *Travelers, Reasoned Textualism, and the New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 815-27 (1999).

⁹² See *Shaw*, 463 U.S. at 97.

unforgiving standard, ERISA preemption is nearly automatic.⁹³

The Court subsequently retreated from *Shaw*'s formulation of ERISA preemption, without (so far, at least) acknowledging that retreat. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,⁹⁴ the Court formulated a more restrained (though still quite broad) understanding of ERISA § 514(a), presuming “that Congress does not intend to supplant state law.”⁹⁵

Travelers involved surcharges New York State imposed as part of its regulation of hospital rates. Pursuant to this regulation, hospitals charged patients covered by Blue Cross/Blue Shield, by Medicaid, or by an HMO only basic billing rates for their hospital stays. Other patients, e.g., those covered by commercial insurers, by self-insured funds, or by volunteer firefighter benefits, paid to the hospital a 13% surcharge for their hospitalizations. Hospitalized patients covered by commercial insurance also paid a second surcharge of 11%, which the hospital remitted to the state. The impact of these surcharges was to encourage employers to switch their medical plans from commercial insurance and self-funding to Blue Cross/Blue Shield coverage to achieve lower net costs for their employees' hospitalizations.

In a straightforward application of *Shaw* and its expansive test for ERISA preemption (“connection with or reference to”), the Second Circuit⁹⁶ held that ERISA § 514(a) preempted New York's hospital surcharges. These surcharges, the appeals court concluded, improperly burdened employers' ERISA-regulated health care plans with higher costs if such plans declined to use Blue Cross/Blue Shield insurance coverage.

In a sharp (but, so far, unacknowledged) break with *Shaw*, the Supreme Court reversed the Second Circuit and upheld the Empire State's hospital surcharges against ERISA preemption challenge. The interpretation of § 514(a) in any situation, *Travelers* declares, starts with the “presumption that Congress does not intend to supplant state law.”⁹⁷ Through § 514(a), Congress sought “to avoid a multiplicity of [state] regulation in order to permit the nationally uniform administration of employee benefit plans.”⁹⁸ The danger to such national uniformity is

⁹³ See Zelinsky, *supra* note 91, at 816.

⁹⁴ 514 U.S. 645 (1995) [hereinafter *Travelers*].

⁹⁵ See *id.* at 654.

⁹⁶ *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 725 (2d Cir. 1993).

⁹⁷ *Travelers*, 514 U.S. at 654.

⁹⁸ *Id.* at 657.

greatest when a state law dictates “employee benefit structures or their administration”⁹⁹ or provides “alternative enforcement mechanisms.”¹⁰⁰ A state law is not ERISA-preempted under § 514(a) merely because of its “indirect economic influence” on employee benefit plans.¹⁰¹

It is hard to reconcile *Travelers*’ more forgiving approach to ERISA preemption with *Shaw*. The Court has, so far, declined to confront the tension in its ERISA preemption case law.¹⁰²

Often, the tension between *Shaw* and *Travelers* does not matter. For example, Maryland’s “Wal-Mart” Act is ERISA-preempted under either approach.¹⁰³ However, as I discuss below, the California Act presents a case where the two different formulations of ERISA preemption lead to two different outcomes. ERISA preempts the Act’s employer mandate and the Act’s authorization of voluntary employer contributions under the *Shaw* standard with its near automatic preemption of state law. However, the Act’s employer mandate and optional employer contributions survive under the revised and more compelling approach to ERISA § 514(a) later embodied in *Travelers*.

V. THE PAYROLL DEDUCTION IRA SAFE HARBOR

ERISA preempts state laws as such laws “relate to any employee benefit plans”¹⁰⁴ governed by ERISA. ERISA identifies two kinds of employee benefit plans,¹⁰⁵ “welfare” plans,¹⁰⁶ which provide fringe benefits such as medical, sickness and death benefit coverage, and “pension” plans,¹⁰⁷ which provide “retirement income to employees”¹⁰⁸ or otherwise result “in a deferral of income by employees for periods

⁹⁹ *Id.* at 658.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 659.

¹⁰² See Zelinsky, *supra* note 93, for a discussion on the tension within the Supreme Court’s ERISA preemption case law.

¹⁰³ Edward A. Zelinsky, *Maryland’s “Wal-Mart” Act: Policy and Preemption*, 28 CARDOZO L. REV. 847, 851-70 (2006).

¹⁰⁴ 29 U.S.C. § 1144(a) (2006).

¹⁰⁵ 29 U.S.C. § 1002(3) (2006).

¹⁰⁶ 29 U.S.C. § 1002(1) (2006).

¹⁰⁷ 29 U.S.C. § 1002(2)(A) (2006).

¹⁰⁸ 29 U.S.C. § 1002(2)(A)(i) (2006).

extending to the termination of covered employment or beyond.”¹⁰⁹

The regulations of the Department of Labor (DOL) create a safe harbor from ERISA regulation for what have come to be called “payroll deduction IRA” arrangements.¹¹⁰ Per the regulations,¹¹¹ a payroll deduction IRA arrangement is not a “pension” plan for ERISA purposes, chiefly because only the employee contributes to his IRA under such an arrangement; there are no employer contributions. Since it is not a pension plan, a payroll deduction device is not an “employee benefit plan” and thus is not regulated by ERISA. Consequently, ERISA § 514(a) does not preempt a state law relating to a payroll deduction IRA arrangement because such a payroll deduction arrangement is not an employee benefit plan for purposes of ERISA. The drafters of the California Act attempted to qualify the Golden State’s program for this safe harbor¹¹² so that the program will constitute a payroll deduction IRA arrangement, subject to state regulation, rather than an ERISA-regulated pension plan with respect to which state law is preempted.

The DOL regulations define a payroll deduction IRA arrangement, outside ERISA’s coverage, as a “completely voluntary”¹¹³ scheme which is

¹⁰⁹ 29 U.S.C. § 1002(2)(A)(ii) (2006).

¹¹⁰ Announcement 99-2, 1991-1 CB 305; *see also* EBSA & IRS, *Payroll Deduction IRAs for Small Businesses*, www.dol.gov/ebsa/publications/PayrollDedIRAs.pdf.

¹¹¹ 29 C.F.R. § 2510.3-2(d) (2013).

¹¹² S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (adding § 100032 to the CAL. GOV’T CODE (2012), describing the Act as permitting and requiring “payroll deposit retirement savings arrangement[s].”).

¹¹³ 29 C.F.R. § 2510.3-2(d)(ii). Employees’ participation in the withholding program created by the Act would be “completely voluntary” because every employee under the Act would have the option to opt out of the program. S.B. 1234 §3 (Cal. 2012) (adding §§ 100014(c)(3), 100032(e)(1) and 100032(g) to the CAL. GOV’T CODE (2012)). There is a counterargument that participation in the program would not be “completely voluntary” since the employee would have the burden of opting out. However, this burden does not seem weighty enough to conclude that employees’ participation in the program would be less than voluntary. The Department of Labor (“DOL”) came to a similar conclusion in the context of health savings accounts (“HSAs”). Specifically, DOL’s Employee Benefits Security Administration concluded that “the establishment of an HSA by an employee [is] ‘completely voluntary’” when an employer creates and funds an HSA as long as the employee “may move the funds to another HSA or otherwise withdraw the funds.” Robert J. Doyle, *Health Savings Accounts – ERISA Q&As*, FIELD ASSISTANCE

solely employee-financed. No contributions can come from the employer.¹¹⁴ Under an IRA payroll arrangement, the “sole involvement of the employer” “is without endorsement to permit the sponsor to publicize the program,” “to collect contributions through payroll deductions,” and to remit such contributions to the employees’ respective IRAs.¹¹⁵

Payroll deduction IRA arrangements contrast with two other IRA-based retirement savings devices, the “simplified employee pension” (SEP)¹¹⁶ and the “simple retirement account (SRA).”¹¹⁷ For purposes of the present discussion, the principal difference between these IRA-based savings devices and payroll deduction IRAs is that employers make contributions to SEPs and SRAs, but do not make contributions under payroll deduction IRA arrangements. Because the employer contributes to a SEP or a SRA, a SEP or a SRA is (unlike a payroll deduction IRA) an ERISA-regulated employee benefit plan.¹¹⁸

Under a SEP, the employer makes contributions to IRAs for its employees in proportion to such employees’ respective compensation.¹¹⁹ SRAs require employer contributions emulating the safe harbor contributions for 401(k) plans. Specifically, an employer sponsoring SRAs for its employees must either match employees’ salary reduction contributions to their IRAs¹²⁰ or must contribute across-the-board to

BULL. NO. 2006-02, Employee Benefits Security Administration, U.S. Dep’t of Labor (Oct. 27, 2006), <http://www.dol.gov/ebsa/pdf/fab2006-2.pdf>. This conclusion is persuasive and confirms that employees’ participation in the withholding program created by the Act would be “completely voluntary” within the meaning of 29 C.F.R. § 2510.3-2(d)(ii).

¹¹⁴ 29 C.F.R. § 2510.3-2(d)(i).

¹¹⁵ 29 C.F.R. § 2510.3-2(d)(iii). Moreover, the employer cannot receive “consideration in the form of cash or otherwise, other than reasonable compensation for services actually rendered in connection with payroll deductions.” 29 C.F.R. § 2510.3-2(d)(iv).

¹¹⁶ 26 U.S.C. § 408(k) (2006).

¹¹⁷ 26 U.S.C. § 408(p) (2006).

¹¹⁸ 29 U.S.C. § 1002(2)(A) (2006).

¹¹⁹ 26 U.S.C. § 408(k)(3) (2006). Before 1997, employers could establish so-called “SAR-SEPs,” simplified employee pensions with salary reduction arrangements under which employees can also contribute to their respective IRAs subject to 401(k)-type deferral testing. While existing SAR-SEPs were grandfathered, new SAR-SEPs can no longer be created. 26 U.S.C. § 408(k)(6)(H) (2006).

¹²⁰ See *infra* notes 204-210 and accompanying text.

employees' IRAs at a rate of 2% of each employee's compensation.¹²¹

As I discuss *infra*,¹²² if a California employer were to make employer contributions under the provisions of the Act authorizing such optional employer contributions, these voluntary employer contributions would convert the California program for this employer from a payroll deduction IRA arrangement,¹²³ limited to employee contributions, into an ERISA-regulated employee pension plan, namely, either a SEP or a SRA financed by employer contributions. As I also discuss below,¹²⁴ under *Shaw*, ERISA § 514(a) preempts the provisions of the Act authorizing employer contributions though those provisions are not preempted under *Travelers*.

VI. THE ACT'S NOTIONAL ACCOUNTS ARE NOT INDIVIDUAL RETIREMENT ACCOUNTS

A. APPLYING THE STATUTORY LANGUAGE OF ERISA AND THE CODE

A fundamental question is whether the accounts established under the Act are individual retirement accounts for purposes of the Code. The drafters of the Act labeled these as "accounts" and intended for these self-proclaimed accounts to qualify as individual retirement accounts.¹²⁵ The Act prohibits the board from implementing "the program if the IRA arrangements" offered under the program "fail to qualify for the favorable federal income tax treatment ordinarily accorded to IRAs under the Internal Revenue Code"¹²⁶

The cash balance-style notional accounts established by the Act do not qualify as individual retirement accounts under the Code as the Act's accounts do not benefit directly from investment gains nor do such

¹²¹ 26 U.S.C. § 408(p)(2)(B)(i) (2006). The 2% employer contributions under simple retirement accounts are similar to the 3% employer contributions under one type of 401(k) safe harbor arrangement. 26 U.S.C. § 401(k)(12)(C) (2006).

¹²² See *infra* notes 203-09 and accompanying text.

¹²³ This assumes that the Act will be amended to convert its cash balance-style "nominal" accounts into true IRAs that allocate investment risk to the account holder.

¹²⁴ See *infra* notes 211-219 and accompanying text.

¹²⁵ S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (adding § 100043 to the CAL. GOV'T CODE (2012)).

¹²⁶ *Id.*

accounts bear investment losses. The accounts created by the Act are notional accounts that give the employee a formula-based defined benefit-type claim against the assets held collectively by the Trust. That claim is not based on the value of those Trust assets. California's program is not a defined contribution arrangement with individual accounts assigning investment risk and reward to the account holder. Accounts under the Act will be credited with an assumed rate of return determined before the commencement of the year.¹²⁷ For any year, the Trust's actual investment performance may prove to be higher, the same as, or lower than the rate assumed before the year began. The board can retroactively allot to the program accounts some, all, or none of the Trust's "excess" investment gains above the stated rate of return. In any event, accounts under the Act will not be decreased to reflect the Trust's investment losses. Consequently, the cash balance-style notional accounts that the Act authorizes are not individual retirement accounts.

Internal Revenue Code § 408, which establishes the "individual retirement account" as a matter of federal law, does not define that statutory term. However, as part of ERISA (which created the IRA),¹²⁸ Congress twice¹²⁹ adopted a statutory definition to distinguish defined contribution arrangements, such as money purchase pensions¹³⁰ and profit sharing plans,¹³¹ from defined benefit pensions. The ERISA (i.e., Title 29) version of this definition makes clear that the term "individual account plan" is synonymous with "defined contribution plan" and provides that,

[t]he term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for

¹²⁷ *Id.* (adding § 100008(b) to the CAL. GOV'T CODE (2012)).

¹²⁸ See An Act to Provide Pension Reform, Pub. L. No. 93-406, § 2002(b), 88 Stat. 829, 959-66 (1974) (adding § 408 to the *United States Code*, creating the individual retirement account).

¹²⁹ As observed *supra*, many provisions of ERISA were adopted twice, once as additions to the Internal Revenue Code and once as additions to Title 29 of the *United States Code*, enforced by the Department of Labor. See *supra* note 6.

¹³⁰ On money purchase pension plans, see ZELINSKY, *supra* note 66, at 2; LANGBEIN ET AL., *supra* note 6, at 50-51; LAWRENCE A. FROLIK & KATHRYN L. MOORE, LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS 33 (3d ed. 2012).

¹³¹ On profit sharing plans, see ZELINSKY, *supra* note 66, at 2, 4, 14; LANGBEIN ET AL., *supra* note 6, at 51-52; FROLIK & MOORE, *supra* note 130, at 33-34.

benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.¹³²

The Internal Revenue Code version of this definition, today part of the tax statute as 26 U.S.C. § 414(i),¹³³ is identical except that the tax law exclusively uses the term "defined contribution plan."

Under this twice-enacted definition, an account exists for retirement savings purposes only when a participant's interest in his own account is "based solely upon the amount contributed to the participant's account, and any income, expenses, gain and losses, and any forfeitures of accounts . . . which may be allocated to such participant's account."¹³⁴ An individual account does not exist for retirement savings purposes if an external formula, operating independently of actual earnings and losses, determines a participant's entitlement under the retirement plan. Thus, a retirement account (in contrast to a defined benefit arrangement) exists only when investment risk is placed directly on the account holder so that all investment gain automatically inures to the advantage of the account holder and investment losses decrease the account holder's entitlement under the plan.

In contrast, the Act's notional, cash balance-style accounts do not reflect the Trust's actual investment experience but instead implement a defined benefit-style formula, namely, contributions augmented by an assumed rate of return unreduced by any losses. Under the California Act, the account holder is entitled to this formula-established amount, regardless of the Trust's actual investment performance. The account holder's interest does not derive directly from the value of the assets held by the Trust. Rather, the account holder has a defined benefit-style, formula-based claim against the collective fund held by the Trust. This formula ignores losses and automatically credits each account with an assumed rate of return, regardless of the Trust's actual investment performance. Hence, the accounts to be created under the Act do not comply with the statutory mandate that IRAs must provide "benefits based solely upon the amount contributed to the participant's account, and any

¹³² 29 U.S.C. § 1002(34) (2006).

¹³³ 26 U.S.C. § 414(i) (2006).

¹³⁴ 29 U.S.C. § 1002(34) (2006).

income, expenses, gains and losses, and any forfeitures”¹³⁵

Suppose, for example, a year for which the California board assumes a return of 3% while the Trust established by the Act actually experiences a net investment gain of 5%. The board could retroactively allocate this “excess” investment gain to the program’s accounts or could consider this superior investment performance in setting the stated return for the following year. The board may also do both or neither. Under any of these scenarios, there will be no direct connection between the Trust’s investment performance and the accounts’ balances. Any investment gain is mediated through the board and its implementation of the statutory command to assume a rate of return before the beginning of each year.

Suppose, moreover, a year in which the Trust losses money on the investments it holds. The Act does not authorize a decrease in account balances to reflect these losses. Following a loss year, the board might assume a 0% return so that account balances stay the same in the face of the prior year’s investment losses. However, the statutory definition of an individual account requires that losses reduce account balances.¹³⁶ As the Act is written, there is no provision for such loss-based reductions to account balances under the California program.

In short, as a statutory matter, all retirement accounts, including individual retirement accounts, must directly reflect investment gains and losses. The formula-based, cash balance-style accounts fashioned by the California Act do not and thus cannot constitute individual retirement accounts under Internal Revenue Code § 408.

B. APPLYING THE CASE LAW ON RETIREMENT ACCOUNTS

Also instructive in this context is the seminal decision of the U.S. Court of Appeals for the Ninth Circuit in *Connolly v. Pension Benefit Guaranty Corp.*¹³⁷ *Connolly*, and its progeny,¹³⁸ confirm that the defined

¹³⁵ *Id.*; I.R.C. § 414(i) (2006).

¹³⁶ *Id.*

¹³⁷ *Connolly v. Pension Benefit Guar. Corp.*, 581 F.2d 729 (9th Cir. 1978).

¹³⁸ *Connolly* has been cited and followed in three subsequent decisions addressing the distinction between defined benefit pensions and defined contribution/individual account plans: *Concord Control, Inc. v. Int’l Union, United Auto., Aerospace and Agric. Implement Workers of Am.*, 647 F.2d 701, 704-05 (6th Cir. 1981); *Matter of Defoe Shipbuilding Co.*, 639 F.2d 311, 313 (6th Cir. 1981); *In re Gray-Grimes Tool Co., Inc. Pension Plan*, 546 F. Supp. 102, 107-09

benefit-style accounts established by the Act are not individual retirement accounts for purposes of the Code.

The question before the court in *Connolly* was whether a multiemployer¹³⁹ pension plan was a defined benefit plan, subject to the plan termination insurance administered by the Pension Benefit Guaranty Corporation (“PBGC”), or was a defined contribution/individual account plan, outside the coverage of the PBGC and its insurance program.¹⁴⁰ Starting with ERISA’s statutory definition of a defined contribution/individual account plan,¹⁴¹ the appeals court concluded that the plan at issue in *Connolly* was a defined benefit pension because benefits were based on a formula rather than the actual investment experience of any particular individual account.

The appeals court noted that, under the *Connolly* plan, “[c]ontributions on behalf of participants are pooled in a general fund . . . [T]he participant has no right, title, or interest in these [contributed] amounts.”¹⁴² Rather, the participant’s entitlement under the plan was based on a specified formula. Such a formula is a feature of a defined benefit plan, which, as its name implies, defines for each participant a retirement benefit by applying a formula established in the plan. This formula applies irrespective of the plan’s actual investment performance.

In *Connolly*, the plan’s formula utilized the participant’s years of service to determine the participant’s retirement benefit. Under the California program, a cash balance-type formula creates a notional account consisting of cumulative contributions adjusted by an assumed rate of return, unreduced by any losses. The board can, but need not, retroactively credit accounts with some or all of the Trust’s “excess” investment earnings. As is true of the cash balance accounts that the Act’s accounts emulate, actual investment performance will not directly increase the participants’ benefits in their accounts in the California program, nor will investment losses decrease such benefits.

Also instructive in this context is the supplementary test deployed by the *Connolly* court, the possibility of underfunding. “[B]y definition, an

(E.D. Mich. 1982).

¹³⁹ For discussion of multiemployer pension plans, see LANGBEIN ET AL., *supra* note 6, at 70-77.

¹⁴⁰ 29 U.S.C. § 1321(b)(1) (2006) (PBGC insurance does not apply to “an individual account plan”).

¹⁴¹ 29 U.S.C. § 1002(34) (2006).

¹⁴² *Connolly*, 581 F.2d at 733.

individual account plan can never be underfunded”¹⁴³ since the account holder is entitled to whatever total his account grows or falls, based on the account’s actual investment performance. In contrast, there can be underfunding with cash balance notional accounts since these are defined benefit devices; if plan assets are less than a cash balance participant’s notional account total, the participant is still entitled to this larger formula-based total. Conversely, if a cash balance plan has more assets than are necessary to pay every participant the amount in his notional account, that excess can revert to the employer.¹⁴⁴

Like the plan at issue in *Connolly*, the California program creates a defined benefit-type cash balance entitlement that may be underfunded (or overfunded). Whether assets in the Trust are more or less than the amount in participants’ notional accounts, the California participants are entitled to their respective formula-based entitlements as reflected in those notional accounts.¹⁴⁵ If assets in the Trust are insufficient to pay these amounts, the account holders will have a claim against the Trust’s collective assets for the holders’ respective formula-based benefits. The California account holder under the Act has a defined benefit-type claim against this total pool of Trust assets, a claim for the formula-based total in his notional account.

Significant in this context is the Act’s authorization of the board to purchase insurance to guarantee against underfunding.¹⁴⁶ As the Ninth Circuit observed in *Connolly*, individual account plans cannot be underfunded. Insurance against underfunding is the hallmark of a defined benefit pension that promises a benefit-based formula independent of the value of the assets actually financing the pension. Today, defined benefit insurance is administered by the PBGC, established by ERISA.¹⁴⁷ If a defined benefit pension plan is covered by such insurance¹⁴⁸ and if the

¹⁴³ *Id.*

¹⁴⁴ Such a reversion is subject to the excise tax of Code § 4980. I.R.C. § 4980 (2006).

¹⁴⁵ S.B. 1234, 2012 Leg., Reg. Sess. § 3 (Cal. 2011) (adding § 100008(c) to the CAL. GOV’T CODE (2012)).

¹⁴⁶ *Id.* (adding § 100010(a)(9) to the CAL. GOV’T CODE (2012)).

¹⁴⁷ The PBGC and its insurance program are established in ERISA § 4001, 29 U.S.C. § 1301 (2006). For background on the PBGC, see LANGBEIN ET AL., *supra* note 6, at 238-40; FROLIK & MOORE, *supra* note 130, at 626-30.

¹⁴⁸ Certain defined benefit plans are not subject to the PBGC and the insurance it provides. 29 U.S.C. § 1321(b)-(c) (2006).

assets held by the plan's trust are inadequate to pay promised benefits, the PBGC's insurance coverage makes up the difference for basic, insured benefits.¹⁴⁹

Under California's Act, the board administering the program and Trust is authorized to obtain similar insurance from a private insurer.¹⁵⁰ This authorization indicates the risk of defined benefit underfunding under the Act. Underfunding insurance is not purchased for a defined contribution account since there is no promised benefit to insure and thus no risk of underfunding against which to insure.

In short, under the statutory definition of a retirement account as explicated by *Connolly*, an individual account benefits directly from investment gain, loses value from investment losses, is not controlled by a formula separate from such gains and losses, and cannot be underfunded since the account holder is entitled to whatever his account balance may be. Hence, the notional accounts under the Act are not individual retirement accounts. Rather, the accounts created under the Act reflect a defined benefit-style formula that gives the account holder a fixed claim against a collectively-invested trust fund. The Trust's investment gains will not automatically pass through to participants' program accounts but rather will be mediated by the board through its choice of an assumed rate of return and its decision whether or not to credit accounts with the Trust's "excess" earnings. Since the Act's accounts can be underfunded (why else should the board buy insurance against the risk of underfunding?), those accounts are not individual retirement accounts.

The same conclusion emerges from the appeals courts' decisions under the Code version of the definition of a defined contribution plan, Code § 414(i).¹⁵¹ The most recent of these appeals court decisions is *George v. United States*.¹⁵² In *George*, the taxpayers were retirees from federal service who, while working, had participated in the Civil Service Retirement System (CSRS). These taxpayers had contributed to the CSRS from their salaries with after-tax dollars while the federal government, as employer, matched those contributions. When they retired, the *George* taxpayers elected to receive their own after-tax contributions as lump sum distributions while the remainder of their respective CSRS retirement

¹⁴⁹ 29 U.S.C. §§ 1322-1322a (2006).

¹⁵⁰ S.B. 1234 § 3 (Cal. 2012) (adding § 100010(a)(9) to the CAL. GOV'T CODE (2012)).

¹⁵¹ I.R.C. § 414(i) (2006).

¹⁵² 90 F.3d 473 (Fed. Cir. 1996).

benefits (attributable to employer contributions and earnings) were paid over time as annuities.

The issue in *George* was whether the lump sum and the annuity constituted a single, integrated contract or whether the lump sum (consisting of the employees' own contributions) was a separate defined contribution pension plan, treated for tax purposes apart from the annuity. Under the former characterization, the lump sum (deemed to be integrated with the annuity) was taxable for income tax purposes. Under the latter characterization, the lump sum (deemed to be a separate defined contribution plan) was a tax-free refund of the taxpayers' own, already taxed contributions.¹⁵³ The *George* taxpayers, relying on Code §§ 72(d) and 72(e)(5)(E), claimed that their contributions to the CSRS constituted a separate defined contribution plan. From this premise, the lump sum payments were the tax-free return of their respective after-tax contributions. The IRS, relying on Code § 72(e)(2)(A), asserted that the lump sum payments to the CSRS retirees were linked to the ongoing annuity payments and were thus fully taxable. The resolution of this issue turned on the applicability of Code § 414(i): were the taxpayers' after-tax contributions a separate defined contribution pension plan or were they part of the annuity paid by the CSRS?

The Federal Circuit, agreeing with two other courts of appeals,¹⁵⁴ held that the taxpayers' after-tax contributions did not constitute a separate defined contribution plan with a "separate account"¹⁵⁵ because a defined contribution plan must have an "investment-performance feature,"¹⁵⁶ i.e.,

¹⁵³ "Employee contributions...under a defined contribution plan may be treated as a separate contract." I.R.C. § 72(d) (2006). A lump sum distribution "received on or after the annuity starting date" is fully includable in gross income. I.R.C. § 72(e)(2)(A) (2006). However, I.R.C. § 72(e)(5)(E) provides the counter rule for a lump sum "in full discharge of the obligation under the contract which is in the nature of a refund of the consideration paid for the contract." I.R.C. § 72(e)(5)(E) (2006). Such a lump sum in the nature of a refund is not taxable, but rather a return of the employees' consideration.

The taxpayers in *George*, relying on Code §§ 72(d)-(e)(5)(E), claimed that their contributions to the CSRS constituted a separate defined contribution plan. Hence, the lump sums they received were in the nature of a tax-free return of the taxpayers' own contributions. 90 F.3d at 477.

¹⁵⁴ *Montgomery v. United States*, 18 F.3d 500 (7th Cir. 1994); *Malbon v. United States*, 43 F.3d 466 (9th Cir. 1994).

¹⁵⁵ I.R.C. § 414(k) (2006).

¹⁵⁶ *George*, 90 F.3d at 477.

investment gains and losses must be allocated to the alleged account holder.

Since the *George* taxpayers were not allocated any investment gains and losses attributable to their after-tax contributions, those taxpayers did not participate in any separate defined contribution pension plan with individual accounts. The lump sum payment from the CSRA did not come from a true individual account that grew from investment gains and incurred investment losses.

Particularly helpful in this context is the *George* Court's discussion of *Guilzon v. Commissioner*,¹⁵⁷ the only appeals court decision holding that the lump sums received by CSRS retirees derive from a defined contribution plan separate from the annuities paid by CSRS to these retirees. Rejecting *Guilzon*, the Federal Circuit correctly observed that, contrary to the conclusion of *Guilzon*, "[u]nder the concept of a defined contribution plan . . . if income is earned, that income is to be added to the participant's account."¹⁵⁸ In contrast, the Act's notional accounts are not true accounts directly absorbing investment risk. Hence, such notional accounts are not individual retirement accounts under Code § 408.

C. CONSIDERING CRITIQUES

Consider in this context seven potential critiques of my conclusion that the program accounts established by the California Act are not individual retirement accounts for purposes of the Code. First, an individual retirement account can be invested in a fixed income instrument. The individual retirement account so invested resembles the notional accounts established under the Act. Thus, this initial critique would continue, the accounts under the Act are not so different from conventional individual retirement accounts after all.

To explore this challenge, let us suppose that an individual retirement account with a balance of \$100 is invested in a corporate bond that pays interest of 2% annually. At the end of the year, this account predictably has \$102, reflecting the original principal and the first year's interest. Suppose now that an account established under the Act is credited with \$100 in employee contributions and that, for the year, the board

¹⁵⁷ 985 F.2d 819 (5th Cir. 1993).

¹⁵⁸ *George*, 90 F.3d at 478.

assumes a rate of return of 2%. At the end of the year, this account under the California Act will also have a balance of \$102. This similarity, the argument goes, implies that the Act's accounts are individual retirement accounts for purposes of Code § 408 since the Act's accounts simulate individual retirement accounts invested in fixed income instruments.

As far as it goes, in this example the individual retirement account resembles the notional account under the Act. However, this resemblance evaporates upon further consideration of investment risk and reward. Consider, for example, a scenario in which interest rates spike mid-year. In this case, the principal balance in the individual retirement account automatically declines as the bond decreases in value. In contrast, the California account holder has a formula-based, fixed dollar claim against the collective assets of the California trust. If those assets go down, or up, in value, the account holder has the same claim for \$102 against the Trust since the assumed rate of interest for the year (2%) was fixed by the California board before the year began.

The story is similar if interest rates decline. In this case, the value of the bond in the individual retirement account rises to the financial advantage of the account holder as the account's balance grows in tandem with the increase in the bond's value. In contrast, the California account holder's entitlement under his notional account is the same fixed, formula-based amount of \$102 even as the value of the bond spikes due to lower interest rates. Under the Act, any investment gain from falling interest rates inures to the Trust and its collective pool, not to any account holder. The board may elect to retroactively allocate some or all of this gain to participants' accounts or may for the following year increase the stated investment return to reflect the prior year's increase in the Trust's assets. But the board need not do so.

Even if the board takes these retroactive steps, there will be no direct link between the Trust's investment performance and participants' account balances. Under the California Act, any connection between investment performance and account balances is mediated by the board through its selection of a stated rate of return and the board's decision whether or not to credit to accounts the Trust's "excess" earnings. At the end of the day, there is a significant difference between an individual retirement account, the value of which is tied directly and automatically to investment gains and losses, and a formula-driven account under the Act, which is not linked directly or automatically to investment gains or losses.

A second rebuttal to the conclusion that the accounts created by the Act are not individual retirement accounts under the Code would assert

that the definition of “account” is different for IRAs than for defined contribution plans, such as money purchase pensions and profit sharing arrangements. If so, Code § 414(i)¹⁵⁹ and the case law decided under it are irrelevant to IRAs.

However, Code § 414(i) is, by its terms, applicable, not only to money purchase and profit sharing plans, but to § 408¹⁶⁰ as well; § 414(i) applies to the “part” of the Code that includes § 408.¹⁶¹ As a textual matter, the term “account” in § 408 is most plausibly read to mean the same thing for IRAs as for other defined contribution plans covered by the same part of the Code, i.e., a retirement account where investment gain and loss automatically and directly inure to the benefit (or detriment) of the account holder.

A third challenge, related to the second, would assert that, in the context of IRAs, it is not in practice important to define rigorously the concept of an “account.” In the context of employer-sponsored retirement plans, the distinction between defined contribution/individual account plans and defined benefit pensions is crucial for many purposes. For example, employers guarantee the benefits promised under defined benefit pensions but do not guarantee outcomes under individual account plans.¹⁶² Congress has imposed limits on the employer stock a defined benefit arrangement may own, but has levied no equivalent restrictions on defined contribution plans.¹⁶³ There are different vesting schedules for defined contribution and defined benefit plans.¹⁶⁴ In these and other settings, it is

¹⁵⁹ I.R.C. § 414(i) (2006).

¹⁶⁰ I.R.C. § 408 (2006).

¹⁶¹ That part of the Code is Part I of Subchapter D which extends from Code § 401 through Code § 420, inclusive, and thus includes Code § 408, governing IRAs. See I.R.C. §§ 401-420 (2006).

¹⁶² Despite its relatively narrow focus, Justice Stevens’ *Nachman* opinion is generally cited as confirming that employers guarantee defined benefit pensions. *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359 (1980). As a statutory matter, it is today the minimum funding rules and the PBGC insurance arrangement which lock employers into the defined benefit commitments they make. I.R.C. §§ 412, 430, 431, 436, 4971 (2006); ERISA § 301, 29 U.S.C. § 1081 (2006) (minimum funding rules); ERISA § 4062, 29 U.S.C. § 1362 (2006) (sponsoring employers liability to PBGC in case of distress termination).

¹⁶³ 29 U.S.C. § 1107 (2006).

¹⁶⁴ Compare I.R.C. § 411(a)(2)(A) (2006), and 29 U.S.C. § 1053(a)(2)(A) (2006) (vesting schedules for defined benefit plans), with I.R.C. § 411(a)(2)(B) (2006), and 29 U.S.C. § 1053(a)(2)(B) (2006) (vesting schedules for defined

critical to determine which plans have “accounts” and which do not. However, the argument would conclude, there are no similar consequences in the context of individual retirement accounts and thus no need to define such accounts with particular rigor.

However, the term “account” does play an important role in the context of individual retirement arrangements as the Code distinguishes individual retirement accounts from individual retirement annuities: such annuities can only be issued by insurance companies complying with state regulation of insurance.¹⁶⁵ It is, moreover, unconvincing to read the term “account” differently at different places within the same statute. Code § 408 was enacted as part of ERISA, which simultaneously embedded the definition of an account in both Code § 414 and the labor, i.e., Title 29, version of ERISA.

A fourth argument would contend that California could defend the Act in its current form by asserting that the Act’s notional accounts fall within the Code’s authorization of individual retirement annuities. If the Act’s notional accounts can, for purposes of the Code, be characterized as such annuities, then it is unnecessary for those accounts to comply with the Code and ERISA requirement that accounts allocate investment gains and losses to account holders.

It is no accident that the drafters and sponsors of the Act elected to characterize the participants’ interests in the California program as “accounts.” By labeling those interests as “accounts,” the proponents of the Act appealed to the broad public acceptance of the now-established defined contribution paradigm with its emphasis on account-based ownership devices¹⁶⁶ such as 401(k) accounts,¹⁶⁷ individual retirement accounts,¹⁶⁸ Section 529 accounts,¹⁶⁹ and health savings accounts.¹⁷⁰ In contrast, despite the persuasive argument for annuities as savings and retirement devices,¹⁷¹ such annuities do not resonate the same way with the public today. Would a majority of the Golden State’s legislators have been

contribution plans).

¹⁶⁵ I.R.C. § 408(b) (2006).

¹⁶⁶ Zelinsky, *supra* note 66, at 31-37.

¹⁶⁷ *Id.* at 49-52.

¹⁶⁸ *Id.* at 52-58.

¹⁶⁹ *Id.* at 64-69.

¹⁷⁰ *Id.* at 62-64.

¹⁷¹ *Id.* at 15-23; TERESA GHILARDUCCI, WHEN I’M SIXTY-FOUR: THE PLOT AGAINST PENSIONS AND THE PLAN TO SAVE THEM 122-25 (2008).

willing to impose mandatory “annuities” on their constituents? I’m skeptical. Framing matters.¹⁷²

Against this background, it is unpersuasive for California to call the notional accounts created in the Act “accounts” when addressing the California populace through the Golden State’s statute books while simultaneously telling the IRS, the DOL, and, ultimately, the courts that these “accounts” are really “annuities” under the Code.

Moreover, if the Act’s accounts are individual retirement annuities for purposes of the Code, those putative annuities cannot be offered by the Trust created under the Act. As a statutory matter, individual retirement annuities must be underwritten by insurance companies, complying with the state’s statutes and regulations pertaining to insurance.¹⁷³ However, the Trust is not required to comply with the insurance statutes and regulations of the Golden State.¹⁷⁴

Just as the defenders of the Act might be tempted in *ipse dixit* fashion to declare the Act’s accounts as annuities, they might also be tempted to proclaim arbitrarily that the Trust is an insurance company even though the Trust need not comply with the same rules as apply to commercial and nonprofit insurers operating in the Golden State.¹⁷⁵ Such a formalistic, indeed hollow, relabeling of the Trust as an insurance company would be unpersuasive. The evident purpose of the statutory

¹⁷² Scholars today give much attention to “framing effects.” At one level, the research on framing effects itself reframes the long-recognized reality that it matters how issues are defined. For contemporary research on framing effects, see Edward A. Zelinsky, *Do Tax Expenditures Create Framing Effects? Volunteer Firefighters, Property Tax Exemptions, and The Paradox of Tax Expenditure Analysis*, 24 VA. TAX REV. 797, 807-11 (2005); Edward J. McCaffery & Joel Slemrod, *Toward an Agenda for Behavioral Public Finance*, in BEHAVIORAL PUBLIC FINANCE 3, 7-8 (Edward J. McCaffery and Joel Slemrod eds., 2006). For a classic instance of an astute politician who understood what we today call framing effects in the context of retirement policy, see ZELINSKY, *supra* note 66, at 113 (discussing Franklin D. Roosevelt’s decision to finance Social Security through payroll taxes so “no damn politician can ever scrap my social security program.”).

¹⁷³ See I.R.C. § 408(b) (2006) (individual retirement annuities must be “issued by an insurance company”); Treas. Reg. § 1.408-3(a) (1986) (individual retirement annuities must be “issued by an insurance company which is qualified to do business under the law of the jurisdiction in which the contract is sold.”); see generally CAL. INS. CODE.

¹⁷⁴ See generally CAL. INS. CODE.

¹⁷⁵ *Id.*

requirement of Code § 408(b) is to assure the holders of individual retirement annuities that those annuities receive the substantive protections of state insurance law. That purpose is eviscerated if an entity, like the Trust, is by *ipse dixit* declared to be an insurance company while relieved of the substantive requirements governing all other insurers.

At the end of the day, California's legislature elected to characterize the Act's accounts as accounts rather than as annuities and chose to offer those accounts through a state-sponsored Trust rather than through insurance companies complying with California's insurance laws. California should be held to those choices. And the notional accounts created by the Act do not qualify as individual retirement accounts since they do not allocate gains and losses to account holders.¹⁷⁶

Yet a fifth challenge to my conclusion that the Act's accounts are not individual retirement accounts would dispute the similarity of the California program to a cash balance-style defined benefit plan. If the assets funding a cash balance pension are inadequate to pay promised benefits, the sponsoring employer is liable for the shortfall.¹⁷⁷ However, California has explicitly disclaimed responsibility for any liabilities of the Trust or the program¹⁷⁸ – a disclaimer not available to the private sector sponsor of a defined benefit plan. Similarly, if there are surplus assets in a cash balance plan when the plan terminates, these assets may revert to the sponsoring employer.¹⁷⁹

An analogy need not be perfect to be persuasive. Even if we take at face value California's declaration that the Golden State's treasury does not stand behind the Trust and the program,¹⁸⁰ the accounts to be established under the Act are notional in nature. Like a participant in a cash balance pension, a participant in the California program will have a formula-based claim against the Trust rather than a true individual account under which investment gains automatically flow through to the

¹⁷⁶ As I discuss *infra*, another state (or even California itself) could pursue a different course from the Act by openly declaring that private sector employees otherwise without work-based retirement savings coverage must purchase individual retirement annuities. See *infra* note 247 and accompanying text.

¹⁷⁷ See ZELINSKY, *supra* note 66, at 14.

¹⁷⁸ S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (amending CAL. GOV'T CODE §§ 100013, 100014(c)(3), and 100036 (2012)).

¹⁷⁹ Subject to the potential reversion tax of I.R.C. § 4980 (2006).

¹⁸⁰ S.B. 1234 (Cal. 2012) (amending CAL. GOV'T CODE §§ 100013, 100014(c)(3), and 100036 (2012)).

participant's account and losses reduce the participant's account balance.

The Act is silent as to the distribution of surplus assets if the Trust were to terminate in overfunded condition. Perhaps the Trust's extra funds would be distributed to present and/or former participants in the program. Or perhaps these surplus assets would go to the California treasury in a manner analogous to a reversion to an employer sponsoring a defined benefit plan. We don't know. In any event, the program and its accounts need not perfectly mimic a private sector cash balance pension for such a pension to be the most useful analogy. That is the case, given the cash balance-style, formula-based entitlement of account holders under the California Act.

A sixth argument is that there is no policy reason to deny individual retirement account status to the accounts to be established under the Act. A believer in the ownership society would disagree, arguing that true individual accounts correspond with cultural norms about ownership and give the account holder a direct stake in the American economy as a result of his unmediated participation in the upside and downside of investment performance.¹⁸¹

Had the 93rd Congress foreseen the possibility of cash balance accounts, it might have drafted Code § 408 to include within the definition of an individual retirement account the kind of defined benefit, notional account established under the California Act. But Congress did not. It is anachronistic to blame Congress for this omission (assuming it was an omission) because the cash balance plan was far in the future and could not have been anticipated in 1974. It is, moreover, not apparent that, had the drafters foreseen the possibility of formula-based cash balance accounts, they would have included them within the definition of individual retirement accounts for purposes of Code § 408. In any event, Congress did not draft Code § 408 in a way which qualifies cash balance accounts as individual retirement accounts since cash balance accounts are formula-based and do not allocate investment gains and losses directly to participants' respective accounts.

Consider finally my argument that the private insurance the Act authorizes the board to purchase is analogous to the insurance the PBGC issues to defined benefit pension plans to protect against the underfunding of promised benefits. This similarity, I argue, indicates that the accounts authorized by the California Act are defined benefit devices, insurable like

¹⁸¹ ZELINSKY, *supra* note 66, at 97-101.

defined benefit pensions, and thus outside the statutory definition of an individual retirement account: insurance is only needed against the risk of underfunding when underfunding can occur. Defined contribution accounts cannot be underfunded since account holders are entitled to whatever their respective accounts are worth, based on actual investment performance.

The counterargument is that the insurance authorized by the Act is similar to an insurance-type product purchased inside an individual retirement account. Such accounts, for example, can invest in guaranteed income contracts (GIC), which, the argument goes, are similar to the insurance the board can buy under the Act.

The controlling difference is the nature of the claim created by an insurance-type product inside an individual retirement account, as opposed to insurance protecting a formula-based benefit. When an individual retirement account is invested in a GIC or similar device, the account holder's entitlement is defined and limited by that contract. If the insurer or other financial institution issuing the GIC defaults, the account holder has no further claim against the account. The GIC (or similar insurance-type device) is an investment like a bond or stock: if the GIC goes belly-up, the loss falls on the individual account holder.

However, the insurance to be purchased under the Act is designed to guarantee a cash balance-style defined benefit formula, i.e., the employees' contributions increased by a stated rate of return, unreduced by investment losses. If the issuer of the insurance acquired by the board defaults, the account holder still has a claim against the Trust for his formula-based benefit. Again, the analogy, while not perfect, is instructive. The insurance to be purchased by the California board underwrites a cash balance-style benefit just as the PBGC issues insurance to protect the equivalent formula-based promises made by defined benefit plans.

D. SUMMARY

In sum, the Act imposes investment reward and risk on the Trust and the collective funds the Trust will hold. The cash balance-style accounts created by the Act are proclaimed by the Act to be "accounts." However, these notional accounts are not individual retirement accounts since the account holder has a formula-based defined benefit-type interest in his account and does not himself benefit directly from good investment performance or suffer from poor investment performance.

VII. NO ERISA PREEMPTION UNDER *TRAVELERS* OF THE ACT'S EMPLOYER MANDATE

Under the Act, the board can only implement the program if the accounts implementing the program qualify as individual retirement accounts under the Code.¹⁸² This caveat reflects the drafters' intent for the program to qualify as an IRA payroll deduction arrangement, subject to state regulation because such an arrangement is not an employee benefit plan for ERISA purposes.¹⁸³ This caveat also assures the participants in the program that they will receive the tax benefits associated with IRAs.¹⁸⁴

Because the accounts established under the Act are not individual retirement accounts, the most compelling course for California's legislature would be to abandon the cash balance-style formula currently embedded in the Act by amending the Act to recast the accounts to be offered by the program as true individual retirement accounts which assign investment risk and reward directly to the participating employees. It is thus necessary to consider whether, if the Act were so amended,¹⁸⁵ the Act's employer mandate would be ERISA preempted. *Shaw* says "yes" while *Travelers* says "no." *Travelers*, as the Court's more recent and more compelling construction of § 514(a) and ERISA preemption, should control and should thus protect the employer mandate of the California Act from ERISA preemption – if the Act's accounts are reformulated as bona fide individual retirement accounts.

The Act's employer mandate explicitly refers to employer-sponsored retirement plans, exempting from the mandate all Golden State employers who sponsor such plans.¹⁸⁶ Under the unforgiving *Shaw* test ("connection with or reference to"), ERISA § 514(a) preempts the Act's employer mandate since that mandate refers to employers' retirement plans by exempting from the mandate employers sponsoring retirement plans for

¹⁸² S.B. 1234 (Cal. 2012) (amending CAL. GOV'T CODE §§ 100013, 100014(c)(3), 100036 (2012)).

¹⁸³ 29 C.F.R. §2510.3-2(d) (2007).

¹⁸⁴ I.R.C. §§ 219, 408(e)(1) and 408A(d)(1) (2006).

¹⁸⁵ In order for the program accounts established under the Act to qualify as individual retirement accounts, it is also necessary for the Trust to satisfy the IRS that the Trust will be administered in a fashion "consistent with the requirements of" I.R.C. § 408. See I.R.C. § 408(a)(2) (2006). It should not be difficult for the Trust to satisfy this standard. See Treas. Reg. § 1.408-2(e) (1986).

¹⁸⁶ S.B. 1234 (Cal. 2012) (amending CAL. GOV'T CODE § 100032(d) (2012)).

their respective workforces.

Consider in this context the last of the *Shaw* line of cases, *District of Columbia v. Greater Washington Board of Trade*.¹⁸⁷ In that case, the U.S. Supreme Court declared as ERISA-preempted a District of Columbia law requiring employers to provide to injured employees receiving workers' compensation the same health insurance employers provide to their active workers. Since employer-provided medical coverage constitutes an ERISA-governed employee benefit plan,¹⁸⁸ the Court held, the D.C. law impermissibly "refer[red] to" such ERISA-regulated employee benefit plans by requiring that injured employees receive the same medical coverage as furnished by the ERISA-regulated employee benefit plans in effect for active employees.

The application of *Greater Washington Board of Trade* to the California Act's employer mandate is straightforward: like the D.C. statute the Court held to be preempted, the California Act explicitly refers to employers' ERISA-regulated employee benefit plans, exempting from the obligation to participate in the Act's state-sponsored withholding program any employer which maintains a retirement plan for its employees.¹⁸⁹ Thus, under the unforgiving *Shaw* test ("reference to"), the Act's employer mandate is ERISA-preempted as the mandate refers to employer-sponsored retirement plans by exempting employers maintaining such plans – just as the District of Columbia statute referred to employer-sponsored medical plans for active employees as the standard for medical coverage to be provided to injured employees.

Travelers, however, undermines *Shaw*. Under *Travelers*' approach to § 514(a), the Act's employer mandate is not ERISA-preempted. Underlying *Travelers*' approach to ERISA § 514(a) are a variety of themes which cannot be reconciled with *Shaw*: the interpretation of § 514(a) in any situation, *Travelers* declares, starts with the "presumption that Congress does not intend to supplant state law."¹⁹⁰ The legislative purpose animating ERISA's preemption provision was "to avoid a multiplicity of [state] regulation in order to permit the nationally uniform administration of employee benefit plans."¹⁹¹ Such national uniformity is particularly at risk when a state law dictates "employee benefit structures or their

¹⁸⁷ 506 U.S. 125 (1992). See Zelinsky, *supra* note 91, at 826.

¹⁸⁸ 29 U.S.C. 1002(1) (2006).

¹⁸⁹ S.B. 1234 (Cal. 2012) (amending CAL. GOV'T CODE § 100032(d) (2012)).

¹⁹⁰ *Travelers*, 514 U.S. at 654.

¹⁹¹ *Id.* at 646.

administration”¹⁹² or provides “alternative enforcement mechanisms.”¹⁹³ A state law is not ERISA-preempted under § 514(a) merely because of its “indirect economic influence” on employee benefit plans.¹⁹⁴ Starting from these *Travelers* premises, the Act’s employer mandate is not ERISA-preempted because there is a presumption that Congress preferred not to supplant the Act, the Act’s employer mandate has no effect on employers maintaining their own retirement plans for their employees, and the Act’s mandate does not impair national uniformity in the administration or content of employer-sponsored retirement plans. Indeed, the Act says nothing about such administration or content.

To explore further the contrast between *Shaw* and *Travelers*, consider the Supreme Court’s first ERISA preemption decision after *Travelers*, *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*¹⁹⁵ Separately-funded apprenticeship programs are ERISA-regulated employee welfare plans.¹⁹⁶ On public construction projects, California law permits contractors to pay lower than prevailing wages to apprentices only if the state approves the apprenticeship program. Under *Shaw*, this California statute refers to and has a connection with ERISA-governed welfare plans, namely separately-funded apprenticeship programs. Hence, applying *Shaw*, the California wage law should be preempted under ERISA § 514(a).

However, following *Travelers*, the *Dillingham* Court sustained the California wage statute as that statute merely had an “indirect economic influence”¹⁹⁷ on ERISA-regulated apprenticeship programs in the Golden State. The impact of the California law was “quite remote”¹⁹⁸ from concerns about plan benefits and plan administration. Hence, the *Dillingham* Court declared, ERISA did not preempt the California statute challenged in that case. *Dillingham* thus buttresses the conclusion that, under *Travelers*’ more forgiving approach, the Act’s employer mandate is not ERISA-preempted.

While less sweeping than *Shaw*, post-*Travelers* ERISA preemption still has substantial bite in particular cases. In *Egelhoff v. Egelhoff ex. rel.*

¹⁹² *Id.* at 658

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 659.

¹⁹⁵ 519 U.S. 316 (1997).

¹⁹⁶ 29 U.S.C. § 1002(1) (2006).

¹⁹⁷ *Dillingham*, 519 U.S. at 329.

¹⁹⁸ *Id.* at 330.

Breiner,¹⁹⁹ for example, the Court held that § 514(a) prevents the application to any ERISA-governed employee benefit plan of a Washington State statute that, on a participant's divorce, automatically revokes any beneficiary designation of the participant's former spouse. The Washington law, the *Egelhoff* Court declared, "interferes with nationally uniform plan administration" of ERISA-regulated plans²⁰⁰ by requiring an employee benefit plan operating in Washington State to disregard a beneficiary designation on file with such plan if the designation names a former spouse as beneficiary.

In contrast, the Act has no impact on California employers maintaining retirement plans or payroll deduction IRA arrangements. These employers can with impunity ignore the Act, the Trust, and the program. The Act does not regulate the content or processes of a California employer's retirement plan or an employer's IRA payroll deduction arrangement. If a California employer is required to enroll in the program (assuming the Act is amended to qualify the Act's accounts as individual retirement accounts), the employer will thereby participate in a program which is not an employee benefit plan for ERISA purposes: California's state-sponsored program (assuming amendment of the Act) will qualify as a payroll deduction IRA arrangement which is not an employee benefit plan under ERISA.²⁰¹

For ERISA preemption purposes, the Act (if amended to establish bona fide individual retirement accounts) is more like the California apprentice wage statute sustained in *Dillingham* than the Washington State divorce-related law stricken in *Egelhoff*. The latter unacceptably impinged upon the administration of ERISA-regulated plans by requiring

¹⁹⁹ 532 U.S. 141 (2001). For discussion of *Egelhoff*, see Edward A. Zelinsky, *Employer Mandates and ERISA Preemption: A Critique of Golden Gate Restaurant Association v. San Francisco*, 50 STATE TAX NOTES 503, 512 (2008) (hereinafter Zelinsky, *Golden Gate II*); Edward A. Zelinsky, *Egelhoff, ERISA Preemption and the Conundrum of the 'Relate To' Clause*, 91 TAX NOTES 1917 (2001).

²⁰⁰ *Egelhoff*, 532 U.S. at 148.

²⁰¹ By way of contrast, an employer subject to the employer mandate of the San Francisco Health Care Security Ordinance must provide specific health care benefits under its own, ERISA-regulated program, or, in the alternative, must participate in the City's Health Access Program (HAP), which establishes an ERISA-governed health care program. See Zelinsky, *Golden Gate II*, *supra* note 199, at 4-7.

administrators to run their respective plans in accordance with Washington State law rather than the pre-divorce beneficiary designations on file with the plan. The California Act, in contrast, does not impinge upon employers' retirement plans or such plans' operations. The Act just requires employers without such plans or IRA withholding arrangements to participate in a state-sponsored IRA withholding program, a program which is not an employee benefit plan for ERISA purposes.²⁰²

As the Court's later and more persuasive²⁰³ interpretation of ERISA preemption, *Travelers* should prevail over *Shaw*. Thus, the Act's employer mandate should survive ERISA preemption if the Act's accounts are recast as individual retirement accounts. Per *Travelers*, the Act has no direct effect on employers' retirement plans and does not affect the content or administration of such plans. The Act will merely require employers without retirement plans to maintain their own IRA payroll arrangements or to participate in the California program, a publicly-administered IRA payroll arrangement which is not an employee benefit plan for ERISA purposes.

VIII. NO ERISA PREEMPTION OF EMPLOYER CONTRIBUTIONS UNDER *TRAVELERS*

Similar observations apply as to the provisions of the Act authorizing employers to make voluntary contributions²⁰⁴ to employees' program accounts: under *Shaw*, this portion of the Act is ERISA-preempted, but, under *Travelers*, the Act's authorization of optional employer contributions survives § 514(a) scrutiny. *Travelers* is the Court's later and more compelling interpretation of § 514(a) and thus should spare from ERISA preemption the Act's authorization of supplemental employer contributions. The Act neither requires employers to make contributions nor requires employers to affirmatively elect against such contributions.

The employer who makes voluntary contributions under the Act to employees' accounts will, by virtue of such contributions, convert the

²⁰² 29 CFR § 2510.3-2(d) (2010).

²⁰³ Despite these rulings the author continues to believe that there is an interpretation of ERISA § 514(a) which is better than either *Shaw* or *Travelers*, namely, to treat § 514(a) as creating a rebuttable presumption of ERISA preemption. See Zelinsky, *supra* note 91, at 839-58.

²⁰⁴ S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (amending CAL. GOV'T CODE §§ 100004(e) and 100012(j) (2012)).

program for such contributing employer from a payroll deduction IRA arrangement into an ERISA-regulated employee benefit pension plan. Payroll deduction IRA arrangements retain that classification only if the employees make all contributions pursuant to such arrangements.²⁰⁵ If a California employer makes contributions under the program, the program would for ERISA purposes thereby become an employee pension plan for that employer, an employer-financed plan which both “provides retirement income to employees”²⁰⁶ and which “results in a deferral of income by employees.”²⁰⁷ Employers making supplemental contributions to employees’ accounts under the Act would need to comply with the rules for either a simplified employee pension²⁰⁸ (SEP) or a simple retirement account²⁰⁹ (SRA). Either way, an employer’s contributions to the program would result for that employer in a pension plan for ERISA purposes, an employer-financed arrangement providing retirement income and deferring income.²¹⁰

Shaw preempts the Act insofar as the Act would take California employers down the path of employer contributions. As to contributing employers, the state-run program and the Trust will be an ERISA-governed pension plan because of such employers’ contributions to the program. Under *Shaw* and its nearly automatic standard for ERISA preemption, the Act would have the ultimate “connection with” an ERISA-regulated employee benefit plan: the Act would create such a plan whenever employers make supplemental contributions to employees’ accounts as

²⁰⁵ 29 C.F.R. § 2510.3-2(d) (2010).

²⁰⁶ 29 U.S.C. § 1002(2)(A)(i) (2006).

²⁰⁷ 29 U.S.C. § 1002(2)(A)(ii) (2006).

²⁰⁸ I.R.C. § 408(k) (2006). S.B. 1234 adds to the Government Code § 100010(b), which requires the board to promulgate regulations “to ensure that the program meets all criteria for federal tax-deferral or tax-exempt benefits, or both.” S.B. 1234 (Cal. 2012) (amending CAL. GOV’T CODE § 100010(b) (2012)). This statutory requirement would mandate regulations qualifying voluntary employer contributions under the program to take the form of either simplified employee pensions or simple retirement accounts.

²⁰⁹ I.R.C. § 408(p) (2006).

²¹⁰ While governmental plans are largely immune from regulation under ERISA, the program created under the Act is not a governmental plan for purposes of ERISA since the program covers employees in the private and nonprofit sectors, not the employees of governments. *See* 29 U.S.C. § 1002(32) (1974) (defining governmental plans as covering government employees); 29 U.S.C. § 1003(b)(1) (1974) (stating that Title I of ERISA does not apply to governmental plans).

such employers' contributions under the Act would, for ERISA purposes, convert their payroll deduction arrangements into employee benefit plans.

Consider in this context the Supreme Court's *Shaw*-based decision in *FMC Corp. v. Holliday*.²¹¹ In *FMC Corp.*, the Court held that ERISA § 514(a) preempts Pennsylvania's anti-subrogation law from applying to self-insured²¹² welfare plans. If, as *FMC Corp.* holds, a state law regulating employee benefit plans impermissibly "relate[s] to"²¹³ the plans the law regulates, a fortiori a state law that creates employee benefit plans is similarly ERISA-preempted as relating to the plans it creates. Hence, under the *Shaw* framework, the California Act, insofar as it establishes an ERISA-governed pension plan for employers' contributions, has an impermissible "connection with"²¹⁴ the employee pension plans the Act thereby establishes.

Again, however, the *Travelers* approach to ERISA-preemption is more forgiving, permitting state laws which have "indirect economic effects" on employers' retirement plans as long as such laws do not impair the nationally uniform content or administration of such plans. The Act's authorization of supplemental employer contributions does not impair national uniformity in the structure or administration of employee benefit plans. Any California employer can ignore the Act's authorization of optional employer contributions. The Act thus has no impact, indirect or otherwise, on such employers.

In two respects, *Egelhoff* is instructive in this context and confirms that, under the more forgiving approach to ERISA preemption inaugurated in *Travelers*, the provisions of the California Act authorizing supplemental employer contributions are distinguishable for ERISA preemption purposes from the Washington State statute the Court struck in *Egelhoff*. First, writing for the *Egelhoff* Court, Justice Thomas observed of the Washington State statute revoking beneficiary designations on divorce that "[u]niformity is impossible . . . if plans are subject to different legal obligations in different states."²¹⁵ In contrast, the California Act's authorization of voluntary employee contributions imposes no "legal obligations" on any California employer, as the Act does not require a

²¹¹ 498 U.S. 52 (1990). See Zelinsky, *supra* note 91, at 822-23.

²¹² The Pennsylvania law survived preemption as to insured ERISA plans as a permitted regulation of insurance. See *FMC Corp.*, 498 U.S. at 60.

²¹³ 29 U.S.C. § 1144(a) (2006).

²¹⁴ *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

²¹⁵ *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001).

California employer to make contributions. The Act simply permits supplemental contributions by an employer that elects to make such optional contributions. No California employer is legally obligated to make voluntary contributions – unlike the Washington State employers in *Egelhoff* who were legally required to follow that state’s law revoking beneficiary designations of former spouses.

Second, an employer in Washington State can elect “to opt out”²¹⁶ of the Washington State statute revoking beneficiary designations on divorce. As Justice Thomas pointed out, this “opt out” option, if replicated by other states, would threaten nationally uniform administration of ERISA-regulated plans by requiring an interstate employer to opt out state-by-state. Thus, if the Washington State statute at issue in *Egelhoff* were reproduced nationwide, “the burden” of opting out of each state’s statute would be “hardly trivial”.²¹⁷ As to the Washington law,

[i]t is not enough for plan administrators to opt out of this particular statute. Instead, they must maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes.²¹⁸

In contrast, a California employer need not elect against supplementary contributions under the Golden State’s Act. A California employer who is ignorant of the optional contributions authorized by the Act suffers no consequences. A nationwide employer could similarly ignore the voluntary employer contributions permitted by any other state statute modeled on the California Act. An employer need not “opt out” of a statute when compliance with that statute is voluntary – as is compliance with the California Act’s provisions permitting, but not requiring, supplementary employer contributions.

Thus, at the end of the day, whether ERISA preempts the California Act’s authorization of optional employer contributions depends (as does the ERISA preemption status of the Act’s employer mandate) upon the standard used to interpret ERISA § 514(a). Under the older, more sweeping *Shaw* test (“reference to or connection with”), ERISA

²¹⁶ *Id.* at 150.

²¹⁷ *Id.* at 151.

²¹⁸ *Id.*

preemption of state law is nearly automatic. By authorizing optional employer contributions, the California Act connects with employers' ERISA-regulated employee benefit plans by creating such plans when employers make optional contributions. *Shaw* thus counsels that § 514(a) preempts the Act's authorization of voluntary employer contributions as such employer contributions would convert the program created under the Act from an IRA payroll deduction arrangement without employer contributions into an ERISA-regulated employee pension plan with such contributions.

However, *Travelers'* more forgiving approach to ERISA preemption protects the Act's authorization of supplemental employer contributions under § 514(a). The California Act neither obligates employers to make voluntary contributions nor requires employers to affirmatively reject an obligation to make such contributions. Thus, the Act's authorization of optional employer contributions survives under the Supreme Court's more recent and more persuasive articulation of ERISA preemption in *Travelers*: employer contributions convert the program into an employee pension plan for ERISA purposes, but the Act imposes no obligations on employers which, under the more forgiving standards of *Travelers*, would trigger ERISA preemption.

Just as it is necessary to amend the Act to convert its notional, cash balance-style accounts into individual retirement accounts, it is also necessary to amend the Act's prohibition on supplementary employer contributions if such contributions "cause the program to be treated as an employee benefit plan under" ERISA.²¹⁹ The drafters of this provision evidently concluded that, if employer contributions convert the Golden State's program into an employee benefit plan for ERISA purposes, ERISA preemption necessarily follows.

Travelers points to a different conclusion: even though for ERISA purposes employer contributions convert the California program into an employee benefit plan for the employers making such optional contributions, the Act is not ERISA-preempted under *Travelers*. The employer contributions authorized under the Act are purely voluntary. The Act imposes no burden on California employers with respect to their retirement plans or with respect to the design or administration of their retirement plans. Hence, per *Travelers*, ERISA does not prohibit employer

²¹⁹ See CAL. GOV'T CODE §100004(e) (2012); CAL. GOV'T CODE §100012(k) (2012).

contributions under the program, even though such contributions convert the program to an employee pension plan for ERISA purposes. The Act should accordingly be amended to delete the Act's current requirement that employer contributions be suspended if they would "cause the program to be treated as an employee benefit plan under" ERISA.

IX. OTHER CHOICES

The foregoing analysis indicates that the Act would survive ERISA-preemption under *Travelers* were the Act amended to recast the California program's accounts as individual retirement accounts which allocate investment reward and loss to the individual account holder. If the Act were so amended, an employer's withholding under the California program would qualify as an IRA payroll deduction arrangement which is, for ERISA purposes, not an employee benefit plan since only amounts withheld from the employees' wages would be paid to the Trust. If any California employers make optional contributions under the Act, for those contributing employers, the program would become an employee pension plan, but would survive ERISA-preemption under *Travelers*. Under the older and tougher *Shaw* standard, the Act's employer mandate is ERISA-preempted, whether or not the employer makes supplementary contributions under the program. However, *Travelers* is the Court's later and more compelling construction of ERISA § 514(a);²²⁰ the Act, if amended to convert its formula-based notional accounts into individual retirement accounts, should survive ERISA preemption under *Travelers* since the Act would impose no obligations or burdens on employers and their retirement plans.

That the Act, as amended, would be legal does not mean that the Act, as amended, would be sound policy. In this final section, I outline some of the alternatives available to a state legislature (or a Congress) that contemplates following California's lead in encouraging retirement savings.

Any such outline starts with the fact that there is, as the Act's advocates observe, a serious problem, namely the failure of moderate and low-income workers to save for retirement. Some critics of the California

²²⁰ However, I continue to believe that there is a better approach to ERISA § 514(a) than either *Shaw* or *Travelers*, namely, construing § 514(a) as creating a presumption of preemption. See Zelinsky, *supra* note 102, at 839-58.

Act portray the Act as an effort to grab private savings to rescue underfunded pensions for public employees.²²¹ Even if that is so, the Act on its face is aimed at a real shortcoming in our national retirement system. Our defined contribution culture places the burden of retirement saving on the worker himself. Most low- and moderately-paid workers save little or nothing for retirement.²²²

Other commentators on the Act raise the opposite fear, namely that California's taxpayers will be seen as implicitly guaranteeing the cash balance-style defined benefits promised to participating employees under the Act in its current form.²²³ From this vantage, the ultimate risk down the road is not using private retirement savings to rescue public pensions, but requiring the public treasury to make good future underfunding of the notional, cash balance-style accounts created under the Act.

Both risks are mitigated if, as I urge, the Act's current notional, cash balance accounts are changed to true individual accounts which allocate directly investment risk and reward to the employee/account holders. If the Act's accounts are converted to individual retirement accounts, there would be no underfunding for California's taxpayers to finance since an individual retirement account holder is simply entitled to his or her account's current total, whatever that total may be in light of investment gains and losses. Moreover, it would be more difficult politically for a future legislature to divert funds from a Trust consisting of accounts under which each account holder, as an individual retirement account owner, has a claim for his particular investment-based balance rather than a fixed, formula-based benefit. As noted above, framing

²²¹ See, e.g., Mimi Walters, *The Government Seizure of Private Retirement Plans*, FOX & HOUNDS (Sept. 19, 2012), <http://www.foxandhoundsdaily.com/2012/09/the-government-seizure-of-private-retirement> (“SB 1234 looks like nothing more than a cynical effort to prop up the floundering public employee pension debt with new funds from private investors . . .”).

²²² LANGBEIN ET AL., *supra* note 6, at 26-27; FROLIK AND MOORE, *supra* note 103, at 5; see DEP'T OF THE TREASURY, *supra* note 5, at 124; see also S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (adding § 100008(c) to the CAL. GOV'T CODE (2012)). (“[O]ver 6.3 million California workers, 75 percent of whom earn less than \$50,000 per year, do not have access to retirement savings opportunities through their jobs.”).

²²³ Keegan, *supra* note 86; Danker, *supra* note 86; Lin, *supra* note 86; DeLeon, *supra* note 87.

matters.²²⁴ And it would matter to an account holder if his balance were reduced by a future legislature's diversion of assets to buttress public employees' pension plans.

Not every problem has a solution nor is the solution to every problem a statute or a public program. However, the supporters of the Act raise a compelling concern when they point to the systematic failure of less affluent workers to save adequately for retirement.

I conclude that, in this area, Brandeisian experimentation²²⁵ by the states is desirable, both to test different models (including the model of no state action) and to respond to different preferences (including a preference for no state action).²²⁶

To take one example, automatic enrollment is an area where state-by-state experimentation could prove productive. It is plausible for the California Act to let workers opt out of the program's coverage. If a low- or moderate-income worker finds her current cash needs too pressing to make retirement savings, that is a regrettable decision with long-term costs, though it is reasonable to let the worker make that decision for herself. On the other hand, if a state legislature with more paternalistic instincts were to make retirement savings mandatory with no ability to opt out, the resulting experiment might produce useful information. While I am skeptical of such paternalism, a preference for state experimentation entails an openness to experiments about which one is not particularly enthusiastic.

At the other end of the spectrum, an equally plausible choice is for states to continue to do nothing about the problem of private retirement savings. There is a vigorous market in retirement products, plans, and services;²²⁷ the federal government gives tax credits to both small

²²⁴ See sources cited *supra* note 172.

²²⁵ The classic statement of the states as laboratories for experimentation is Justice Brandeis's dissent in *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932).

²²⁶ My predisposition for state experimentation leads me to skepticism about ERISA preemption, which, even under *Travelers*, emphasizes national uniformity. See Zelinsky, *supra* note 102, at 865-68; Zelinsky, *Golden Gate II*, *supra* note 199, at 514.

²²⁷ Indeed, the financial services industry has been the sales force for the defined contribution paradigm, providing services, investments and plans. Zelinsky, *supra* note 66, at 51-52, 96-97.

employers establishing qualified plans²²⁸ and to low-income individuals undertaking retirement savings.²²⁹ A state legislator concerned about the negligible retirement savings of rank-and-file workers could reasonably conclude that these market-based alternatives and federal tax credits occupy the field to the exclusion of any state-based policies.

Alternatively, that legislator could conclude that the state, instead of enacting a California-style Act, should supplement the federal tax credits for employers and workers with state tax credits, just as some states supplement the federal earned income tax credit²³⁰ with an additional state tax credit on earned income.²³¹ Or that legislator could instead define the problem as lack of knowledge and conclude that the appropriate state policy is to publicize the federal tax credits for small employers establishing qualified plans and for low-income workers who save for their respective retirements.²³²

Among the interesting features of the California Act is the prospect²³³ (some would say, inevitability)²³⁴ that CalPERS, the state pension plan for the Golden State's public employees, will invest part or all of the funds held by the Trust for private sector workers. If the legislature proceeds with the Trust retaining the Act's notional, cash balance-style accounts, having a state pension fund take responsibility for the Trust's investments increases the risk that a future legislature will be compelled to use taxpayer funds to cure any shortfall. Even though the California legislature has explicitly disclaimed any state guarantee of the program's accounts,²³⁵ if CalPERS (or another public agency) oversees the investment of employees' withheld wages, at least some participants in the

²²⁸ I.R.C. § 45E (2006).

²²⁹ I.R.C. § 25B (2006).

²³⁰ I.R.C. § 32 (2006).

²³¹ See, e.g., N.Y. TAX LAW § 606(d) (McKinney 2014); Marc Heller, *State Battles Loom on Earned Income Tax Credit, Consultants Tell Staffers*, BLOOMBERG BNA DAILY TAX REPORT, Jan. 25, 2013, at G-1.

²³² The California Act authorizes the board in charge of the program and Trust to "[d]isseminate information" about these federal tax credits. S.B. 1234, 2012 Leg., Reg. Sess. (Cal. 2012) (adding § 100012(e) to the CAL. GOV'T CODE (2012)).

²³³ S.B. 1234 (Cal. 2012) (adding § 100004(c) to the CAL. GOV'T CODE § (2012)).

²³⁴ Keegan, *supra* note 86.

²³⁵ S.B. 1234 (Cal. 2012) (adding §§ 100013, 100014(c)(3), 100036 to the CAL. GOV'T CODE (2012)).

state-sponsored program will conclude that the state which, through its pension fund, directs the investment of their retirement savings stands behind the investment performance of the state's own agency. The disclaimer of state liability the California legislature placed in the Act²³⁶ can be eliminated by a future legislature. There will be greater political pressure to cure any future shortfall with tax-generated funds if the California's own pension fund fails to achieve the stated, cash balance-style return promised to program participants by the board.

Even if the California legislature amends the Act to create true individual retirement accounts or another state's legislature modifies California's approach to create such accounts, state pension funds have not been without their own problems.²³⁷ Moreover, if bona fide individual retirement accounts were invested by CALPERs or another state agency, some account holders will likely conclude that the state is, at some level, a guarantor of adequate investment performance.

On the other hand, prominent invoices, including David Swenson,²³⁸ Professor Forman,²³⁹ and Professor Munnell,²⁴⁰ argue that rank-and-file employees will never be good investors. From this premise, it is a potentially valuable service for the state to provide to these employees state pension plans' professional investing skills to manage

²³⁶ *Id.* (adding § 100013 to the CAL. GOV'T CODE (2012)).

²³⁷ Peter Lattman, *Ex-Chief of Calpers is Charged with Fraud*, N.Y. TIMES, March 19, 2013, at B3; Reuven Fenton and Carl Campanile, *Jailbird Hevesi is Free Out after 20 Mos.*, N.Y. POST, Dec. 13, 2012, at 8; Edward A. Zelinsky, *Public Pensions' Unrealistic Rate of Return Assumptions*, OUPBLOG (Aug. 6, 2012, 8:30AM), <http://blog.oup.com/2012/08/public-pensions-unrealistic-rate-of-return-assumptions/>; Edward A. Zelinsky, *Public Pensions, Private Equity, and the Mythical 8% Return*, OUPBLOG (March 5, 2012, 8:30AM), <http://blog.oup.com/2013/03/public-pensions-private-equity-return/>.

²³⁸ DAVID F. SWENSEN, UNCONVENTIONAL SUCCESS: A FUNDAMENTAL APPROACH TO PERSONAL INVESTMENT 4 (2005) ("Even with a massive educational effort, the likelihood of producing a national of effective investors seems small.").

²³⁹ Jonathan Barry Forman & Gordon D. Mackenzie, *Optimal Rules for Defined Contribution Plans: What Can We Learn from the U.S. and Australian Pension Systems*, 66 TAX LAWYER 613, 633 (2013) ("On average, individual workers tend to be pretty poor investors.").

²⁴⁰ ALICIA H. MUNNELL, STATE AND LOCAL PENSIONS: WHAT NOW 187 (2012) ("Since employees shoulder all the risks in a 401(k) system, they have to make good decisions for tehse plans to work well. But employees make mistakes at every step along the way.").

such employees' retirement accounts.

Here again my personal preference is for state experimentation, despite my skepticism about some of the possible experiments.²⁴¹ A state could plausibly mandate that every private employer maintain an retirement savings arrangement for its employees (whether a qualified plan or a payroll deduction IRA program) without the state itself getting into the business of investing private employees' retirement savings.²⁴² This is the approach embodied in President Obama's proposed employer mandate, i.e., employers with more than ten employees would be required to maintain retirement plans or IRA savings programs, but there would be no public investment vehicle like the California Trust.²⁴³

The argument for investing retirement funds privately (rather than through a public entity like the Trust) is reinforced by both the DOL's recently-adopted regulations requiring fee disclosure²⁴⁴ and soon-to-be proposed regulations heightening the fiduciary obligations of investment advisors.²⁴⁵ If successful, these regulations should reduce the fees paid by pension plans and participants and should better align the interests of investment counselors with the interests of these plans and participants. The skeptics²⁴⁶ could retort that, even with these desirable changes, most employees will never be good investors and thus would benefit from the investment services of CalPERS and other professionally-run state pension funds. Different states' experiments would help determine who is right.

Yet a final alternative for a legislature favoring the kind of cash

²⁴¹ Edward A. Zelinsky, *State-Administered Retirement Plans for the Private Sector: A Bad Idea*, OUPBLOG (May 21, 2008, 12:55 PM), http://blog.oup.com/2008/05/private_sector_retirement_plans/.

²⁴² See JONATHAN BARRY FORMAN, *MAKING AMERICA WORK* 234 (Kathleen Courrier et. al. eds., 2006) ("Employers without a retirement plan should be required to offer payroll-deduction IRAs to interested employees.").

²⁴³ DEP'T OF THE TREASURY, *supra* note 5, at 125.

²⁴⁴ 29 C.F.R. § 2550.404a-5(c) (2013). While there is substantial merit to these new regulations, the adoption of these (and other) new regulations should be offset by countervailing reductions of other, less productive regulatory burdens. Edward A. Zelinsky, *The Paternalistic Ideology of ERISA and Unforgiving Courts: Restoring Balance Through a Grand Bargain*, 26 HOFSTRA LAB. & EMP. L.J. 341, 350-53 (2009).

²⁴⁵ Kristen Ricaurte Knebel, *Fiduciary Re-Proposal "Not Finished," Will Go To OMB Next Year, Borzi Says*, BNA PENSION & BENEFITS DAILY, Nov. 16, 2012, at 4.

²⁴⁶ Swensen, *supra* note 237, at 4; Forman & Mackenzie, *supra* note 238, at 633; Munnell, *supra* note 239, at 187.

balance formula embodied in the Act would be to mandate that employers purchase for their otherwise uncovered employees individual retirement annuities²⁴⁷ offered by insurance companies. State-mandated annuities are likely to meet greater popular resistance than state-mandated accounts. In our defined contribution culture, the norm for savings is today based on the account model.²⁴⁸ But cultures change and can be changed.

A particular interesting variant of the mandatory annuity alternative is for the state requiring such annuities to charter a state-sponsored insurance company to provide annuities. A state-run company could be the exclusive purveyor of annuities for those employees participating under the state retirement savings program or the state provider of annuities could instead be a TVA-style public option, competing against private insurers. While my personal enthusiasm for this possibility is limited, a commitment to Brandeisian experimentation implies that I could be surprised.

X. CONCLUSION

The California Secure Choice Retirement Savings Trust Act is important both because of California's size and status as a trendsetter and because the Act targets a pressing problem, the lack of retirement savings by low-income workers. The notional cash balance-style accounts created by the Act do not qualify as individual retirement accounts since the accounts authorized by the Act create a defined benefit-type, formula-based claim against a collectively-managed fund. Under the Code and ERISA, individual retirement accounts directly allocate investment gains and losses to the individual account holder.

The Act could be amended to recast its accounts as true individual retirement accounts that assign investment risk and loss directly to the account holder. If so, the Act's employer mandate and supplemental employer contributions should survive ERISA-preemption under *Travelers*. Legality does not equate with wisdom and thus the Act, along with President Obama's proposed federal mandate, should provoke debate about the need and best means to encourage greater retirement savings by the less affluent. In that debate, I favor state-by-state experimentation rather than any single approach to the task of encouraging greater retirement savings.

²⁴⁷ I.R.C. § 408(b) (2012).

²⁴⁸ Zelinsky, *supra* note 66, at 31-37.

MINDING THE GAP: SEEKING AUTISM COVERAGE IN CLASS ACTIONS WHEN STATE AND FEDERAL LAWS FAIL

DANIELLE M. JAFFEE*

This Note examines the recent trend towards class actions to challenge insurers' denial of autism treatment coverage. The author examines how state and federal laws regarding insurance coverage of autism treatment creates a gap allowing insurers to deny coverage, even in spite of the overwhelming proof of the beneficial nature of autism treatment for autistic individuals. Past individual challenges of insurers' actions gave little guidance to consumers about the legal obligations of insurers for autism treatment and recent collective action has done little to provide more. The author examines the decisions of three courts determining the certification of class challenges to insurers' denials, and proffers how consumers can successfully challenge insurers' practices in class actions moving forward.

I. INTRODUCTION

Currently one in sixty-eight children in the United States is diagnosed with Autism Spectrum Disorder, a number that continues to increase nearly seventeen percent each year.¹ These growing numbers have put increasing pressure on insurance companies to determine what, if any, coverage they provide for individuals living with autism and even more pressure on governments to enact laws ensuring assistance for thousands of citizens.² The pressures and actions of insurers, though plentiful, have left a

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¹ *Autism Has High Costs to U.S. Society*, HARVARD SCH. OF PUB. HEALTH (Apr. 25, 2006), <http://archive.sph.harvard.edu/press-releases/2006-releases/press-04252006.html> [hereinafter *High Costs*]; *CDC Estimates 1 in 68 Children has Been Identified with Autism Spectrum Disorder*, CTRS. FOR DISEASE CONTROL AND PREVENTION (March 27, 2014), http://www.cdc.gov/media/releases/2014_p0327-autism-spectrum-disorder.html.

² *See generally Insurance Coverage for Autism*, NAT'L CONFERENCE OF STATE LEGISLATURES (Aug. 2012), <http://www.ncsl.org/issues-research/health/autism->

clear gap of coverage for autism treatment in the self-insured market. With no federal or state laws to fall back on, individuals are often forced to turn to the legal system for assistance. While individual claims for autism treatment have been brought before the courts for over twenty years, a recent trend towards class actions has painted an unclear picture of the rights of the insured to challenge insurers and the ability of courts to allow class challenges in an area generally considered one of individual review by insurance companies.

This Note examines the recent movement toward class action lawsuits against health insurance providers to ensure coverage for autism treatment. Part II reviews what autism is, its growing prevalence in the United States, and its treatment. Part III provides a brief overview of state and federal laws regarding insurance coverage of autism treatment and why it leaves the door open for courtroom battles. Part IV examines past individual legal challenges for coverage that set the stage for current class actions. Part V discusses several recent claims for coverage through class action lawsuits and the vastly different and contradictory rulings district courts issued regarding class certification. Part VI compares the class actions and how the divergent court rulings fail to provide a legal bridge for the autism coverage gap created by federal and state laws. Finally, part VII looks to establish an approach to determine class certification for future class action filings on autism coverage in light of the confusing precedent.

II. AUTISM: WHAT IT IS, HOW TO TREAT IT, AND ITS GROWING PREVALENCE IN AMERICA

Autism is a developmental disease that is being diagnosed at increasing rates in America. It is generally held that early intervention and treatment of autism helps children better develop, however, disputes frequently arise between individuals, health care providers, and insurers as a result of the nature of treatment championed for autistic children.

and-insurance-coverage-state-laws.aspx [hereinafter NCSL]; *Essential Health Benefits*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Feb. 19, 2014); *Preventative Care*, HEALTHCARE.GOV, <http://www.hhs.gov/healthcare/rights/preventive-care/index.html> (last visited Feb. 19, 2014).

A. AUTISM, THE DISEASE

The National Institute of Child Health and Human Development defines autism as a complex developmental disability that results in problems with social interactions and communication.³ Autism manifests itself in individuals differently and thus there are varying diagnoses that require different levels and amounts of therapy.⁴ Combined, “classic” autism, Asperger syndrome, and atypical autism (often diagnosed as Pervasive Developmental Disorder) are part of the Autism Spectrum Disorder⁵ (ASD).⁶

Autism usually emerges in a child before the age of three and is diagnosable under the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV).⁷

Although at one time it was believed that autism was a product of nurture rather than nature, recent research has shown a clear link between autism and genetics. Several studies which examined familial relationships and autism diagnoses show that in families where one child has been diagnosed with autism there is an increased likelihood that a second child in the family will also be diagnosed with autism.⁸ While studies continue to shed light on certain factors that increase the risk of autism, including birth

³ *Autism Spectrum Disorder (ASD): Condition Information*, NAT’L INST. OF CHILD HEALTH & HUMAN DEV. (Dec. 18, 2012), <http://www.nichd.nih.gov/health/topics/autism/conditioninfo/Pages/default.aspx> [hereinafter NICHD].

⁴ *Id.*

⁵ For purposes of this Note, the use of the term autism will encapsulate all Autism Spectrum Disorders.

⁶ NICHD, *supra* note 3.

⁷ *Facts, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 20, 2013), <http://www.cdc.gov/ncbddd/autism/facts.html>; *Diagnostic Criteria, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 26, 2013), <http://www.cdc.gov/ncbddd/autism/hcp-dsm.html>; THE DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS, §299.00 (Am. Psychiatric Ass’n 4th ed.) (1994).

⁸ Two studies have shown that parents who have a child diagnosed with ASD have a 2-18% chance of having a second child diagnosed with ASD; while other studies have shown an increased diagnosis rate of 36-95% in identical twins when one child is diagnosed with ASD. *Research, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 19, 2012), <http://www.cdc.gov/ncbddd/autism/research.html#howmany>.

to older parents⁹ and children with certain genetic or chromosomal conditions,¹⁰ there is still much unknown about what causes autism. Currently, the CDC is conducting a multi-year study to identify additional factors linked to autism diagnoses.¹¹

B. THE GROWING PREVALENCE OF AUTISM

In the last forty years the diagnoses of autism in the United States have increased substantially. In 1975 the prevalence of autism diagnoses per person was 1 in 5,000; in 1985 it increased to 1 in 2,500 and in 1995 it reached 1 in 500.¹² Since 2001 the number has increased from 1 in 250 to 1 in 68 in 2014.¹³ Autism is now more common than Down syndrome or childhood cancer.¹⁴ Autism diagnosis trends also show a bigger impact on males. The current diagnosis rates reflect boys are five times more likely to be diagnosed with autism than girls.¹⁵

Currently, over 1.5 million Americans are diagnosed with autism. While the number is alarming, more alarming is that the rate of individuals diagnosed with autism is growing 10-17% per year, meaning in five years the number of individuals in America diagnosed with autism could be larger than the population of New Hampshire.¹⁶

⁹ Maureen S. Durkin et al., *Advanced Parental Age and the Risk of Autism Spectrum Disorder*, 168 AM. J. EPIDEMIOLOGY 1268, 1268 (2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2638544/pdf/kwn250.pdf>.

¹⁰ *Data and Statistics, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 26, 2013), <http://www.cdc.gov/ncbddd/autism/data.html> [hereinafter *Data and Statistics*].

¹¹ *SEED, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 3, 2014), <http://www.cdc.gov/ncbddd/autism/seed.html>.

¹² *AUTISM SPEAKS, SELF-FUNDED EMPLOYER TOOL KIT 22*, available at http://www.autismspeaks.org/sites/default/files/docs/gr/erisa_tool_kit_9.12_0.pdf [hereinafter *Employer Toolkit*].

¹³ *CDC Estimates 1 in 68 Children has Been Identified with Autism Spectrum Disorder*, CTRS. FOR DISEASE CONTROL & PREVENTION (March 27, 2014), <http://www.cdc.gov/media/releases/2014/p0327-autism-spectrum-disorder.html>.

¹⁴ Geoffrey Cowley, *Understanding Autism*, NEWSWEEK (July 30, 2000, 5:20 PM), <http://www.newsweek.com/understanding-autism-161485>.

¹⁵ Boys are diagnosed at a rate of 1 in 54 while girls are diagnosed at a rate of 1 in 252. *Data and Statistics*, *supra* note 10.

¹⁶ *High Costs*, *supra* note 1; *New Hampshire QuickFacts from the US Census Bureau*, U.S. CENSUS BUREAU (Jan. 16, 2014), <http://quickfacts.census.gov/qfd/states/33000.html>.

C. TREATING AUTISM SPECTRUM DISORDERS

Much of the discussion pertaining to insurance coverage for autism centers on insurance companies covering the treatment expenses that a family incurs as a result of the diagnosis. Because autism is a developmental disorder, the treatment of the disease focuses on not only medication, but additionally, social skills, communication, speech therapy, and sensory integration training.¹⁷ Such therapies are often deemed by insurance companies to be either educational or experimental,¹⁸ thus eliminating their burden to provide coverage because insurance policies exclude “experimental” and “educational” treatments as terms of their contract.¹⁹

The key to treatment for autism comes from research establishing that early intervention can dramatically improve a child’s development and therefore children with autism are encouraged to begin receiving services between birth and three years of age.²⁰ Thus, the bulk of expenses for autism treatment come between the first few years of life when children are undergoing intensive treatment programs to ensure steady development.

The most notable form of treatment and the central issue at hand in the pending class actions against insurers is Applied Behavioral Analytics (ABA). ABA is defined as “the science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change.”²¹ ABA therapy is a highly structured one-on-one coaching led by a certified instructor in which a child engages

¹⁷ *Treatment, Autism Spectrum Disorders*, CTRS. FOR DISEASE CONTROL & PREVENTION, (Dec. 20, 2013), <http://www.cdc.gov/ncbddd/autism/treatment.html> [hereinafter *Treatment*].

¹⁸ Insurance companies commonly provide themselves a loophole that allows them to deny a request for coverage of experimental treatments, favoring instead that all procedures covered are thoroughly tested and proven effective. *See generally* Jim Williams, *When Insurers Won’t Pay for Experimental Treatments*, ABC NEWS (Feb. 22, 2012), <http://abcnews.go.com/WNT/story?id=131212&page=1>.

¹⁹ Angela Barner, *Unlocking Access to Insurance Coverage for Autism Treatment*, 6 J.L. ECON. & POL’Y 107, 108 (2009).

²⁰ *Treatment*, *supra* note 17.

²¹ Paul Mooney et. al., *Behavior Modification/Traditional Techniques for Students with Emotional and Behavioral Disorders*, in 22 BEHAVIORAL DISORDERS: IDENTIFICATION, ASSESSMENT, AND INSTRUCTION OF STUDENTS WITH EBD 173, 174 (Jeffrey P. Bakken et al. eds., 2012).

in positive reinforcement exercises targeting areas such as language, play, learning, and real-life functioning.²² Studies and advocates strongly encourage the use of ABA treatment in the early stages of life to ensure proper development for children with autism, often stating that if a child receives ABA therapy early there is a strong likelihood that the child will eventually be able to attend regular classes.²³

Behavior analysis treatment for children with autism started in the 1960s when Ivar Lovaas and others at the University of California, Los Angeles, conducted a study amongst forty children diagnosed with autism and subjected them to various amounts of behavior analysis treatment.²⁴ The original study showed a substantial improvement in individuals that underwent forty hours of one-on-one ABA treatment, many of whom were successfully mainstreamed into a regular classroom.²⁵ Further studies have also shown that ABA therapy results in long and short-term gains in intellectual function and educational progress.²⁶

In 1999, the U.S. Department of Health and Human Services issued a report of the Surgeon General on mental health showing substantial support for ABA therapy and its proven efficacy.²⁷ Then again in 2001, the U.S. Surgeon General's report on mental health further corroborated these findings, asserting that ABA therapy minimizes socially unacceptable behavior while increasing socially appropriate behavior, communication skills, and learning abilities for children with autism.²⁸

As a result of years of toting the advantages of ABA therapy, most autistic children participate in the intensive program. Generally, the treatment is administered for thirty to forty hours a week for three to four years, costing families several thousands of dollars.

²² Iver Peterson, *High Rewards and High Costs As States Draw Autistic Pupils*, N.Y. TIMES (May 6, 2000), <http://www.nytimes.com/2000/05/06/nyregion/high-rewards-and-high-costs-as-states-draw-autisticpupils.html?page-wanted=all&src=pm>.

²³ Barner, *supra* note 19, at 110; Peterson, *supra* note 22.

²⁴ Beth Rosenwasser & Saul Axelrod, *The Contributions of Applied Behavior Analysis to the Education of People with Autism*, 25 BEHAV. MODIFICATION 671, 672 (October 2001), available at <http://bmo.sagepub.com/content/25/5/671>.

²⁵ *Id.* at 672.

²⁶ Barner, *supra* note 19, at 111.

²⁷ U.S. DEP'T OF HEALTH AND HUMAN SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 163-64 (1999), available at <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.

²⁸ Barner, *supra* note 19, at 111.

D. THE COSTS OF TREATMENT: HEAVY BURDENS ON FAMILIES AND STATES BUT POCKET CHANGE FOR INSURERS

In 2006, Harvard released a report by Michael Ganz, MS, PhD that examined the growing costs of autism coverage on individuals, families, and society.²⁹ The report found that it costs society \$35 billion annually to care for individuals with autism and \$3.2 million for an individual to cover their own care over a lifetime.

Further, Ganz and other studies have found, individuals with autism incur twice as many expenses for care as the typical American in their lifetime. Reports have shown that it can total up to \$81,900 for a family to provide adequate treatment to a child with autism, including speech therapy, occupational therapy, and ABA treatment.³⁰ A child with autism will incur 2.5 times more outpatient costs and 2.9 times more inpatient costs in their lifetime than an individual without autism.³¹ These costs only increase if an individual's insurance company fails to cover even some of the treatment.

Ganz's report also examined the cost to society as a whole for autism. These figures considered the effect of autism on both individuals with the disease and their family/caregivers. Considerations included the lower level of employment procured by autistic individuals, including decreased pay and benefits, as well as lower savings value due to increased expenses for medical treatment, therapies, and special programming requirements.³² The study also accounted for the loss or impairment of work time for family members of autistic individuals, including missed work, reduced hours, lower-paying jobs with more flexible requirements, or leaving the workforce entirely to care for their autistic family member.³³

While the numbers for individuals and families coping with autism are often staggering and equivalent to an individual's annual income, the cost for insurers is far less. The Council for Affordable Health Insurance (CAHI) released information in 2009 claiming that an autism mandate,

²⁹ See generally Michael L. Ganz, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, 161 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 343 (2007).

³⁰ Laura C. Hoffman, *Ensuring Access to Health Care for the Autistic Child: More is Needed Than Federal Health Care Reform*, 41 SW. U. L. REV. 435, 437 (2012).

³¹ *Id.*

³² Ganz, *supra* note 29, at 348.

³³ *Id.* at 344.

legislation that requires health insurers to cover autism treatment, only increases the cost of health insurance by about 1%.³⁴ CAHI cautions that the cost could increase if more services are mandated, but they still estimate only a one to three percent increase.³⁵

Further, in the absence of insurance coverage, many families that cannot carry the financial burden of treatment expenses move their children into the Medicaid system, which may cover autism treatment at a higher rate than private insurers. Medicaid coverage is often superior to private insurance because state Medicaid programs offer some level of mental health services coverage and reimbursement,³⁶ while private insurance may not. With nearly 50% of Medicaid beneficiaries suffering from diagnosable mental health disorders in a given year,³⁷ the pressure to keep citizens with access to private health insurance out of the state Medicaid programs is growing. The more individuals with medical conditions that the Medicaid system absorbs, the greater financial burden placed on a state to finance the expanding costs of the program, an even heavier burden with many states struggling from significant state budget deficits.

III. WHAT THE LAWS SAY AND WHY IT IS A BATTLE FOR COVERAGE

Over the last few decades autism coverage proponents have experienced a number of victories in the quest to ensure coverage. However, even in light of moves by both the federal and state governments, efforts have fallen short of reaching millions of Americans, most notably those covered by employer-sponsored health plans.³⁸

³⁴ Victoria C. Bunce, *The Growing Trend Toward Mandating Autism Coverage*, 152 COUNCIL FOR AFFORDABLE HEALTH INS. ISSUES & ANSWERS (Mar. 2009), available at www.cahi.org/cahi_contents/resources/pdf/n152AutismTrend.pdf.

³⁵ *Id.*

³⁶ *Mental Health Services*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Mental-Health-Services-.html> (last visited Mar. 22, 2014).

³⁷ BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH: PREVENTION WORKS, TREATMENT IS EFFECTIVE, PEOPLE RECOVER, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 1, 7, available at http://www.hhs.gov/partnerships/aca_act_and_community/aca_behavioralhealth.pdf.

³⁸ *Employer Toolkit*, *supra* note 12, at 33.

A. FEDERAL

The work on the federal level to guarantee autism coverage has been spotty at best. The federal government has made broad strokes in an attempt to make mental illness and behavioral treatment a staple of health plan coverage. However, while these efforts are admirable, each one falls short of truly providing coverage for such ailments.

At the forefront of autism coverage is the Mental Health Parity Act, originally passed by Congress in 1996 and amended to fix certain loopholes in 2008.³⁹ Together the laws require group health plans to establish financial requirements and treatment limits for mental health and substance abuse services that are no less restrictive than the requirements and limitations imposed on medical and surgical benefits.⁴⁰ Mental Health Parity impacts autism coverage in that the DSM, which serves as the basis for the definition of mental health ailments for both laws and insurers, clearly classifies autism as a mental health disorder. The problem with the act as it is structured is that it does not require mental health benefits coverage; it simply states that if, and only if, a health plan already covers mental health, such benefits shall be no less restrictive. This in turn leaves the option open for health insurers to simply not offer mental health coverage to avoid being subject to such regulations.

Another federal attempt at providing mental health coverage, and specifically autism coverage, to citizens can be found in the Patient Protection and Affordable Care Act (ACA). First, section 1302(b) of the ACA requires all individual and small group plans to provide coverage for “essential benefits.”⁴¹ Originally the Secretary of Health and Human Services was slated to establish a list of required essential benefits that each state must use as their minimum requirements, giving autism advocates hope that treatment would be covered under the mental health and behavioral health treatment category of “essential benefits.”⁴² However, in December 2011, the administration announced the intention that each state would be free to create their own list of “essential benefits” to serve as the

³⁹ 42 U.S.C. § 300gg-26 (2006).

⁴⁰ *Id.*

⁴¹ CENTER FOR CONSUMER AND INSURANCE OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., ESSENTIAL HEALTH BENEFITS BULLETIN 1-2 (2011), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

⁴² See generally AUTISM SPEAKS, COVERAGE OF AUTISM SERVICES UNDER THE AFFORDABLE CARE ACT’S ESSENTIAL HEALTH BENEFITS PACKAGE (Oct. 11, 2011).

benchmark for all small and individual plans sold within the state.⁴³ Resulting from the state flexibility approach, only eleven states deemed autism treatment coverage an essential benefit in their benchmark plans.⁴⁴

Second, section 1001(5) of the ACA requires small group and individual health plans to provide preventative care services at no cost to the insured.⁴⁵ As established by the Department of Health and Human Services, based in part on the recommendation and scoring of the U.S. Preventative Services Task Force, autism screenings for children aged eighteen to twenty-four months are considered a mandatory preventative service.⁴⁶

While the efforts of ACA will undoubtedly help provide coverage to many individuals, it still falls short of reaching the growing number of plans that are just outside of the federal regulations. Large group plans are specifically exempt in the language of the ACA.⁴⁷ Any employer-sponsored plan or individual health plan that was established prior to the passing of the ACA is deemed grandfathered, and thus protected from such requirements so long as they maintain grandfather status, which, for many, will be several years.⁴⁸ Self-funded benefit plans are regulated by the

⁴³ Christine Vestal & Matt McKillop, *Health Law Explained: The States Gain New Flexibility in Setting Policies*, THE PEW CHARITABLE TRUSTS (Jan. 3, 2012), <http://www.pewstates.org/projects/stateline/headlines/health-law-explained-the-states-gain-new-flexibility-in-setting-policies-85899375384>.

⁴⁴ Christine Vestal, *Q&A: How ACA Will Affect People With Autism*, THE PEW CHARITABLE TRUSTS (Aug. 9, 2013), <http://www.pewstates.org/projects/stateline/headlines/qa-how-aca-will-affect-people-with-autism-85899496217>.

⁴⁵ See 42 U.S.C. § 300gg-13 (2012) (codifying § 1001(5) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)).

⁴⁶ *What Are My Preventative Care Benefits?*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3> (last visited Dec. 17, 2013).

⁴⁷ Sarah Barr, *FAQ: Grandfathered Health Plans*, KAISER HEALTH NEWS (Nov. 13, 2013), <http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx>.

⁴⁸ The law is structured to remove grandfathered status once a plan makes “significant” changes that result in increased costs or decreased benefits to participants. This caveat ensures that inevitably most, if not all, plans will comply with the ACA requirements. Current studies state that the number of individuals covered by grandfathered plans has begun to steadily decline and will continue downward in the coming years. Current numbers show that 48% of those covered by their employers are enrolled in grandfathered plans in 2012, down from 54% in 2011. *Id.*

Employee Retirement Income Security Act and exempt from all requirements described above under federal law.

B. STATE

In the absence of comprehensive requirements on the federal level for autism coverage, many states have taken it upon themselves to implement legislation requiring insurers to cover autism. Indiana passed the first meaningful piece of autism coverage legislation in 2001. The law requires individual and group insurance plans to provide coverage for the treatment of pervasive developmental disorders, including autism, that have been prescribed by an individual's treating physician.⁴⁹

It was not until several years later that the movement to require autism coverage took hold and laws began appearing in several states. Currently thirty-seven states and the District of Columbia have laws that address autism coverage, with the bulk of states adopting such legislation in the last four to five years.⁵⁰

The content of autism coverage laws varies from state to state, with thirty-one states specifically requiring insurers to provide for the treatment

⁴⁹ IND. CODE §§ 27-8-14.2-3, 27-8-14.2-4, 27-8-14.2-5 (2013).

⁵⁰ Nine states adopted laws in the 2007-2008 legislative session, eight states in the 2009 legislative session, nine states in the 2010 legislative session, six states in 2011, and three states in 2012. NCSL, *supra* note 2; ALA. CODE § 27-54A-2 (2013); ALASKA STAT. § 21.42.397 (2012); ARIZ. REV. STAT. ANN. §§ 20-826.04, 20-1057.11, 20-1402.03, 20-1404.03 (2007); ARK. CODE ANN. § 23-99-418 (2013); CAL. HEALTH & SAFETY CODE §§ 1374.72, 1374.73 (2013); COLO. REV. STAT. § 10-16-104 (2013); DEL. CODE ANN. tit. 18, § 3366 (2013); FLA. STAT. §§ 627.6686, 641.31098 (2013); 215 ILL. COMP. STAT.5/356Z.14 (2013); IND. CODE §§ 27-8-14.2, 27-13-7-14 (2013); IOWA CODE § 514C.28 (2013); KAN. STATE ANN. § 76-6524 (2013); KY. REV. STAT. §§ 304.17A-142, 143 (2013); LA. REV. STAT. ANN. § 22:1050 (2013); ME. REV. STAT. ANN. tit. 24-A § 2768 (2013); MASS. GEN. LAWS ANN. ch. IV §§ 32A-22, 25 (2013); MICH. COMP. LAWS ANN. § 550.1416e (2013); MO. REV. STAT. § 376.1224 (2013); MONT. CODE ANN. §§ 33-22-515, 33-22-706 (2013); NEV. REV. STAT. § 689A.0435, 689B.0335 (2013); N.H. REV. STAT. ANN. § 417-E:1-2 (2013); N.J. REV. STAT. §§ 17:48-6ii, 17:48-A-7ff, 17B:26-2.1cc, 17B:27-46.iii, 17B:27A-7.16, 17B:27A-19.20 (2013); N.M. STAT. ANN. §§ 59A-22-49, 59A-23-7.9, 59A-46-50, 59A-47-45 (2013); N.Y. INS. LAW §§ 3216, 3221 (2013); R.I. GEN. LAWS § 27.20.11 (2013); S.C. CODE ANN. § 38-71-280 (2013); TEX. INS. CODE ANN. § 1355.015 (2013); VT. STAT. ANN. tit. 8 § 4088i (2013); VA. CODE ANN. § 38.2-3412.1:01 (2013); W. VA. CODE § 5-16B-6e (2013); WIS. STAT. § 632.895(12m) (2013).

of autism.⁵¹ Overall, the laws implemented throughout the country establish varying annual cap limits on how much an insurer is required to pay out, from no limit to \$50,000 a year, and also varying age limits that an insurer is required to cover, such as coverage for life or just for the first two to six years of life.⁵²

While states have made great strides to ensure autism coverage for their citizens, it should be noted that because of the Employee Retirement Income Security Act (ERISA) pre-emption discussed next, self-insured plans⁵³ are exempt from these state level requirements. This means that 29% of children aged 0-18 that are covered by self-insured plans might not have autism coverage.⁵⁴ While several self-insured plans, such as those offered by Microsoft, Eli Lilly, and Home Depot, voluntarily provide autism benefits,⁵⁵ such actions are not mandated by law and therefore there is no guarantee as health care expenses rise that these companies will continue to provide these benefits.

C. ERISA

One of the biggest roadblock to coverage for autism can be found in ERISA. While efforts have been made on the federal level to establish requirements of coverage and equal treatment, and even on the state level to specifically require autism coverage, many plans can still be exempt from such mandates⁵⁶ leaving millions⁵⁷ without a safety net.

ERISA applies to health benefit plans offered in the private industry, but its most notable impact on health insurance laws comes in its protection of self-insured plans – or plans where the employer has taken on

⁵¹ NCSL, *supra* note 2.

⁵² *Employer ToolKit*, *supra* note 12, at 25.

⁵³ The term self-insured plan refers to health benefit plans in which the plan sponsor, an employer, directly funds the health benefits for its enrollees. In contrast, fully-insured plans refer to situations in which an employer purchases group health insurance from an insurer. Michael J. Brien & Constantijn W.A. Panis, *Self-Insured Health Benefit Plans*, U.S. DEP'T OF LABOR 4 (Mar. 23, 2011), <http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport032811.pdf>.

⁵⁴ *Employer Toolkit*, *supra* note 12, at 33.

⁵⁵ *Id.* at 35.

⁵⁶ 29 U.S.C. § 1144 (2006).

⁵⁷ *Employer Health Benefits: 2013 Summary of Findings*, KAISER FAMILY FOUND. & HEALTH RES. & EDUC. TRUST, 1 (Aug. 20, 2013), [available at http://kff.org/private-insurance/report/2013-employer-health-benefits/](http://kff.org/private-insurance/report/2013-employer-health-benefits/).

the financial risk of funding, managing, and administering, its health plan.⁵⁸ Under section 514 of ERISA, self-insured health benefit plans are insulated from many state insurance laws, specifically state insurance mandates. While the first clause, section 514(a), establishes the broad preemption power of ERISA,⁵⁹ specifically, the Supreme Court has held that the key term of section 514(a), “relate to,” should be given its “broad common-sense meaning,” so as to displace all state laws that are in connection with, or making reference, to an employee benefit plan,⁶⁰ section 514(b)(2)(A), the “savings clause,” reserves the right of states to regulate insurance generally.⁶¹ Under this provision even if a state law is preempted under section 514(a) it can still be allowed so long as it regulates insurance, or in other words, if the state law is “specifically directed toward entities engaged in insurance . . . [and] . . . substantially affect[s] the risk pooling arrangement between the insurer and the insured.”⁶²

However, the Deemer clause, section 514(b)(2)(B), establishes the one exception to the right of states to regulate insurance and is the pinpoint clause that exempts self-insured from state mandates.⁶³ The Deemer clause restricts states’ regulation of insurance to only insurance companies and contracts, not plans themselves. Therefore, a self-insured plan is neither an insurance company nor a contract, thus exempt from state regulations and mandates. This loophole created by the ERISA is what allows many plans to be free from autism treatment requirements, thus creating a gap of coverage for millions of Americans.

⁵⁸ Matt Leming, *More Employers Weigh Self-Funded Health Plans*, SOC’Y FOR HUMAN RES. MGMT. (Aug. 14, 2009), <http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/SelfFunded.aspx..aspx>.

⁵⁹ ERISA shall “supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” 29 U.S.C. §1144(a).

⁶⁰ *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97-98 (1983).

⁶¹ 29 U.S.C. § 1144(b)(2)(A).

⁶² *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

⁶³ This Deemer clause states that no employee benefit plan “shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] contracts.” 29 U.S.C. §1144(b)(2)(B).

IV. THE PAST: PRIOR LEGAL BATTLES FOR AUTISM COVERAGE

The inability of federal and state laws to ensure coverage and the escalating cost of autism treatment has left many struggling for a way to hold insurers liable for treatment. Some individuals have turned to the judicial system as a means to require insurers to provide coverage for treatment. In these individual claims, courts have relied on the insurers' inadequacies to establish individuals' rights to autism treatment coverage, stating that insurers' unsubstantiated rejections of treatment are not enough to uphold a denial of benefits. However, while several individual cases exist, none of the courts have established a precedent that would extend beyond the individuals before them. Each ruling was narrowly tailored to the case at hand, failing to establish a rule or guideline of when, and if, a court would require an insurer to provide specific coverage.

The fight for health insurance coverage of autism is no stranger to the court system. Dating back to the early 1990s, several individual claims against health insurers have been brought seeking coverage for autism treatment. Collectively these individual claims show a deference of the courts to the needs and requirements of individuals over those of health insurers.

The early predecessor to such claims came in 1990 when *Kunin v. Benefit Trust Life Insurance* was heard before the Ninth Circuit.⁶⁴ Kunin was covered by an employer health plan, operated by Benefit Trust that refused to cover his numerous claims. In 1986, Kunin's son was diagnosed with autism and underwent thirty days of treatment, which cost over \$54,000.⁶⁵ The disagreement arose when Benefit Trust stated the policy only allowed for up to \$10,000 for "mental illness or nervous disorders" reimbursement.⁶⁶ The insurer held that autism was classified as a mental illness and therefore Kunin was responsible for costs beyond the reimbursement maximum.⁶⁷

In the opinion, the Court held that the classification of autism as a mental illness was an arbitrary and capricious decision by the insurer because they failed to substantiate the determination. Specifically, the Court stated that the so-called expert the insurers relied on for such a classification had failed to disclose material information, including what

⁶⁴ *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990).

⁶⁵ *Id.* at 535.

⁶⁶ *Id.*

⁶⁷ *Id.*

other doctors he had consulted or his experience or particular expertise concerning autism, to establish a well-founded reasoning behind the determination.⁶⁸ Further, the Court noted that the insurer had failed to make any effort to talk with the boy's own physicians to determine the basis for diagnosis and the recommended treatment before establishing the classification.⁶⁹ In light of these facts and because the policy in question was vaguely worded as to not contain a definition or explanation of mental illness, the Ninth Circuit found that the insurer was obligated to pay the full amount of the claim.⁷⁰ While the case brought the issue of coverage for autism treatment to the forefront, the fact that it turned on the definition of mental illness in the policy language only established a case-specific holding for an insurer's liability.

Following the Ninth Circuit's decision, the district court for the Northern District of Illinois again displayed the proclivity of courts to favor the insured over the insurers in the face of inadequate rationale. In *Wheeler v. Aetna Life Ins. Co.*, the Plaintiff argued that Aetna wrongfully denied coverage of medical treatment for his son who suffered from numerous conditions, including autism.⁷¹ The majority of the argument centered on coverage for speech therapy, physical therapy, ABA therapy, and sensory integration therapy, most of which Aetna refused to cover, citing various reasons, specifically the lack of evidence that such therapies are effective.⁷² Aetna argued that it had the right to reject coverage of certain therapies because the language of the policy granted them discretion to determine "to what extent employees and beneficiaries are entitled to benefits," however the Court rejected this argument, stating that the discretionary decisions of Aetna must still be reasonable and must provide the insured with "every reason for [their] denial of benefits at the time of denial."⁷³

The Court then went on to examine three letters issued by Aetna in which "they utterly fail to consider the actual language of the plan at issue," and thus had failed to provide adequate reasoning for their rejections.⁷⁴ The Court found that the actions of Aetna were, in effect, classifying autism as a developmental disorder which was covered by the

⁶⁸ *Id.* at 537-38.

⁶⁹ *Id.* at 538.

⁷⁰ *Id.* at 541.

⁷¹ *Wheeler v. Aetna Life Ins. Co.*, No. 01 C 6064, 2003 WL 21789029, at *1 (N.D. Ill. July 23, 2003).

⁷² *Id.* at *3-4.

⁷³ *Id.* at *4-7.

⁷⁴ *Id.* at *9.

policy but then subsequently denying all treatment for developmental delays caused by autism.⁷⁵ The Court held these actions by the insurer, if allowed, “[w]ould in effect render the provisions for coverage for autism meaningless.”⁷⁶

Although not a traditional individual claim, the Sixth Circuit issued another judicial opinion showing deference to protecting the rights of individuals to receive coverage of autism treatment in *Parents’ League for Effective Autism Services v. Jones-Kelly*.⁷⁷ The guardians of three Medicaid-eligible children filed for a preliminary injunction against Ohio to prevent the state from implementing amendments that would effectively stop funding autism treatment.⁷⁸ After the Centers for Medicare and Medicaid Services (CMS) issued proposed rules that would limit Medicaid coverage for rehabilitative services, Ohio promulgated amendments to its own Administrative Code, one of which limited coverage by defining rehabilitative services as those that would restore an individual to their prior functioning level.⁷⁹ The new amendments effectively eradicated state funding to programs that provided autism treatment to Medicaid children. The lawsuit claimed such actions violate federal Medicaid law that provides eligible children with such services.⁸⁰ Plaintiffs in the case argued that these rules deny funding to facilities responsible for providing autism treatment to Medicaid-eligible children.⁸¹ The Court did not rule on the merits, but instead granted a temporary restraining order to prevent the state from implementing the amendments.⁸² The decisions, although not conclusive, signaled the judicial system’s hesitance to allow actions that would eliminate adequate coverage for autism treatment in state-run Medicaid programs.

It was not until several years after these cases that a district court would consider the question that currently plagues the class actions for autism treatment: does an insurer’s designation of ABA therapy as “experimental” warrant their refusal to cover such treatment under the terms of their plans? In *McHenry v. PacificSource Health Plans*, the Court

⁷⁵ *Id.* at *13.

⁷⁶ *Id.* at *13.

⁷⁷ *Parents’ League for Effective Autism Servs. v. Jones-Kelley*, 339 Fed. App’x. 542, 542 (6th Cir. 2009).

⁷⁸ *Id.* at 543.

⁷⁹ *Id.* at 545.

⁸⁰ *Id.* at 545-46.

⁸¹ *Id.* at 551-52.

⁸² *Id.* at 543-44, 552.

considered whether an insurance carrier was responsible to an ABA therapist after a child had been diagnosed with autism and his pediatrician prescribed ABA therapy.⁸³ After seeing the therapist for four months, PacificSource denied payment citing its policy that allowed them to deny coverage for experimental or investigational procedures, as well as academic or social skills training.⁸⁴ To support its rejection, PacificSource stated that there was “no ‘gold standard’ for the treatment of autism, and there is much debate in the literature regarding the efficacy of any one approach, including ABA . . . [thus] it [is] clear that ABA [is] not a well-proven or evidence-based standard of medical care.”⁸⁵

The Court rejected both arguments, holding that ABA is supported by decades of research and application, and stated that ABA is an acknowledged autism treatment by several government agencies, including the Department of Health and Human Services and the National Institute of Mental Health, and professional organizations, including the American Psychological Society.⁸⁶ Further, the court stated that although ABA treatment may have incidental benefits related to education and social skills for autistic children, its main focus is modifying behaviors pertinent to every area of the child’s life and thus not solely an academic or social skills program.⁸⁷ In the end, the Court found that ABA therapy was medically necessary for Wheeler’s autism treatment.⁸⁸

While the judicial prerogative has been to favor the insured and coverage for autism treatment, the Court’s failure to rule in a broader context leaves the critical question of all these claims unanswered: will, and should, insurers be required to provide coverage of autism treatment to their insured?

⁸³ *McHenry v. PacificSource Health Plans*, 679 F. Supp. 2d 1226, 1228-29 (D. Or. 2010).

⁸⁴ *Id.* at 1228.

⁸⁵ *Id.* at 1236.

⁸⁶ *Id.* at 1237-38.

⁸⁷ *Id.* at 1240-41.

⁸⁸ *Id.* at 1248. In the end, the Court ruled against a Motion for Summary Judgment, stating that a secondary reason for denial of payments based on the ABA therapists lack of credentialing was enough to support a refusal of PacificSource to reimburse. *Id.* at 1245-46.

V. THE PRESENT: BANDING TOGETHER TO CHALLENGE INSURERS FOR AUTISM COVERAGE

After years of individual claims against insurers, a new breed of cases regarding autism coverage began to appear before the courts. In 2010 and 2011, insured individuals, who had been denied insurance coverage for ABA, began banding together to challenge their individual carriers. Three separate claims for class certification were brought before federal courts to directly challenge their insurer's denial of coverage for ABA therapy.⁸⁹ The carriers stated the same reasoning for denial in all cases: ABA is an investigative and experimental treatment. The charges of the insured were the same: the insurance carrier should provide coverage under my policy for ABA treatment for autism.⁹⁰ However, the similarities ended there. In the three cases, often with nearly identical facts, the reasoning of the judges resulted in very different outcomes for class certification.

The first judge reasoned that the presented class failed to establish commonality, or failed to establish that there was a common question of law or fact applicable to the entire class.⁹¹ The court reasoned that a claim for autism treatment would require individualized review of an insured's claim and medical treatment to determine if ABA therapy is actually experimental,⁹² thus a "determination of [the common question's] truth or falsity" would not have resolved the central issue of all claims "in one stroke."⁹³ The second judge found no such failure to establish commonality, and determined that an insurance company's across the board determinations regarding ABA therapy meant a common question of if ABA therapy was a covered benefit existed.⁹⁴ Further, the judge stated that even though the entitlement award for the denied benefit might require individualized review under Federal Rule of Civil Procedure 23(b)(3), such determinations do not predominate over the common question plaguing all class members.⁹⁵ Finally, the third judge found that such classes can easily be certified under common questions as the court is only seeking to

⁸⁹ See generally *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081 (E.D. Tenn. Feb. 19, 2010); *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789 (E.D. Mich. July 14, 2011); *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489 (E.D. Pa. Aug. 12, 2011).

⁹⁰ *Id.*

⁹¹ FED. R. CIV. P. 23(a)(2); *Graddy*, 2010 WL 670081, at *9.

⁹² See *Graddy*, 2010 WL 670081 at *9.

⁹³ *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011).

⁹⁴ See *Potter*, 2011 WL 9378789, at *6.

⁹⁵ See *id.*

determine whether the denial of ABA claims are appropriate.⁹⁶ However, limitations on relief apply in relation to who composes the class.⁹⁷ These rulings create three distinct interpretations of the applicability of class adjudication of autism claims.

A. *GRADDY*, 2010

First, in *Graddy v. Blue Cross BlueShield of Tennessee Inc.*, a group of individuals covered by Blue Cross BlueShield of Tennessee (BCBST) moved for class certification in a claim against the insurer because of their denial of coverage for ABA therapy for autistic individuals.⁹⁸ The Plaintiffs in the case claimed that the actions of BCBST violated ERISA, the Tennessee Autism Equity Act, and the Tennessee Consumer Protection Act. Specifically, the claim stated that BCBST violated its fiduciary duties to the Plaintiffs when it failed to fairly and properly construe and interpret the language of the health plans for the exclusive purpose of providing benefits to the members of the plan.⁹⁹ Further, they alleged that the Tennessee Autism Equity Act required BCBST to provide benefits and coverage for the treatment of autism at the same level it provided for other neurological disorders and that it had failed to do so when it rejected the claims.¹⁰⁰ Finally, the Plaintiffs claimed BCBST had engaged in unfair and deceptive trade practices, violating the Tennessee Consumer Protection Act.¹⁰¹

Under the Federal Rules of Civil Procedure (FRCP) Rule 23(b)(2), the Plaintiffs moved to certify a class of all insured under the BCBST policy who have, or will make, a claim for coverage for ABA therapy and

⁹⁶ See *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *4 (E.D. Pa. Aug. 12, 2011).

⁹⁷ See *id.* at *4–6. In a subsequent amended complaint, Judge Sanchez allowed a second representative to be added to the class to capture all current Cigna members who had submitted ABA claims that were subsequently denied under Cigna's current company-wide policy. However, in the subsequent case Judge Sanchez denied the motion to certify a (b)(2) class because the class in its entirety sought individualized monetary damages, which were not certifiable under (b)(2). *Churchill v. Cigna Corp.*, No. 10-6911, 2012 WL 3590691, at *10 (E.D. Pa. Aug. 21, 2012) [hereinafter *Churchill II*].

⁹⁸ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *3 (E.D. Tenn. Feb. 19, 2010).

⁹⁹ *Id.* at *1-4.

¹⁰⁰ *Id.* at *6.

¹⁰¹ *Id.*

BCBST denied such coverage on the basis that ABA is deemed investigative or experimental.¹⁰² The class argued that BCBST had established “a deliberate company-wide policy to deny all claims for ABA treatment, even though it knows the terms of its Plans provide coverage for the treatment” and further that such denials were made in bad faith and on baseless grounds.¹⁰³

The court rejected class certification on the basis that the class failed to meet the commonality requirement of FRCP 23(a)(2), requiring that “there are questions of law or fact common to the class.”¹⁰⁴ Here, the court reasoned, a claim of breach of fiduciary duty under ERISA requires most questions be answered through individualized review of each class member’s claim, diagnosis, therapy and determination if ABA truly was experimental for their precise condition.¹⁰⁵ Specifically, proving breach of fiduciary duty requires showing a connection between the fiduciaries actions and the harm caused to the individual. The court focused on the varying degrees of autism and how each diagnosis was different. The court reasoned that, “individuals suffering from . . . autism ‘may exhibit the characteristic traits of autism . . . in any combination, and in different degrees of severity,’” and therefore, “the varied behavioral disorders exhibited by patients with ASD, and the question of whether such behavior disorders may or may not be treated by ABA,” means that the class shares no homogeneity that would allow them to operate as a class.¹⁰⁶

The court specifically reserved ruling on the merits of the claim until the complaint could be amended by Graddy to establish an individual claim against BCBST’s decision to deny coverage for ABA treatment.¹⁰⁷ The concluding statements of the court in this opinion showed support for individual claims of autism coverage against insurers that had been stated in prior cases as well as the growing policy support found on the state and federal level for autism coverage, but stopped short of allowing a class action against an insurer.¹⁰⁸

It should be noted that in 2013 the District Court for Oregon addressed a similar class seeking only injunctive relief and, in contrast to

¹⁰² *Id.* at *4.

¹⁰³ *Id.* at *3, *5.

¹⁰⁴ FED. R. CIV. P. 23(a)(2).

¹⁰⁵ *Graddy*, 2010 WL 670081, at *9-10.

¹⁰⁶ *Id.* at *8-10.

¹⁰⁷ *Id.* at *10.

¹⁰⁸ *Id.* at *9-10.

Graddy, was granted certification.¹⁰⁹ In *A.F. v. Providence*, the Plaintiff class included all current members of Providence health plans who had been, or will be up to the time of certification, diagnosed with autism.¹¹⁰ The class sought injunctive relief against Providence to prevent them from uniformly applying a policy exclusion that excludes all coverage for ABA therapy.¹¹¹ After a lengthy discussion of the requirements of a proper class under Rule 23(a), the judge certified the class finding that “injunction would provide specific and meaningful relief to all named class members.”¹¹² Particularly, the judge found that resolving the question raised by the Plaintiffs would provide “complete relief as to the *specific* issue raised by the [class], even if it does not ultimately address every class members’ needs or issues.”¹¹³ While *AF* is the most recent iteration of the autism class action, the opinion issued by the court offers little beyond what has already been expressed in the earlier autism class action court rulings. The vast majority of the *AF* opinion focuses on the checklist requirements of class certification and therefore this author believes it does not warrant further discussion.

B. *POTTER*, 2011

In the second class action claim, the District Court for the Eastern District of Michigan certified a class claim against Blue Cross Blue Shield of Michigan (BCBSM) and its rejection of ABA treatment for autism.¹¹⁴ In *Potter v. Blue Cross Blue Shield of Michigan*, the class brought suit under ERISA claiming first, that BCBSM had improperly denied claims on the basis that ABA is deemed experimental or investigative and second, that BCBSM had denied them the opportunity for a full and fair review of the claim.¹¹⁵

Michael Porter, acting as class representative, made a motion to certify a class containing two subclasses. Subclass A was defined as all insureds under a BCBSM policy who made a claim, or will make a claim,

¹⁰⁹ *A.F. v. Providence Health Plan*, No. 3:13-CV-00776-SI, 2013 WL 6796095 (D. Or. Dec. 24, 2013).

¹¹⁰ *Id.* at *4.

¹¹¹ *Id.* at *1.

¹¹² *Id.* at *10.

¹¹³ *Id.* at *11 (emphasis in original).

¹¹⁴ *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789 (E.D. Mich. July 14, 2011).

¹¹⁵ *Id.* at *2.

for ABA therapy and the claim was, or will be, denied on grounds that such treatment is investigative or experimental.¹¹⁶ Subclass B was defined as all insured under a BCBSM policy who did not make a claim for ABA “in light of Defendant’s policy that such treatment is deemed to be investigative or experimental.”¹¹⁷

The court found that the numerosity standard was easily met, determining that, based on the business size of BCBSM and the number of students diagnosed with autism in Michigan schools, joinder would be impractical, if not impossible.¹¹⁸ Further, the class shared a common question as all of the claims depended on the same contention: there is no reasonable basis for stating that ABA is experimental and not a mainstream medical treatment. Therefore all claims of the class would be addressed when the court determines if the insurer had improperly deemed ABA treatment experimental.¹¹⁹

It was noted that the area of most difficulty on its face was determining the members of the class. While subclass A was easily distinguishable based on the likelihood of BCBSM maintaining records on claims filed, subclass B would be theoretically difficult because of the subjective nature of ascertaining why an individual did not file a claim. However, the court rejected this obstacle, stating that they can assume that if an individual failed to file a claim for ABA treatment, it was a result of them either being told, or somehow learning, that BCBSM deemed all such treatment experimental and excluded from coverage. Therefore, instead of going through the burden of processing an insurance claim only to have it rejected, the individual that received ABA treatment and did not submit the claim did so only because of the BCBSM policy.¹²⁰

The judge here explicitly disagreed with *Graddy*, noting that, although the cases are similar, determining the case would not require answering individualized questions. BCBSM made an across-the-board determination that ABA treatment is experimental and therefore not a covered benefit, thus BCBSM’s determination was not made after considering each individual claim and medical need, but rather based on its uniform determination that ABA is experimental.¹²¹

¹¹⁶ *Id.* at *4.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at *5.

¹¹⁹ *Id.* at *6.

¹²⁰ *Id.* at *4-5.

¹²¹ *Id.* at *8.

The class was then certified under Rule 23(b)(3) with the presumption that, since the class claim was that ABA claims were improperly rejected by BCBSM because of an experimental classification, no member of this class would have another reason for being rejected by BCBSM and therefore the class would require no individualized determination.¹²² Further, the Court rejected BCBSM's contention and the *Graddy* Court's reasoning, that individual determinations would be needed to decipher how much each class member was entitled to under their claim, explaining that such determinations do not predominate over the common issue that BCBSM improperly denied their ABA claims.¹²³

C. *CHURCHILL*, 2011

The third class action, filed in the Eastern District of Pennsylvania, came to a very different conclusion than the other two courts. In *Churchill v. Cigna Corp.*, the Court differed from *Graddy* by choosing to certify a class action against an insurer for coverage of ABA treatment, but unlike *Potter*, the Court refused to include in the class members of the health insurance plan that had not filed claims for ABA.¹²⁴

The Plaintiffs in *Churchill* charged that Cigna had improperly denied their claim for ABA treatment¹²⁵ of autism in violation of ERISA and thus sought benefits and equitable relief.¹²⁶ The complaint alleges that under Cigna's uniform Medical Coverage Policy, Cigna excluded coverage of ABA on the basis that such treatment is deemed, "experimental, investigational or unproven' for the treatment of [autism]," and therefore

¹²² *Id.*

¹²³ *Id.* On March 30, 2013, the district court issued judgment in favor of the plaintiff class. *Potter v. Blue Cross Blue Shield of Michigan*, 10-CV-14981, 2013 WL 4413310, at *1 (E.D. Mich. Mar. 30, 2013). The Court found that BCBS' denials were arbitrary and capricious and therefore overturned the denial of benefits. *Id.* at *6. The Court remanded the claims for re-administration by BCBS, stating that "the remand is not an opportunity for BCBS to invent new bases for denial of claims that were not previously asserted." *Id.* at *12-13.

¹²⁴ *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *1 (E.D. Penn. Aug. 12, 2011).

¹²⁵ *Id.* The original complaint stated that Cigna rejected both ABA and Early Intensive Behavioral Intervention treatment on the grounds that both treatments were experimental, however, the Court reasoned that Early Intensive Behavioral Intervention was encapsulated by ABA and therefore both treatments will be referred to simply as ABA. *Id.* at *1 n. 2.

¹²⁶ *Id.* at *1.

excluded from coverage.¹²⁷ Kristopher Churchill, acting as the class representative, made a motion to certify two subclasses, similar to those proposed in *Potter*, under Rule 23(b)(2) and (3).¹²⁸ The first group, subclass A, was defined as all insureds enrolled in a plan administered or offered by Cigna who had made a claim, or will make a claim, for ABA therapy which was denied, or will be denied, on the grounds that such treatment is investigative or experimental.¹²⁹ The complaint also moved to have subclass B certified as all insured who were enrolled in a plan administered or offered by Cigna who did not make a claim for ABA therapy in light of Defendant's policy that ABA is "deemed to be investigative or experimental."¹³⁰

The Court established that certification could only be granted to an amended version of subclass A.¹³¹ In its reasoning, the Court found that, although the entire class met the numerosity requirement,¹³² they failed to meet the typicality and adequacy of representation standards of Rule 23.¹³³ Under its determination, the Court found that the entirety of subclass A shared a common question revolving around if Cigna's denial based on a claim that ABA therapy is investigative and experimental was a proper reasoning for denial.¹³⁴ Therefore, answering a single question, common to all members of the class, would address the individual claims.¹³⁵

However, the Court opted to narrow Subclass A in two ways.

¹²⁷ *Id.*

¹²⁸ *Id.* at *1-2. Rule 23 (b)(2) states that "a class action may be maintained . . . if . . . the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." FED. R. CIV. P. 23(b)(2). Rule 23(b)(3) states that "a class action may be maintained . . . if . . . the court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy." FED. R. CIV. P. 23(b)(3).

¹²⁹ *Churchill*, 2011 WL 3563489, at *2.

¹³⁰ *Id.*

¹³¹ *Id.* at *5.

¹³² The Court determined, based on the size of Cigna's business coupled with the growing prevalence of autism diagnoses in America, that even if a small fraction of Cigna members had filed claims for ABA, subclass A would still be too large and too geographically diverse to "render joinder practical." *Id.* at *3.

¹³³ *Id.* at *4-5.

¹³⁴ *Id.* at *4.

¹³⁵ *Id.*

First, because Churchill was no longer a member of a Cigna health plan he could not adequately represent the interests of current members as he lacked any discernible interest in seeking injunctive relief to prohibit Cigna from rejecting ABA claims.¹³⁶ Therefore, the class would have to be limited to only individuals that were former members of Cigna's health insurance plans.¹³⁷

Second, the Court rejected the reasoning that had been upheld in *Potter*, in that the class could not contain individuals who had failed to file a claim for ABA treatment.¹³⁸ The Court found the logic of *Potter* unpersuasive, stating that individuals may have chosen to not file a claim for a variety of reasons, not simply because they knew of Cigna's policy against ABA reimbursement, and in such cases Cigna's policy can therefore not be held to cause harm.¹³⁹

In the end, the Court chose to certify a class of former Cigna members that had submitted claims for ABA treatments that had been rejected by Cigna.¹⁴⁰ In doing so, the Court dismissed Cigna's argument that it had rejected ABA claims for a variety of reasons, often noted on the rejection letters sent to plan members. The Court found that, although Cigna listed a variety of reasons as to why it rejected the claim, including the argument that there might be differences in diagnoses and the type of ABA treatment received, Cigna had still made a class-wide determination that ABA was experimental in all cases and that was the basis for their continuous rejections.¹⁴¹

¹³⁶ *Id.* at *4-5. In a subsequent filing the class was amended to capture current members of the health insurer by adding a second class representative who was currently enrolled in a Cigna health plan. *Churchill II*, No. 10-6911, 2012 WL 3590691, at *1 (E.D. Pa. 2012).

¹³⁷ *Churchill*, 2011 WL 3563489, at *4-5.

¹³⁸ *Id.* at *8.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at *6. On November 26, 2013 a Notice of Class Action Settlement was sent to class members. Notice of Class Action Settlement, *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489 (E.D. Penn. Aug. 12, 2011), available at <http://www.washingtonautismadvocacy.org/updates/wp-content/uploads/Notice-of-ABA-Settlement-Cigna.pdf>. The proposed settlement entitled class members to monetary damages for rejected ABA claims. *Id.* at 2. A fairness hearing was conducted on February 19, 2014. *Id.* at 3. At the time of publication, a final settlement was not yet approved by the court.

VI. CONFLICTING RULINGS HIGHLIGHT THE SUBJECTIVE DETERMINATIONS THAT CREATE THE LEGAL TOOLS AVAILABLE TO CONSUMERS

While the movement to provide coverage for autism treatment has made great strides both in law and in the courtroom, many questions remain. Can you bring a class action against an insurance company to require coverage for ABA treatment? The answer depends on the district. Districts following *Graddy* require individual claims, not class actions, while districts following *Potter* and *Churchill* say certain class actions will work. Can a certified class encapsulate all members of a plan, or only those who have filed a claim that was rejected? A judge could find the presumption that an individual failed to file a claim because they knew of the insurance company's policy applicable, while other judges may believe such a presumption is baseless.

On the face the three class actions look similar. A group of individuals who could not receive health insurance coverage for autism treatment, all filing a claim under ERISA to answer a simple question: is a health insurer's denial of ABA therapy on the grounds that it is "experimental" reasonable? However, the judges in these three cases viewed what was before them in drastically different lights. The contrasting rulings highlight the problems that arise from a class action against an insurance company for denial of benefits. Such cases require a court to rule generally on issues that are very often individual: is this specific claim covered under this specific policy for this specific individual?

A. WHAT'S IN A DEFINITION

The first difference can be seen in the class definitions that were presented for certification. Many may believe that minor differences in class definitions before the court can explain the conflicting rulings, but the differences were slight and easily malleable as demonstrated by the *Churchill* Court's willingness to edit the class definition in its certification.¹⁴²

In *Graddy*, the Court rejected the most basic class definition offered: current and former plan members who had submitted a claim for ABA therapy and were denied because of the company policy deeming

¹⁴² See *Churchill*, 2011 WL 3563489, at *7.

ABA therapy experimental.¹⁴³ Here, the Eastern District of Tennessee rejected the class on the basis that every class member would require an “individualized assessment as to the ultimate propriety of the benefits decision.”¹⁴⁴ The Court reasoned that, although ABA treatment is beneficial to individuals diagnosed with autism, it is not always the preferred and appropriate therapy, nor is the amount required set in stone. Rather, each individual diagnosis requires individual review to determine what therapy is needed, how much, and to what level it should be covered by the health insurance plan.¹⁴⁵

On the other hand, the *Potter* Court found no such individualized assessment is required and went so far as to broaden the class definition. The Court certified a class that contained current and past members of the health plan who received ABA treatment regardless of whether they had or had not submitted a claim to the insurer.¹⁴⁶ The Court directly disagreed with *Graddy*, determining that a company-wide policy deeming ABA therapy experimental had been applied across the board without individual assessment of claims, and therefore individual review of the claims, or not claims, was not necessary. The company policy on its own was at issue, and therefore the issue is capable of remedy without individual assessment.

Finally, *Churchill* was originally presented with the same broad class definition that occurred in *Potter*, a class that consisted of current and former members who had received ABA treatment regardless of if they had filed a claim.¹⁴⁷ Rather than rejecting the class entirely or accepting the class definition, the *Churchill* Court opted to apply judicial discretion and narrow the class definition. In doing so, limited the class to only those individuals who had made claims to their insurer, finding that such a definition was apt for class certification.¹⁴⁸ The *Churchill* Court rejected the reasoning of the *Graddy* Court.¹⁴⁹ Such discretion emphasizes the uncertainty regarding class actions against insurers and the ability to use general determinations against a business that relies on individual appraisals.

¹⁴³ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *4 (E.D. Tenn. Feb. 19, 2010).

¹⁴⁴ *Id.* at *9.

¹⁴⁵ *Id.* at *10.

¹⁴⁶ *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 WL 9378789, at *1, *4 (E.D. Mich. July 14, 2011).

¹⁴⁷ *Churchill*, 2011 WL 3563489, at *2.

¹⁴⁸ *Id.* at *8.

¹⁴⁹ *Id.* at *8, n. 13.

B. HOW MUCH, IF ANY, RELIEF IS APPROPRIATE

The second significant difference between the cases rested with what type of class-wide relief that would be appropriate. In *Graddy*, the Court found that the class could not seek injunctive relief under Rule 23(b)(2) because the class' claim rested on a breach of the fiduciary duty imposed under ERISA which could only be proven by a clear link between the breach of duty and the harm experienced. For the Court, such a link was dependent on the equities of each individual claim, which would in turn require an individual evaluation of each class member, their diagnosis, treatment plan, and specific claim. With a lack of homogeneity within the class, final injunctive relief would not be appropriate for the class as a whole.¹⁵⁰

However, the *Potter* Court found such reasoning inapplicable, and determined that not only could the class of current and former members be extended to include individuals who had not even filed a claim, but also that they could seek both injunctive and monetary relief.¹⁵¹ For the Eastern District of Michigan, a class of individuals denied coverage of a specific treatment, as the result of a company-wide policy are entitled first, to injunctive relief¹⁵² to prevent the company from applying such a policy and second, to monetary relief¹⁵³ that would provide reimbursement for their out-of-pocket expenses.¹⁵⁴ The Court held that although individuals would be entitled to varying amounts depending on their claim, individual entitlement amounts did not predominate over the fact that all members of the health plan had been denied benefits solely on the company policy that deemed ABA therapy "experimental".¹⁵⁵

Finally, in *Churchill*, the Court walked the line between the opposing opinions of the earlier courts when it ruled that a class of individuals who had made a claim for ABA that was denied could not seek injunctive relief, but could receive monetary relief. The Court found that the question of what was owed to the consumers turned on the status of the individuals in the class. Since one subclass contained former members of the Cigna health plans, injunctive relief was inappropriate because former

¹⁵⁰ *Graddy*, 2010 WL 670081 at *8.

¹⁵¹ *Potter*, 2011 WL 9378789 at *9-10.

¹⁵² *Id.* at *9.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at *1.

¹⁵⁵ *Id.* at *9.

members would not be seeking a ruling requiring Cigna to change its company policy for they would receive no benefit from such a change in policy.¹⁵⁶ However, the other class of current members who had filed claims could seek monetary damages rather than injunctive relief.

While all three classes commonly sought at least partial relief under Rule 23(b)(2), the rulings provided three contradictory holdings on whether such relief is applicable. The competing approaches and reasoning leave individuals and lawyers without any clear answers. Is a challenge of an insurance company for an unreasonable denial of benefits available as a class action, and if it is, what relief can be offered?

VII. HOW TO APPROACH AUTISM CLASS ACTIONS IN LIGHT OF AN UNCLEAR PATH FROM THE COURTS

Autism coverage class actions paint a blurry picture at best. The complicated web of federal and state laws striving to provide autism coverage is often sidestepped by ERISA's distinction between insured and self-insured, leaving plans free to reject claims for treatment. Individual challenges to these tactics, while often successful, have proven inefficient. In order to truly clarify answers, the insured have pursued claims collectively, but even collective action has resulted in three different judicial approaches. First, courts have determined that individual questions matter in resolving the reasonableness of an insurer's decision and therefore must be reviewed independently.¹⁵⁷ Others have found that when a company applies an across-the-board determination regarding a benefit, a remedy may also be provided across-the-board.¹⁵⁸ Still other courts have stated that although you may overcome the individualized nature of diagnosis and treatment plans, you cannot bind people who never acted, even if they were harmed by the actions of an insurance company.¹⁵⁹

Even though the picture is complicated and the precedent confusing, moving forward courts can apply a standard that allows for individuals to collectively challenge insurance companies and fill the gap left by federal and state legislation of autism coverage. Taking into

¹⁵⁶ *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *6-7 (E.D. Penn. Aug. 12, 2011).

¹⁵⁷ *Graddy v. Blue Cross Blue Shield of Tenn.*, No. 4:09-cv-84, 2010 WL 670081, at *9-10 (E.D. Tenn. Feb. 19, 2010).

¹⁵⁸ *Potter*, 2011 WL 9378789, at *6, *8.

¹⁵⁹ *Churchill*, 2011 WL 3563489, at *7-8.

consideration the requirements and policy basis of Rule 23(a) and (b)(2),¹⁶⁰ allowing class actions against insurers best serves the interest of an efficient judicial system and with proper limitations can strike the balance of providing global peace to all parties while still allowing for individual assessments that insurance companies rely on in business.

Determining if an insurance company's decision to rule ABA therapy as experimental is reasonable does not require an individualized assessment of every claim. Rather, the company-wide policy is in question, not the individual denials; therefore if a court were to determine reasonableness they would determine an answer to a common question to all class members. As the advisory committee notes state, "necessity for a class action is greatest when the courts are called upon to order . . . the alteration of the status quo in circumstances such that a large number of persons are in a position to call on a single person to alter the status quo"¹⁶¹ Applicable here, the courts are being asked to evaluate the company policies regarding ABA therapy, rather than each individual rejection of such a claim. Courts should not be looking at whether every denied claim was appropriate, nor should they conclude that anyone with an autism diagnosis is entitled to ABA therapy. Rather, appropriate analysis of the court should focus on the company policy that hinders millions of Americans' access to benefits they need. If autism coverage class action

¹⁶⁰ Pertinent subsections are as follows:

(a) Prerequisites. One or more members of a class may sue or be sued as representative parties on behalf of all members only if:

- (1) the class is so numerous that joinder of all members is impracticable;
- (2) there are questions of law or fact common to the class;
- (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
- (4) the representative parties will fairly and adequately protect the interests of the class.

(b) Types of Class Actions. A class action may be maintained if Rule 23(a) is satisfied and if . . .

- (2) the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole

FED. R. CIV. P. 23.

¹⁶¹ FED. R. CIV. P. 23(b)(1)(A) advisory committee's note.

claims are accepted by the court as a challenge to insurers' company-wide policies rather than individual claims for benefits, a court can sustain a class certification pursuant to the goals of Rule 23 outlined in the advisory committee notes.

However, while such questions can be answered for the class, two distinct limitations discussed in *Graddy* and *Churchill* must be established to ensure uniformity in application and adherence to the requirements and goals of class actions. First, as the class action jurisprudence stands now, class actions challenging an insurer's policy towards coverage of autism treatment should be limited to injunctive relief. As Rule 23(b)(2) states, "[when] the party opposing the class has acted . . . on grounds that apply generally to the class . . . final injunctive relief . . . is appropriate [for] the class as a whole."¹⁶² Specifically, this has been interpreted to establish two requirements. First, that the party opposing the class, here the insurers have acted, or refused to act, on grounds generally applicable to the class as a whole, and second, any final injunctive relief settling the legality of the behavior is appropriate to the class as a whole.¹⁶³ Applying such interpretation here, an insurance company who makes and enforces a company-wide policy, irrespective of each individual, that deems certain well-accepted procedures as experimental and thus never coverable, has acted on grounds applicable to all plan members who sought or are seeking such treatment and in turn, determination of a court regarding the legality of such a policy applies generally to the class.

As the Supreme Court has stated, "[t]he key to the (b)(2) class is the 'indivisible nature of the injunctive or declaratory remedy warranted — the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them.'"¹⁶⁴ Under this principle, if the policy is deemed unreasonable, injunctive relief that prevents them from applying such policy applies generally for the entire class of effected individuals. A Rule 23(b)(2) class grants members of an insurance plan the opportunity to collectively challenge insurers on the limited question of if a policy is reasonable. This allows individuals to create a stronger driving force based in unity, while still preserving the right of insurers to make individual assessments. Preventing an across-the-board policy opposing a treatment does not strip from insurers the right to review claims for treatment and determine if it fits within the plan language

¹⁶² FED. R. CIV. P. 23(b)(2).

¹⁶³ 2 ALBA CONTE & HERBERT B. NEWBERG, NEWBERG ON CLASS ACTIONS § 4:11 (4th ed. 2002).

¹⁶⁴ Wal-Mart Stores, Inc. v. Dukes, 131 S. Ct. 2541, 2557 (2011).

and is appropriate. Rather, review of a company-wide policy and its application prevents an insurer from establishing a policy that unfairly hurts and impedes the rights of consumers without consideration for the actual claim, plan language, or any other information relied on by insurers typically when reviewing a benefit claim.

While our current jurisprudence lays a clear and straightforward path towards injunctive relief, an area worthy of further exploration is the potential for success as a (b)(3) class seeking reimbursement. Although some lower courts have begun to explore reasoning that would support a (b)(3) class against insurers for claim denials, the success is limited and Supreme Court jurisprudence signals a pushback. Courts that have supported (b)(3) classes against insurers first find predominance in the form of the overriding legal issue of the class, rather than focusing on the individualized damages that would arise. For example, in *Bauer v. Kraft Foods Global, Inc.*, a local union and retired employees sued an employer under ERISA and their collective bargaining agreement because of the elimination of a health plan and increased cost of prescription drugs.¹⁶⁵ The district court reasoned that the “overriding legal issue” presented was whether the employer’s plan amendments violated the class members rights generally.¹⁶⁶ Since that question predominated and the only subsequent issue would be damages, certification under (b)(3) was applicable.¹⁶⁷ Applied to autism class actions, the overriding legal issue, whether the insurer’s denial of coverage for autism treatment is reasonable, would predominate over any other issue presented.

Although such an argument could be made, in order to certify an autism class action as a (b)(3) class, courts must be willing to view individualized damages as secondary to the overriding legal issue, thus maintaining predominance. As such, in order for a (b)(3) class to prevail a court must accept the argument that while the amount of individual damages may vary, the formula used to calculate them is consistent across the board. The Fourth Circuit accepted a similar proposition in *Ward v. Dixie National Life Insurance Co.*, a class action against insurers claiming that supplemental cancer insurance policies require payment to the insured at the rate of the actual charged treatment, rather than the lesser amount medical providers received from insurers.¹⁶⁸ This reasoning is easily transferable to autism class actions in that the requested monetary damages

¹⁶⁵ *Bauer v. Kraft Foods Global, Inc.*, 277 F.R.D. 558, 558 (W.D. Wis. 2012).

¹⁶⁶ *Id.* at 563.

¹⁶⁷ *Id.* at 563-564.

¹⁶⁸ *Ward v. Dixie Nat’l Life Ins. Co.*, 595 F.3d 164, 180 (4th Cir. 2010).

of the class are simply the cost of treatment not covered by the insurer, a simple and standard equation for all members of the class.

Despite the fact that the argument may be made in favor of a (b)(3) class action against insurers, a recent decision of the Supreme Court in *Comcast Corp. v. Behrend* raises concerns about the acceptance of such a “one formula for all” argument.¹⁶⁹ While the Plaintiffs in *Comcast* developed a formula for damages that incorporated four theories of antitrust impact, it failed to distinguish which specific theory applied.¹⁷⁰ Thus, one segment of the class could have damages based on the theory that Comcast overcharged because of the elimination of provider competition, while another segment is entitled to damages because of Comcast’s increased bargaining power.¹⁷¹ Justice Scalia made clear that, while a uniform damages equation may exist, one must first ensure that there is a “translation of the legal theory of the harmful event into an analysis of the economic impact of that event.”¹⁷² Under this principle, concerns about a universal formula for an autism class action may be raised. Although an insurer has a company-wide policy of denial for ABA therapy, perhaps even absent such a policy, a claim may still be denied. For instance, an insured might receive ABA therapy from a non-covered provider, thus subject to a different reimbursement rate, or conceivably, although the child is on the autism spectrum, ABA therapy is not the recommended treatment and thus not covered. Directly contrasted to the holding in *Comcast*, while uniform damages may apply, the harmful event of a company-wide policy does not directly translate to the economic impact; other factors may also contribute. Under the *Comcast* precedent and the shaky ground on which a (b)(3) class for denied insurance claims rests, this author would hesitate without a clearer showing by the courts to pursue such a class.

Further, there is concern and caution for a class action seeking monetary damages for a denial of benefits inherent in the insurance world. Insurance companies, as part of their business model for assuming risk, maintain the ability to review claims individually and determine in each case what is allowed. If a class action were allowed to seek monetary damages, the individual question of how much each plan member was entitled to would be answered universally, removing from the insurer the business right to review the claim. Normally, for an insurer, monetary

¹⁶⁹ *Comcast Corp. v. Behrend*, 133 S. Ct. 1426 (2013).

¹⁷⁰ *Id.* at 1430-31.

¹⁷¹ *Id.* at 1433-34.

¹⁷² *Id.* at 1435.

relief would involve a close examination by the insurer of the claim, the policy, the diagnosis, and the treatment plan. A class action would remove such independent review applied by insurers in all other claims. Therefore, in allowing the insured to challenge insurance companies as a class action, they should be limited in injunctive or declaratory relief, which addresses these concerns and controls the reach of the class action.

Second, in allowing a class action for injunctive relief, the court must limit the class definition to capture only individuals who are currently part of the plan regardless of if they have filed a claim or not. As discussed above, class actions for autism treatment should be limited to seeking injunctive relief, which sets the foundation for limiting class members to those currently enrolled in the plan. The claims at issue in these class actions are similar to issues arising in employment class actions when a class includes present and former employees. Under such circumstances, courts have reasoned that only current, and not former, employees would be affected, meaning the class would no longer fall within the perimeters of Rule 23(b)(2).¹⁷³ Past members of an insurance plan cannot share the same interest as current members in seeking injunctive relief, for past members would receive no benefit from a ruling that prevents insurers from issuing uniform rejections of ABA therapy.¹⁷⁴ Therefore, if only injunctive relief class actions are to be certified in regards to autism treatment claims, class members must be limited to those that would receive actual relief via an injunction, not open to all those who have been wronged in the past.

Finally, contrary to the rationale applied by *Churchill* to reject a broad class encompassing those who submitted claims and those who did not, the restriction to only injunctive relief claims requires no such separation. As a result of being restricted to 23(b)(2) classes, any class action brought before a court would be considered a mandatory class and therefore, regardless of a claim's status, all members of the plan and the

¹⁷³ 2 WILLIAM B. RUBENSTEIN, NEWBERG ON CLASS ACTIONS § 4:32 (5th ed. 2011); see *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2559-60 (2011); *Chen-Oster v. Goldman, Sachs & Co.*, 877 F. Supp. 2d 113, 121 (S.D.N.Y. 2012) (interpreting the Supreme Court's decision in *Dukes* to reason that former employees "have no material stake in whether their former employer is or is not enjoined . . . since they are no longer there.").

¹⁷⁴ See *Churchill v. Cigna Corp.*, No. 10-6911, 2011 WL 3563489, at *4 (E.D. Penn. Aug. 12, 2011), where the Court notes why it cannot certify a class encompassing current and past plan members that is represented solely by a past plan participant. The former plan participant has an "incentive . . . to seek only the highest amount of monetary relief possible, not injunctive relief from which he could not benefit." *Id.* at *5.

class would receive the same relief. A ruling that prevents an insurer from applying a company-wide policy prohibiting coverage of ABA therapy because of experimental status would have the same benefit for all insured. Whether they filed a claim or not, the insurer would no longer be allowed to enforce the policy that prevented coverage and all individuals would be free to submit claims as they see fit.

Churchill's final paragraphs sufficiently outline why a broad class approach is unpersuasive, stating a presumption that *all* insured failed to submit a claim based on the insurance providers company policy to deny ABA coverage is impractical.¹⁷⁵ As the *Churchill* Court found, there are a “multitude of reasons why a beneficiary might fail to file a claim,” and depending on the situation, the insurer’s policy designating ABA therapy experimental would not be the actual cause of harm to the individual.¹⁷⁶ By limiting remedies in these class actions a court removes the need to determine the motivations of each class member. While there still remains a “multitude of reasons why a beneficiary might fail to file a claim,” such considerations no longer warrant examination by the courts to determine appropriate remedies.¹⁷⁷

Although judicial precedent has done little to pave a clear path for autism treatment class actions against insurers, future class certification and class action claims can be better analyzed. Consideration can be given to the three recent holdings of *Graddy*, *Potter*, and *Churchill*, but the approach that will best serve individuals and insurers finds its base in no single case. Individuals should be empowered to unify in challenges against their insurers when denied autism treatment coverage but within limits that respect and preserve insurers’ autonomy to maintain individualized review.

VIII. CONCLUSION

With state laws unable to reach self-insured plans and federal laws failing to address the gap of required coverage that results from ERISA preemption provisions, it is unlikely we will see a decrease in courtroom battles for treatment coverage. While individual claims will undoubtedly continue, the recent showing of three class actions focused on the same

¹⁷⁵ *Id.* at *7-8.

¹⁷⁶ *Id.* at *8.

¹⁷⁷ *Id.* The Court also states that the Third Circuit precedent requiring ERISA plaintiffs to file a claim for benefits before a request for judicial interference would prohibit them from following such a presumption. *Id.*

question, presents the court system with a new challenge: establishing an understanding of the extent to which class actions can be brought to challenge insurers' practices. With a complicated web of state laws, federal regulations, and unclear judicial precedent, the court system must seriously examine its approach to complicated class action lawsuits. In doing so, one must look no further than the most recent class certification rulings, which, although contradictory, can serve as a patchwork for future court decisions.

NFL'S LITIGATION SKATES ONTO THE ICE

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This article addresses the insurance implications of the pending concussion litigation between the National Hockey League and its current and former players. The author draws comparisons to similar litigation brought against the National Football League and the NFL's interactions with its insurers to forecast the obstacles the parties in the NHL litigation will face in establishing coverage by the many insurance carriers who have insured the NHL over time. The author identifies obstacles including determining the moment when coverage is "triggered" and whether certain actions by the NHL will preclude coverage and relieve the insurers of their duty to defend because of the policies' "expected or intended" clauses.

I. INTRODUCTION

Days before the National Football League ("NFL") kicked off its 2013 season, it took strides toward resolving the biggest legal threat in its ninety-four year history: concussion litigation. The NFL made a preliminary settlement with approximately 4,500 former players and agreed to pay \$765 million.¹ In the settlement, the NFL included a specific provision explaining that the settlement "cannot be considered an admission by the NFL of liability, or an admission that plaintiffs' injuries were caused by football."² While many assumed that this settlement would be accepted, the judge handling this litigation denied preliminary approval

* University of Connecticut School of Law, Juris Doctor Candidate, 2014. I would like to thank Professor Patricia McCoy for her invaluable assistance in writing this Note through multiple drafts. I would also like to thank my mother and best friend, Leona Chodosh, for her unwavering support and for inspiring me to always chase my dreams.

¹ Arthur L. Caplan & Lee H. Igel, *What's Unsettled About the NFL Concussions Settlement*, FORBES.COM (Aug. 30, 2013), <http://www.forbes.com/sites/leeigel/2013/08/30/whats-unsettled-about-the-nfl-concussions-settlement/>.

² Mark Fainaru-Wada, et al., *NFL, Players Reach Concussion Deal*, ESPN.COM, (Aug. 29, 2013), http://espn.go.com/nfl/story/_/id/9612138/judge-nfl-players-settle-concussion-suit.

of the settlement.³ In the coming months, the NFL will likely try to restructure this settlement, or at a minimum, prove that it is fair through appropriate documentation in order to put this case behind it.

The settlement will be historic, as it will change all contact sport organizations and how they approach concussions, but its likely settlement is a bit *unsettling*, as it will allow the NFL to avoid answering numerous questions that could have resulted in a multi-billion dollar case.⁴

Despite the NFL concussion litigation settlement being imminent, the NFL's insurers' responsibility for paying for this settlement is still uncertain.⁵ The insurers' duty to indemnify is unlikely to be triggered because there is evidence that the NFL committed intentional torts that would be excluded from coverage. Conversely, the insurers' duty to defend seems more definite and it is likely that under the NFL's current Comprehensive General Liability ("CGL") policies, the NFL's insurers' duty to defend will be triggered through the settlement process thus far and through trial if the settlement negotiations are unsuccessful. While it appears that, eventually, this litigation will be resolved in a settlement, some players may still choose to opt out of the settlement if one is reached.⁶

As the NFL's insurers' duty to defend would likely be triggered, these insurers should take a closer look at their policies moving forward. However, the NFL's insurers are not the only ones who should be evaluating their policies for potential exposure. In fact, all insurers of contact sports in the United States must evaluate the policies they are offering to their contact sport insureds in this concussion era. This includes the National Hockey League ("NHL" or the "League") who, mere months

³ Mem., In Re: Nat'l Football League Players' Concussion Injury Litig., No. 2:12-md-02323-AB (E.D. Pa. Jan. 14, 2014) at 10.

⁴ See Rick Maese & Cindy Boren, *NFL, Former Players Settle Concussion Lawsuits*, WASH. POST (Aug. 29, 2013), http://articles.washingtonpost.com/2013-08-29/sports/41578247_1_former-players-nfl-players-association-nfl-retirees.

⁵ Sheena Harrison, *NFL Settles Concussion Claims, but Insurers' Role in Paying Costs Still Unclear*, Bus. Ins., (Sept. 8, 2013), <http://www.businessinsurance.com/article/20130908/NEWS06/130909875>.

⁶ See, e.g., Steve Fainaru & Mark Fainaru-Wada, *Lawyer Blasts Concussion Agreement*, ESPN.COM (Jan. 14, 2014), http://espn.go.com/espn/otl/story/_/id/10295307/attorney-blasts-concussion-deal-recommend-clients-continue-sue-nfl (Some of the players' lawyers have suggested that even if the NFL concussion litigation does eventually settle, certain players will choose to opt out of the settlement agreement and continue to sue the NFL.).

after the NFL and its players reached a preliminary settlement, are now facing similar concussion litigation.⁷ In the NHL, a similar class action lawsuit currently consisting of ten former players “seek[ing] to represent a class of more than 10,000 retired NHL players”⁸ is alleging, among other claims, fraudulent misrepresentation by concealment, fraudulent misrepresentation by nondisclosure, fraud, negligent misrepresentation, and negligence.⁹ These types of large, player-led, class action lawsuits will undoubtedly change the face of contact sports forever and will require insurers to decide if they should change the policies they offer to their contact sport insureds or insure them at all.

As some concussion litigation may proceed in the NFL, and as the NHL has its own upcoming litigation, both of these organizations will likely turn to their insurers to defend and indemnify them. This Note focuses on the numerous insurance issues that will be addressed in both class actions by examining the progress made thus far in both cases. More specifically, this Note discusses these insurance issues by examining some of the arguments that the NFL's insurers did advance,¹⁰ which the NHL's insurers may also advance, to potentially limit or nullify their liability to the leagues. Additionally, this Note evaluates the likelihood that if concussion litigation does proceed to trial, courts will implement a continuous trigger theory to decide when the insured's policies are triggered. Due to the resulting potential liability of such a theory, insurers have an even stronger incentive to alter their policies going forward to avoid future exposure for millions of dollars to current and former injured players.

Parts I and II discuss the medical background of concussions and the general history of the NFL concussion litigation. Part III examines the arguments that were left unanswered in the NFL concussion litigation and how they are likely to unfold in the NHL concussion litigation.

Part IV concludes that a continuous trigger theory would likely be used to determine insurance coverage in circumstances such as the

⁷ See, e.g., Paul D. Anderson, *Concussion Litigation Strikes the NHL*, NFL CONCUSSION LITIG. (Nov. 26, 2013), <http://nflconcussionlitigation.com/?p=1542>.

⁸ *Id.*

⁹ See, e.g., Class Action Complaint, Leeman, Aitken, et. al. v. Nat'l Hockey League & NHL Bd. of Governors, No. 1:13-cv-01856 (D.D.C. Nov. 25, 2013) at 36-46.

¹⁰ Paul D. Anderson, *NFL's Insurer Balks at Concussion Defense*, NFL CONCUSSION LITIG. (Sept. 16, 2012), <http://nflconcussionlitigation.com/?p=1026>.

concussion litigation presenting latent harm. Specifically, there are three competing theories about what triggers coverage for concussion injuries: the initial exposure trigger theory, the manifestation trigger theory, and the continuous trigger theory. This Part argues that a CGL policy is triggered at the point of exposure to a mild traumatic brain injury (“MTBI”) through the time when a players’ neurological disease manifests itself. Accordingly, using either the point of exposure or the point of manifestation alone to trigger insurance policies would not align with the reasonable expectations of the insured, as the injury does not occur at either of these discrete moments. Moreover, because it is extremely difficult to determine exactly when the players’ MTBIs occurred, the manifestation trigger theory and the initial exposure trigger theory would be too difficult to implement. In cases presenting this type of latent harm, a continuous trigger would be the best approach to determine when an insurance policy is triggered, considering this difficulty of ascertaining when the players’ injuries “occurred.” As such, insurers should address this in their policies, and some insurers may choose to do so by adding concussion exclusions or providing a definition for “trigger” in the event of a concussion.

Part V considers that the insurers will likely argue that the League intended or expected the injuries that the players suffered, which may exclude these injuries from coverage. Finally, Part VI explains that there is a strong likelihood that the insurers will be required to defend the League under their current insurance policies despite the fact that the players’ claims may potentially not be covered.

II. MEDICAL BACKGROUND

The NFL concussion litigation greatly heightened concern for concussions in not only the NFL, but in all contact sports. For this reason, it is likely that sports’ medical personnel nationwide will focus more on the causes and diagnoses of concussions for the foreseeable future. The American Association of Neurological Surgeons (“AANS”) defines a concussion as an “injury to the brain that results in temporary loss of normal brain function, [which is typically] caused by a blow to the head.”¹¹

¹¹ See *Concussion*, AM. ASSOC. OF NEUROLOGICAL SURGEONS (Dec. 2011), <http://www.aans.org/Patient%20Information/Conditions%20and%20Treatments/Concussion.aspx> (explaining that neurosurgeons and other brain-injury experts emphasize that although “some concussions are less serious than others, there is no such thing as a ‘minor concussion’”).

The AANS notes that concussions are serious injuries and cautions that “[e]ven mild concussions should not be taken lightly.”¹² When concussions are ignored or otherwise improperly treated prior to a player reentering a game or practice, that player is more likely to suffer another concussion.¹³ This is especially troubling because sources suggest that the harm caused by concussions has a cumulative effect and can result in neuropsychological impairment and neurologic abnormalities.¹⁴ This link between concussions and neurologic abnormalities and diseases has been illustrated by numerous players’ stories.¹⁵ In fact, in 2012, researchers announced that thirty-four NFL players “whose brains were studied suffered from chronic traumatic encephalopathy (“CTE”), a degenerative brain disease brought on by repeated hits to the head that results in confusion, depression and, eventually, dementia.”¹⁶

CTE has also been discovered in former hockey players’ brains.¹⁷ For instance, in 2011 the brain of Derek Boogaard, a twenty-eight-year-old hockey player, was studied after he died from what was ruled an accidental

¹² *Id.*

¹³ Michael W. Collins & Kristen L. Hawn, *The Clinical Management of Sports Concussion*, 1 CURRENT SPORTS MED. REPORTS 12, 12 (2002).

¹⁴ *Id.* See AM. ASSOC. OF NEUROLOGICAL SURGEONS, *supra* note 11 (cautioning that one concussion soon after another “does not have to be very strong for its effects to be deadly or permanently disabling”).

¹⁵ See, e.g., Sydney Lupkin, *CTE, a Degenerative Brain Disease, Found in 34 Pro Football Players*, ABC NEWS (Dec. 3, 2012), <http://abcnews.go.com/Health/cte-degenerative-brain-disease-found-34-pro-football/story?id=17869457> (“Researchers at Boston University’s Center for the Study of Traumatic Encephalopathy published the largest case series study of CTE to date, according to the center. Of the 85 brains donated by the families of deceased veterans and athletes with histories of repeated head trauma, they found CTE in [sixty-eight] of them. Of those, [thirty-four] were professional football players, nine others played college football and six played only high school football.” Additionally, several NFL players have committed suicide in recent years whose brains contained CTE including former Kansas City Chiefs player Jovan Belcher, former NFL players Junior Seau, Dave Duerson, former Pittsburgh Steelers player Terry Long, and former Philadelphia Eagles player Andre Waters.).

¹⁶ *Id.*

¹⁷ See John Branch, *Derek Boogaard: A Brain ‘Going Bad,’* N.Y. TIMES (Dec. 5, 2011), http://www.nytimes.com/2011/12/06/sports/hockey/derek-boogaard-a-brain-going-bad.html?pagewanted=1&_r=1. (In the preceding two years, CTE was also discovered in the brains of two other former NHL players, Reggie Fleming and Rick Martin.).

overdose.¹⁸ The neuropathologist at the Boston University's Center for the Study of Traumatic Encephalopathy, who has examined nearly eighty brains of former athletes, was shocked by how advanced the degree of brain damage was in such a young player.¹⁹ A few months after Boogaard's death, two more young NHL players were found dead: Rick Rypien, a twenty-seven-year-old player who committed suicide, and Wade Belak, a twenty-seven-year-old player who reportedly hanged himself.²⁰ At the time of this writing, it appears that neither player's brain was studied for CTE.²¹

A. NFL LITIGATION AND SETTLEMENT

As more news surfaced of past contact sports players who committed suicide and had CTE in their brains, numerous NFL players took a historic step and brought a class action lawsuit against the NFL. In August 2011, the first professional football players filed lawsuits against the NFL alleging more than ten counts, including fraudulent concealment, fraud, negligent misrepresentation, and negligence.²² The players' claims centered around the premise that the NFL did know, or at least should have known, about the potentially serious implications of sustaining concussions and not only failed to inform players, but also intentionally hid this information from them.²³ If these lawsuits proceed to court, the players would face numerous obstacles. Obstacles include possible dismissal due to arbitration clauses in the collective bargaining agreements that they entered into with the League,²⁴ difficulty proving that their injuries

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ See, e.g., Pat Hauldren, *NHL Enforcers Deadly and Dying*, EXAMINER.COM (Sept. 2, 2011) <http://www.examiner.com/article/nhl-enforcers-deadly-and-dying>.

²² See, e.g., Plaintiffs' Amended Master Admin. Long-Form Complaint, In Re: Nat'l Football, No. 2:12-md-02323-AB (E.D. Pa. Jul. 17, 2012).

²³ See generally *id.* at 15-44.

²⁴ The League argued that the players' claims were preempted by the arbitration clauses in the players' collective bargaining agreements ("CBAs"), Defendant's Motion to Dismiss, In Re: Nat'l Football, at 6, 7, 15. No. 2:12-md-02323-AB (E.D. Pa. Aug. 30, 2012), and up until the settlement made little effort to set forth arguments countering the players' claims due to this CBA argument. See *id.* at 14-34. The validity of this preemption argument would have been crucial had the case not settled because if all of these claims were preempted by the CBAs the players will be forced to pursue their case through the "agreed-to arbitration

occurred while playing professional football in the NFL,²⁵ and difficulty proving that they did not expect their injuries.²⁶

In a proactive response, many of the NFL's insurers filed motions for declaratory judgment in which they asked a court to determine whether they had a duty to defend and/or indemnify the NFL. For example, Alterra America Insurance Company ("Alterra"), one of the NFL's insurers, filed a complaint seeking a declaration of relief with respect to both its duty to defend and its duty to indemnify the NFL against ninety-three different lawsuits brought by former players.²⁷ Alterra contended that since the underlying claims filed by the players alleged that the NFL acted

procedures" in the CBAs. Paul D. Anderson, *The Almighty CBA*, NFL CONCUSSION LITIG. (Aug. 30, 2012), <http://nflconcussionlitigation.com/?p=1080>. This defense will also be available to the NHL in its upcoming class action. Anderson, *supra* note 7.

²⁵ Due to the pressure that players feel, fewer concussions are reported because players try to exude toughness and feign feeling healthy. Michael Farber, *The Worst Case*, SPORTS ILLUSTRATED (Dec. 19, 1994), <http://sportsillustrated.cnn.com/vault/article/magazine/MAG1006087/index/index/htm>. While many players deny having symptoms when playing, the plaintiffs still blamed the NFL for these attitudes and alleged that the NFL promotes football by glorifying the brutality of the sport and representing that "putting big hits on others is a badge of courage and does not seriously threaten one's health." Plaintiff's Amended Complaint, *supra* note 22, at 11. The plaintiffs' complaint further asserts that the League professed to its players that collisions, regardless of the injuries they lead to, are a normal consequence of football and "a measure of the courage and heroism of players." *Id.* Due to these factors, it can certainly be argued that players intended and/or expected these injuries.

²⁶ Players would have trouble arguing that they did not intend and/or expect their injuries when players such as Al Toon, a former wide receiver for the New York Jets, who retired from football at age twenty-nine after sustaining his ninth diagnosed concussion stated that "[he] chose the profession and [he] understood the perils of the profession when [he] was playing." William C. Rhoden, *Two Ex-Jets Have Moved On, but Concussion Effects Linger*, N.Y. TIMES (Nov. 20, 2011), http://www.nytimes.com/2011/11/21/sports/football/concussion-effects-linger-for-two-ex-jets.html?pagewanted=all&_r=0. See also Plaintiff's Amended Complaint, *supra* note 22, at 13 (Ernest Givens stated, "I get knocked out a lot, I get concussions, I get broken noses, that is part of being a receiver, that's what separates you from being a typical receiver than a great receiver.")

²⁷ *Alterra Balks at Defending NFL in Concussion Suits*, INSURANCE JOURNAL.COM (Aug. 16, 2012), <http://www.insurancejournal.com/news/east/2012/08/16/259710.htm>.

fraudulently, it should not be required to defend the League against the players' lawsuits.²⁸ Soon after Alterra filed its motion for declaratory relief, other insurers, including Travelers and Allstate, filed similar pleadings.²⁹ Allstate also sought declaratory relief in relation to any alleged duty to indemnify, claiming that "any past or future duty to indemnify the NFL Defendants may be limited or precluded by a number of factual or legal defenses."³⁰

After these insurers filed declaratory relief motions in New York, the NFL brought a declaratory relief action in Los Angeles Superior Court regarding the coverage duties of thirty-two insurance carriers pursuant to 187 commercial liability policies that were issued over a fifty to sixty year period.³¹ The NFL then moved to dismiss the New York lawsuits, which the defendant insurers argued against on forum non conveniens grounds.³² The Los Angeles Superior Court ordered the California proceeding stayed pending the outcome of the New York actions and, despite the NFL's appeal, this decision was affirmed.³³ As such, the declaratory relief motions are ripe for decision in the Supreme Court of New York.

²⁸ *Id.*

²⁹ Consolidated Reply of Defendants Nat'l Football League and NFL Props., LLC in Support of Motions to Dismiss Claims of TIG Insurers, Travelers Insurers, and Allstate, Discover Prop. & Cas. Co., et al. v. Nat'l Football League, et al., No. 652933/2012 (N.Y. Sup. Ct. Nov. 2, 2012) at 2. Discover Property & Casualty Insurance Company has filed a motion to dismiss or stay on forum non conveniens grounds suggesting that California is an inconvenient and improper forum. *See id.* at 1.

³⁰ Answer of Defendant Allstate Ins. Co. and Crossclaim for Declaratory Judgment against Defendants Nat'l Football League and Nat'l Football League Props., LLC, Discover Prop. & Cas. Co., et al. v. National Football League, et al., 14, No. 652933/2012 (N.Y. Sup. Ct. Aug. 28, 2012). In its cross claim, Allstate alleges twenty-five factors that may limit or preclude its duty to indemnify including that Allstate's policies do not provide coverage for claims that arise from conduct that is in violation of the law or public policy, the policies do not cover bodily injury which did not take place during the policy period, and the excess insurance policy does not provide coverage for any bodily injury or damage that was expected or intended. *See id.* at 14-15.

³¹ Nat'l Football League et al., v. Fireman's Fund Ins. Co. et al., No. B245619, 216 Cal. App. 4th 902, 908 (Cal. Ct. App. May 28, 2013).

³² *See* Consolidated Reply of Defendants, *supra* note 29, at 25-26; Discover Prop. & Cas. Co. et al., *supra* note 29.

³³ Mem. of Law of Defendants Nat'l Football League and NFL Props. LLC in Support of Motion to Dismiss or Stay Discover Complaint and Counterclaims and

As Allstate's cross-claim illustrates, the insurers' claims are predicated on the merits of the underlying case between the NFL and its players.³⁴ At the time of this writing, these declaratory relief motions have yet to be decided. However, due to the fact that the court would be required to analyze the underlying claims of the players' lawsuit against the NFL in order to decide these motions, the Supreme Court of New York should refrain from granting the insurers' request for declaratory relief in order to allow the issues to be decided by the proper fact-finders, the jury. If the courts do deny the insurers' motions for declaratory relief, the insurers would likely be required to defend the NFL. Nevertheless, if this case settles and no players choose to opt out of the settlement, these motions become wholly irrelevant.

While there is a strong likelihood that the insurers would have a duty to defend, it is just as likely that they would not be required to indemnify the NFL. The NFL's insurers possess several potential arguments that can nullify their duty to indemnify the NFL. In the event that this case proceeds to trial or players choose to opt out of a settlement and continue to sue the NFL, the NFL's insurers could argue that the NFL intended and/or expected these injuries. The NFL conducted studies of concussions in professional football spanning from 1994 to 2005, examining periods during the 1990s and 2000s.³⁵ One of the most significant NFL studies was conducted in 1994³⁶ and was set in motion by then Commissioner of Football, Paul Tagliabue, who formed the Mild Traumatic Brain Injury Committee ("Committee").³⁷ The Committee's goal was to study concussions (also referred to as mild traumatic brain injuries

Cross-Claims of TIG Insurers and Allstate at 11-12, *Discover Prop. & Cas. Co. et al. v. Nat'l Football League et al.*, No. 652933/2012 (N.Y. Sup. Ct. Sept. 17, 2012).

³⁴ Allstate is claiming it does not owe a duty to defend based on the potential of intended and/or expected injury and arguments that injuries did not occur within the policy period which would go to the heart of the trigger issues of the underlying case. *See Answer of Defendant Allstate Ins. Co.*, *supra* note 30, at 15.

³⁵ *See, e.g.*, Nathan Fenno & Luke Rosiak, *NFL Concussion Lawsuits*, WASH. TIMES (July 19, 2013), <http://www.washingtontimes.com/football-injuries/>.

³⁶ The concussion problem was a rampant issue as early as 1994. In that year, data supplied by twenty-eight NFL teams demonstrated that from 1989 to 1993, 341 players on the twenty-eight teams in the League had suffered from 445 concussions. Farber, *supra* note 25. This equated to about two and a half concussions for every 1,000 plays. *Id.*

³⁷ Paul Anderson, *A New Era of Pro Football*, NFL CONCUSSION LITIG. (Oct. 17, 2012), <http://nflconcussionlitigation.com/?p=1194>.

or MTBIs), in professional football and to determine their potential long-term effects.³⁸

After fifteen years, the Committee released several studies that are now all considered extremely controversial.³⁹ One of these studies, “Concussion in Professional Football: Summary of the Research Conducted by the National Football League’s Committee of Mild Traumatic Brain Injury,” refuted the link between concussions and neurodegenerative diseases.⁴⁰ The study noted that “arbitrary return-to-play guidelines may be too conservative for professional football . . . [and] many NFL players can safely be allowed to return to play on the day of the injury after sustaining a [M]TBI.”⁴¹

Based on this and other evidence, the insurers could argue, similar to what the players alleged in their complaint, that the NFL intentionally misled the players about the potential consequences of concussions. If proven, this would bar the NFL from coverage under its CGL policies. The insurers could successfully argue that during the fifteen-year period when the Committee was conducting studies, the NFL concealed and/or misrepresented the long-term effects of concussions from its players and knew that its studies were misleading.⁴² The argument that the NFL concealed information, was explored in the October 2009 and January 2010 Judiciary hearings before the House of Representatives. The Committee on the Judiciary (the “Judiciary”) held a hearing to determine the severity of the concussion problem in football and the potential remedies that were available.⁴³

At these hearings, the NFL was questioned about a pamphlet dealing with concussions, which it distributed to its players. The pamphlet stated:

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* (discussing Elliot J. Pellman & David C. Viano, *Concussion in Professional Football: Summary of the Research Conducted by the National Football League’s Committee on Mild Traumatic Brain Injury*, 21 NEUROSURGICAL FOCUS (2006)).

⁴¹ *Id.*

⁴² See Plaintiffs’ Amended Master Admin. Long-Form Complaint, *supra* note 22, at 33.

⁴³ See *Legal Issues Relating to Football Head Injuries (Pt. I): Hearing Before H. Comm. on the Judiciary*, 111th Cong. 1 (2009) (statement of Rep. John Conyers, Chairman, H. Comm. on the Judiciary).

Question: if I have had more than one concussion, am I at increased risks for another injury? Answer: Current research with professional athletes has not shown that having more than one or two concussions leads to permanent problems if each injury is managed properly. It is important to understand that there is no magic number for how many concussions is too many.⁴⁴

Thus, the NFL was informing its players that there is “no magic number” of concussions that makes a player more prone to suffer long-term neurological damage at the same time when numerous studies showed a link between any blunt force trauma, such as that occurring in football, and premature death among athletes. This type of questionable behavior lends support to the players’ allegations that the NFL concealed information from them.⁴⁵ Similarly, during these Judiciary hearings, the NFL Commissioner, Roger Goodell, would not unequivocally agree that there was proof of a link between concussions and neurodegenerative diseases.⁴⁶ One Judiciary member referred to the League’s denial as a blank rejection and accused the League of minimizing the fact that this link existed.⁴⁷

If the NFL concussion litigation does not settle, or some players opt out of the settlement and continue to sue the NFL, courts would be required to analyze these and other defenses to coverage for nearly 200 CGL policies due to the fact that from 1968 to 2012 the NFL was covered by insurance policies issued by thirty-two insurance carriers.⁴⁸ Nevertheless, this analysis has yet to occur, as two years after the first players filed their lawsuits against the NFL, the NFL entered into a preliminary settlement with the players for \$765 million. From this settlement amount, \$675 million will

⁴⁴ *Id.* at 115-16.

⁴⁵ See Plaintiffs’ Amended Master Admin. Long-form Complaint, *supra* note 22, at 1.

⁴⁶ See *Legal issues relating to football head injuries. Pt. I*, *supra* note 43, at 116-18 (2009) (statement of Comm’r of Football, Roger Goodell, H. Comm. on the Judiciary).

⁴⁷ *Id.* at 116. (statement of Representative John Conyers, Chairman, H. Comm. on the Judiciary) (statement of California Representative Linda T. Sanchez).

⁴⁸ *Fireman’s Fund Ins. Co.*, 216 Cal. App. 4th at 906.

[c]ompensate former players and families of deceased players who have suffered cognitive injury Other money will be used for baseline medical exams, the cost of which will be capped at \$75 million. The NFL also will fund research and education at a cost of \$10 million The settlement will include all players (whether they were part of the suit or not) who have retired as of the date on which the court gives preliminary approval Current players are not eligible. The NFL has [twenty] years to pay the full amount of the settlement, but half of the total must be paid within the first three years and the rest over the next [seventeen] years.⁴⁹

According to ESPN, the compensation program is designed to last for up to sixty years and will allow retired players who later develop neurological diseases or conditions to apply for compensation.⁵⁰

While it appeared as though the NFL concussion litigation was concluding, the judge handling this litigation denied preliminary approval of the settlement, explaining that, “I’m primarily concerned that not all Retired NFL Football Players who ultimately receive a Qualifying Diagnosis or their related claimants will be paid.”⁵¹ This judge commended both sides for arriving at this preliminary settlement,⁵² but explained that she was not convinced that the settlement “ha[d] no obvious deficiencies, grant[ed] no preferential treatment to segments of the class, and [fell] within the range of possible approval.”⁵³ The NFL will likely still arrive at a settlement with its players; however, one attorney explained that he believes that the current settlement does not adequately compensate many of the players and indicated that even if the settlement is approved by the judge, many players may “opt out” of the settlement and continue litigation against the NFL.⁵⁴

⁴⁹ Fainaru-Wada, *supra* note 2.

⁵⁰ *Id.*

⁵¹ Mem., In Re: Nat’l Football League Players’ Concussion Injury Litig., *supra* note 3.

⁵² Fainaru-Wada, *supra* note 2.

⁵³ Mem., In Re: Nat’l Football League Players’ Concussion Injury Litig., *supra* note 3 (citing Cordy v. USS-Posco Indus., No. 12-553, 2013 WL 4028627 at *3 (N.D. Cal. Jul. 31, 2013)).

⁵⁴ Fainaru & Fainaru-Wada, *supra* note 6.

Thus, these settlement discussions and the litigation that may follow are only the beginning of the conversation that will take place nationwide about concussions in sports. In fact, in the past three years since the initial lawsuits in the NFL concussion litigation were filed, a new era of professional football has emerged in which players are informed about the risks they face when they step onto the field.⁵⁵ In this new era, players no longer make their own medical determinations as to when they obtain a head injury. Instead, independent neurologists decide when concussed players can return to the game.⁵⁶ This change has not been limited to the NFL, however, and this leads to the question: how will the numerous issues in the NFL concussion litigation be resolved if this case does not settle? And, how will these questions be answered in the context of the NHL concussion litigation? To evaluate the insurance issues that will arise in the NFL concussion litigation if it proceeds and in the NHL concussion litigation, this Note will focus on the upcoming NHL concussion litigation.

III. INSURANCE CONTRACT BACKGROUND IN NHL CONCUSSION LITIGATION

One type of insurance policy that the NHL has is a CGL policy that insures the League for injuries that players sustain as long as those injuries are not excluded from coverage. Although the specific policies sold to the NHL by its insurers are not available to the public, the typical CGL policy's terms and provisions will be similar to the clauses of the NHL's CGL insurance policies which the courts will be required to analyze.⁵⁷ Like the NFL did, when the NHL defends the newly formed player-led class action, it will likely turn to its insurers for indemnification relying on its "insuring clause" within its CGL policy.⁵⁸ A typical insuring clause

⁵⁵ See Anderson, *supra* note 37.

⁵⁶ *Id.*

⁵⁷ The insurance contracts will only be analyzed if these cases are not subject to mandatory arbitration. The League will argue that the players' claims are subject to mandatory arbitration pursuant to the players' collective bargaining agreements. See Anderson, *supra* note 7.

⁵⁸ See *Fireman's Fund Ins. Co. et al.*, 216 Cal. App. 4th at 908; Appellants' Brief, *Nat'l Football League & NFL Props. LLC, v. Fireman's Fund Ins. Co., et al.*, 2013 WL 233176 (Cal. App. 2 Dist.) at 1-2 (internal citations omitted) (The NFL and NFL Properties filed an action in California against thirty-two general liability insurers that issued 187 primary and excess insurance policies to one or

provides that the insurer “will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which [the] insurance applies.”⁵⁹ The NHL’s general liability insurers are likely as extensive as the NFL’s insurers in number⁶⁰ and as such, these lawsuits coupled with those ongoing in the NFL, will undoubtedly affect how insurers choose to insure any contact sport organization in the future.

In the NHL, this discussion regarding how to cover the League in this concussion era may have already begun in the context of disability insurance. For instance, in 2012, one of the Pittsburgh Penguins’ top players, Sidney Crosby, was sidelined for most of the season due to concussion-related injuries.⁶¹ Since Crosby had been injured and out of the lineup for more than thirty games, the Penguins relied on their disability insurance policy to cover Crosby’s nine million dollar salary. Analysts have suggested, however, that this “security blanket is poised to disappear”⁶² because insurance companies may cease to insure these athletes, forcing teams to take on these million-dollar contracts alone.⁶³ For the Penguins, this is especially troubling because if Crosby, who has one year remaining on his contract, returns to the ice, he will be in line for a new long-term contract for approximately ten million dollars a year. But if no insurance company is willing to insure him against concussions, the Penguins may not be able to afford to retain him.⁶⁴

The chief executive of one New York-based insurer, HCC Specialty, noted that “[r]ight now you’ve got [ten] percent of the [L]eague

both over a forty-four year period. “The NFL Policyholders sued twelve primary insurers for breach of their duty to defend the NFL Policyholders in underlying tort litigation filed by former NFL players, and sued all 32 insurers for a declaratory judgment that their policies cover any liability that might be incurred in the tort litigation.”)

⁵⁹ TODD A. ROSSI & MARK D. MESE, *THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY* 109 (Alan Rutkin & Robert Tugander eds., 2010); *See* TOM BAKER, *INSURANCE LAW AND POLICY* 358 (2008).

⁶⁰ *Fireman’s Fund Ins. Co. et al.*, 216 Cal. App. 4th at 906.

⁶¹ *See* Rick Westhead, *Concussions Could Ruin NHL Teams If Insurers Pull Coverage*, THESTAR.COM (Jan. 30, 2012), http://www.thestar.com/sports/hockey/2012/01/30/concussions_could_ruin_nhl_teams_if_insurers_pull_coverage.html.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *See id.*

affected by concussions . . . [w]hile I don't know where the breaking point is, at some point, if it keeps trending this way, [insurance] companies are not going to be able to insure NHL players for concussions."⁶⁵ Another insurer, Toronto-based Sutton Special Risk, an insurer for "off-ice insurance to more than 400 NHL players," rewrote its insurance application form in order to focus more attention on players' concussion histories and help protect itself from liability for players with past concussions.⁶⁶

Due to the vast number of players who have been sidelined with concussions in the NHL, there is no question that this is one of the most prevalent issues in the League today. Despite the magnitude of the concussion problem in the NHL, the president of Sutton Special Risk professed that it is too early to say that the insurance industry will change the policies that it offers to NHL players because the industry is still evolving.⁶⁷ With that said, it is likely a matter of time before this discussion of limiting or revoking the League's insurance for players with concussions transcends the context of disability insurance to that of general liability insurance. Insurers will need to make difficult decisions to protect themselves from this concussion epidemic that will remain at the forefront of contact sports for the foreseeable future. While insurers may decide to take steps to limit their liability through modifying the policies that they offer to their contact sport insureds, insurers will still stand behind their current policies in the upcoming NHL litigation and likely argue that even under their current policies they do not have a duty to defend or indemnify the League.

⁶⁵ *Id.*

⁶⁶ *See id.* (Sutton Special Risk's president noted, "[w]e used to have one question asking players their history with cardiac issues and other problems like concussions . . . [n]ow, concussions have their own section. We're asking about frequency, how bad they were and how many games they missed. We know you're not recovered from brain injuries because the symptoms go away. This is not an organ like the liver that can regenerate itself.").

⁶⁷ *See NHL concussions put player insurance in question*, CBC SPORTS (Jan. 31, 2012), <http://www.cbc.ca/sports/hockey/nhl/nhl-concussions-put-player-insurance-in-question-1.1132073>. *But see* Westhead, *supra* note 61 (according to one player agent, new contracts will contain concussion exclusions, making it impossible for teams to insure players with past concussions against future brain injuries).

A. NHL CONCUSSION LITIGATION

In the NHL class action complaint, the players are alleging numerous counts, including fraudulent misrepresentation by concealment, fraudulent misrepresentation by nondisclosure, fraud, negligent misrepresentation, and negligence.⁶⁸ The players' claims rest on the growing body of medical evidence linking concussions to long-term injury as well as on evidence that the League knew or should have known of those medical studies but took no remedial action to prevent injury until 1997.⁶⁹ The players note that in 1997 the NHL created a concussion program to conduct research about the effects of concussions on players' brains. Despite conducting that research, the players allege that the NHL did nothing to actually *prevent* injury to its players for another fourteen years.⁷⁰ Additionally, the players assert that the NHL continues to ignore the extensive medical research linking hockey to brain injuries and fosters violence in the sport by, among other things, "refusing to ban fighting and body checking and by continuing to employ hockey players whose main function is to fight or violently body check players on the other team."⁷¹ Observing that the NHL has an annual gross income of \$3.3 billion,⁷² the players argue that the NHL has promoted a culture of violence and "purposefully profits from the violence they promote."⁷³

The players contend that the NHL did not make any significant changes to prevent concussions until 2010 when it made body checking with the head a penalty.⁷⁴ After 2010, the NHL made other noteworthy safety changes including requiring a doctor, as opposed to a trainer, to examine its players for concussions off the ice and away from the bench⁷⁵ and changing its concussion protocols to forbid any concussed player from

⁶⁸ See, e.g., Compl., *supra* note 9, at 36–46.

⁶⁹ See *id.* at ¶ 7.

⁷⁰ See *id.* at ¶ 11.

⁷¹ *Id.* at ¶ 17; see also *id.* at ¶ 133 (not outlawing fighting and body checks in the NHL is significant because "[o]nly [twenty eight percent] of the reported concussions in the Cusimano report were the result of a called penalty while [approximately sixty four percent] of the total concussions were caused by body checking. A legal body check to the other player's body can still result in the checked player's head hitting the ice, boards or glass, resulting in a concussion.").

⁷² *Id.* at ¶ 78.

⁷³ *Id.* at ¶ 89.

⁷⁴ *Id.* at ¶ 112.

⁷⁵ *Id.* at ¶ 116.

returning to the game in which they received the concussion.⁷⁶ Similar to the allegations in the NFL concussion litigation, the NHL players' overall argument is that "[t]he NHL knew that repetitive head impacts in hockey games and practices created an unreasonable risk of harm to NHL players⁷⁷ . . . [but] withheld [and/or concealed] the information it knew about the risks of head injuries in the game from then-current NHL players and former NHL players."⁷⁸ Moreover, the players allege in their complaint that the NHL "deliberately delayed implementing the changes to the game it knew could reduce players' exposure to the risk of life-altering head injuries because those changes would be expensive and would reduce its profitability."⁷⁹

Overall, the NHL players' allegations are very similar to those made by the NFL players in their class action lawsuit.⁸⁰ For that reason, it is likely the League's insurers will react in a similar way to how the NFL's insurers have acted thus far. Yet, even if the NHL and NFL cases both do not proceed to trial, these two concussion litigation class action lawsuits will motivate insurers to protect themselves from future concussion lawsuits. Hence, regardless of the results of these litigations, insurers must confront the fact that under their current CGL policies, they are possibly responsible for at least defending, and also potentially indemnifying, their insured in the event of a lawsuit based on concussions and related long-term injuries.

Due to their likely liability, insurers may take steps to make it clear in their policies what the trigger is in the event of a concussion. If insurers do attempt to alter their policies, it is possible that they could face push back from individual state insurance regulators, depending on the state. However, because the NHL and NFL are both such large entities, it is possible they will not be required to obtain permission to alter their CGL

⁷⁶ See *id.* at ¶ 118 (a standard that other countries adopted in 2004).

⁷⁷ *Id.* at ¶ 170.

⁷⁸ See *id.* at ¶¶ 177, 200.

⁷⁹ *Id.* at ¶ 201.

⁸⁰ But see Anderson, *Concussion Litigation Strikes the NHL*, *supra* note 7 ("Although the legal theories are similar [between the NFL and NHL concussion litigation], the factual allegations in the NHL litigation are far less damning than those asserted against NFL. There is no evidence — at least publicly — that shows the NHL created (1) a brain injury committee, (2) headed by a rheumatologist and (3) spent 15-plus years creating false studies."). Additionally, unlike the NFL, the NHL was not questioned for their actions in relations to concussions in their league by Congress and have not denied that their sport can cause brain damage. *Id.*

policies. Additionally, insurers must contemplate how their exclusions for intended and/or expected injuries may assist them in avoiding indemnification and their duty to defend in any continuing litigation.

IV. OPEN QUESTIONS AFTER THE NFL CONCUSSION LITIGATION

A. TRIGGERS AND OCCURRENCES

An insurance policy comes into effect or is *triggered* when a relevant condition of the policy has occurred; at that time, the insurers' obligations become due.⁸¹ In many insurance cases, the "trigger" of coverage is not at issue.⁸² When the cause or the injury itself does not occur at a discrete moment, however, and instead materializes over time, it can be difficult to determine what policies were triggered and exactly when they were triggered.⁸³

The conditions that trigger an insurance policy are called occurrences. An "occurrence" is defined as "an accident, including injurious exposure to conditions, which results during the policy period in bodily injury or property damage neither expected nor intended from the standpoint of the insured."⁸⁴ A typical CGL policy states that the bodily injury or property damage must be caused by an occurrence that takes place during the policy period.⁸⁵ In either sport, it is undisputed that the affected NFL and NHL players sustained bodily injuries, which are defined as "bodily injury, sickness or disease sustained by a person."⁸⁶ The bodily injuries at issue are the neurodegenerative disorders and diseases that the plaintiffs sustained due, at least in part, to repeated head traumas while playing NFL football and NHL hockey.

In cases such as these, where harm accrued over a long period of time, coverage will turn on the presence of a trigger. However, the standard CGL policy does not clearly specify which trigger theory is applicable. This is the difficulty with latent harms, or "harms that may not

⁸¹ ROSSI & MESE, *supra* note 59, at 109.

⁸² *See id.*

⁸³ *See* BAKER, *supra* note 59, at 375.

⁸⁴ ROSSI & MESE, *supra* note 59, at 110.

⁸⁵ *See* BAKER, *supra* note 59, at 358.

⁸⁶ *Id.* at 369.

develop into symptomatic diseases for significant periods of time.”⁸⁷ With latent harms, a player is injured, but the injury does not immediately manifest itself. In these instances, a player is arguably injured once they receive a concussion, as their brain may begin to develop a neurodegenerative disease, but these neurodegenerative diseases do not manifest themselves for many years. Thus, in cases presenting latent harms, a court must decide what type of trigger theory to impose.

B. TRIGGER THEORIES

Courts typically apply one of three main trigger theories to determine when an insurance contract is triggered: the initial exposure trigger theory, the manifestation trigger theory, or the continuous trigger theory. In the case of latent harms, courts are forced to consider the difficulty of determining the point at which an insured became injured. Courts were faced with similar questions in the asbestos context and considered the unworkability of the initial exposure and manifestation trigger theories and the insured's reasonable expectations. Inhaling asbestos is a type of latent harm because a person who inhales asbestos does not appear ill until a long period of time after exposure, when they begin to exhibit symptoms. While an injured person is not aware that they have been exposed to asbestos, they are still ill from the moment of their initial exposure to the asbestos through the point in time when they exhibit signs of diseases such as mesothelioma.

Consequently, in dealing with asbestos cases, these courts employed a continuous trigger theory, finding that the manifestation trigger theory and the initial exposure trigger theory, which both utilize a discrete moment to trigger insurance policies, were too difficult to apply due to issues of proof regarding the timing of the injuries. While both the manifestation and initial exposure trigger theories were implemented in earlier asbestos cases, more recent cases have applied a trigger theory more akin to the continuous trigger theory.⁸⁸

⁸⁷ Note, *Latent Harms and Risk-Based Damages*, 111 HARV. L. REV. 1505, 1506 (1998).

⁸⁸ See, e.g., *J.H. Fr. Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 506 (Pa. 1993); *AC & S, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 973 (3d Cir. 1985); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1046-47 (D.C. Cir. 1981).

If the NFL and NHL concussion cases proceed to trial, one of the most difficult insurance coverage issues will be determining when the players' injuries actually occurred. Some of the plaintiffs' neurological injuries may have begun before they started playing professional football or professional hockey.⁸⁹ There is no feasible way to differentiate which injuries were exacerbated by playing in the NHL or NFL from those which occurred for the first time while playing in the NHL or NFL. Accordingly, it would be nearly impossible to use either an initial exposure theory or a manifestation theory to trigger the insurance policies.

Additionally, neither of these theories would protect the reasonable expectations of the insured, the NHL. "Under the 'doctrine of reasonable expectations,' an insured is entitled to all the coverage he may reasonably expect to be provided according to the terms of the policy."⁹⁰ Only "an unequivocally conspicuous, plain and clear manifestation of the [insurer's] intent to exclude coverage will defeat that expectation."⁹¹ In asbestos cases, courts recognized that attempting to confine an injury in cases of latent harm to one discrete moment would undercut the purpose of the insured's policy and ignore the reasonable expectations of the insured.⁹² This is due to the fact that insureds purchase policies so that they can be covered for injuries that occur during the policy period. This expectation of coverage is not altered in instances of latent harm where injuries do not occur at finite moments. Thus, if either an initial exposure theory, which covers the injury if the insured is exposed to the cause during the policy period, or a manifestation theory, which covers the injury if it manifests itself during the policy period, is utilized, the insurer would be excused from covering the vast majority of the latent harm.

⁸⁹ Stuart Dean, *Concussion: A Word Not Easily Defined and Why that Spells Trouble for Football*, NFL CONCUSSION LITIG. (Oct. 19, 2012), <http://nflconcussionlitigation.com/?p=1200>.

⁹⁰ Ky. Ass'n of Counties All Lines Fund Trust v. McClendon, 157 S.W.3d 626, 634 (Ky. 2005). The reasonable expectations doctrine "calls for an ascertainment of the insured's expectations, followed by a necessarily subjective determination of whether that expectation is reasonable." 2 Couch on Ins. § 22:11.

⁹¹ *McClendon*, 157 S.W.3d at 634.

⁹² See *Keene*, 667 F.2d at 1045.

1. Initial Exposure Trigger Theory

The initial exposure trigger theory utilizes the date when the insured was first exposed to the harm that caused them to have a bodily injury to trigger an insurance policy.⁹³ The Sixth Circuit implemented this exposure theory in a 1980 asbestos case due to its conclusion that bodily injury from asbestos began with the first exposure to and inhalation of asbestos.⁹⁴ While the injury of neurodegenerative diseases can and often does begin with the initial exposure to MTBIs, it would be difficult to pinpoint a precise time as the “initial exposure” because if players did not exhibit symptoms of a concussion, no official diagnostic medical test was conducted when a player was hit.⁹⁵ Additionally, since there are numerous symptoms of concussions,⁹⁶ and these symptoms can be subtle, concussions are often misdiagnosed or entirely undiagnosed.⁹⁷

In view of these problems of proof, there are two major difficulties in ascertaining the timing of a player's injury. First, it would be extremely difficult to determine when players received their first concussion or any concussion at all, especially in the case of veteran players who played at a time when even less was known about concussions. Second, it would be nearly impossible to conclude that a player who sustained a concussion was in the early stages of developing a neurodegenerative disorder. In fact, all of the hockey and football players who died or committed suicide and were found to be suffering from CTE were not diagnosed until death because, at

⁹³ ROSSI & MESE, *supra* note 59, at 116.

⁹⁴ *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1218 (6th Cir. 1980).

⁹⁵ See Ira R. Casson et al., *Concussion in the National Football League: An Overview for Neurologists*, 26 *NEUROLOGIC CLINICS* 217, 217 (2008); Dan Rosen, *New concussion protocol goes into effect tonight*, NHL.COM (Mar. 16, 2011), <http://www.nhl.com/ice/news.htm?id=556289> (discussing NHL practices prior to protocol change in 2011 for concussion testing after injury).

⁹⁶ Symptoms are either (1) somatic, including headaches, dizziness, balance problems, and nausea, (2) cognitive, including memory, concentration and processing speed problems, or (3) affective including anxiety and depression. Suzanne Leclerc et al., *Recommendations for Grading of Concussion in Athletes*, 31 *SPORTS MED.* 629, 634 (2001).

⁹⁷ See Collins, *supra* note 13, at 1.

the time of this writing, CTE can only be diagnosed post mortem.⁹⁸ Due to this inability to determine the “initial exposure,” an initial exposure trigger theory is not well suited to concussion litigation.

Additionally, the initial exposure trigger theory does not comport with the insured’s reasonable expectations. In *Keene*, the court analyzed the appropriate trigger of coverage for the latent harm of asbestos.⁹⁹ The court noted that if exposure was deemed to be a discrete injury that triggered coverage,

[T]he subsequent development of a disease would be characterized best as a consequence of the injury. Future stages of development would not constitute new injuries and therefore would not trigger additional coverage. Under that interpretation, a manufacturer who bought a comprehensive general liability policy would not bear the risk of liability for diseases that occurred due to exposure during a covered period. It would, however, bear the risk of liability for diseases that manifest themselves during the covered period, but that occur because of exposure at a time when the manufacturer held no insurance. As a result, the manufacturer’s purchase of insurance would *not* constitute a purchase of certainty with respect to liability for asbestos-related diseases. The insured would remain uncertain as to future liability for injuries whose development began prior to the purchase of insurance . . . such an exclusion is inconsistent with [the insured’s] reasonable expectations when it purchased the policies.¹⁰⁰

This same analysis is applicable in this latent harm context. Insureds purchase insurance to obtain certainty that they will be covered for liability. Practically speaking, however, the insurers who issued policies to the League when its players were first exposed to MTBIs are different from the insurers who insured it decades later when the players’ injuries manifested themselves as neurological disorders. Thus, the problem with using an

⁹⁸ See Gary W. Small et al., *PET Scanning of Brain Tau in Retired National Football League Players: Preliminary Findings*, 21 AM. J. GERIATRIC PSYCHIATRY 138, 139 (2013).

⁹⁹ *Keene*, 667 F.2d at 1042.

¹⁰⁰ *Id.* at 1044.

initial exposure theory in this context is that an insured, here the League, reasonably expects that if it were liable for damages, such as now when it is being sued by past players, that it would be covered. However, the League would not be covered or would be covered for only a fraction of the time because the players' injuries had been developing for years after the initial exposure.

Due to the latency of the injuries, however, the analysis for determining the trigger of coverage cannot commence until the point of manifestation. Therefore, precisely when the League would expect players' injuries to be covered by the League's insurance policies, when the injuries became apparent, the League would not be covered. Because this would not conform with the NHL's reasonable expectations, the initial exposure trigger theory should not be applied to this litigation.

2. Manifestation Trigger Theory

Under the manifestation trigger theory, insurance coverage is triggered when the damage or injury manifests itself or becomes apparent.¹⁰¹ In a 1982 asbestos case, the First Circuit adopted a manifestation theory on grounds that an injury is not diagnosed or felt until it becomes evident.¹⁰²

Over time, however, the limitations of the manifestation trigger theory have become apparent. A manifestation trigger theory would be exceptionally difficult to implement in the concussion context. In these concussion cases it is difficult to pinpoint at what time the players' neurodegenerative diseases became apparent. For instance, was it when a player obtained a concussion and felt dizzy, when a player could not remember the name of his children, or somewhere in between these two moments? In this type of litigation, where thousands of players' careers are involved, making the determination of when players' injuries manifested would be unworkable. In fact, "[c]ourts in recent years have been moving away from the manifestation trigger because of the difficulty in determining what constitutes manifestation of an injury concluding that this trigger theory is 'inherently unworkable.'"¹⁰³

¹⁰¹ ROSSI & MESE, *supra* note 59, at 112.

¹⁰² See *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12, 19 (1st Cir. 1982).

¹⁰³ Gwen M. Rogers, *Medical Monitoring, Trigger of Coverage Analysis, and the Duty to Defend*, 13 GEO. MASON L. REV. 869, 890-91 (2005).

Additionally, limiting the trigger to the one finite moment of manifestation does not fully protect the reasonable expectations of the insured. If manifestation was the sole trigger of coverage, then the insurance companies would only bear a fraction of the insured's total liability due to the fact that harm was occurring long before manifestation.¹⁰⁴ That result would "undermine the function of the insurance policies" because when an insured purchases policies, the insured could reasonably expect to be free of the risk of being liable for injuries that "it could not have been aware prior to its purchase of insurance."¹⁰⁵ If the disease manifested soon after a player sustained a MTBI, these losses would be covered and the insurer would compensate the insured. However, in the case of neurodegenerative diseases that are caused by earlier concussions, insurers would not be liable due to the fact that a long period of time exists between exposure and manifestation.¹⁰⁶

Therefore, "to accept the argument that *only* manifestation triggers coverage — and allow insurers to terminate coverage prior to the manifestation of many cases of disease — would deprive [the insured] of the protection it purchased when it entered into the insurance contracts."¹⁰⁷ In the latent harm context, the insured purchased a policy believing an injury that occurred during the policy period would be covered and not expecting that only injuries that occurred *and manifested* themselves during the policy period would be covered. As one court explained in the asbestos context:

The fact that a doctor would characterize cellular damage as a discrete injury does not necessarily imply that the damage is an 'injury' for the purpose of construing the policies. At the same time, the fact that an ordinary person would characterize a fully developed disease as an 'injury' does not necessarily imply that the manifestation of the disease is the point of 'injury' for purposes of construing the policies.¹⁰⁸

¹⁰⁴ See *Keene*, 667 F.2d at 1045-46.

¹⁰⁵ *Id.* at 1046.

¹⁰⁶ See *id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974, 984 (N.J. 1994).

This same logic applies in the concussion context: while a doctor may consider a concussion a discrete injury, that does not necessarily imply that the damage of a concussion is an “injury” for purposes of construing an insurance policy. At the same time, the fact that an ordinary person would characterize a fully developed neurological disease as an “injury” does not necessarily imply that the manifestation of the disease is the point of “injury” for purposes of construing the policies.

In the context of concussion litigation, like “the context of asbestos-related disease[s], the term[] ‘bodily injury,’ . . . standing alone, simply lack[s] the precision necessary to identify a point in the development of a disease at which coverage is triggered.”¹⁰⁹ Due to the fact that the general terms of an insurance policy in the latent harm context lack precision, courts are left to rely on the practicality of implementing a trigger theory and determining if that theory comports with the reasonable expectations of the insured. In this context, utilizing the manifestation theory would prove to be unworkable due to the difficulty in ascertaining when the injury is manifested. In order to determine the trigger in the NHL litigation, courts must ask whether the players suffered MTBIs *while* they were playing in the NHL and if the head traumas that occurred during their professional careers caused the neurological damage complained of, as opposed to other head impacts the players sustained in earlier or later time periods. At first glance, this may seem simple to ascertain. However, these players have been playing competitive hockey for years, throughout childhood into middle school and high school and through college all prior to entering the NHL. Consequently, both the initial exposure theory and the manifestation theories are unworkable.

3. Continuous Trigger Theory

More recent CGL policies define an occurrence as “an accident, including *continuous or repeated* exposure to substantially the same general harmful conditions.”¹¹⁰ Policies employing this “occurrence” definition embrace a continuous trigger theory, which entails providing coverage from the date of the initial exposure to the date when the injury manifests itself.¹¹¹

¹⁰⁹ *Keene*, 667 F.2d at 1043.

¹¹⁰ *BAKER*, *supra* note 59, at 371 (emphasis added).

¹¹¹ *See ROSSI & MESE*, *supra* note 59, at 118.

This theory was formulated because courts concluded that an insured should not be without coverage when they reasonably expected that they would be covered.¹¹² In the asbestos context, the continuous trigger theory has gained widespread acceptance.¹¹³ In fact, in *Keene*, even when the insurance policy at issue did not utilize continuous trigger language, the D.C. Circuit found that while

The policy language [did] not direct [it] unambiguously to either the ‘exposure’ or ‘manifestation’ interpretation, [i]n the context of asbestos-related disease[s], the terms ‘bodily injury,’ ‘sickness’ and ‘disease,’ standing alone, simply lack the precision necessary to identify a point in the development of a disease at which coverage is triggered In interpreting a contract, a term’s ordinary definition should be given weight, but the definition is only useful when viewed in the context of the contract as a whole.¹¹⁴

Thus, courts in the asbestos context now have guidance from language in insurance policies that use the term “continuous,” and when there is no such language, courts examine the context of the contract as a whole. In other words, while newer insurance policies, which utilize continuous language in defining an occurrence, provide clearer guidance that a continuous trigger theory is appropriate, under older policies the NHL can still rely on its reasonable expectations because the term “injury” does not clearly guide courts to adopt either a manifestation or initial exposure trigger theory.

Another reason courts utilize the continuous trigger theory in the asbestos context is that it is supported by medical research. Medical research has revealed “that bodily injury occurs during the exposure period . . . [and] it continues to occur past the point of manifestation . . . until the

¹¹² See *Keene*, 667 F.2d at 1044.

¹¹³ Rogers, *supra* note 103 (citing Robert D. Fram, *End Game: Trigger of Coverage in the Third Decade of CGL Latent Injury Litigation*, 454 PRACTISING L. INST. 9, 15 (1993); *Keene*, 667 F.2d at 1047; *Skinner Corp. v. Fireman's Fund Ins. Co.*, No. C95-995WD, 1996 WL 376657, at *1 (W.D. Wash. Apr. 3, 1996); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 703 (Cal. Ct. App. 1996); *Owens-Illinois, Inc.*, 650 A.2d at 995; *Owens-Corning Fiberglas Corp. v. Am. Centennial Ins. Co.*, 660 N.E.2d 770, 792 (Ohio Misc. 1995); *J.H. France Refractories Co.*, 626 A.2d at 506-07).

¹¹⁴ *Keene*, 667 F.2d at 1043.

claimant's death."¹¹⁵ Asbestos inhalation is a latent harm under the same rationale that concussions are a latent harm — a person who breathes in asbestos but does not become ill for a long period of time is similar to the plaintiffs in this litigation who were *exposed* to MTBIs and were thus in the preliminary stages of neurological disease, but did not know they were injured until symptoms of neurological damage *manifested* at a much later time. Thus, in both cases, a continuous trigger theory provides the greatest possible redress for the victims and for the League.¹¹⁶

Moreover, a continuous trigger better suits the NHL concussion litigation because it best addresses the problems of proof, which make the manifestation and exposure theories unworkable. Again, it is nearly impossible to determine when someone is injured due to the latent nature of this harm. These proof problems and the inability of both the manifestation and initial exposure trigger theories to fully cover the plaintiffs' reasonable expectations make the continuous trigger theory the best approach for deciding when the NHL's insurance policies are triggered.

While it would be more beneficial for insurers to control what trigger theory courts implement by adding language into their policies, a continuous trigger theory does have one advantage for insurers. Courts have determined that the term "occurrence" suggests that the policy was intended to cover more than a single accident, and instead, covers continuous or repeated exposure to the same general harm.¹¹⁷ Typically, insurance policies will contain a provision that explains that continuous exposure to the same harm is one occurrence so that the insurer will only be liable for their policy limits for a single occurrence.¹¹⁸ This approach benefits the insurers because consolidating all the individual injuries as one "occurrence" would, to some extent, diminish the insurers' liability to its insured. This single occurrence policy limit factor, however, would be a silver lining to a very dark cloud, as judges will likely invoke the continuous trigger theory as the most workable standard limiting insurers' ability to avoid coverage.

Insurers in the NHL and other contact sports are likely to take additional steps in the near future to protect themselves so that they are not liable for the entire span of a player's career when a player develops a

¹¹⁵ *Armstrong World Indus., Inc.*, 52 Cal. Rptr. 2d at 702.

¹¹⁶ See ROSSI & MESE, *supra* note 59, at 118.

¹¹⁷ PATRICK J. BOLEY, *THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY* 75-76, (Alan Rutkin & Robert Tugander eds., 2010).

¹¹⁸ *Id.* at 76.

neurodegenerative disease from their contact sport career. Insurers have a few options for how to protect themselves. For instance, when insurers issue replacement policies for older policies that have expired, they may be able to change the trigger of coverage or the scope of coverage itself.

As briefly noted above, one option would be to define the trigger of coverage as the first diagnosed concussion or the first diagnosis of a neurological disorder in their insurance policies to avoid leaving the question of the trigger up to a judge. Additionally, insurers could add concussion exclusions into their policies to avoid covering players with histories of concussions. This may result in pushback from individual NHL teams as well as the press and the public at large, however, if the NHL's insurers turn their backs on players who have been in the League for a number of years. Another option that insurers have would be to put pressure on the NHL to change its policies about fighting and other safety measures in order to insure the League for concussion-related injuries. This would likely reduce the number of concussions, as many of the NHL players who had CTE in their brains were termed the "NHL enforcers,"¹¹⁹ players known for their aggressive fighting in the League. At a minimum, insurers will likely expand their underwriting of concussions by asking more thorough and extensive questions about a player's concussion history so they can properly assess and price the risk. While insurers could take an even bigger step to protect themselves and stop insuring the NHL and its players, since the NHL, a multi-billion dollar industry,¹²⁰ is a real profit center, it would be very difficult for insurers to walk away from it.

V. EXPECTED AND/OR INTENDED INJURIES

Aside from alleging that its insurance policies were not triggered due to a particular trigger theory, insurers can also argue that the League expected and/or intended its players' concussions. While the insurers could raise this defense to coverage, they may find it difficult to persuade a court that the League intended and/or expected that the players would have long-term neurological diseases. There is ample evidence that physical injuries in contact sports are expected, but courts have yet to draw a parallel between physical injuries, which are expected and/or intended, and cognitive or neurological injuries.

¹¹⁹ Branch, *supra* note 17.

¹²⁰ See Compl., *supra* note 9, at ¶ 78.

A. EXPECTED INJURIES ARE NOT "OCCURRENCES."

In order for an event to be covered under a CGL insurance policy, it must also take place by chance.¹²¹ If the policyholder has control over the risk, the event may not be considered an "occurrence."¹²² Under the typical CGL policy, for "bodily injury" to be covered, it must occur during the policy period and cannot, prior to the policy period, be known to have occurred by any insured.¹²³ Under this provision, if players knew they had sustained MTBIs prior to entering the NHL, the insurer may not be liable.

The argument that the League expected and/or intended these injuries may be difficult to sustain, however, because not all concussions lead to neurodegenerative diseases. Additionally, not all players who previously sustained concussions knew that they had been injured. Moreover, the League was unlikely to have access to information about players' injuries prior to them entering the League.

Despite these obstacles, the insurers could still allege that the League expected that the players might sustain long-term neurological injuries due to the violent nature of the game of hockey. Under this theory, the insurers could argue that they do not have a duty to indemnify the League because CGL policies contain an exclusion for intended or expected injury. This provision provides that, "'bodily injury' or 'property damage' expected or intended from the standpoint of the insured" is excluded from coverage.¹²⁴ Expected injury typically requires that the insured "knows or reasonably anticipates" that there is a high probability that the insured's conduct will cause harm.¹²⁵ Therefore, the insurers may be able to show that the NHL had knowledge about the risks that the players were facing by playing professional hockey and thus knew, or at least reasonably anticipated, that they were more prone to suffering from long-term cognitive injuries.

Additionally, the League could be liable for failing to inform its players of these health risks if the insurers can show that the League possessed information about the seriousness of MTBIs and remained silent.

¹²¹ JOEL R. MOSHER, *THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY* 52 (Alan Rutkin & Robert Tugander eds., 2010).

¹²² *Id.* at 53.

¹²³ *See id.* at 57.

¹²⁴ CHARLES PLATTO, *THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY* 147 (Alan Rutkin & Robert Tugander eds., 2010).

¹²⁵ *Id.* at 151.

Moreover, if the League engaged in intentional misconduct by fraudulently concealing information, as the players allege, the League's conduct could be excluded from coverage.¹²⁶

Thus, the question of what injury the League expected or intended is central. Absent evidence to the contrary, it is likely that the League expected that its players could sustain short-term physical injuries but not long-term neurological harms. However, this distinction between the types of injury that players would experience may not be enough to secure coverage.¹²⁷ The *Evans* test, which some courts utilize, requires that the insured intended its conduct and intended some kind of injury, but once these requirements have been met, it is "immaterial that the actual harm caused is of a different character or magnitude from that intended" by the insured.¹²⁸ Under the *Evans* test, if the insurers proved that the League intended or expected that the players would be injured, it would be immaterial if the League intended or expected eventual neurological harm, and therefore these claims would not be covered under the NHL's insurance policies. Courts applying the *Evans* test rationalize its implementation by explaining that this test is consistent with both parties' reasonable expectations and is aligned with public policy.¹²⁹ Thus, under the *Evans* test, a court may find that the League expected or intended to act in a way that would result in some type of injury to the players and therefore its claims would be not covered by its insurance policies.

One notable difference about this argument in the NFL context is that there is no condoned physical fighting in the NFL. As the hockey players' complaint alleges:

For decades, the NHL has been aware or should have been aware that multiple blows to the head can lead to long-term brain injury, including but not limited to memory loss, dementia, depression, and CTE and its related symptoms.

¹²⁶ See ROSSI & MESE, *supra* note 59, at 109-10 (An "occurrence" must be accidental, resulting "in bodily injury or property damage neither expected nor intended from the standpoint of the insured," and thus if the insured acted intentionally it would not be an occurrence.).

¹²⁷ See ERIC MILLS HOLMES, 21 HOLMES' APPLEMAN ON INSURANCE 2D § 132.2[B][2] (2002) (citing *Tenn. Farmers Mut. Ins. Co. v. Evans*, 814 S.W.2d 49, 55 (Tenn. 1991)).

¹²⁸ *Evans*, 814 S.W.2d at 55; see also *Ohio Cas. Ins. Co. v. Henderson*, 939 P.2d 1337, 1343 (Ariz. 1997).

¹²⁹ *Iowa Kemper Ins. Co. v. Stone*, 269 N.W.2d 885, 887 (Minn. 1978).

Indeed, since the NHL has permitted bare-knuckle, on-ice fighting from its inception to the present, the NHL knew or should have known that the nearly century-old data from boxing was particularly relevant to professional hockey.¹³⁰

Boxing was one of the first sports to conduct research on the dangerous impacts of multiple blows to the head.¹³¹ Due to that widely known research, the insurers have a strong argument that the League intended and/or expected the players' injuries by allowing and supporting fighting.¹³² From the prospective of the insurers, due to the fighting in the NHL the insurers could invoke the exclusion to avoid indemnifying the League. Nevertheless, this does not mean that the League's insurers will be able to avoid their duty to defend.

¹³⁰ Compl., *supra* note 9, at ¶¶ 98, 99.

¹³¹ See Robert A. Stern et. al., *Long-term Consequences of Repetitive Brain Trauma: Chronic Traumatic Encephalopathy*, 3 PM&R S460, S461 (2011) (“[I]t has been known for some time that contact sports may be associated with neurodegenerative disease. In 1928, Martland described a symptom spectrum in boxers, which he termed ‘punch drink,’ that appeared to result from the repeated blows experience in the sport, particularly in slugging boxers who took significant head punishment as part of their fighting style.”).

¹³² The League can also argue that pursuant to the doctrine of assumption of the risk that “a person who voluntarily participates in a sporting activity generally consents, by his or her participation, to those injury-causing events, conditions, and risks which are inherent in the activity.” *Cotty v. Town of Southampton*, 64 A.D.3d 251, 253 (N.Y. App. Div. 2009). “Inherent risks in a sport are those that are “known, apparent, natural, or reasonably foreseeable consequences of the participation.” *Id.* at 253-54. Some jurisdictions have limited their application of assumption of risk, and the doctrine's application has become one of the most unsettled areas of tort law. DAVID HORTON, *Extreme Sports and Assumption of Risk: A Blueprint*, 38 U.S.F. L. REV. 599, 601 (2004). However, even if this doctrine is inapplicable, this doctrine is a subset of the intended/expected injury doctrine, which the insurers and the League can still utilize. Nonetheless, this note is focusing on the insurers arguments against the League and not the League's arguments against the players.

VI. RAMIFICATIONS FOR THE DUTY TO DEFEND

Under a CGL policy, the insurer is obligated to defend and indemnify its insured.¹³³ These two duties are integrated because the insurer will have a stronger incentive to defend fully if it will be held financially responsible through a duty to indemnify if it loses the case. Courts have viewed the duty to defend as broader than the duty to indemnify.¹³⁴ Because an insurer's obligation to defend is broader, an insurer may be "contractually bound to defend despite not ultimately being bound to indemnify."¹³⁵ This situation often arises when it comes to light during litigation that the insured is not factually or legally liable or that the occurrence is outside the policy's coverage.¹³⁶ Specifically, an insurer could be required to defend its insured throughout litigation and at the conclusion of trial obtain a ruling that provides that the claims are outside of the policy's coverage, and thus the insurer would not be required to indemnify its insured.

A. DUTY TO DEFEND

The typical language establishing the insurer's duty to defend in a CGL policy provides,

We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which the insurance does not apply. We may, at our discretion, investigate any occurrence and settle any claim or "suit" that may result¹³⁷

¹³³ LAURIE E. DUGONITHS, *THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY* 231 (Alan Rutkin & Robert Tugander eds., 2010).

¹³⁴ *Id.* at 234. This duty to defend is broader because the insurer may be required to defend a claim even though it is not actually covered by the insured's policy, but the insurer will only have to indemnify if the asserted claim is covered by the policy. *Litz v. State Farm Fire & Cas. Co.*, 695 A.2d 566, 570 (Md. 1997).

¹³⁵ *Fulton Boiler Works, Inc. v. Am. Motorists Ins. Co.*, 828 F. Supp. 2d 481, 488 (N.D.N.Y. 2011).

¹³⁶ *See, e.g., id.*

¹³⁷ DUGONITHS, *supra* note 133, at 231.

The scope of the insurer's duty to defend depends on the nature of the allegations set forth in the complaint and not on the ultimate basis of the liability of the insured.¹³⁸ Typically, the duty to defend is determined by the "eight-corners" rule.¹³⁹ Under the eight-corners rule, when an insured is sued by a third party, the insurer must determine its duty to defend from the terms of the policy and the pleadings of the third-party claimant.¹⁴⁰ Most courts do not allow insurers to examine evidence outside the four corners of these two documents.¹⁴¹ Thus, looking exclusively at the allegations that the players have made against the NHL, since there is a claim for negligence, the insurers will likely be required to defend.

This conclusion is also supported by the Supreme Court of California's decision in *Gray*, in which the court held that an insurer had a duty to defend its insured despite the fact that the complaint stated that the insured intentionally caused bodily injury.¹⁴² In *Gray*, the court focused on the specific CGL policy in which the insurer made two promises:

[1.] To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage, and [2.] the company shall defend any suit against the insured alleging such bodily injury or property damage and seeking damages which are payable under the terms of this endorsement, even if any of the allegations of the suit are groundless, false, or fraudulent.¹⁴³

The Court in *Gray* concluded that without further clarification, the insured would reasonably expect that the insurer would defend him against lawsuits seeking damages for bodily injury, whatever the alleged cause of the injury, whether intentional or inadvertent.¹⁴⁴

¹³⁸ *Id.* at 234-35.

¹³⁹ *Id.* at 236.

¹⁴⁰ *Id.*

¹⁴¹ See *GuideOne Elite Ins. Co. v. Fielder Rd. Baptist Church*, 197 S.W.3d 305, 307 (Tex. 2006).

¹⁴² *Gray v. Zurich Ins. Co.*, 419 P.2d 175, 179 (Cal. 1966).

¹⁴³ *Id.* at 173.

¹⁴⁴ *Id.* But see DUGONITHS, *supra* note 133, at 241 (A minority of jurisdictions permit insurers to consider evidence outside of the complaint and the policy in evaluating the duty to defend.) However, even in those jurisdictions examining

A minority of jurisdictions permit insurers to consider evidence outside of the complaint and the policy in evaluating the duty to defend.¹⁴⁵ However, even in those jurisdictions, examining outside information would likely prove insufficient in persuading a court to determine that the insurers do not have a duty to defend the League.

B. INSURERS' DECLARATORY JUDGMENTS

Theoretically, the insurer is not forced to defend the insured if the insurer believes the claims alleged against it would not be covered under the insured's policy. One option the insurer possesses is to deny its duty to defend. If the insurers refused to defend in the case at bar, the NHL would have two options. First, it could settle the cases to avoid the risk of potentially losing an exorbitant amount of money at trial. Second, the NHL could litigate the case. In the first hypothetical situation, if any of the insurers refused to defend the NHL and a judgment was rendered against the NHL, the insurer would no longer have the ability to re-litigate any factual issues.¹⁴⁶ Moreover, if the NHL could demonstrate that it made a reasonable settlement in good faith and its insurers wrongfully refused to defend it, then the insurers would be required to compensate the League for that settlement.¹⁴⁷ In the second scenario, if the League could prove that the insurers wrongfully refused to defend it, the insurer would also be required to compensate the League for the verdict and the cost of litigation.¹⁴⁸

Since these methods of refusing to defend are precarious, insurers typically file a motion for declaratory judgment in which they ask a court to determine whether they have a duty to defend. Nevertheless, courts typically will not grant declaratory relief if the issues giving rise to the conflict between the insured and insurer are entangled with the issues that will ultimately determine whether the insurer is liable to the

outside information would likely prove insufficient in persuading a court to determine that the insurers do not have a duty to defend the League.

¹⁴⁵ DUGONITHS, *supra* note 133, at 241.

¹⁴⁶ Gallagher v. Dupont, 918 So.2d 342, 348 (Fla. Dist. Ct. App. 2005).

¹⁴⁷ *Id.*

¹⁴⁸ Adam M. Smith & Caroline L. Crichton, *Bad Faith under a Commercial General Liability Policy*, in THE REFERENCE HANDBOOK ON THE COMPREHENSIVE GENERAL LIABILITY POLICY 311, 317 (Alan Rutkin & Robert Tugander eds., 2010); DUGONITHS, *supra* note 133, at 255.

policyholder.¹⁴⁹ Just as many insurers filed motions for declaratory judgment in the NFL concussion litigation, it is likely that the NHL's insurers and the hockey teams' individual insurers will file similar motions seeking to avoid defending and/or indemnifying the League or the teams.

VII. CONCLUSION

It is likely that in the near future other contact sport organizations will follow the lead of the NFL and NHL players, as many participants in other popular American sports such as wrestling, rugby, soccer, and lacrosse “all risk exposure to brain injur[ies] that range from asymptomatic subconcussive blows to symptomatic concussion[s] to more moderate or severe traumatic brain injur[ies].”¹⁵⁰

Regardless of what contact sport organizations engage in concussion litigation, however, all of the insureds will likely turn to their insurers to both defend and indemnify them. While it will behoove insurers insuring contact sport organizations that have yet to bring this type of concussion litigation to be proactive in amending their policies, insurers in the current NHL concussion litigation will not necessarily be required to indemnify the League. One of the main reasons the League may be able to avoid indemnification is due to the fighting that takes place in the League. Insurers may be successful in demonstrating that the League intended and/or expected that its players were at a heightened risk to suffer from neurodegenerative diseases and be able to avoid indemnifying the League against the players since bare-knuckle fighting has been part of the sport since its inception.¹⁵¹ If the League's insurers were able to avoid indemnification and the League was required to pay for this litigation by itself, it could conceivably self-insure due to its vast revenues.¹⁵² Nonetheless, depending on how large of an award the players received, this

¹⁴⁹ See *Gendron v. Delozzo*, No. 04-0907, 04-0999, 2005-0027, 2007 WL 4471053, at *7-9, *11 (R.I. Super. Ct. Dec. 7, 2007).

¹⁵⁰ See Stern et. al., *supra* note 131, at 460.

¹⁵¹ *Class Action Compl., Leeman, Aitken, et. al. v. Nat'l Hockey League & NHL Bd. of Governors*, No. 1:13-cv-01856, 22 (D.D.C. Nov. 25, 2013).

¹⁵² See *id.* at 19. This would have also been the case in the NFL concussion litigation and will still be the case if the NFL's insurers are not required to assist the NFL in the settlement. Glenn M. Wong, *SN Concussion Report: NFL Could Lose Billions in Player Lawsuits*, SPORTING NEWS.COM (Aug. 22, 2012), <http://aol.sportingnews.com/nfl/story/2012-08-22/nfl-concussion-lawsuits-money-bankrupt-players-sue-head-injuries>.

litigation could be very problematic for the League as the game of hockey could become less profitable after this litigation if it eliminates or largely limits the fighting that fans have come to expect.

Conversely, if the insurers are required to indemnify the League, it will be costly for the insurers, especially in the event that a continuous trigger theory is used, which will trigger more policies. Despite potentially costing insurers more, courts should implement this trigger theory, as it is the most appropriate trigger for these cases presenting latent harm as it best comports with the League's reasonable expectations and addresses the difficulty of ascertaining the timing of the players' injuries. In the future, contact sport insurers, including the NFL's and NHL's insurers, who wish to avoid a court implementing a continuous trigger may modify their policies to identify a specific trigger in relation to concussions or include additional language to clearly limit their liability to a discrete moment.

While the League's insurers may avoid indemnifying it, since the underlying complaint alleges negligence and other claims that could be covered by the insurance policies, it appears likely that the League's insurers will be required to defend it. But it is also likely that both the NHL's and NFL's concussion cases will settle.

Although it is likely that both of these concussion cases may fail to ever reach trial, these two lawsuits will have an undeniable impact reaching past insurance law and touching on all contact sports in the United States. Parents now consider football and hockey more dangerous for their children than ever before, and players now realize that there are serious long-term risks that could affect their quality of life associated with playing these sports. Thus, while this litigation will greatly affect insurers and their relationship with contact sport organizations, it will also change two of the most popular American sports for generations to come.

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