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Brendan S. Maher
brendan.maher@law.tamu.edu

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CREATING A PATERNALISTIC MARKET FOR LEGAL RULES AFFECTING THE BENEFIT PROMISE

BRENDAN S. MAHER*

Notwithstanding the fact that ERISA was enacted to protect employee benefits, courts have narrowly construed the relief available when benefits are denied out of concern that a stronger remedy would be too costly for the system to bear. Judges, I argue, are ill equipped to make this policy judgment. Instead, a regulated, subsidized, paternalistic market should be created to permit the benefit players themselves to choose and price the strength of the remedy they desire. This is a superior means to reach the right level of remedial strength for the most players. To protect against undesirably weak remedial options being selected, I propose the market should have a highly protective default remedial option, clear disclosure rules, subsidies, and a regulatory floor.

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* Principal, Stris & Maher LLP; JD, Harvard Law School; AB, Stanford University. This Article incorporates concepts that I initially explored in *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 *FORDHAM L. REV.* 2297 (2008) and in *Understanding and Problematising Contractual Tort Subrogation*, 40 *LOY. U. CHI. L.J.* 49 (2008). It also draws upon my experience litigating and advising on Employee Retirement Income Security Act (ERISA) cases before the Supreme Court of the United States, namely *Sereboff v. Mid Atlantic Medical Services Inc.*, 547 U.S. 356 (2006) (argued by my law partner, Professor Peter K. Stris) and *LaRue v. DeWolff, Boberg & Associates, Inc.*, 128 S. Ct. 1020 (2008) (also argued by Professor Stris).

This piece has benefited from the substantial input of Professor Shaun Martin at the University of San Diego Law School, Professor John Bronsteen of the Loyola University of Chicago Law School, and Professor Radha Pathak of Whittier Law School, each of whom has previously written about ERISA or litigated ERISA issues before the Supreme Court. I am very grateful for the many hours they devoted to sharing their thoughts. Also invaluable have been the many insightful conversations I have had over the past year and a half with attorneys from the Department of Labor and the American Association of Retired Persons, as well as with the many participants in talks held before organizations such as the Texas State Bar and the Association of Pension Professionals and Actuaries. I additionally owe thanks to Professor J. J. Prescott of the University of Michigan Law School and former Texas State Supreme Court Justice Deborah Hankinson for their advice and support.

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I also join “the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.”

—Justice Ruth Bader Ginsburg¹

INTRODUCTION

The sleepy-sounding Employee Retirement Income Security Act of 1974 (ERISA)² is a legal iceberg. While only small portions of the mammoth statute are readily visible to the casual observer, ERISA has a greater impact on the course and development of the law governing election-deciding “kitchen-table” issues—wages, pensions, and health care—than any other single piece of the United States Code. The Supreme Court of the United States routinely wrestles with ERISA disputes that affect trillions of dollars, and has decided nine ERISA cases since 2004 alone.³

For the unfamiliar, ERISA directly affects everyone who receives health care or retirement benefits from a private employer—over 150 million Americans.⁴ As health-care costs rise and America ages,

1. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) (quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (Cal. App. 2003)).

2. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C. §§ 1001-1461 (2006)).

3. See *Metro. Life Ins. v. Glenn*, 128 S. Ct. 2343 (2008); *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 128 S. Ct. 1020 (2008); *Beck v. Pace Int’l Union*, 127 S. Ct. 2310 (2007); *Howard Delivery Serv., Inc. v. Zurich Am. Ins. Co.*, 547 U.S. 651 (2006); *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 346 (2006); *Aetna Health*, 542 U.S. 200; *Cent. Laborers’ Pension Fund v. Heinz*, 541 U.S. 739 (2004); *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1 (2004).

4. EMPLOYEE BENEFIT RES. INST., FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 15 (2005), available at <http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp20.pdf> (estimating at least 150 million); PAUL FRONSTIN, EMPLOYEE BENEFIT RES. INST., ISSUE BRIEF NO. 305, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: UPDATED ANALYSIS OF THE MARCH 2006 CURRENT POPULATION SURVEY 4 fig.1 (May 2007) (estimating approximately 160 million); David A. Hyman & Mark Hall, *Two Cheers for*

ERISA's heavy footprint continues to deepen, very likely quite beyond the expectations of its drafters. Accordingly, judicial and scholarly attention has largely focused on describing the content and contour of ERISA's influence (such as the significance of trust law,⁵ or the Act's preemptive reach⁶) in a sensible collective effort to render an opaque statute meaningful to those subject to its considerable and ever-widening dominion. This Article approaches ERISA with a very different ambition—to change it.

To set the stage, a benefit—before receipt—is simply a promise of deferred compensation. ERISA's animating policy judgment was that the benefit promise needed specialized protection against breach—protection that would render benefit promises less risky to the employee, but more costly in other ways. Yet ERISA's ambitious prioritization of promise protection over promise cost left out a crucial detail in a multitrillion dollar game: how steep a protection/cost trade-off is acceptable?

This Article's proposed answer is to create a regulated, subsidized market in which remedial rules affecting the benefit promise are chosen and priced by the benefit players. The proposed market is paternalistic: it “nudges” players toward a higher level of benefit protection.⁷

Employment-Based Health Insurance, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26 (2001) (estimating 177 million).

5. The intersection of trust law and ERISA has, in particular, been profoundly explored by Professor Langbein. See, e.g., Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1108 (1988); John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 217 [hereinafter Langbein, *Trusts*]; John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1342 (2007) [hereinafter Langbein, *Trust Law*]; John H. Langbein, *What ERISA Means By “Equitable”*: *The Supreme Court's Trail of Error In Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1321–38 (2003) [hereinafter Langbein, *What ERISA Means*].

6. See John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2303 n.22 (2008) (noting that many scholars have recently written about preemption).

7. See generally RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008) (promoting the use of default rules that take into account cognitive biases to encourage socially desirable choices). A narrow application of the idea of nudging benefit players into more desirable choices was recently put into practice by the Pension Protection Act of 2006, Pub. L. No. 109-280, 120 Stat. 780 (codified as amended in scattered sections of 26 and 29 U.S.C.). The Act encourages employers to enroll employees automatically in defined-contribution plans absent an employee choosing to opt out. See *id.* Default enrollment options are expected to increase employee participation in such plans significantly. See John Beshears et al., *The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States* 6–8 (Nat'l Bureau of Econ. Research, Working Paper No. 12009, 2006), available at

Part I.A offers a concise historical account of ERISA as a legislative response to a series of pension crises in the 1960s and 1970s, briefly describes ERISA's operative contours and present-day immensity, and sets forth the statute's explicit *raison d'être*: to protect the benefit expectations of working Americans.

Part I.B supplies the analytical framework through which the consequences of ERISA's central policy choice and the challenges in policy implementation are made apparent. Specifically, ERISA sought to effect its protective aims by federalizing and increasing the "robustness" (the likelihood of full performance) of the benefit promise. Robustness is not free; in a reasonably well-functioning labor market, there is a theoretical cost—wage reduction, benefit reduction, or benefit elimination—associated with any legal rule increasing benefit-promise robustness. The legislative justification for incurring such a price is one of fairness and social justice; what is not evident or immediately ascertainable from ERISA's language is the tolerable level of cost above which robustness's presumptive supremacy should evaporate.

Part II analyzes ERISA's central remedy for those beneficiaries who have been denied promised benefits, and its three defining judicial glosses: (1) the unavailability of traditional consequential damages, (2) mandatory administrative review, and (3) deferential judicial review. In each instance, when faced with weakly ambiguous statutory text, courts have indulged their own policy intuitions and prioritized cost over robustness—contrary to ERISA's intent. Unhappy with this result, observers have criticized judicial reasoning but struggled to offer reform proposals that can achieve the right balance between robustness and cost.

In Part III, I offer a solution that prioritizes robustness while accounting for cost. Specifically, I propose the creation of a regulated "robustness market" that (1) paternalistically requires that all plans offer a highly protective remedial option, (2) permits less protective remedial options to be made available at discounted prices, and (3) uses subsidies and a regulatory floor to protect weaker players. Compared to the current system, this is a superior means to reach the right level of benefit robustness for the most players. It takes into account varying circumstances and individual preferences (on risk, cost, and wages) in a way the existing regime cannot. It also provides policymakers with more reliable information about the incremental costs associated with various robustness levels (as well as indirect information about costs

unrelated to robustness changes). Such will be of considerable use in establishing future policy agendas.

This Article concludes by noting that—given the growing acknowledgement of the need for benefit reform (particularly health care) that incorporates, to some degree, additional choice, additional regulation, and additional government expenditure—my proposal resonates with emerging perceptions and faces a propitious political environment.

I. ERISA: FEDERALIZING THE BENEFIT PROMISE

In analytical terms, an employee benefit prior to receipt is simply an (1) employer promise of (2) deferred compensation (3) in a particular form, for example, a pension or health care.⁸ A benefit plan is the operating scheme by which the benefits promise is administered and effectuated.⁹ ERISA, through a series of expansive statutory definitions inspired by the law of trusts, federalized benefit promises and plans in order to provide benefit “security.”¹⁰ I review the statute’s history, contours, and policy justification below.

A. History, Purpose, and Scope

Following a decade of congressional study, ERISA was enacted in 1974 in the aftermath of a string of broken benefit promises by high-profile employers.¹¹ The statute’s avowed aim was to ensure that the nation’s employees and their dependents would, in the future, receive

8. Bradley R. Duncan, *Judicial Review of Fiduciary Claim Denials Under ERISA: An Alternative to the Arbitrary and Capricious Test*, 71 CORNELL L. REV. 986, 1003 (1986) (noting that benefits were formerly regarded as gifts, but are now regarded as a portion of compensation); see also Gordon L. Clark & Ashby H.B. Monk, *Conceptualizing the Defined Pension Promise: Implications from a Survey of Expert Opinion* 6 (July 2007) (unpublished paper), available at <http://ssrn.com/abstract=1004743> (noting that *Inland Steel Co. v. NLRB*, 170 F.2d 247 (7th Cir. 1948) was a seminal case treating pension and health-care benefits as deferred compensation).

9. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

10. The quoted word *security* alludes to ERISA’s title: “The Employee Retirement Income *Security* Act of 1974” (emphasis added).

11. *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980) (noting that ERISA was enacted after “almost a decade of studying the Nation’s private pension plans”). In the years prior to ERISA’s passage, numerous high-profile pension plans had failed, leaving workers with little recourse. For a comprehensive survey of the fascinating political history of ERISA, see JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 51–79 (2004).

all the benefits they had been promised.¹² Senator Harrison A. Williams offered a memorably florid description of ERISA's purpose:

[A] pension reform law is now a reality because of the hardship, deprivation and inequity suffered by American working people The discipline of law will enable this and succeeding generations of workers to face their retirement period with greater confidence and greater security¹³

ERISA's strategy for improving benefit security was the federal imposition of "minimum standards . . . assuring the equitable character of [benefit] plans and their financial soundness."¹⁴ Broadly speaking, these "minimum standards" are: (1) specific funding, vesting, and disclosure requirements for benefit plans; (2) government insurance for plans that fail; (3) the placement of fiduciary duties upon plan operators and administrators; and (4) a passel of specialized statutory remedies if ERISA provisions or plan terms are violated.¹⁵ The foregoing safeguards were openly held out to be necessary improvements upon insufficient protections previously available to employees under existing federal and state law.¹⁶

12. H.R. REP. NO. 93-533 (1973), as reprinted in 1974 U.S.C.C.A.N. 4639, 4639 ("The primary purpose of [ERISA] is the protection of individual pension rights"). Senator Javits, an ERISA cosponsor, referred to it as a "pension 'bill of rights.'" 120 CONG. REC. 29935 (1974) (statement of Sen. Javits); see also Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 358-60 (1994) (noting the primary purpose of ERISA was to protect beneficiaries); Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U. L.Q. 311, 349 (1998) ("ERISA was enacted to inform and protect employees.").

13. 120 CONG. REC. at 29935. The "discipline of law" later proved to be personally challenging for Senator Williams. In the 1980s he was convicted of bribery and conspiracy charges, for which he served time in federal prison. Douglas Martin, *Ex-Senator Harrison A. Williams Jr., 81, Dies: Went to Prison over Abscam Scandal*, N.Y. TIMES, Nov. 20, 2001, at A17.

14. 29 U.S.C. § 1001(a) (2006). Although ERISA's enactment was impelled by pension-plan failures, ERISA ambitiously sweeps within its ambit more than pension plans; it also governs employer-provided "welfare" plans. *Id.* § 1002(1). Together, pension and welfare plans cover every meaningful employer benefit plan offered in America; pension plans encompass both traditional, fixed pensions as well as 401(k) and similar "defined contribution" plans, while welfare plans include plans that provide health care, disability benefits, and life insurance. See *id.* § 1002(3).

15. See Bronsteen et al., *supra* note 6, at 2310-11.

16. S. REP. NO. 93-127 (1973), as reprinted in 1974 U.S.C.C.A.N. 4838, 4854 ("It is intended that the coverage under [ERISA] be construed liberally to provide the maximum degree of protection for working men and women covered by private retirement programs.").

ERISA's draftsmen were inspired by, and borrowed heavily from, trust law—a body of law that affords heightened protection to promisees.¹⁷ That trust law was ERISA's conceptual parent, as has been widely noted, is evident from examination of the statute's text and construction. Employers “sponsor” plans that are, with limited exceptions, set up as trusts.¹⁸ All plans must have a “named fiduciary” who need “control and manage the operation and administration of the plan” in the best interests of the beneficiaries.¹⁹ The named fiduciary and the plan are, in design and practice, analogs to a trustee and a trust (with the employees and their dependents similarly analogous to trust beneficiaries).²⁰

To ensure the efficacy of the ERISA legislation and its uniform application, Congress explicitly denied, with important exceptions, the states' authority to regulate benefit plans: “[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”²¹ This explicit grant of preemption later received an important and augmentative judicial postscript. Separate and apart from the statute's express preemptive provision, courts interpreting ERISA after its passage (including the Supreme Court)

17. H.R. REP. NO. 93-533 at 4649 (“The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts.”); *see also id.* at 4655 (“The enforcement provisions have been designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of the Act.”).

18. *See* 29 U.S.C. § 1103(a), (c)(1).

19. *Id.* §§ 1102(a)(1), 1104(a)(1). Of course, the named fiduciary may designate others to assist him in the plan's operation. *Id.* § 1105(c). To the extent they exercise discretion regarding management of the plan or its assets, they are considered cofiduciaries. *Id.* § 1002(21)(A)(iii) (defining *fiduciary* as any party who “has any discretionary authority or discretionary responsibility in the administration” of the plan or its assets).

20. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (“ERISA abounds with the language and terminology of trust law.”); *see also* Fischel & Langbein, *supra* note 5, at 1108 (“The drafters of ERISA intended to apply rules and remedies similar to those under traditional trust law to govern the conduct of fiduciaries.”); Langbein, *What ERISA Means*, *supra* note 5, at 1321–38 (describing ERISA as a “regime of federal trust law”). Plan administrators are controlled, directly or indirectly, by the employer. *See generally* Bronsteen et al., *supra* note 6.

21. 29 U.S.C. § 1144(a). The legislative history makes clear that the pursuit of uniformity through preemption was intended to *augment* protections for participants. 120 CONG. REC. 29197 (1974) (statement of Rep. Dent) (“With the preemption of the [benefit] field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.”); *see also Boggs v. Boggs*, 520 U.S. 833, 836, 840 (1997) (“[ERISA is a] congressional mandate for [the] uniform and comprehensive regulation [of benefit plans and] the congressional scheme to assure the security of plan participants and their families in every State.”).

have identified a separate basis for ERISA preemption of state law: conflict preemption. Even for those state laws that fall outside of ERISA's explicit preemptive reach, if said law is "incompatible" with other provisions of ERISA, it is likely superseded on conflict-preemption grounds.²²

Thus, today, as a consequence of both explicit congressional intent and judicial gloss, the obligations imposed and the rights conferred within the world of private employee-benefit plans are, with rare and opaque exceptions, exclusively governed by a federal law written and enacted to protect benefit recipients.²³ And that world is enormous: recent estimates are that ERISA pension plans hold over \$4 trillion in assets, while ERISA welfare plans provide health insurance for over 150 million people.²⁴

B. Promise Robustness Versus Promise Cost

Let us step back from ERISA briefly and consider more broadly the nature and risk of the benefit promise. Although benefits were once inaccurately treated as gifts, today it is widely acknowledged that

22. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377–80 (2002) (explaining the Court's conflict-preemption jurisprudence with respect to state laws "held to be incompatible with ERISA's enforcement scheme"); see also Neville M. Bilimoria, *Beware HMOs: The Future of HMO Medical Malpractice Liability Is Uncertain*, 1 DEPAUL J. HEALTH CARE L. 711, 716–17 (1997) (discussing ERISA conflict preemption).

23. See, e.g., *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 146–50 (2001) (holding that a state statute with a connection to ERISA plans is expressly preempted by ERISA); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (holding that a state law "distinctively" regulating insurance is not preempted by ERISA); *Boggs*, 520 U.S. at 839–54 (holding that ERISA preempts a state law allowing a nonparticipant spouse to transfer by testamentary document the spouse's community-property interest in undistributed benefits); *Dist. of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 129–33 (1992) (holding that a state law merely referring to benefit plans administered by ERISA is preempted by ERISA); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (noting that ERISA does not preempt certain state garnishment or severance-pay statutes); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (holding that ERISA preempts a state law prohibiting subrogation claims against ERISA benefits where the plan is not "deemed" an insurance plan); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988) (holding that ERISA preempts even state statutes designed to "help effectuate ERISA's underlying purpose"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) (holding that common-law claims relating to an employee-benefit plan are preempted by ERISA).

24. See sources cited *supra* note 4; see also JOHN MACDONALD, EMPLOYEE BENEFIT RES. INST., "TRADITIONAL" PENSION ASSETS LOST DOMINANCE A DECADE AGO, IRAS AND 401(K)S HAVE LONG BEEN DOMINANT (2006), available at <http://www.ebri.org/pdf/publications/facts/fastfacts/fastfact020306.pdf>. These estimates, of course, predate the severe market crash of 2008–09.

benefits are a bargained-for component of the employer-employee labor deal.²⁵

Benefits have long posed a challenge for policymakers because of their time horizon. Unlike wages, benefits are a compensation promise where the employer's performance (paying the benefit) occurs long after the employee labor that earned the benefit. The obvious concern is promise-performance risk: that the employer-promisor will reap the value of the employee-promisee's labor and then refuse to perform (i.e., pay) on the benefit promise. The conceptual solution to the problem of promise risk is self-evident: subject the employer-promisor to some mix of liability and damage rules that will appropriately deter against and/or compensate for underperformance.²⁶

Differing legal rules governing the benefit promise, of course, result in varying levels of promise risk. The weaker the remedy for breach, the riskier the promise becomes to the employee. To conveniently reference the total level of benefit-promise risk associated with a given legal rule, I will use the term *benefit-promise robustness* hereinafter. Robustness is increased if, for a considered legal rule, the level of benefit-promise risk to a beneficiary is decreased, relative to an alternative rule.²⁷ Imagine you have been promised something—it does not matter what. If you would pay a peppercorn or more to use legal rule *A* over legal rule *B* when enforcing that promise, legal rule *A* is more robust.

Robustness is not costless; increasing it has significant consequences. A simple analytic heuristic demonstrates, in theory, what consequences will likely flow from a legal change that increases benefit robustness.

Benefits, as noted previously, are a portion of compensation, with total compensation being the sum of wage earnings plus promised benefits.²⁸ But benefit promises come with the risk that the promisor

25. Peter M. Rehon, *The Pension Expectation as Constitutional Property*, 8 HASTINGS CONST. L.Q. 153, 170–72 (1980) (“[M]ost courts in the late nineteenth and early twentieth centuries viewed noncontributory private pensions plans as mere gratuities granted at the sufferance of the employer and revocable at any time for any reason.”).

26. See, e.g., George L. Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 617–19 (1994) (expressing a need under ERISA for a full measure of damages for compensatory and deterrence purposes).

27. I use *robust* with reference to its common meaning, that is, vitality, health, or strength. I am not adopting any formal meanings of the term sometimes employed in fields such as computer science or genetics.

28. $C = B + W$, where *C* is compensation, *W* is wages (or salary), and *B* is the time-discounted value of the bundle of benefits being provided. See, e.g., Alan C. Monheit & Philip F. Cooper, *Health Insurance and Job Mobility: Theory and*

may underpay (or not pay at all) on the promised benefits, so the expected cost/value of promised benefits must be reduced by that performance risk.²⁹ Put simply, if an imaginary employer promises \$100 in benefits, but there is only a 90 percent chance the employer will deliver on the promise, the \$100 is only worth \$90. Modifying legal rules to increase the robustness of the benefit promise increases the percentage chance that the benefit promise will be performed, and thus the employer's expected cost of making the promise. Assume purely for the sake of argument that ERISA increased the chance an employer's promise of \$100 in benefits would be fully paid by 5 percent. That would mean that ERISA made the benefit promise \$5 more costly to the employer.

How that incremental cost is borne can vary in several ways.³⁰ Holding the total compensation the employer is willing to offer steady, legal rules increasing promise robustness should have some combination of the following effects on the employer's offer of compensation: (1) the employer can keep the offered bundle of benefits constant, but reduce its wage offer to pay for the increased benefit robustness; (2) the employer can keep wages steady, but offer a reduced bundle of benefits to pay for the increased robustness;³¹ or (3) the employer can no longer offer benefits at all, but offer higher wages instead.³² More generally, increasing benefit-promise robustness will

Evidence, 48 INDUS. & LAB. REL. REV. 68, 80 (1994) (defining *compensation* as "the value of wages, health insurance, and other fringe benefits").

29. That is, $C = W + (B \times P\%)$, where $P\%$ is equal to the likelihood that the benefit promise will be performed as expected.

30. This is important, because often discussions of the cost of increasing benefit security are unspecific and insufficiently cognizant of ERISA's fundamental trade-off. Two specific matters are of import. First, Congress, having studied benefit reform for ten years before enacting ERISA, was certainly aware that making benefit promises more secure would result in wage and other trade-offs, but passed ERISA anyway. See sources cited *supra* note 11. Increased cost was assumed. Of course, this does not mean Congress thought wages and benefits would not both grow; the entire *total* of compensation can grow—particularly if worker productivity increases—even as the proportion of wages and benefits selected for a given level of compensation constantly changes. Second, recognition that employers and employees are currently making benefit/wage trade-offs is an important part of understanding the appeal of the robustness-market solution. See *infra* Part III.

31. A reduced bundle of benefits could be expressed as narrower coverage, a lower policy limit, a higher deductible, and so on.

32. That is, holding C constant, if $P\%$ increases, we can expect either a reduction in W , a reduction in B , or, in some cases, an elimination of B altogether (with a corresponding increase in W). See, e.g., Peter M. Van Zante, *Mandated Vesting: Suppression of Voluntary Retirement Benefits*, 75 NOTRE DAME L. REV. 125, 132 (1999) (noting that compensation in the form of retirement benefits will result in lesser amounts of other forms of compensation). Which cost consequence occurs depends on a variety of factors and is beyond the scope of this Article. But, generally

likely lead to (1) wage reduction, (2) benefit reduction, or (3) benefit elimination.³³ Those three effects (in whatever combination) are the conceptual “cost” of robustness; as promise robustness increases, so does promise cost.

How that cost *manifests* itself in actuality across firms, sectors, and the aggregate labor market—that is, what combination of wage reduction, benefit reduction, and benefit elimination occurs—depends, among other factors, on market conditions, bargaining power, the tax status of benefit payments, and the preferences of the individual employers and employees doing the negotiating.³⁴ The specifics of a promise-cost increase are empirical questions, but, analytically, promise cost rises, in *some* way, with promise robustness.³⁵ There is a trade-off.

Returning to ERISA, Congress’s animating assumptions on the trade-off of promise robustness and promise cost were not mysterious. ERISA was not passed because the previous state of benefits law in 1974 was that benefits promises were *too* robust. ERISA was enacted for the opposite reason: Congress and virtually all experts believed existing law in 1974 rendered the benefits promise insufficiently robust.³⁶ By imposing the minimum standards described above—vesting

speaking, benefit elimination is more likely in small firms that cannot tolerate high cost growth in the underlying benefit, firms of any size that do not prefer the uncertainty of benefit costs, and firms that can readily engage part-time workers in lieu of full-time employees. *See, e.g.*, U.S. GOV’T ACCOUNTABILITY OFFICE, EFFORTS TO CONTROL EMPLOYER COSTS AND THE IMPLICATIONS FOR WORKERS, at introductory page, *available at* <http://www.gao.gov/new.items/d07355.pdf>.

33. The comparison is made relative to *ceteris parabis*, a less robust legal scheme. *Cf.* Sharon Rabin-Margalioth, *Cross-Employee Redistribution Effects of Mandated Employee Benefits*, 20 HOFSTRA LAB. & EMP. L.J. 311, 313 n.6 (2003) (discussing the compensating-wage-differential theory: “[I]f there are two identical workers in identical jobs and one is provided health insurance, the worker without health insurance will receive higher wages.”).

34. *See, e.g.*, Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums* 15 (Nat’l Bureau of Econ. Research, Working Paper No. W11160, 2005), *available at* <http://ssrn.com/abstract=673247> (discussing the empirical effect of rising health premiums on wages and full-time versus part-time employment).

35. For example, employees may prefer slightly lower wages to a reduction in benefits. RICHARD IPPOLITO, *THE ECONOMICS OF PENSION INSURANCE* 18–19 (1989) (noting evidence that workers accept lower cash wages in return for pensions). Regarding robustness, certainly it is reasonable that workers would prefer slightly lower wages over plans with reduced protection; people purchase insurance because they value its protection against catastrophic loss more than they value the modest increase in income they would enjoy if they forewent insurance. Indeed, if workers value a benefit more than it costs the employer to provide it, then they would be willing to accept a higher wage cut. *See generally* Dwight R. Lee, *Why Workers Should Want Mandated Benefits to Lower Their Wages*, 34 ECON. INQUIRY 401 (1996).

36. *See supra* notes 11–20 and accompanying text.

rules, disclosure rules, the imposition of heightened duties, and explicit remedies—ERISA federalized and mandated increased robustness. Benefit promises would be clearer, more reliable, better backed, administered with more care, and protected by special remedies. Benefit-promise robustness was prioritized as a policy goal, in spite of the attendant increase in promise cost.

The policy rationale for ERISA's prioritization of robustness emerges upon consideration of the national environment at the time of the statute's enactment. Recall that ERISA was enacted in the wake of several high-profile pension-plan failures, leaving thousands of employees without retirement benefits they had spent their careers earning.³⁷ Legislative sympathy for Americans put in such positions ran understandably high. In such an environment (and since), fairness concerns—ensuring fewer broken promises—acquired a powerful persuasive and political appeal. Broken promises are intuitively troubling, but particularly so in the benefit universe, where the two largest components are health care and retirement income. Both involve steep cliffs of marginal disutility; beneficiaries relying on a benefit promise for health care and retirement income are particularly vulnerable and face particularly harsh consequences in the case of performance failure, namely, destitution or death.

Yet, if the core of ERISA's policy objective was clear—robustness over cost—the *boundaries* were not.³⁸ To wit, the consuming question for the last three decades has been: how steep a price was Congress willing to incur for increased robustness? ERISA's text has been, in practice, largely unhelpful in resolving this question. The complicated, interlocking statute is neither a model of clarity or completeness; it is a multidimensional legal maze. In response, courts have, with surprising frequency, aggressively interpreted a statute designed to be protective as affording less benefit protection than equivalently reasonable

37. See *supra* note 11.

38. See, e.g., *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262–63 (1993) (“There is . . . tension between the primary [ERISA] goal of benefiting employees and the subsidiary goal of containing pension costs.” (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981))); see also Norman Stein, *ERISA and the Limits of Equity*, 56 LAW & CONTEMP. PROBS. 71, 73 (1993) (“[T]he overarching policy decision to furnish retirement and health benefits through the private employment market rests uneasily on competing notions: government regulation is necessary to ensure that private law adequately delivers benefits, but too much regulation diminishes the willingness of employers to sponsor plans at all.”). Other manifestations of cost arising from additional regulation are wage and benefit reductions, as I explained above.

readings of the statute's text would require.³⁹ The result has been judicially inspired legal rules which decrease benefit robustness.

II. JUDGING ERISA'S BENEFIT-DENIAL REMEDY

Although ERISA employed several statutory means by which to shore up benefit robustness, one method—offering an explicit remedy for benefit denial—has received a staggering amount of judicial attention. That remedy is set forth in 29 U.S.C. § 1132(a)(1)(B) (“(a)(1)(B)”), and is triggered by the actual or anticipated denial of benefits.⁴⁰

39. Joseph F. Cunningham, *ERISA: Some Thoughts on Unfulfilled Promises*, 49 ARK. L. REV. 83, 86 (1996) (“The extent to which the law has developed without any consideration of ERISA’s purposes, principles, language and legislative history is remarkable, and stands as a paradigm of how federal courts should not develop common law.”).

40. The language provides that a participant may sue to “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B) (2006). The other remedies commonly invoked by beneficiaries are in 29 U.S.C. §§ 1132 (a)(2)–(3). These also have significant limitations.

Section 1132(a)(2) provides a cause of action designed to recover from the breaching fiduciary any plan monies lost or any illicit fiduciary gain and restore the same *to the plan* (which may then distribute monies to the beneficiary). *Id.* § 1132(a)(2). Examples of (a)(2) claims include suits alleging the fiduciary imprudently invested in the employer’s stock, *In re Schering-Plough Corp. ERISA Litig.*, 420 F.3d 231, 232–33 (3d Cir. 2005); *LaLonde v. Textron, Inc.*, 369 F.3d 1, 2–3 (1st Cir. 2004), that the fiduciary improperly failed to diversify investments, *Coan v. Kaufman*, 457 F.3d 250, 253 (2d Cir. 2006), or that a fiduciary failed to account for plan liquidity needs, *GIW Indus., Inc. v. Trevor, Stewart, Burton & Jacobsen, Inc.*, 895 F.2d 729, 731 (11th Cir. 1990). The (a)(2) remedy, by its terms, is triggered only by a fiduciary breach that either inflicts a loss to the plan or nets the fiduciary illicit profits made through use of the plan’s assets; injuries to individuals that do not injure the plan are not recoverable, and thus compensatory damages suffered solely by individuals are not recoverable. *See* 29 U.S.C. § 1132(a)(2).

Section 1132(a)(3) claims are limited to claims that are equitable and that were “typically” available in premerger equity courts under the circumstances at bar. *Sereboff v. Mid Atl. Med. Servs.*, U.S. 126 S. Ct. 1869, 1873 (2006) (construing (a)(3)); Brendan S. Maher & Radha Pathak, *Understanding and Problematising Contractual Tort Subrogation*, 40 LOY. U. CHI. L.J. 49, 80 (2008) (discussing the Supreme Court’s (a)(3) jurisprudence). Much scholarship has been devoted to explaining and criticizing the Supreme Court’s designedly anachronistic view of (a)(3) claims; exploring its intricacies is not necessary here. Suffice it to say that under current Supreme Court jurisprudence, although individuals may pursue claims against fiduciaries or others who have violated duties under the terms of the plan or under ERISA itself, the recovery of compensatory or punitive damages is not authorized by (a)(3). *See, e.g.*, Colleen E. Medill, *Resolving the Judicial Paradox of “Equitable” Relief Under ERISA Section 502(A)(3)*, 39 J. MARSHALL L. REV. 827, 831 (2006) (“[The Supreme Court has] overreacted by embracing the law-equity paradigm,

Examples of (a)(1)(B) claims include classic examples of benefit-promise breach: the denial of severance benefits in connection with a sale of a corporate division,⁴¹ the termination of disability benefits based on a plan administrator's finding of disability status,⁴² the denial of life-insurance coverage on grounds that the deceased committed suicide,⁴³ and, of course, the denial of coverage for particular medical procedures on the grounds that they are outside plan coverage.⁴⁴

Importantly, ERISA's remedies—including (a)(1)(B)—are exclusive; alternate state statutory or common-law remedies in connection with benefit denial are preempted.⁴⁵ Thus, for a beneficiary faced with a wrongful benefit denial, (a)(1)(B) is of primary, if not sole, importance.

The judicial construction of, and glosses on, (a)(1)(B) are illuminative of the bench's answer to ERISA's open policy question of how much robustness at what price. As explained below, the remedy has been narrowly construed by the courts in three crucial ways: (1)

resulting in a rigid rule that only remedies 'typically' available in a court of equity are available under Section 502(a)(3).").

41. See, e.g., *Firestone Tire & Rubber Co. v. Bruch*, 498 U.S. 101, 105–06 (1989). Other decisions involving (a)(1)(B) severance denials include *Colucci v. Agfa Corp. Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005); *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 824, 826 (7th Cir. 2004); *Cassidy v. Akzo Nobel Salt, Inc.*, 308 F.3d 613, 614–15 (6th Cir. 2002).

42. See, e.g., *Groves v. Metro. Life Ins. Co.*, 438 F.3d 872, 874–75 (8th Cir. 2006) (finding that disability benefits were properly denied where the employee could perform some work).

43. See, e.g., *Critchlow v. First UNUM Life Ins. Co. of Am.*, 378 F.3d 246, 259–61 (2d Cir. 2004) (finding that a policy covered death because the deceased did not intend to kill himself).

44. See, e.g., *Manny v. Cent. States, Se. & Sw. Areas Pension & Health & Welfare Funds*, 388 F.3d 241, 244, 246–47 (7th Cir. 2004) (finding that gastric bypass surgery was not covered because it was "cosmetic"). Benefit claims contesting medical-coverage denials are perhaps the most common type of (a)(1)(B) claim. See Kathryn J. Kennedy, *The Perilous and Ever-Changing Procedural Rules of Pursuing an ERISA Claims Case*, 70 UMKC L. REV. 329, 329 (2001) ("[I]t has actually become commonplace to see certain health benefits *denied* to claimants on various theories, e.g., medical necessity, investigatory/experimental exclusions, and other analogous cost-containment provisions."); see also Bronsteen et al., *supra* note 6, at 2304–19 (arguing that various factors increase the likelihood that wrongful denials will occur most frequently in a health-insurance setting).

45. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive."). The Court has not backed away from this sentiment in the two decades since *Pilot Life* was decided. See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002) ("We concluded that Congress had not intended causes of action under ERISA itself beyond those specified in § 1132(a).").

traditional consequential damages are unavailable, (2) the exhaustion of internal review of a denial by the plan fiduciary is a precondition to suit, and (3) courts defer to a plan administrator's benefit decisions.

These significant curtailments have left ERISA beneficiaries with a benefit-denial remedy that undermines, rather than strengthens, benefit protection. Consequential damages would increase protection by furthering compensatory and deterrence aims, elective internal review would increase protection by not obstructing a beneficiary's path to an impartial adjudicator, and de novo judicial review would increase protection by decreasing the likelihood of biased or negligent decisions by the plan administrator. The judicial rejection of those robustness-increasing legal rules is (1) largely unconnected to strictly textual readings of ERISA, (2) in tension with Congress's animating policy assumption in enacting the statute, and (3) indulgent of unreliable judicial policy intuitions about the dangers of increasing promise cost.

A. No Traditional Consequential Damages

ERISA's current legal rule on damages for benefit denial or mishandling surprises the casual observer. For example, if a plan wrongfully denies a participant medical treatment, and as a result of that denial the participant's condition worsens, an (a)(1)(B) action is understood to be limited to the value of the denied benefit.⁴⁶ Recovery of traditional consequential damages is not permitted. The favored rationale for this view is textual; the statutory phrase "benefits due . . . under the terms of the plan" does not include "extracontractual"

46. As the Supreme Court explained in *Massachusetts Mutual Life Insurance Co. v. Russell*:

Significantly, the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan—§ 502(a)(1)(B) . . . says nothing about the recovery of extracontractual damages, or about the possible consequences of delay in the plan administrators' processing of a disputed claim. Thus, there really is nothing at all in the statutory text to support the conclusion that such a delay gives rise to a private right of action for compensatory or punitive relief.

473 U.S. 134, 144 (1985). Although *Russell* involved an (a)(2) claim, not an (a)(1)(B) claim, the lower courts of appeals understood *Russell* to bar the recovery of consequential or punitive damages under (a)(1)(B). See, e.g., *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 31 (5th Cir. 1993) (relying on *Russell* and granting no punitive or consequential damages under (a)(1)(B)); *Reinking v. Phila. Am. Life Ins. Co.*, 910 F.2d 1210, 1220 (4th Cir. 1990) (same); see also Richard Rouco, *Available Remedies Under ERISA Section 502(a)*, 45 ALA. L. REV. 631, 648 (1994) ("[The *Russell* Court's] observations on the structure and legislative history of ERISA outlined a position which significantly influenced the [(a)(1)(B)] constructions adopted by lower courts.").

consequential or punitive damages.⁴⁷ Thus, because the “terms of [a] plan” only explicitly promise an entitlement to *benefits*, and consequential damages are not benefits, they are not recoverable under (a)(1)(B).

The notion that (a)(1)(B) prohibits consequential damages has been criticized by commentators (including myself) on multiple grounds.⁴⁸ The immediate trouble is textual; the very terms of (a)(1)(B) provide a cause of action for a beneficiary to “recover benefits due” as well as to “enforce his rights under the terms of the plan.”⁴⁹ The “right” to a “benefit” was originally conferred, depending on one’s view, under principles of contract or trust. So as to prevent inadequate compensation and insufficient deterrence in case of breach, rights conferred by contract or trust fundamentally include both the right itself and a right of (foreseeable) consequential damages (or the functional equivalent) for interference with the right.⁵⁰ The notion that ERISA’s drafters—seeking as they were to increase legal protections—wrote ERISA with the intent to shear off the consequential-damages component of the benefit right is facially suspect and inconsistent with ERISA’s legislative history.⁵¹ The statute in fact says nothing about limiting consequential damages; presumably it would have announced such a notable departure from the long-settled legal understanding governing the dual nature of a right.

47. *Conover v. Aetna US Health Care, Inc.*, 320 F.3d 1076, 1080 (10th Cir. 2003) (“Nowhere does the Employee Retirement Income Security Act allow consequential or punitive damages. Damages are limited to the recovery of benefits due . . . under the terms of the plan.”); *Harsch v. Eisenberg*, 956 F.2d 651, 655 (7th Cir. 1992) (denying consequential damages because the beneficiaries were limited to “contractual claims by providing only for actions based upon or arising ‘under the terms of the plan’”); *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 824 (1st Cir. 1988) (noting that damages are “extracontractual” if not “within the terms” of the plan).

48. Bronsteen et al., *supra* note 6, at 2327–28; *see also* Flint, *supra* note 26, at 647 (noting that a judicial conclusion wherein consequential damages were not available “is pure fiction—caused either by vicious judicial and legal subterfuge or, more likely, gross judicial and legal malpractice on the part of [the] Supreme Court”).

49. 29 U.S.C. § 1132(a)(1)(B) (2006).

50. *See, e.g.*, Flint, *supra* note 26, at 611; *see also* Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, Class Actions and the Patient’s Bill of Rights* 26 (University of Chicago, Law & Econ. Working Paper No. 112, 2000), available at <http://ssrn.com/abstract=253328> (noting a need for consequential damages under ERISA “has considerable force, and may in the end be convincing”).

51. Dana M. Muir, *Fiduciary Status as an Employer’s Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391, 461 (2000) (criticizing the judiciary’s narrow construction of ERISA remedies because ERISA’s text and legislative history provides “the basis for recovery of foreseeable consequential damages”).

Context strengthens the argument. Timely delivery is a more pronounced expectation for a benefit promise (compared to other types of promises), because benefit delay in health care and retirement has acute consequences. Withheld retirement benefits, for recipients who have no other means of producing income, is a very severe financial harm. Delay or denial of health-care payments, of course, can result in serious injury or death. Benefit promises, more so than other promises, are likely to decline precipitously in value if promise performance is delayed significantly. The inherent expectation in being the beneficiary of such a promise is that the promise will be performed in a timely fashion; one would expect, on both compensatory and deterrence grounds, for the available damages remedy to reflect that reality.

It is puzzling that a statute designed to protect beneficiaries would be interpreted in a way that actively frustrates compensatory and deterrence aims. The puzzle evaporates if one concludes—as industry groups have seemingly persuaded courts—that promise-cost concerns associated with permitting consequential damages are significant enough to overcome ERISA’s presumption of benefit robustness.⁵²

B. Mandatory “Administrative” Review

Although the Supreme Court has not yet addressed the issue, the federal courts of appeals are largely in agreement that a participant bringing an (a)(1)(B) claim must first exhaust any internal review process provided for under the plan.⁵³ One expects a favorable reception for the doctrine when it reaches the Supreme Court; recently, in *LaRue v. DeWolff, Boberg & Associates, Inc.*,⁵⁴ Chief Justice John Roberts’s widely noted concurrence spoke approvingly of ERISA’s

52. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 n.17 (1985) (rejecting extracontractual damages and noting that “Congress was concerned lest the cost of federal standards discourage the growth of private pension plans”). Industry groups routinely file amicus briefs before the Supreme Court (and the appellate courts) arguing that changes in damage rules will have devastating financial effects. See, e.g., Margaret Cyr-Provost, Note, *Aetna v. Davila: From Patient-Centered Care to Plan-Centered Care, A Signpost or the End of the Road?*, 6 HOUS. J. HEALTH L. & POL’Y 171, 203–04 (2005) (noting that the American Association of Health Plans and the U.S. Chamber of Commerce have filed amicus briefs before the Supreme Court urging that consequential damages have strong effects on the “cost of co-payments, deductibles, and premiums”). In my personal experience, industry and business groups have unfailingly asserted that stronger ERISA remedies will result in unacceptably high costs.

53. See Kennedy, *supra* note 44, at 358–59 n.158 (collecting decisions holding the administrative-exhaustion requirement in benefit-denial cases).

54. 128 S. Ct. 1020, 1027 (2008).

administrative-exhaustion requirement as an important “safeguard[] for plan administrators.”⁵⁵

Yet, nowhere does ERISA’s text require administrative exhaustion.⁵⁶ The operative provision provides that plans “afford a reasonable *opportunity* to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”⁵⁷ The most popular judicial rationale justifying an exhaustion precondition to suit is one of odd implication: that, by including a provision that requires plans to *offer* administrative-review procedures, Congress impliedly intended that participants be *required* to use it. As the United States Court of Appeals for the Ninth Circuit put it, in the oft-cited *Amato v. Bernard*⁵⁸ case, “[It would] be anomalous if the same good reasons that presumably led Congress and the Secretary to require covered plans to provide administrative remedies for aggrieved claimants did not lead courts to see that those remedies are regularly used.”⁵⁹

At least as strong as the Ninth Circuit’s “presumption” is the opposite one—that Congress had “good reasons” to mean exactly what it wrote, which was for participants to have the opportunity for administrative review.⁶⁰ By its terms, an opportunity is not a

55. *Id.* at 1027 (Roberts, J., concurring).

56. It is misleading to refer to the requirement as “administrative” exhaustion. Internal review by plan fiduciaries bears little or no resemblance to genuine administrative review. See Donald T. Bogan, *Reply to Judge Easterbrook: The Unsupported Delegation of Conflict Adjudication in ERISA Benefit Claims Under the Guise of Judicial Deference*, 57 OKLA. L. REV. 21, 27 (2004); Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 729–31 (2004). Nonetheless, I will often use the term *administrative* to reflect the dominant, if erroneous, nomenclature.

57. 29 U.S.C. § 1133(2) (2006) (emphasis added).

58. 618 F.2d 559 (9th Cir. 1980).

59. *Id.* at 567. That argument could likewise be justified to construe the statute in the opposite direction; that, as Congress explicitly granted litigation remedies, *they* should be as regularly used as possible.

60. Much has been made of the fact that ERISA’s legislative history says that with respect to suits to enforce benefit rights under the plan or to recover benefits under the plan . . . [a]ll such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.

H.R. REP. NO. 1280, at 327 (1973) (Conf. Rep.), as reprinted in 1974 U.S.C.C.A.N. 4639, 5107. Courts have interpreted this snippet to mean that the administrative-exhaustion requirement established under section 301 of the Labor-Management Relations Act (LMRA) applies to ERISA claims. See, e.g., *Barrowclough v. Kidder, Peabody & Co.*, 752 F.2d 923, 939 (3d Cir. 1985); *Amato*, 618 F.2d at 567–68. Such is an ambitious misreading of two sentences of legislative history. See,

requirement. Nor, tellingly, does the text of (a)(1)(B)—that is, the text of the remedy itself—require that the opportunity be seized before commencing suit.⁶¹ Rather, the text of (a)(1)(B) never mentions 29 U.S.C. § 1133.⁶² Had Congress desired administrative review to be mandatory prior to commencement of suit, one suspects it would have said so (as it has elsewhere).⁶³

Providing an option of administrative review also makes policy sense, given ERISA's core objective of protecting employees. Lawsuits are expensive, and, particularly for small claims, not cost-justified for participant-claimants. Were a lawsuit the claimant's only option, wrongful denials of smaller claims might never be contested at all. For larger claims, the calculus is different. ERISA's tolerance of conflicted administrators becomes very relevant.⁶⁴ The likely complicated nature of a high-value claim and the heightened possibility of bias combine to undermine the chance that internal review will result in fair resolution of the claim.⁶⁵ Moreover, to the extent that a factual record is created

e.g., Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 17 (1992) (“[Contrary to perceptions,] the reference to section 301 of the LMRA does not mean that courts should import into ERISA the specific rules that have been developed under section 301. Neither the Conference Report nor any other document suggests that Congress intended such a result or that such a reading of the passage is even remotely plausible.”); G. Richard Shell, *ERISA and Other Federal Employment Statutes: When Is Commercial Arbitration an “Adequate Substitute” for the Courts?*, 68 TEX. L. REV. 509, 559 (1990) (arguing that the passage merely refers to whether ERISA actions arise under federal law rather than state law).

61. See 29 U.S.C. § 1132 (a)(1)(B).

62. See *id.*

63. Compare *id.*, with *id.* § 411(a)(4) (discussing the exhaustion requirement in the statutory text of the Labor-Management Reporting and Disclosure Act of 1959).

64. ERISA, as written, does not require that plan fiduciaries be independent from the employer (the “plan sponsor”). See *id.* § 1108(c)(3). Employers can and often do serve as, or control, plan fiduciaries. See *Donovan v. Bierwirth*, 538 F. Supp. 463, 468 (E.D.N.Y. 1981) (stating the legislative history is clear that a “party-in-interest may serve as a fiduciary in addition to being an officer” (quoting H.R. REP. NO. 1280 (1973))); Fischel & Langbein, *supra* note 5, at 1126 (“[T]he statute leaves the plan sponsor to pick the fiduciary and, if the sponsor pleases, to do it from the ranks of management. Sponsors routinely exercise this authority.”). That ERISA tolerates the possibility (and indeed the likelihood) of such conflicted fiduciaries has been roundly criticized by observers. See Bronsteen et al., *supra* note 6, at 2300; Cunningham, *supra* note 39, at 90 (describing benefit determinations by conflicted fiduciaries as a “kangaroo court”); Norman Stein, *Three and Possibly Four Lessons About ERISA that We Should, but Probably Will Not, Learn from Enron*, 76 ST. JOHN’S L. REV. 855, 869 (2002) (noting that fiduciaries prioritize their own interests).

65. Lord Eldon, high chancellor of Britain in the nineteenth century, pithily expressed the appeal of competent counsel generally: “Truth is best discovered by powerful statements on both sides of the question.” William W. Schwarzer, *Dealing with Incompetent Counsel—The Trial Judge’s Role*, 93 HARV. L. REV. 633, 636 (1980) (quoting Lord Eldon).

upon which a reviewing court later relies, a claimant who chooses to proceed through the administrative-review process without any assistance from counsel may be considerably disadvantaged when the matter is litigated.

Given ERISA's protective intent, it is unlikely that Congress intended for administrative review to be a necessary precondition for a lawsuit, particularly for a large benefit dispute involving complicated considerations.⁶⁶ More likely is that Congress (correctly) assumed that beneficiaries themselves would assess whether their claims were low-value, simple claims easily resolvable through administrative review, or whether their claims were high-value, sophisticated claims more amenable to fair resolution through litigation, and act accordingly. Indeed, that is entirely harmonious with ERISA's stated intent of protecting participants' interests. Making administrative review elective also serves as a sensible counterbalance to ERISA's tolerance of conflicted fiduciaries. In contrast, it is difficult to view the dominant judicial interpretation, based on a thin textual reed of negative implication, as anything more than an implicit policy judgment that elective administrative review is simply "too costly" to be worth it.⁶⁷

C. Judicial Deference

The third crucial judicial gloss upon ERISA's benefit-denial remedy is judicial deference to a plan administrator's decision to deny benefits. In the landmark ERISA case *Firestone Tire & Rubber Co. v. Bruch*,⁶⁸ at issue was the denial of severance entitlement in connection with the sale of a corporate division.⁶⁹ Firestone's position was that ERISA itself imbued Firestone with the sole discretion to make plan-benefit determinations, including on the litigated question of severance entitlement.⁷⁰ Firestone accordingly urged judicial deference; the suing employees urged de novo review.⁷¹ As ERISA's text supplies no

66. Conison, *supra* note 60, at 29 (arguing that legislative history proves that internal review was intended to be an alternate, not necessary, option for claimants).

67. See, e.g., *Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 402 (7th Cir. 1996) (noting that mandatory administrative review prevents frivolous lawsuits and decreases "the cost and time of claims settlement").

68. 489 U.S. 101 (1989).

69. *Id.*

70. *Id.* at 112-13.

71. *Id.* at 114.

standard of review for benefit determinations, the Court was forced to articulate one.⁷²

The Court ruled that the appropriate level of judicial review of benefit-determination decisions was de novo review, and explained that a deferential standard of review “would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.”⁷³ Nonetheless, in a momentous and fateful detour, the Court explained that deferential review would be appropriate where “the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”⁷⁴ *Firestone*’s weak caveat was that, “if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r]’ in determining whether there is an abuse of discretion.”⁷⁵ Plans, given the judicial green light to draft themselves into a favorable abuse-of-discretion world of review, did so en masse.⁷⁶

Firestone has long been sharply criticized by observers, such as Professor John Langbein, who described *Firestone*’s command of deferential review when plan terms confer discretion on the fiduciary as “an ill-considered aside.”⁷⁷ Others noted that deference to ERISA administrators is not supported by the specific rationales that favor judicial deference in other settings, such as where a donative trustee or government agency is imbued with discretion.⁷⁸ I (with Professors John Bronsteen and Peter Stris) have argued elsewhere that, because of the structure of ERISA, virtually all plan fiduciaries are afflicted with agency risk; that is, they are biased either obviously or subtly in favor of the plan sponsor, and that such agency risk imperils ERISA’s

72. The decision expressly limited itself to (a)(1)(B) actions. *Id.* at 108 (“We express no view as to the appropriate standard of review for actions under other remedial provisions of ERISA.”).

73. *Id.* at 113–14.

74. *Id.* at 115.

75. *Id.* (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)).

76. In the wake of *Firestone*, Professor Langbein predicted that most plans would thereafter award discretion to their administrators so as to secure more permissive judicial review—which is precisely what happened. See Langbein, *Trusts*, *supra* note 5, at 220. Similarly, post-*Firestone*, defense counsel immediately advised that “[p]lan sponsors and drafters should craft new plans, and review and amend existing ones, to incorporate this elective deferential review of benefit claims decisions.” Michael S. Beaver, *The Standard of Review in ERISA Benefits Denial Cases After Firestone Tire & Rubber Co. v. Bruch: Revolution Or Déjà Vu?*, 26 TORT & INS. L.J. 1, 1 (1990).

77. Langbein, *Trust Law*, *supra* note 5, at 1342; see also *id.* at 1338–39 (“ERISA’s regime of judicial review of fiduciary decision making of benefit denials ought . . . to be understood as beyond the reach of self-serving plan terms.”).

78. See *supra* note 56.

legislative aims in general—a problem aggravated by deferential review.⁷⁹

Firestone's much criticized standard of review spawned a torrent of litigation on two fronts: first, how to determine when a legally cognizable conflict of interest exists; and second, how to “weigh” the conflict as a “factor.” The federal circuits differed widely in their conclusions.⁸⁰ Only last term, in *Metropolitan Life Insurance Co. v. Glenn*,⁸¹ did the Supreme Court confront both issues.

Glenn involved the denial of disability benefits by an insurance company, MetLife, that both administered and paid benefits for an employee-welfare plan offered by employer Sears Roebuck.⁸² The United States Court of Appeals for the Sixth Circuit held that MetLife suffered from a conflict of interest before concluding that MetLife had acted arbitrarily and capriciously in denying benefits.⁸³ The Supreme Court affirmed.⁸⁴

The *Glenn* decision offered two holdings of significance. First, it held that there is a conflict of interest when the fiduciary both determines eligibility for and pays out claims.⁸⁵ Second, the Court declined to change the “abuse of discretion” standard of review.⁸⁶ That is, even assuming a conflict exists, the abuse-of-discretion standard still applies.⁸⁷ However, courts must now consider how severe the conflict is as part of the process of determining whether an abuse of discretion occurred.⁸⁸ Thus, for example, if claims administrators are “wall[ed] off” from the plan’s finance personnel, the conflict matters less than if “circumstances” raise concern that a conflict “affected” the decision to deny benefits.⁸⁹ The Court explicitly declined to give further specifics on how to weigh conflicts, explaining that there are no “talismanic

79. See generally Bronsteen et al., *supra* note 6 (arguing ERISA’s tolerance of conflicted fiduciaries negatively affects the delivery of health care in America).

80. See Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 OKLA. L. REV. 637, 652–54 n.71 (2005) (discussing the standards of “conflict” review across circuits).

81. 128 S. Ct. 2343 (2008).

82. *Id.* at 2346–47.

83. *Glenn v. MetLife*, 461 F.3d 660, 674 (6th Cir. 2006). MetLife disputed that a conflict existed. *Id.* at 666.

84. 128 S. Ct. at 2352.

85. *Id.* at 2348 (finding the existence of a conflict where a “plan administrator both evaluates claims for benefits and pays benefits claims”).

86. *Id.* at 2350.

87. *Id.* at 2346 (“[T]he significance of the [conflict] will depend upon the circumstances of the particular case.”).

88. *Id.* Precisely how this will differ in practice from *Firestone's* standard is not clear.

89. *Id.* at 2351.

words that can avoid the process of judgment,”⁹⁰ and thus no “one-size-fits-all procedural system that is likely to promote fair and accurate review.”⁹¹

The immediate problem with the Court’s reasoning is that there *is* a procedural system likely to promote fair and accurate review: de novo review. Aside from the obvious merit of *itself* being “fair and accurate,” de novo review has the additional benefit of consonance with ERISA’s language. Recall that 29 U.S.C. § 1133 requires that a participant have an opportunity for “full and fair” internal review.⁹² De novo review increases the likelihood that internal administrative review will actually be full and fair because it incentivizes plans to practice scrupulously fair decision making (so as to reduce the chance of costly litigation). Absent this cost deterrent, benefit decision makers are less likely to invest the time and care needed to avoid mistakes, and are more likely to succumb to the temptation of self-interested decisions.⁹³ De novo judicial review, as an impartial check, considerably increases the odds that administrative review will be full and fair in the first instance.⁹⁴

Arguments not explicitly made in *Glenn* but commonly advanced in favor of judicial deference deserve some attention. One theory is that plan administrators are more familiar with the plan and thus better positioned to resolve plan meaning than judges, whose exposure to plan language is “episodic and occasional.”⁹⁵ However, that an administrator is facile with plan terms does not address, at all, whether he will provide *fair* review to a given beneficiary, as ERISA requires. Facility is not fairness, and the reality is that most if not all fiduciaries are

90. *Id.* at 2345 (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 489 (1951)).

91. *Id.* at 2351. A simple summary of *Glenn*’s standard might be: “Courts have wide discretion to determine when there is an abuse of discretion.” Justice Scalia, in his dissent, was unimpressed with the Court’s amorphous test, comparing it to “chuck[ing things] into a brown paper bag and shak[ing them] up to determine the answer.” *Id.* at 2358 (Scalia, J., dissenting).

92. 29 U.S.C. § 1133 (2006).

93. See George Lee Flint, Jr., *ERISA: Reformulating the Federal Common Law for Plan Interpretation*, 32 SAN DIEGO L. REV. 955, 960 (1995) (noting that judicial deference is “extremely detrimental to litigating participants denied benefits”); see also Cunningham, *supra* note 39, at 90 (criticizing deference to biased administrators).

94. In a world of elective administrative review, de novo judicial review also makes it more likely that participants—who are themselves cost sensitive—will perceive administrative review as likely to be fair, and thus choose it over suit.

95. See, e.g., *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006 (4th Cir. 1985); see also *Brogan v. Holland*, 105 F.3d 158, 164 (4th Cir. 1997).

conflicted.⁹⁶ Moreover, ERISA intends for the benefit promise to be expressed in a fashion comprehensible to the “average plan participant.”⁹⁷ The average plan participant has, at best, an “episodic and occasional” exposure to plan language. From this perspective, a judge’s lack of day-to-day familiarity with a particular plan’s terms makes the court a superior, rather than inferior, interpretative arbiter.

Another oft-suggested justification for deference relies upon a comparison to common-law trusts.⁹⁸ There, a settlor may confer discretion on a trustee, and courts defer to the trustee’s discretion in such an instance.⁹⁹ The wishes of the settlor, who supplies the trust res, are presumptively reflected in the discretion of the trustee, and thus entitled to judicial deference.¹⁰⁰ So too should be the rule in ERISA, or so the argument goes. There are at least two flaws in this reasoning. First, under ERISA, the *employees* can more accurately be thought of as playing the role of the settlor. Although the employer is nominally the settlor, the employees are the effective settlors, as they are the ones

96. See generally Bronsteen et al., *supra* note 6, at 2297, 2299; see also Langbein, *Trust Law*, *supra* note 5, at 1316 (“Most ERISA plan benefit denials are the work of conflicted decisionmakers.”).

97. 29 U.S.C. § 1022 (a) requires that:

A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries The summary plan description shall include [material information about benefit terms], shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

See also 29 C.F.R. § 2520.102-2 (2008) (setting forth U.S. Department of Labor requirements and recommendations on the appropriate language of summary plan descriptions). Where there is conflict between the language of the plan document itself and the language of the summary plan description, the language of the summary plan description governs. See, e.g., *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 n.1 (9th Cir. 1993) (stating the summary plan description governs); *Hansen v. Cont’l Ins. Co.*, 940 F.2d 971, 982 (5th Cir. 1991) (same); *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) (same); *McKnight v. S. Life & Health Ins. Co.*, 758 F.2d 1566, 1570 (11th Cir. 1985) (same).

98. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113–14 (1989) (noting the private-trust rationale was offered in this case).

99. RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) (“Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion.”).

100. RESTATEMENT (THIRD) OF TRUSTS § 4 (2003) (“The phrase ‘terms of the trust’ means the manifestation of intention of the settlor with respect to the trust provisions expressed in a manner that admits of its proof in judicial proceedings.”); see also RESTATEMENT (THIRD) OF PROPERTY: WILLS AND OTHER DONATIVE TRANSFERS § 10.1 (2001) (“The controlling consideration in determining the meaning of a donative document is the donor’s intention.”).

funding the trust with foregone wage compensation.¹⁰¹ One struggles to justify a presumption that employees would wish to limit the reviewing power of an impartial judge regarding a benefit denial.¹⁰² Second, ERISA was created to enhance protections for employees; that employers could, through drafting, “impose a standard of review that would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted”¹⁰³ without ceding anything in return runs counter to ERISA’s purpose and finds no support in ERISA’s text or legislative history.¹⁰⁴

Also periodically argued is that administrators are ideally equipped to balance the needs of current benefit claimants with future claimants, and thus deserving of deference from judges.¹⁰⁵ This argument assumes that resources saved by denying one claim will be shifted to other claimants. Common circumstances suggest otherwise. For example, where an insurance company is the payer of health benefits, a claim denied is simply money the insurance company does not pay out. Nothing requires the insurance company to set aside that saved money for the benefit of other potential claimants. Similarly, in a defined-benefit pension plan, the employer is effectively the residual beneficiary

101. See *supra* Part I.B. This is true (controlling for tax effects) even of employer contributions. Money the employer contributes is still functionally foregone compensation. Cf. Albert de Roode, *Pensions as Wages*, 3 AM. ECON. REV. 287, 287 (1913) (“A pension system . . . is really paid by the employee, not perhaps in money, but in the foregoing of an increase in wages which he might obtain except for the establishment of a pension system.”); see also *supra* Part I.A.

102. The exception is where an employee believes the cost of additional protections is greater than the risk of loss associated with a review scheme having weaker judicial review. See *infra* Part III.

103. *Firestone*, 489 U.S. at 114.

104. Trust law is also a poor analog regarding deference because it presupposes, generally, the presence of an unconflicted trustee, and because it fails to account for ERISA’s regulatory intent (as opposed to the contractarian nature of trust law). See Langbein, *Trust Law*, *supra* note 5, at 1326–27, 1343. For a detailed exploration of the negative impact ERISA’s tolerance of conflicted trustees has had on America’s health-care system, see generally Bronsteen et al., *supra* note 6.

105. See, e.g., E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 TENN. L. REV. 511, 524 (1998) (arguing the fiduciary is ideally suited “to honor the competing claims of the plan’s other and future beneficiaries”). Courts sometimes express this idea in terms of a fiduciary’s duty to the plan as a collective entity. See, e.g., *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir. 1999) (“Fiduciary obligations extend primarily to the plan as it relates to all beneficiaries, not just to individual claimants.”). In addition to the other difficulties mentioned in the text, a further problem with this argument is that it proves too much. Put simply, it will *always* justify—absent hyperclear plan terms—denying benefits. It is unlikely that was Congress’s goal when passing ERISA.

when payouts are minimized.¹⁰⁶ Nor, in any event, is there a compelling reason to believe decision makers denying benefit claims are routinely making long-term judgments about the effect granting or denying a given claim will have on the ability to pay future classes of claims.

The most compelling explanation as to why deferential review has survived for almost two decades is that courts have simply concluded that the alternative, *de novo* review, is not worth the extra cost. This conclusion was acknowledged in *Glenn*, where Justice Stephen Breyer assumed the increase in costs would be so enormous that a *de novo* rule would only be justifiable had ERISA affirmatively required such a standard (which it did not). Justice Breyer's memorable formulation of the point was: "Congress does not hide elephants in mouseholes."¹⁰⁷ Yet, *de novo* review may, for some benefit-plan participants, be an elephant worth the price of admission. To that possibility I turn next.

III. A "ROBUSTNESS MARKET"

ERISA prioritizes robustness over cost but fails to specify by how much.¹⁰⁸ Courts have failed to strike a balance that seems consistent with ERISA's purpose.¹⁰⁹ The solution is to create a paternalistic, regulated, subsidized "market" for robustness.¹¹⁰ I propose that Congress amend ERISA (and other necessary law) as follows.¹¹¹

106. Minimized payouts, like exceptional investment performance, can reduce future funding obligations. See, e.g., Jeffrey N. Gordon, *Employees, Pensions, and the New Economic Order*, 97 COLUM. L. REV. 1519, 1519, 1542 (1997) (discussing a range of ways in which "[i]n the historically dominant defined benefit pension plan, the sponsoring firm, not the employee, is the residual claimant").

107. *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2351 (2008) (quoting *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 468 (2001)). In fairness, Justice Breyer was alluding to both increased costs of plan administration (which would have the effects described *supra* Part II.B) as well as increased burdens on the courts (which would not have those effects).

108. See *supra* Part I.

109. See *supra* Part II.

110. I should be careful to note that I sketch in this Part a new conceptual approach, not a concrete plan of reform regarding every detail of implementation. Obviously implementation specifics will vary depending on the benefits at issue, the type of plan, and plan size, among many other factors. I do not intend to resolve here, for example, the ideal way of charging for alternative robustness options in a defined-benefit pension plan, or whether there should be exemptions for businesses or plans below a certain size.

111. There is no constitutional obstacle to Congress passing legislation that permits parties to an agreement to select (within limits) damages or the appropriate standard of review. Lee Goldman, *Contractually Expanded Review of Arbitration Awards*, 8 HARV. NEGOT. L. REV. 171, 188 (2003) (noting there is "no independent constitutional argument against" selecting a level of judicial review).

First, require that any employee-benefit plan *must* offer a three-pronged, highly robust, default remedial option of (1) elective administrative review, (2) *de novo* judicial review, and (3) consequential damages for benefit denials.¹¹² Second, permit plans to offer lower-priced, lower-robustness options—for example, mandatory administrative review, deferential judicial review, or no consequential damages¹¹³—to those participants willing to opt out from the high-robustness baseline remedial option.¹¹⁴ Third, require the offer of the less robust options to be explained in a manner comprehensible to the average plan participant. Fourth, establish a regulatory floor for minimum robustness levels, to be administered by the U.S. Department of Labor (and subject to agency adjustment based on varying individual and market conditions).¹¹⁵ Fifth, subsidize robustness choices made by plan participants of lower income levels.

In Part III.A below, I explore the fundamental attraction of a robustness market; in Part III.B, I argue that anchoring the market to a high-robustness default is appropriate, given ERISA's original and still valid objective; in Part III.C, I address concerns about market imperfections and propose legislative and regulatory mechanisms to safeguard against undesirable market outcomes.

112. ERISA currently does not require that an employer offer a plan. I do not opine on whether that should change; merely that, to the extent an employee-benefit plan covered by ERISA is offered, it should conform to the conceptual scheme proposed herein.

113. The listed options are not exhaustive. For example, an option could be that the participant agrees to mandatory administrative review only for claims under \$1,000.

114. To prevent strategic play, the opt-out ability of a participant would be limited to a specified period each year, and would not be retroactive to a dispute already existing.

115. The idea is to prohibit and/or limit, via regulation, robustness rules that are so weak that they are presumptively undesirable. *See infra* Part III.C. Calls for potent regulatory safeguards in markets generally have become stronger in light of the recent financial meltdowns, for which regulatory failure was identified as a key culprit. *See, e.g.,* Roger Altman, *Modern History's Greatest Regulatory Failure*, FIN. TIMES (London), Sept. 17, 2008 *available at* http://www.ft.com/cms/s/0/1dc86ec4-84ce-11dd-b148-0000779fd18c.dwp_uuid=11f94e6e-7e94-11dd-b1af-000077b07658.html (attributing America's financial meltdown to "the greatest regulatory failure in modern history"); Francis Fukuyama, *The Fall of America, Inc.*, NEWSWEEK.COM, Oct. 4, 2008, <http://www.newsweek.com/id/162401> ("Washington failed to adequately regulate the financial sector and allowed it to do tremendous harm to the rest of the society."); Sam Zuckerman, *Finance Sector Enters New Era of Regulation*, S.F. CHRON., Oct. 5, 2008, *available at* <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/10/05/MNF013AB10.DTL> ("Amid the wreckage of the U.S. financial system . . . the new era of finance will be one of much greater regulation and much less risk.").

A. The Attraction of a Robustness Market

The conceit central to all markets is that the buyers and sellers of a good are in the best position to value it.¹¹⁶ Here the “good” is benefit-promise robustness sold and bought in the form of remedial legal rules. The seller of robustness is the benefit promisor; the buyer is the beneficiary.

Consider the robustness associated with the legal standard of judicial review. De novo review offers stronger protection of the benefit promise than deferential review; the former reduces the chance that indolent or biased administrators will wrongfully deny a promised benefit. But de novo review is also more costly to benefit promisors, because the scope (and thus cost) of litigation is broader than under deferential review, and because they are less likely to prevail than under deferential review.¹¹⁷ Which rule—that is, how “much” judicial review—is preferable?

The answer is that it depends on the actual magnitude of the robustness increase associated with de novo review over deferential review, the magnitude of the corresponding increase in cost, and the content of the individual players’ preferences. A robustness market is an attractive means of answering those questions because the players would be economically forced to determine their true preferences and value the options on the table as accurately as possible.

Imagine a hypothetical health-care plan that offers all beneficiaries a de novo review option and a deferential-review option (with correspondingly different premiums).¹¹⁸ The plan (or its insurer) would price the differing options based on the expected cost difference in administering a plan under the different robustness rules. Participants, in turn, would compare the premium price differential to the perceived risk of benefit denial associated with each option. Those who chose de novo review would value the incremental robustness increase more than the foregone wages associated with more costly premiums; those selecting deferential review would value increased wages more than the robustness decrease. Currently this robustness choice is determined by judges—with no reliable reference to (1) the true incremental increase or decrease in robustness, or (2) the true cost of the robustness

116. See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 11 (4th ed. 1992) (“By a process of voluntary exchange, resources are shifted to those uses in which the value to the customer, as measured by willingness to pay, is highest.”).

117. This cost is likely expressed in the form of wage reduction, benefit reduction, or benefit elimination. See *supra* Part I.B.

118. I use a welfare-plan example, see *supra* note 14, for ease of discussion. But, the principle is not confined to welfare plans. As mentioned previously, however, implementation specifics will vary with circumstance. See *supra* note 110.

change.¹¹⁹ Judges, in essence, make broad guesses that deferential review is not that much worse than de novo review in terms of a decrease in robustness, but that it is much more costly in terms of increasing promise cost.¹²⁰ Market players—who internalize the consequences, positive and negative, of choosing respective rules—are better able to value the trade-off (and with more precision).

Judges are also limited because their determinations are divorced from circumstantial variations that alter rule value. Consider that for beneficiaries who are participants in a plan that engages hard-working, studiously neutral administrators, the value of the increased robustness associated with de novo review is likely to be low. For beneficiaries who are participants in a plan that engages lazy, biased administrators, the value of the increased robustness associated with de novo review is likely to be very high. Circumstances vary, and individual players are better situated to factor such information into the bargaining that would occur in a robustness market. Judges, in contrast, have information about only those instances before them and must guess about the rest.

Moreover, even if a judge had perfect information about the actual incremental change in robustness and cost in a given circumstance—for example, how often de novo review would result in a different benefit decision than deferential review—the current scheme does not align *individual* preferences.¹²¹ Neither employees nor employers are all alike. Employees and employers have differing compensation and risk preferences among their own populations. Some employees might prefer a more costly plan (i.e., lower wages) with a more robust promise; others might prefer a less costly plan (i.e., higher wages) with a less robust promise.¹²² Similarly, employers have differing views of promise cost. Employers concerned with being overturned frequently would charge more for the de novo judicial-review option; employers overturned less frequently would charge less. There are innumerable details on which judgment and preference can differ. A robustness market would permit players to better match their respective

119. Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451, 1455 (1988) (noting that public rules are made with “no real information about the subjective preferences of the people whom they wish to protect”).

120. Justice Breyer, for example, believes the difference in cost is elephantine. See *supra* note 107 and accompanying text.

121. Epstein, *supra* note 119, at 1455 (stating that public rules disregard “individual differences in taste and demand”).

122. See, e.g., Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 26 (1999) (noting varying preferences for different combinations of wages and insurance). Professor Korobkin is referring to the level of insurance coverage, not robustness, but the principle is the same.

preferences for a given combination of cost, wages, benefits, and benefit robustness.¹²³

B. The Paternalistic Baseline: High Robustness

In theory, employees could bargain for increased robustness (if they so desired) without legislative assistance. In practice, that will not happen. Employees face disadvantages in information, expertise, and risk tolerance, as well as collective-action problems. Absent intervention, unfair (and insufficiently robust) bargains are likely to be struck. This—along with a concomitant concern about the consequences of broken benefit promises—is what prompted ERISA's passage in the first instance. Bargaining differentials (and the socially undesirable consequences of poor benefit bargains) specific to the labor market remain today.¹²⁴

The complex nature of choosing among robustness rules suggests anchored choice (i.e., where a concrete default option exists) is the preferable choice architecture.¹²⁵ Having the default rule as the one that offers the most protection is consistent with the presumption of having a protective statute in the first place. People who do not pay enough attention to conduct a meaningful assessment of the risk of benefit-promise failure will be defaulted to the most robust option; people who do pay attention to risk will easily be able to move to a less robust option if the price is right. Part of the reason protective statutes such as ERISA exist is because the former group exists.

Requiring all plans to offer the high-robustness option also prevents the option from disappearing solely because of market imperfections, information asymmetries, or bargaining-power discrepancies.¹²⁶ As a result of the default option being kept on the

123. Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 183 (1986) (“[Bargaining allows] the most efficient combination of efforts to manage risk in accordance with their respective comparative advantages and their respective risk preferences.”).

124. See, e.g., Kenneth G. Dau-Schmidt, *Meeting the Demands of Workers into the Twenty-First Century: The Future of Labor and Employment Law*, 68 IND. L.J. 685, 688–95 (1993) (discussing employee bargaining problems).

125. Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1201 (2003) (noting that more complex decisions are amenable to the use of a default option “that has been selected with some care”).

126. That is, many employees may lack the awareness, ability, sophistication, or incentives to insist on a high-robustness option. See, e.g., David Charny, *The Employee Welfare State in Transition*, 74 TEX. L. REV. 1601, 1618 (1996) (“[I]t appears that workers are not generally well-informed about particular aspects of firms’ pension, firing, and health and safety records.”) In another setting, Professors Brown

market, plans will be forced to price it for real, rather than merely claiming (with no market consequence) to policy makers that it costs some (unreliable) estimated amount.

Presumably, plans will also offer less robust remedial options at lower prices, and through that process the price of robustness decreases will be disaggregated and made more transparent. Any plan that offers a less robust option will be effectively revealing the incremental cost it attaches to a more highly robust option. Employees (and competitors) will be able to see that at Company *A*, the default robustness option is much more costly than it is at Company *B*.¹²⁷ That increased transparency of incremental cost will assist employees (and employers) in decision making regarding the selection of the optimal level of robustness, benefits, and wages; it will also lead to pricing that is more accurate.¹²⁸ The freedom of plans to competitively price, and employees to accept, less robust options will stimulate product differentiation in a market where, originally, information asymmetries and bargaining-power differentials would have made the market uniform. The rise of a granular, transparent market for remedial options of varying strength will be better suited to satisfy individual preferences than the current judge-centric scheme.

Aside from empowering the players to better effectuate their actual preferences (which is true generally of increased product differentiation),¹²⁹ market-induced incremental pricing of robustness would be of enormous use to policy makers. A market price on a given robustness rule would obviously provide some real-world measure of

and Gopalan have shown that, owing to superior bargaining power of corporate management, there is virtually no variance in corporate bargains struck between shareholders and management regarding waivers of liability. J. Robert Brown, Jr. & Sandeep Gopalan, *Opting Only In: Contractarians, Waiver of Liability Provisions, and the Race to the Bottom* 3–4 (University of Denver, Legal Studies Research Paper No. 08-02, 2008), available at <http://ssrn.com/abstract=1087404>. This is evidence that bargain diversity can quickly disappear where bargaining differentials exist.

127. Cf. Mark Geistfeld, Note, *Imperfect Information, the Pricing Mechanism, and Products Liability*, 88 COLUM. L. REV. 1057, 1062 (1988) (“By separating the price charged for a product from the price charged for its warranty, a modified warranty pricing system can help ensure that prices do convey useful information about product risks to imperfectly informed consumers.”).

128. Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 656 (1979) (“If comparison shopping is convenient . . . [and] if prices and terms in a market are quoted in standard and relatively clear fashion, the market, other things equal, is more likely than not to be competitive.”).

129. See, e.g., Thomas C. Arthur, *The Costly Quest for Perfect Competition: Kodak and Nonstructural Market Power*, 69 N.Y.U. L. REV. 1, 33–35 (1994) (discussing the virtues of even modest product differentiation).

the rule's cost and value.¹³⁰ The regulated-market price is not a perfect metric, nor does it properly account for indirect costs associated with the rule, such as additional use of judicial resources, but a regulated market can provide some quanta of legitimate data on the cost and popularity of a given rule.

Such data can assist policy makers in analyzing the social desirability of the rule. Obviously, if the price is high but the rule is deemed to further other policy ends (such as a fairness aim), subsidization of a particular rule (by offering targeted tax credits of a certain size) may be warranted to ensure that all individuals are capable of choosing the rule. Alternately, if the rule's price is very low but perceived to be socially desirable, the most sensible policy prescription might be to require additional disclosures about the rule. In many cases, no additional policy modification may be required: the market may get it right.

Moreover, robustness price changes over time—particularly compared to other changes—could reveal information of considerable policy value. For example, if the price difference between a consequential-damages option and a no-consequential-damages option stays roughly flat across the aggregate market over a given period, while health-care premiums otherwise rise over the same period, that suggests that health-care costs have risen for reasons that are independent of growth in damage awards. Conversely, if the average price of the consequential-damages option skyrockets, that suggests something has changed about the country's damage regime. Extracting information from the market in this fashion will not be effortless, but it will be far easier than doing so in today's priceless world. Ultimately, market information is not perfect, and observers would need to be careful to appropriately weigh the information conveyed by market prices within a comprehensive policy prism. That caveat notwithstanding, pricing information about robustness rules would be of significant value.

130. See, e.g., Charles R. Plott & Kay-Yut, *Information Aggregation Mechanisms: Concept, Design and Implementation for a Sales Forecasting Problem 1* (Cal. Inst. of Tech., Social Science Working Paper No. 1131, 2002), available at http://www.hpl.hp.com/personal/Kay-Yut_Chen/paper/ms020408.pdf (“[P]rices in naturally occurring, free markets make important contributions to information transmission in economies.”); see generally F.A. Hayek, *The Use of Knowledge in Society*, 35 AM. ECON. REV. 519, 525 (1945) (discussing how prices and markets permit the communication of information and expression of choices in a dynamic fashion).

C. Sensible Restraints: Subsidies, Disclosure, Regulation

Any scheme that requires players to pay to exercise their preferences runs the risk of being unfair to those who lack means. Here, one might be concerned that plans may very well price the default option so highly that many lower-income individuals could not afford it. A superior solution, it might be argued, would be to simply amend ERISA to mandate high-robustness rules.¹³¹

I am sensitive to this concern, but offer two preliminary observations. First, a mandated solution would force high-robustness promises (with the expected resulting decrease in wages or benefits)¹³² on everyone, including individuals who prefer additional wages or benefits to increased robustness. (This is true of a mandatory rule of any type: it is not tailored to individual preferences.) Second, a mandatory-robustness rule would undermine policy makers' efforts to gather detailed information about the true price of robustness increases, because there would be no extant price points in the market associated with different levels of robustness. Neither of these two observations, of course, is responsive to the social-justice concern that the less well off will lack the wherewithal to purchase the default option (the option with high robustness), and that is unfair and undesirable. The answer, in my view, is to provide a government subsidy to those making benefit choices. Such is consistent with most current plans for health reform, for example, and would (assuming the price of the default option is not exorbitantly high)¹³³ permit individuals who prioritize a high level of benefit-promise robustness to express that preference.

A further concern is that individuals' expressed preferences might not reflect their true preferences as a result of misinformation or misunderstanding.¹³⁴ ERISA's current rule is that summary plan descriptions must be written in a language understandable by the average plan participant.¹³⁵ This rule makes policy sense as it

131. L. Darnell Weeden, *An HMO Does Not Owe an ERISA Fiduciary Duty to Its Employee Beneficiaries: After Pegram v. Herdrich, Who Will Speak for the Working Class?*, 23 W. NEW ENG. L. REV. 381, 386 (2002) (stating that ERISA should be amended to "use traditional common law liability concepts of torts, contracts, and trusts" to protect beneficiaries and assure quality care).

132. See *supra* Part I.B.

133. If it were, that would be relevant information to consider when deciding whether to increase the size of applicable subsidies and to set policy generally.

134. Daphna Lewinsohn-Zamir, *In Defense of Redistribution Through Private Law*, 91 MINN. L. REV. 326, 330 (2006) ("Fulfillment of people's actual preferences might result in a reduction in their welfare, if their desires are based on misinformation, mistakes, or lack of self-respect and self-esteem.").

135. See *supra* note 97. If there is a conflict between the two, summary plan description language trumps contrary plan language. *Id.*

significantly enhances the chance that beneficiaries understand the terms of the benefit deal. So too it should be the case with respect to robustness rules. Plans would have to explain in comprehensible English the difference between the default high-robustness option and less robust options being offered.¹³⁶

Beginning with a highly robust option also achieves important nudging effects that will ameliorate other cognitive shortcomings that might otherwise, *tabula rosa*, result in suboptimal choices for a given person.¹³⁷ Setting the default as the most protective option and requiring moves away from it to be explained in clear English protects against poor decision making, but also leaves room for strong, informed choices (and the corresponding benefits of permitting choice obtainment) to manifest themselves.¹³⁸

A final worry is that, in general, a small number of weaker players might be unjustly exploited, notwithstanding the high-robustness default, clear disclosure rules, and subsidies. For example, plans might offer heavy discounts for an extremely weak robustness option, (e.g., much lower premiums for a health-care plan that permits judicial review but requires the beneficiary to pay, up front, the cost of the plan's attorneys in any dispute). The solution is to establish a regulatory floor (determined by the Department of Labor) as to the weakness of robustness options that may be permissibly reached through bargaining.¹³⁹ An initial floor of (1) no consequential damages, (2) *Glenn* review of administrator decisions, and (3) judicial deference to administrator decisions is a sensible starting point.¹⁴⁰ The Department

136. Indeed, one modest advantage of the proposal is that all beneficiaries would be aware, *ex ante*, that robustness rules exist. Currently, beneficiaries only learn about robustness rules (and how unfavorable they can be) after they have a claim dispute.

137. Sunstein & Thaler, *supra* note 125, at 1159 ("Often people's preferences are unclear and ill-formed, and their choices will inevitably be influenced by default rules, framing effects, and starting points.").

138. Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 U. PA. L. REV. 1211, 1212 (2003) ("A regulation is asymmetrically paternalistic if it creates large benefits for those who make errors, while imposing little or no harm on those who are fully rational. Such regulations are relatively harmless to those who reliably make decisions in their best interest, while at the same time advantageous to those making suboptimal choices.").

139. Jeffrey O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 VA. L. REV. 1475, 1483 (1988) (discussing regulatory limits on contractual variations).

140. That is, after all, the current set of rules. While they are, in my view, undesirable, they are not so grossly unfair that they should be barred from the market. I do not here resolve conclusively the acceptable floor, because that would necessarily be

would be authorized to raise or lower the floor depending on a to-be-determined set of circumstantial conditions, such as, for example, (1) company size, (2) beneficiary income level, and (3) rate of judicial reversal of plan decisions. A regulatory floor subject to limited modification based on agency discretion would serve as an appropriate but flexible safeguard against grossly undesirable bargaining outcomes.

CONCLUSION

America's benefit system is on the precipice of a significant change. There is a political appetite for reform,¹⁴¹ there is an emerging policy consensus that some combination of regulated choice and additional government expenditure is desirable,¹⁴² and there is a widespread legal view that ERISA's central objective of protecting benefits has been frustrated by an uncooperative judiciary.¹⁴³

a function of political realities (and compromises), the consideration of which is beyond this Article's scope.

141. See, e.g., Amanda Gardner, *Report Compares Health-Care Platforms of Presidential Candidates*, WASH. POST, Oct. 2, 2008 ("Currently, some 82 percent of Americans think the health-care system either has to be rebuilt completely or needs to undergo a massive overhaul."). The urgency and depth of the desire for reform, particularly in health care, is evidenced by the rise of bipartisan policy groups demanding action, such as DividedWeFail.Org. The group is a bipartisan policy coalition (consisting of AARP, Business Roundtable, Service Employees Union, and National Federation of Independent Business) devoted to "engaging the American people, businesses, non-profit organizations, and elected officials in finding bi-partisan solutions to ensure affordable, quality health care and long-term financial security—for all of us." AARP.org, About Us, http://www.aarp.org/issues/dividedwefail/about_us (last visited Mar. 4, 2009).

142. For example, in their health-care-reform plans, both 2008 presidential candidates Obama and McCain urged some level of choice and competition, and agreed that some level of government expenditures (be it through subsidies or credits) was warranted to ensure that poorer Americans were able to select reasonable options for the provision of their health-care and retirement benefits. See BARACK OBAMA AND JOE BIDEN'S PLAN TO LOWER HEALTH CARE COSTS AND ENSURE AFFORDABLE, ACCESSIBLE HEALTH COVERAGE FOR ALL (2008), available at <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf> (proposing, inter alia, choice and subsidies); STRAIGHT TALK ON HEALTH SYSTEM REFORM (2008), available at <http://www.allhealth.org/BriefingMaterials/McCainPlan-1222.pdf> (proposing, inter alia, choice and tax credits); see also Mark V. Pauly, *Blending Better Ingredients for Health Reform*, HEALTHAFFAIRS.ORG, Sept. 16, 2008, <http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w482v1> (noting that similarities between the McCain and Obama plans include a "desire to offer a range of insurance options to the currently uninsured and a desire to redistribute the help and incentives government gives for insurance purchasing"). Obviously the candidates had significant differences, but their commonalities are important.

143. See generally Bronsteen et al., *supra* note 6; Langbein, *Trust Law*, *supra* note 5; see also Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under*

My proposal is consistent with these realities. Rather than permitting the continuance of implicit and uncertain policy making by judges ill equipped for the task, I propose changing the system. Begin with a paternalistic default option of high benefit-promise robustness—consequential damages, elective administrative review, and de novo judicial review—and allow the relevant players to bargain, at decreased prices, for alternate remedial rules of lesser strength. To address bargaining-power discrepancies, information asymmetry, and cognitive biases, make the default option a required option, preserve the current requirement that a change in benefits must be written in a way comprehensible to the average beneficiary, and establish a regulatory floor. To address financial inequity, subsidize the choices of poorer Americans.

The ninety-third Congress, which enacted ERISA, was fundamentally right to instantiate minimum standards to strengthen the benefit promise, even at increased cost. Its policy failure was to leave unspecified the degree to which higher cost should be tolerated. Groping for an answer, the judiciary has embraced strained statutory readings in tension with ERISA's explicit protective purpose. Nor, in any event, could the judiciary realistically fashion an answer sufficiently granular to be responsive to individual preferences. In contrast, a regulated robustness market is capable of striking an appropriate and fluid balance between the competing policy objectives of promise security and promise cost—with a thumb on the scale favoring security. Which, of course, was ERISA's aim in the first place.

ERISA, 31 LOY. U. CHI. L.J. 29, 68 (1999) ("Congress has failed to meet its own purpose of providing protection for participants and beneficiaries and must act to remedy this dreadful state."). Often criticized in tandem with ERISA's narrow view of remedies is the broadly expansive view of preemption the Supreme Court has taken, further undermining ERISA's protective aims. See, e.g., Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption?: A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 38 (1996) ("It is a rich irony that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws."); Dana M. Muir, *Contemporary Social Policy Analysis and Employee Benefit Programs: Boomers, Benefits, and Bargains*, 54 WASH. & LEE L. REV. 1351, 1356 (1997) ("ERISA's broad preemptive force intersects with its narrowly construed substantive provisions to create regulatory voids that undermine the security of current benefit promises.").