Hiding in Plain Sight: ERISA's Cure for the $1.4 Trillion Health Benefits Market

Amy B. Monahan[†] **& Barak D. Richman**[††]

Since 1974, the Employee Retirement Income Security Act (ERISA) has imposed fiduciary duties on those who manage and administer employee benefit plans. But for the largest employee benefits—retirement benefits and health plans, which together constitute 13% of total national compensation—ERISA's fiduciary duties have played very different roles. For retirement benefits, ERISA scrutinizes plan managers and requires employers to select plan investments with care. For health plans, there is a regulatory vacuum, as ERISA imposes few federal requirements yet preempts state efforts to ensure quality plan offerings. In short, ERISA has advanced protections for retirement plans but mostly curtailed protections for the nearly 165 million Americans who receive health insurance from employers.

The tragedy is that health benefit plans are in dire need of regulatory scrutiny. The costs of health insurance have risen dramatically faster than inflation, cutting into worker take-home pay and inflicting disproportionate harm on middle- and lower-income workers, while the generosity of employer-provided plans has thinned. The sorry state of employer-sponsored health insurance is due, in part, to inattention and inadequate probity from the parties subject to ERISA's fiduciary obligations. In sharp contrast, the efficiency and value of retirement benefits have improved over that same period.

Because of what ERISA requires, and because of what managers of employee health benefits have failed to do, there is enormous opportunity to employ ERISA to enhance the value of health benefits for employees, which also means enhancing the value of the nation's entire health sector. A handful of pioneering lawsuits have just started invoking ERISA to subject health benefits managers to fiduciary obligations, and more are certain to come. Now is the time for ERISA jurisprudence to confront the consequences of neglecting health insurance, for courts to consider what demands ERISA imposes on health

† Distinguished McKnight University Professor and Melvin C. Steen Professor of Law, University of Minnesota.

†† Alexander Hamilton Professor of Business Law, George Washington University Law School. Senior Scholar, Clinical Excellence Research Center, Stanford University School of Medicine. The authors thank Darren Fogarty, Robert Kaplan, Peter Lee, Tom Miller, Arnold Milstein, Jeffrey Pfeffer, Kevin Schulman, and Sara Singer, for early and ongoing conversations that inspired, informed, and shaped this long-running project. We are also grateful for helpful feedback and comments received from Allison Hoffman, Govind Persad, and participants at workshops held at University of Virginia School of Law, Boston University School of Law, Boston College Law School, Catholic University of America Columbus School of Law, and University of Denver Sturm College of Law.

benefits managers, and critically, for the Department of Labor to exercise its regulatory authority under ERISA and enforce fiduciary obligations that the statute imposes and the market sorely needs. This Article documents ERISA's authority over health benefits managers, explains why ERISA litigation is on the upswing, and offers guidance on how the Department of Labor could establish regulatory safe harbors to bring accountability and predictability to the enormous health benefits marketplace.

Introduction

Approximately $1.4 trillion per year[1] is spent on employer-provided health and retirement plan benefits—nearly the entire GDP of [2]Spain.[3] Federal law has, since the passage of the Employee Retirement Income Security Act of 1974 (ERISA), attempted to protect the quality and security of those benefits.[4] ERISA imposes fiduciary duties on employers in their management and administration of all employee benefit plans, requiring them to act solely in the best interest of plan participants and with the "care, skill, . . . and diligence" of a prudent person.[5]

But ERISA's impact on workers and their benefit plans has been severely lopsided. About $460 billion is spent on retirement benefits,[6] the provision of which enjoys robust ERISA safeguards.[7] Employers selecting investment options for 401(k) plan participants, for example, are guided by Department of Labor regulations that specify the factors to be considered in selecting investments, the minimum number of investment vehicles to be offered, and how investment options must allow a participant to achieve a diversified portfolio.[8] These standards are further clarified through a significant volume of case law challenging employers' investment selections and the reasonableness of plan fees,[9] and professional publications abound offering advice to retirement plan managers on how to comply with ERISA's fiduciary standards.[10] The combination of detailed guidance and significant compliance pressure appears to have been effective over time: retirement plan administrative fees have

1. This $1.4 trillion figure was calculated using the percentages in the Bureau of Labor Statistics report and the 2023 values for personal income from the Bureau of Economic Analysis report. Bureau of Lab. Stat., *Employer Costs for Employee Compensation – June 2024*, DEP'T OF LAB. 4 tbl.1 (June 2024), https://www.bls.gov/news.release/pdf/ecec.pdf [https://perma.cc/ZYC4-YMVQ] (explaining that retirement benefits and health plans together constitute approximately 13% of total national compensation, and 10% of total private sector compensation). Bureau of Economic Analysis, *Personal Income and Outlays, December 2024*, DEP'T OF COM. 5 tbl.1, https://www.bea.gov/sites/default/files/2025-01/pi1224.pdf [https://perma.cc/MDK5-9KG6].

2. *GDP, Current Prices*, IMF, https://www.imf.org/external/datamapper/NGDPD@WEO/OEMDC [https://perma.cc/64LK-PQHE].

3. *GDP, Current Prices*, IMF, https://www.imf.org/external/datamapper/NGDPD@WEO/OEMDC [https://perma.cc/64LK-PQHE] (reporting Italy's GDP at $2.46 trillion in 2025).

4. *See* 29 U.S.C. § 1001(a) (2018) (explicitly stating that "the continued well-being and security of millions of employees and their dependents are directly affected by [employee benefit] plans" and that "safeguards [should] be provided with respect to the establishment, operation, and administration of such plans").

5. *Id*. §§ 1102(21)(A), 1104(a)(1)(B).

6. Bureau of Lab. Stat., *supra* note 11**Error! Bookmark not defined.**, at 4 tbl.1 (figure calculated by authors based on amounts spent on retirement plans compared to the total spent on health and retirement plans).

7. *See infra* Section I.B.

8. 29 C.F.R. § 2550.404c-1 (2024).

9. *See infra* Section I.B.1.

10. *See infra* note 81.

decreased and investment options have shifted toward higher quality and lower cost funds, both of which materially contribute to participants' retirement savings adequacy.[11]

In contrast, the over $908 billion spent on employer health plans[12] that provide health coverage for a majority of Americans[13] has received almost no attention from federal regulators.[14] The Department of Labor has not promulgated a single regulation detailing the factors an employer must consider when selecting a health plan administrator or the process by which employers should manage health benefits in employees' best interest.[15] And, perhaps because of this lack of guidance, there has been virtually no litigation challenging an employer's selection of a health plan administrator or insurer.[16] Most importantly, there is no evidence to suggest that employers engage in the type of rigorous analysis or performance monitoring of insurers and administrators that is expected of a fiduciary. Given the enormous economic significance that employer-provided health plans (commonly referred to as "employer-sponsored insurance" or "ESI") play in the life of working Americans and in the American economy, and the central role such plans have in American social policy, this is a severe abdication of regulatory responsibility.

11. *See infra* Section I.B.2.

12. Bureau of Lab. Stat., *supra* note 1, at 4, tbl.1. This figure includes only employer contributions to employee benefits, thus excluding employee contributions to insurance premiums, which on average amount to 17% of total premiums for single coverage and 29% for family coverage. *See 2023 Employee Health Benefits Survey*, KAISER FAMILY FOUNDATION (Oct. 18, 2023), https://www.kff.org/report-section/ehbs-2023-summary-of-findings [https://perma.cc/93TD-GUZ3]. Therefore, a more accurate estimate of the total funds controlled by employers as fiduciaries is closer to $1.7 trillion.

13. Katherine Keisler-Starkey, Lisa N. Bunch & Rachel A. Lindstrom, *Health Insurance Coverage in the United States: 2022*, U.S. CENSUS BUREAU 2 (Sept. 2023), https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf [https://perma.cc/567N-AMQ6] (finding that 54.5% of the population was covered by employment-based coverage, compared to 18.8% covered by Medicaid and 18.7% covered by Medicare).

14. *See infra* Section I.C. While the Affordable Care Act did impose some federal regulation on employer health plans, that regulation did not address fiduciary duties or any related issues.

15. *See infra* Section I.C.1.

16. *See id.*; *see also infra* Section III.A.

Not coincidentally, ESI plans are frequently criticized for their high costs,[17] faulty provider networks,[18] and role in reducing take-home pay.[19] In 2023, the average premium for an employer health plan was equal to 19% of median wages of an employee electing single coverage, while the average premium for family coverage was equal to over one-quarter of the median household income.[20] And because health plan premiums are a flat dollar amount and not charged as a percentage of income, these enormous costs have an outsized effect on low- and moderate-income workers and their families. To add to the pain, these dollar amounts reflect only the cost of enrolling in coverage, and do not take into account the deductibles, co-payments, and other cost-sharing that is required of individuals when they access needed medical care.

Moreover, there is substantial evidence suggesting that employers as a group have not been good custodians of their benefit plans[21] and that health plan insurers and administrators lack meaningful incentives to

17. *See, e.g.*, Aditi P. Sen, Jessica Y. Chang & John Hargraves, *Health Care Service Price Comparison Suggests That Employers Lack Leverage to Negotiate Lower Prices*, 42 HEALTH AFFS. 1241, 1247 (2023) (noting "groundswell" of interest in reducing health care spending growth in private insurance, and providing evidence that employers appear to be ineffective in negotiating lower prices); CONG. BUDGET OFF., POLICY APPROACHES TO REDUCE WHAT COMMERCIAL INSURERS PAY FOR HOSPITALS' AND PHYSICIANS' SERVICES 5-7 (2022), https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf [https://perma.cc/FKW3-9E5Y] (noting the extent to which the prices paid by employer health plans far exceed the rates paid by public programs).

18. Alain C. Enthoven, *Employer Self-Funded Health Insurance is Taking Us in the Wrong Direction*, HEALTH AFFS. BLOG (Aug. 13, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210811.56839 [https://perma.cc/R8VJ-JGRL].

19. *See, e.g.*, CONG. BUDGET OFF., supra note 17, at 5; Mark J. Warshawsky & Andrew G. Biggs, *Income Inequality and Rising Health-Care Costs*, WALL ST. J. (Oct. 6, 2014, 12:14 PM ET), https://www.wsj.com/articles/mark-warshawsky-and-andrew-biggs-income-inequality-and-rising-health-care-costs-1412568847 [https://perma.cc/FZW7-LUXG]; *see also* Lydia Saad, *More Americans Delaying Medical Treatment Due to Cost*, GALLUP NEWS (Dec. 9, 2019), https://news.gallup.com/poll/269138/americans-delaying-medical-treatment-due-cost.aspx [https://perma.cc/RVJ7-VER2] (reporting that in 2019 a record 25% of surveyed Americans say they or a family member delayed treatment for a serious medical condition due to cost); David U. Himmelstein, Robert M Lawless, Deborah Thorne, Pamela Foohey & Steffie Woolhandler, *Medical Bankruptcy: Still Common Despite the Affordable Care Act*, 109 AM. J. PUB. HEALTH 431, 432 (2019) (finding that 58.5% of bankruptcy filers between 2013-2016 reported that medical expenses contributed either "very much" or "somewhat" to their bankruptcy); Sara R. Collins, Petra W. Rasmussen, Sophie Beutel & Michelle M. Doty, *The Problem of Underinsurance and How Rising Deductibles Make It Worse*, THE COMMONWEALTH FUND (May 20, 2015), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_may_1817_collins_problem_of_underinsurance_ib.pdf [https://perma.cc/V74J-QATN] (finding that 23% of all nonelderly adults were underinsured in 2014, based on their out-of-pocket costs, excluding premiums, equaling or exceeding 10% of their household income); Fumiko Chino, Jeffery M. Peppercorn, Christel Rushing, Arif H. Kamal, Ivy Altomare, Greg Samsa & S. Yousuf Zafar, *Out-of-Pocket Costs, Financial Distress, and Underinsurance in Cancer Care*, 3 JAMA ONCOLOGY 1582, 1584 (2017) (finding that 16% of insured cancer patients experienced high or overwhelming financial distress as a result of out-of-pocket treatment costs).

20. *See infra* text accompanying note 158.

21. *See, e.g.*, Sen et al., supra note 17 (finding that self-insured employer plans typically pay higher rates than even insured employer plans); *see also infra* Section II.A.

compete on value,[22] creating a strong implication that the absence of ERISA scrutiny has had real consequences. The failure of employers to demand value from health insurers and healthcare providers has permitted the broader spread of inefficiencies throughout the health sector, leading Warren Buffet to call medical costs "the tapeworm of American economic competitiveness."[23]

The good news is that ERISA's existing statutory language imposes robust fiduciary duties, including the duty to act solely in the best interests of plan participants, on both retirement *and* health plan managers.[24] While prior literature has acknowledged this truth, no regulatory material, judicial ruling, or academic article has explored in any detail what it means for health plan decision-makers to be subject to fiduciary duties. Given the enormous financial and social importance of health benefits for workers and their families, articulating and enforcing ERISA's obligations could bear valuable fruit, including mitigating how the costs of employer-provided health plans have eaten into worker take-home pay, forced layoffs, and exacerbated economic inequality.

We write not just at a time when the burdens of health insurance are intolerable, but also when a nascent collection of innovative lawsuits has just started exploring how ERISA might penalize managers for imprudently administering employee health benefits.[25] These lawsuits offer insights into both the law and the current health insurance market, but the most pressing lesson they offer is the need for regulatory certainty. We therefore make the case that the Department of Labor should capitalize on its authority under ERISA to promulgate regulations detailing the contours of health plan fiduciary duties. If it were to do so as it has for retirement plans, it could require employers to consider factors such as cost, quality, and value in selecting a health plan administrator and spending healthcare dollars on their employees' behalf. Because employers wield significant market power in purchasing healthcare, requiring employers to act prudently should generate sorely needed efficiencies not just for their employees, but in all of America's healthcare markets.[26]

22. *See, e.g.*, CONG. BUDGET OFF., supra note 17, at 9-10 (noting employers' "limited price sensitivity" with respect to health plan rates).

23. Andrew Ross Sorkin, *Forget Taxes, Warren Buffett Says. The Real Problem is Health Care*, N.Y. TIMES (May 8, 2017), https://www.nytimes.com/2017/05/08/business/dealbook/09dealbook-sorkin-warren-buffett.html [https://perma.cc/ULQ4-QW5L].

24. *See* 29 U.S.C. § 1104 (2018) (specifying ERISA's fiduciary duties without limitation based on plan type).

25. *See infra* note 208 and accompanying text.

26. *See, e.g.*, Jacob Glazer & Thomas G. McGuire, *Multiple Payers, Commonality and Free-Riding in Health Care: Medicare and Private Payers*, 21 J. HEALTH ECON. 1049, 1050-51 (2002) (describing the interdependence across commercial insurers, Medicare and Medicaid on both price and non-price dimensions); Mark Katz Meiselbach, Yang Wang, Jianhui Xu, Ge Bai &

Our argument rests not only on clear statutory language but also on a fundamental economic argument. Employee benefits are part of an employee's earned compensation, and when employers pledge to manage these benefits for employees, they become custodians over funds that belong to employees. This is most cleanly illustrated in the case of pension funds, which consist of savings that employees have already earned and which employers manage for future payments, but it is also the case for defined contribution retirement plans and health benefits. Both the law and labor markets recognize that employers are not obligated to provide retirement or health plans, but employers that withhold such benefits are compelled, to attract comparable employees, to compensate with higher wages.[27] Employers thus are both in spirit and in economic reality in possession of their employees' dollars, and they should be appropriately liable as fiduciaries when exhibiting inadequate prudence in managing those funds.

We begin in Part I with our core argument. We detail the fiduciary duties ERISA imposes upon employee benefit managers, and we observe that ERISA's statutory language clearly and categorically applies to all employee benefit plans, including health benefits. We then document that regulatory and enforcement attention has regrettably failed to scrutinize the provision of health benefits, showing that regulation of health plan fiduciary duties have markedly diverged from corresponding retirement plan fiduciary duties. Retirement fiduciaries are subject to voluminous rulemaking and vigorous enforcement,[28] whereas there is not a single regulation that details how fiduciary standards should operate in the health plan context and very little enforcement of the existing statutory standards.

We then turn in Part II to document the current state of employer-provided health plans, along with an examination of whether employers act as effective agents for their employees in health plan decision-making. We emphasize three central observations: First, although employer-provided health plans are colloquially described as a benefit, the total cost of such coverage—even amounts notionally treated as "employer" contributions towards the cost of coverage—translates into an equal reduction in take-home pay.[29] This is critical because it emphasizes that the dollars being spent on health benefits are, in substance, amounts that have been earned by employees in exchange for their labor. Second, health plan premiums represent a significant portion of overall worker compensation,

Gerard F. Anderson, *Hospital Prices for Commercial Plans are Twice Those for Medicare Advantage Plans When Negotiated by the Same Insurer*, 42 HEALTH AFFS. 1110, 1110-11 (2023) (finding that insurers pay significantly more with commercial plans than Medicare Advantage plans for identical services, suggesting that commercial insurance is subject to incentives that may not lead to competitive prices).

27. Jonathan Gruber, *Health Insurance and the Labor Market*, *in* HANDBOOK OF HEALTH ECONOMICS 645, 690 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

28. *See infra* Section I.B.1.

29. *Id.*

especially for lower-wage employees.[30] This explains both why healthcare cost inflation, reflected in increases in insurance premiums, has significantly eroded worker take-home pay and the urgency in forcing greater conservation of employee benefit dollars.[31] And third, much of the American healthcare market, which consumes nearly one-fifth of the entire domestic economy,[32] is financed through employer-sponsored plans. If employers were to demand more value from their healthcare expenditures, the market should operate more efficiently for all purchasers, thereby creating more value for employees and substantial welfare gains for the entire American economy. It represents a policy opportunity at an enormous scale.

In Part III, we make the case for how and why the Department of Labor can, and urgently should, exercise its authority under ERISA to require employers to be better custodians of employee health dollars. We begin by reviewing the nascent litigation in this space, explore preliminary lessons from these early suits, and identify why they establish the need for industry-wide regulations. Consistent with existing statutory duties, we argue that the Department of Labor should provide specific guidance to employers that requires consideration of medical provider cost and quality, along with other relevant factors, as part of the existing duty of prudence owed to plan participants. We further propose that the Department of Labor should offer an incentive in the form of a regulatory safe harbor for employers who select at least one plan option that maximizes clinical quality while minimizing cost through the use of a high-value provider network.

While an employer-based system of health insurance may not be anyone's ideal for financing a national healthcare system, ERISA offers an untapped mechanism to improve the U.S. health system as we find it. Our proposal offers a clear path to improving how healthcare is purchased by the nation's most important purchasers, and how such improvements will increase the quality and value of health benefits, worker take-home pay, and the performance of U.S. healthcare markets.

30. Sam Hughes, Emily Gee & Nicole Rapfogel, *Health Insurance Costs Are Squeezing Workers and Employers*, CTR. FOR AM. PROGRESS (Nov. 29, 2022), https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers [https://perma.cc/MWE8-GHKY].

31. Health plan premium growth has far outpaced inflation and wage growth over time. *See Employer Health Benefits 2023 Annual Survey*, KAISER FAM. FOUND., 41-42 (2023), https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf [https://perma.cc/HXQ6-CTBP].

32. *National Health Expenditure Fact Sheet*, CTR. FOR MEDICARE & MEDICAID SERV (2024), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet [https://perma.cc/K8RQ-KA4D].

I. ERISA's Inconsistent Application to Retirement and Health Benefits

ERISA applies to all categories of employee benefit plans.[33] Aside from some notable exclusions for plans offered by governmental and church employers,[34] the statute applies "to any employee benefit plan if it is established or maintained by any employer [or] by any employee organization or organizations representing employees."[35] The plain language squarely includes health insurance benefits as it does retirement benefits, and it is clear that Congress intended the bill to apply to both types of plans.[36]

When it comes to fiduciary duties, however, the parity ends there. In the decades following ERISA's enactment, its fiduciary duties have been expounded, interpreted, and implemented in the retirement plan context, where rulemaking and enforcement have produced significant improvements for plan participants, but they have not been applied to health plans in any meaningful sense. This Part begins with a brief overview of ERISA's general fiduciary standards and then describes the divergent paths of health and retirement plan fiduciary duties.

A. ERISA's Fiduciary Standards

ERISA's fiduciary provisions are grounded in the common law of trusts,[37] and ERISA's drafters intended to "apply rules and remedies similar to those under traditional trust law to govern the conduct of fiduciaries."[38] This approach to fiduciary duties makes sense given the legislative focus on traditional pension plans, which are funded through employer contributions with assets held in trust for the benefit of plan participants. These common law trust duties focus on protecting plan assets and ensuring that trustees do not use such funds for their own benefit or to their own advantage.[39] The statute was a predictable response to well-

33. 29 U.S.C. § 1003(a) (2018).

34. *Id.* § 1003(b).

35. *Id.* § 1003(a).

36. *See* 29 U.S.C. § 1001 (declaring ERISA's policy to "protect . . . the interests of participants in employee benefit plans"); *id.* § 1002(3) (defining "employee benefit plan" as an "employee welfare benefit plan or an employee pension benefit plan"); *id.* § 1002(1) (defining an "employee welfare benefit plan" to include a plan that provides "medical, surgical, or hospital care or benefits"); *see also* Dana Muir & Norman Stein, *Two Hats, One Head, No Heart: The Anatomy of the ERISA Settlor/Fiduciary Distinction*, 93 N.C. L. REV. 459, 472 (2015).

37. Beck v. PACE Int'l Union, 551 U.S. 96, 101 (2007) (explaining that the inquiry of whether fiduciary duties are implicated "is aided by the common law of trusts which serves as ERISA's backdrop"); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989) ("ERISA abounds with the language and terminology of trust law.").

38. Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1108 (1988).

39. Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391, 398 (2000). For a critique of ERISA's reliance on common law trust duties, see Natalya Shnitser, *Trusts No More: Rethinking the Regulation of Retirement Savings in the United States*, 2016 B.Y.U. L. REV. 629.

publicized instances of employers flouting these fiduciary obligations by mismanaging employee retirement funds or executing deals that brought personal gain.[40]

ERISA specifies that plan fiduciaries owe the plan both a duty of loyalty and a duty of prudence.[41] The duty of loyalty requires a fiduciary to act "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits . . . and defraying reasonable expenses of administering the plan."[42] The duty of loyalty is interpreted to prevent self-dealing on the part of plan fiduciaries, and operates to prevent employers from using benefit plan assets for their own purposes. An employer may not, for example, divert retirement plan contributions or health plan premiums to cover company cash flow, even on a short-term basis.[43] Neither may an employer use plan assets to save company jobs, even if doing so would benefit only plan participants, because the employer's motivation when using plan assets must only concern the provision of *plan* benefits, not any other type of benefit.[44] And an employer may not accept commissions or other kickbacks for placing investments or engaging in contracts with plan funds.[45]

The duty of prudence requires a fiduciary to act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent [person] acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."[46] The duty of prudence is often thought of as a process-based duty. Compliance is generally shown by having in place a robust decision-making process that ensures fiduciaries have access to and consult the relevant information necessary to make plan decisions, and that such decisions are

40. *See* Richard A. Ippolito, *Pension Security: Has ERISA Had Any Effect?,* 1987 AEI J. ON GOV'T & SOC'Y 15, 15 (noting that "ERISA's genesis was the common view that fraud was a pervasive problem in the pension market: firms reduced wages in exchange for pension promises, then failed to honor these obligations"); Alicia H. Munnell, *ERISA: The First Decade – Was the Legislation Consistent with Other National Goals?*, 19 U. MICH. J. L. REFORM 51, 51 (1985) (noting that, prior to the passage of ERISA, some pension plans "were administered in a dishonest, incompetent, or irresponsible" manner).

41. 29 U.S.C. § 1104(a) (2018).

42. *Id.*

43. *See* 29 C.F.R. § 2510.3-102 (2024) (defining employee contributions to employee benefit plans to be "plan assets," and requiring that such amounts be "segregated from the employer's general assets" as soon as reasonably possible).

44. *See* 29 U.S.C. § 1104(a)(1)(A)(i) (2024) (providing that fiduciaries shall discharge their duties "for the exclusive purpose of . . . providing benefits to participants"), which is interpreted by the Department of Labor to refer to *plan* benefits, not general economic or other benefits. *See, e.g.*, Interpretive Bulletin Relating to Investing in Economically Targeted Investments, 29 C.F.R § 2509 (2024). For a critique of this interpretation, see generally David H. Webber, *The Use and Abuse of Labor's Capital*, 89 NYU L. REV. 2106 (2014) (arguing that the fiduciary duty should be owed primarily to the members, beyond merely maximizing returns to funds).

45. *See, e.g.*, Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 590 (8th Cir. 2009) (complaint survived motion to dismiss where plaintiff alleged that revenue-sharing payments were "kickbacks paid by the mutual fund companies in exchange for inclusion of their funds in the Plan").

46. 29 U.S.C. § 1104(a)(1)(B) (2024).

carefully considered.[47] A fiduciary may not have "a pure heart and an empty head."[48] However, the duty of prudence is evaluated based on "'the circumstances . . . prevailing' at the time the fiduciary acts,"[49] not based on the soundness of the decision's outcome in hindsight. In interpreting this standard, the Supreme Court has noted that "[a]t times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise."[50]

The duty of prudence is implicated in all fiduciary decision-making, including the selection of service providers and investments, the monitoring of such investments and vendors on an ongoing basis, and ensuring adequately trained staff to field plan-related questions.[51] Fiduciaries are expected to consult outside experts to inform their decisions where the circumstances warrant, but they may not blindly rely on expert advice. As the Court of Appeals for the Third Circuit has explained, "While we would encourage fiduciaries to retain the services of consultants when they need outside assistance to make prudent investments and do not expect fiduciaries to duplicate their advisers' investigative efforts, we believe that ERISA's duty to investigate requires fiduciaries to review the data a consultant gathers, to assess its significance and to supplement it where necessary."[52]

B. ERISA's Protection of Retirement Benefits

ERISA's fiduciary duties have been readily applied to retirement plans. The Department of Labor has been actively engaged in rulemaking to detail and clarify how fiduciary duties apply to such plans, and there have been many waves of private enforcement holding retirement plan managers to ERISA's standards. The resulting body of law and administrative guidance offer useful counsel in the selection of retirement plan investments and a diverse range of related topics, such as investment policies, proxy voting, the selection and monitoring of service providers, disclosure of fee sharing arrangements, the purchase of annuities for

47. EMPLOYEE BENEFITS LAW, ch. 10, § IV.B.1 (Russell L. Hirschhorn ed., 2022) (ebook); *see also* Wildman v. Am. Century Serv., 362 F. Supp. 3d 685 (W.D. Mo. 2019) (finding no breach of the duty of prudence where fiduciaries took into account all relevant information and relied on a set of "best practice" procedures to carefully reason to a decision).

48. Donovan v. Cunningham, 716 F.2d 1455, 1467 (5th Cir. 1983).

49. Fifth Third Bancorp v. Dudenhoeffer, 573 U.S. 409, 425 (2014).

50. Hughes v. Northwestern University, 595 U.S. 170, 177 (2022).

51. GIW Indus., Inc. v. Trevor, Stewart, Burton & Jacobsen, Inc., 895 F.2d 729, 732-33 (11th Cir. 1990); Griggs v. E.I. DuPont de Nemours & Co., 237 F.3d 371, 380 (discussing the fiduciary responsibility to provide "complete and accurate information" to participants upon request, or where silence itself might be harmful).

52. In re Unisys Sav. Plan Litig., 74 F.3d 420, 435 (3d Cir. 1996); *see also* Howard v. Shay, 100 F.3d 1484, 1489 (9th Cir. 1996) (noting that, while the use of an independent expert is evidence of a thorough investigation, "it is not a complete defense to a charge of imprudence").

terminating plans, and the selection of lifetime income providers.[53] As we detail below, regulation of retirement plan fiduciary duties is not only robust, but it has also been effective in driving plan improvements that benefit employees.

1. Voluminous Regulations and Active Enforcement

In the immediate years following ERISA's enactment, the Department of Labor promulgated several rules addressing ERISA's fiduciary duties as they apply to retirement plans.[54] Because Section 401(k) had not yet been added to the tax code, these early fiduciary duty regulations primarily concerned the fiduciary responsibilities that applied to traditional pension plans, where the employer was solely responsible for funding the plan and investing its assets.[55] This early focus on retirement plan rulemaking makes sense in historical context, given that the catalyzing events for ERISA's passage were well-publicized shortcomings in pension plan management and funding, as well as a brewing crisis in union pensions.[56]

The Department of Labor's most significant and most detailed guidance regarding retirement benefits came in 1979, shortly after the statute's passage, in its issuance of "Investment Duties." These regulations, which have been regularly updated and were amended as recently as 2022,[57] provide guidance on the specific factors that should be considered by a fiduciary when making investment decisions in order to comply with the duty of prudence, and these factors largely reflect modern portfolio theory.[58] The regulations advise fiduciaries to consider not only the risk of

53. *See* 29 C.F.R. §§ 2550.400c-1-408g-2 (2024).

54. *See, e.g.*, 29 C.F.R. §§ 2550.404a-1 (2024) (regulating investment duties, promulgated on June 26, 1979) & 2550.404b-1 (2024) (regulating plan assets held outside the United States, promulgated on October 4, 1977).

55. Section 401(k) was enacted in 1978 with an effective date of 1980, nearly six years after ERISA's enactment. *See* Revenue Act of 1978, Pub. L. No. 95-600, § 135(a), 92 Stat. 2763, 2785 (1978). For an example of early ERISA rulemaking focusing on pension plans, see 29 C.F.R. § 2550.404a-1 (2024) (first promulgated at 44 Fed. Reg. 37225 (June 26, 1979)).

56. Merton C. Bernstein, *ERISA: How It Came to Be; What It Did; What to Do About It*, 6 DREXEL L. REV. 439, 440 (2014); James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 683-84 (2001); EMPLOYEE BENEFITS LAW, *supra* note 47, at ch. 1, § II.

57. Investment Duties, 44 Fed. Reg. 37225 (June 26, 1979) (codified at 29 C.F.R. § 2550.404a-1); Financial Factors in Selecting Plan Investments, 85 Fed. Reg. 72883 (Nov. 13, 2020) (codified at 29 C.F.R. §§ 2509, 2550); Fiduciary Duties Regarding Proxy Voting and Shareholder Rights, 85 Fed. Reg. 81694 (Dec. 16, 2020) (codified at 29 C.F.R. §§ 2509, 2550); Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights, 87 Fed. Reg. 73884 (Dec. 1, 2022) (codified at 29 C.F.R. § 2250).

58. *See generally* Harry Markowitz, *Portfolio Selection*, 7 J. FIN. 77 (1952) (introducing modern portfolio theory). For an examination of the intersection of modern portfolio theory and the duty of prudence, see Stewart E. Sterk, *Rethinking Trust Law Reform: How Prudent Is Modern Prudent Investor Doctrine?,* 95 CORNELL L. REV. 851, 861-62 (2010); Michael T. Johnson, *Speculating on the Efficacy of "Speculation": An Analysis of the Prudent Person's Slipperiest Term of Art in Light of Modern Portfolio Theory*, 48 STAN. L. REV. 419, 420 (1996).

loss and opportunity for gain of a given investment, but also require consideration of how that investment fits in relation to the portfolio as a whole—its diversification, its liquidity and current return relative to anticipated cash flow requirements, and its projected return relative to funding objectives.[59] While some commentators argued that the duty of prudence was an inappropriate vehicle for such guidance given its fact-dependent nature, the Department of Labor took the position that specifying factors to be considered was an appropriate and helpful exercise, and that the regulations were "in the nature of a 'safe harbor'"—providing one method of establishing prudent action, not the exclusive method.[60] Litigation has added additional nuance to the regulations, specifying additional requirements such as the duty to regularly monitor plan investments and remove any imprudent ones.[61]

Retirement-plan fiduciary duty guidance has also kept pace with significant changes in the retirement plan landscape in the decades since ERISA's passage. The most prominent example of this is the Department of Labor's extensive rulemaking on the composition of investment menus in participant-directed Section 401(k) plans,[62] a type of retirement savings plan that was not legally permitted until several years after ERISA became law.[63] In addition to specifying details regarding the investment alternatives that must be available to a participant, the regulations also address required disclosures regarding the investment vehicles and the scope and details of how participants must be permitted to make investment elections.[64] More recently, the Department of Labor has offered guidance on other contemporary issues, such as when and to what extent a retirement plan may consider environmental, social, and governance factors in selecting plan investments,[65] and whether allowing participants to invest retirement savings in cryptocurrency satisfies the duty of prudence.[66]

59. Investment Duties, 44 Fed. Reg. 37225 (June 26, 1979) (codified at 29 C.F.R. § 2550.404a-1).

60. 44 Fed. Reg. 37222 (June 26, 1979) (discussing the regulation codified at 29 C.F.R. § 2550.404a-1 and explaining that "the Department does not view compliance with the provisions . . . as necessarily constituting the exclusive method for satisfying the requirements of the prudence rule").

61. Tibble v. Edison Int'l, 575 U.S. 523, 530 (2015).

62. 29 C.F.R. § 2550.404c-1 (2024).

63. *See* Revenue Act of 1978, Pub. L. No. 95-600, § 135(a), 92 Stat. 2763, 2785 (1978).

64. *Id.*

65. *See* Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights, 87 Fed. Reg. 73822 (Dec. 1, 2022) (codified at 29 C.F.R. § 2550.404A-1); Financial Factors in Selecting Plan Investments, 85 Fed. Reg. 72846 (Nov. 13, 2020) (codified at 29 C.F.R. §§ 2509, 2550); Interpretive Bulletin Relating to Investing in Economically Targeted Investments, 73 Fed. Reg. 61734 (Oct. 17, 2008) (codified at 29 C.F.R. § 2509); Interpretive Bulletin Relating to the Fiduciary Standard Under ERISA in Considering Economically Targeted Investments, 59 Fed. Reg. 32,606 (June 23, 1994) (codified at 29 C.F.R. § 2509).

66. U.S. DEP'T OF LABOR, COMPLIANCE ASSISTANCE RELEASE NO. 2022-01, 401(K) PLAN INVESTMENTS IN "CRYPTOCURRENCIES" 1-3 (March 10, 2022).

In addition to, and perhaps because of, this body of thorough guidance, retirement plan fiduciary duties are frequently litigated, with class actions being commonplace.[67] While these legal challenges take many different forms, two common types of claims involve concerns that are readily applicable to the health benefits context: claims that the administrative fees charged by the plan's recordkeeper are unreasonable, and claims that plan fiduciaries have selected an imprudent investment menu for a participant-directed retirement plan. Administrative fee cases typically rest on Department of Labor guidance that the fees charged by a service provider must be reasonable in light of the service provided.[68] Success in these cases often turns on the ability to establish that the recordkeeping fees paid by the plan exceeded those of plans of comparable size given the level of services provided.[69]

In cases challenging the selection of a plan's investment menu, plaintiffs often challenge the inclusion of high-cost retail level funds when identical or substantially similar, lower-cost institutional class funds are available.[70] Similar claims have challenged the selection of higher-cost actively managed funds over lower-cost passively managed funds.[71] These lawsuits have often been successful and have led in many cases to large settlements.[72]

67. *See* Jacklyn Wille, *Flood of 401(k) Fee Lawsuits Spur Wave of Early Plaintiff Wins*, BLOOMBERG L. (Apr. 5, 2022), https://news.bloomberglaw.com/employee-benefits/flood-of-401k-fee-lawsuits-spur-wave-of-early-plaintiff-wins [https://perma.cc/ZK4Y-HH9H] (finding that more than 170 such lawsuits had been filed since 2020); *see also* George S. Mellman & Geoffrey T. Sanzenbacher, *401(k) Lawsuits: What are the Causes and Consequences?*, BOSTON COLLEGE CENTER FOR RETIREMENT RESEARCH, 2 (May 2018), https://crr.bc.edu/wp-content/uploads/2018/04/IB_18-8.pdf [https://perma.cc/H487-JCPT] (showing prevalence of 401(k)-related lawsuits from 2006-2017). Similar dynamics can be seen in the higher education sector, which has experienced a wave of class action lawsuits related to section 403(b) plan management. *See* John Morahan & Aaron Turner, *Retirement Plan Lawsuits: Preparing for the Storm*, NEW ENG. J. HIGHER EDUC. (2017), https://nebhe.org/journal/retirement-plan-lawsuits-preparing-for-the-storm [https://perma.cc/3JXJ-GX3L]; Jose Martin Jara, *ERISA: Thou Shall Not Pay Excessive Fees!*, AM. BAR ASS'N (Mar. 1, 2019), https://www.americanbar.org/groups/real_property_trust_estate/resources/ereport/2018-2022/erisa-thou-shall-not-pay-excessive-fees [https://perma.cc/46C5-NV4W].

68. *See, e.g.*, Smith v. CommonSpirit Health, 37 F.4th 1160, 1169 (6th Cir. 2022); Larson v. Allina Health System, 350 F.Supp.3d 780, 803-04 (D. Minn. 2018); Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 600-01 (8th Cir. 2009); Matney v. Barrick Gold of North America, 80 F.4th 1136, 1145 (10th Cir. 2023).

69. *See, e.g.*, *CommonSpirit Health*, 37 F.4th at 1160.

70. *See, e.g.*, Hughes v. Northwestern Univ., 595 U.S. 170, 174 (2022); Forman v. TriHealth, Inc., 40 F.4th 443, 450 (6th Cir. 2022); Gaines v. BDO USA, LLP, 663 F.Supp.3d 821, 826-27 (N.D. Ill. 2023).

71. *See, e.g.*, *CommonSpirit Health*, 37 F.4th at 1161.

72. Wille, *supra* note 67; *see also* Beagan Wilcox Volz & Emily Laermer, *Legal Settlements Squeeze Fees for US Employee Retirement Plans*, FIN. TIMES (May 21, 2017), https://www.ft.com/content/927df5a0-3ca2-11e7-821a-6027b8a20f23 [https://perma.cc/7WZ9-Q728]; Jara, *supra* note 67.

The threat of these private actions—and the class action settlements that can easily deliver attorneys' fees that are six or seven figures[73]—generate robust enforcement and deterrence. Standards articulated by the Department of Labor clearly play a role. Even relatively small differences in fee levels (whether administrative or asset-based) can drive substantial differences in retirement savings when compounded over decades.[74] Employers accordingly are driven to meaningfully invest attention to fiduciary duties and take extra care in monitoring administrative costs, the attractiveness of investment options, and all specific tasks that have attracted attention from regulators and plaintiff's attorneys.

2. Efficiencies Achieved

There is substantial evidence that regulatory guidance and its vigorous enforcement have improved fiduciary decision-making in the retirement plan context and thereby increased the value of retirement benefits. For example, one survey found that the average asset-weighted administrative fee declined from 57 basis points to 46 basis points between 2006 and 2016.[75] Similarly, whereas administrative fee lawsuits against plans in 2020 were typically brought where recordkeeping fees exceeded $35 per participant per year, they now are brought against plans with fees above $20 per participant per year.[76] There is additional evidence that plan fiduciaries have shifted toward lower-cost passively-managed funds, and have become more selective about including specialty asset classes within a plan's investment menu.[77] While participant-level investment decisions

73. *See, e.g.*, Joint Motion for Preliminary Approval of Class Settlement Ex. A at 20, Munro v. Univ. of S. Cal., No. 2:16-cv-06191 (C.D. Cal. Feb. 23, 2023) (requesting $4.3 million in attorneys' fees as part of retirement plan class action settlement); Jacklyn Wille, *Lawyers Seek Fees for $2.6 million Aurora Health Retirement Deal*, BLOOMBERG L. (Feb. 24, 2023), https://news.bloomberglaw.com/employee-benefits/lawyers-seek-fees-for-2-6-million-aurora-health-retirement-deal [https://perma.cc/MA7K-HQMJ] (lawyers seeking $900,000 in fees and litigation costs as part of retirement plan class action settlement agreement).

74. *See, e.g.*, DEP'T OF LABOR, A LOOK AT 401(K) PLAN FEES 2 (Sept., 2019), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/a-look-at-401k-plan-fees.pdf [https://perma.cc/CNF4-PYRE] (explaining that a 1% increase in retirement plan fees will reduce retirement savings by 28% over 35 years). The Supreme Court has held that, in actions involving a breach of fiduciary duty in an individual account plan, the losses suffered can be credited to an individual's account and do not need to be credit to the plan as a whole. LaRue v. DeWolff, Boberg & Assoc., 552 U.S. 248, 256 (2008). The result is that individual plaintiffs may directly benefit where a breach of fiduciary duty and corresponding loss have been established.

75. Mellman & Sanzenbacher, *supra* note 67, at 5-6.

76. Wille, *supra* note 67.

77. Mellman & Sanzenbacher, *supra* note 67, at 4-5. *But see* Ian Ayres & Quinn Curtis, *Beyond Diversification: The Pervasive Problem of Excessive Fees and "Dominated Funds" in 401(k) Plans*, 124 YALE L.J. 1476, 1495-1507 (2015) (providing empirical evidence of suboptimal investment menus and high fees in 401(k) plans).

within 401(k) plans often appear sub-optimal,[78] investment menus in such plans encourage participants to achieve efficient and diversified portfolios,[79] making plans with investment options superior to non-plan options or chance.[80]

Anecdotal evidence also supports the hypothesis that regulation and litigation have driven improvements in proactive fiduciary compliance. Several publications, with titles such as "The War on Retirement Fees: Is Anyone Safe?" offer guidance to plan fiduciaries, advising them to put in place sound governance structures, review plan investments and fee arrangements regularly, and negotiate fees "early and often."[81] While plan fiduciaries are understandably unenthusiastic about the prevalence of litigation in this area, the consensus appears to be that vigorous enforcement of fiduciary standards have driven real improvements for retirement plan participants.[82]

C. ERISA's Failure to Regulate or Enforce Health Plan Fiduciary Duties

Whereas ERISA rulemaking, scrutiny, and enforcement have been robust regarding retirement benefits managers, and whereas such regulatory efforts appear to have meaningfully improved retirement plan quality and value, there both has been little effort to ensure that health benefits managers are held to their fiduciary obligations and little evidence that those managers have acted prudently. Indeed, there is sparse

78. *See, e.g.*, ALICIA H. MUNNELL & ANNIKA SUNDÉN, COMING UP SHORT, THE CHALLENGE OF 401(K) PLANS 68-94 (2004); Gary R. Mottola & Stephen P. Utkus, *Red, Yellow, and Green: Measuring the Quality of 401(k) Portfolio Choices*, *in* OVERCOMING THE SAVINGS SLUMP: HOW TO INCREASE THE EFFECTIVENESS OF FINANCIAL EDUCATION AND SAVINGS PROGRAMS 119 (Annamaria Lusardi ed., 2009).

79. Ning Tang, Mitchell, Olivia S. Mitchell, Gary R. Mottola & Stephen P. Utkus, *The Efficiency of Sponsor and Participant Portfolio Choices in 401(k) Plans*, 94 J. PUB. ECON. 1073, 1083 (2010).

80. Keith C. Brown & W. Van Harlow, *How Good Are the Investment Options Provided by Defined Contribution Plan Sponsors?*, 1 INTL. J. PORTFOLIO ANALYSIS & MGMT. 3, 27-28 (2012).

81. Steven J. Friedman, Susan Katz Hoffman & Ellen N. Sueda, *Steps Every 401(k) Fiduciary Should Take to Avoid Participant Lawsuits*, 11 J. RETIREMENT PLAN. 11, 14 (2008); *see also Reducing Your 401(k) Litigation Risks – 10 Questions Employers Need to Ask ASAP*, FISHER PHILLIPS (Oct. 14, 2022), https://www.fisherphillips.com/news-insights/reducing-401k-litigation-risks-10-questions-employers-ask-asap.html [https://perma.cc/5T7B-7L4B] (suggesting employers should verify, among other things, that the fiduciary committee confirm that it is using the lowest fee alternative for each investment option); Alison L. Martin & Lars C. Golumbic, *The War on Retirement Fees: Is Anyone Safe?*, https://www.chubb.com/content/dam/chubb-sites/chubb-com/us-en/global/global/documents/pdf/2020-05.06-17-01-0271-war-on-retirement-plan-fees.pdf [https://perma.cc/TU6N-KCWW] (offering various tips to reduce the likelihood of facing an excessive fee claim, such as retaining qualified independent experts to advise on fee levels).

82. *But see* Mellman & Sanzenbacher, *supra* note 67, at 6 (expressing concern that fiduciary duty litigation may result in fiduciaries becoming sub-optimally conservative in their decision-making, potentially resulting in a loss of gains from innovation). For several arguments regarding the ineffectiveness of ERISA's fiduciary standards and resulting litigation, see generally Ayres & Curtis, *supra* note 77. And for an argument for broader interpretation of retirement plan fiduciary duties, see generally Webber, *supra* note 44.

indication that any legal standards for health plan decision-making have been given any serious consideration by either employers or regulators, even though the statute's plain meaning and intent was to protect employee-earned compensation that came in the form of benefits.

There may be historical explanations for the lack of attention given to this area of law. First, Congress in 1974 was relatively unconcerned with ERISA's impact on health plans because, as one key staffer who was involved in ERISA's passage explained, "there was no crisis in health plans in 1974."[83] At the time, nearly 80% of all employees had health coverage through an employer,[84] and there were few if any perceived problems with such coverage.[85] This was in sharp contrast to retirement benefits at the time, which were plagued by various mismanagement scandals.

Second, health insurance benefits in the 1970s were fundamentally different than they are today. Nearly all employer-provided health benefits at the time were financed through the purchase of insurance contracts,[86] which were subject to state regulation and remained so even after ERISA's passage.[87] In addition, health plans at the time were generally indemnity plans, which simply reimbursed the usual and customary rate for any medically necessary service from any licensed provider.[88] Health plans in the 1970s did not direct medical care or health behaviors as is typical today and did not routinely assume responsibility for managing chronic conditions.[89] Relatedly, national healthcare expenditures were merely 7.8% of national GDP, compared to 17.3% in 2022,[90] and thus did not pose

83. Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century*, *in* EMPLOYEE BENEFITS LAW: AMERICAN BAR ASSOCIATION, EMPLOYEE BENEFITS LAW, lxviii (Steven J. Sacher et al. eds., 2d ed. 2000).

84. Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, 18 HEALTH AFFS. 62, 65 (1999) (documenting that in 1977, 78.2% of employees under age 65 had employer-based health insurance).

85. *See* Gordon, *supra* note 83, at lxviii. (noting that the 1950s and 1960s "brought an unabated stream of coverage and benefits improvements" with no managed care and no evidence of out-of-control medical cost inflation).

86. Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 554 (2013); Laura A. Scofea, *Information Letter 03-13-1986, The Development and Growth of Employer-Provided Health Insurance*, BUREAU OF LAB. STATS. 6-7 (Mar. 1994), https://www.bls.gov/opub/mlr/1994/03/art1full.pdf [https://perma.cc/8VKD-7A2M].

87. 29 U.S.C. § 1144(b)(2)(A) (2024) (exempting state insurance laws from ERISA preemption).

88. INSTITUTE OF MEDICINE, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 71-72 (Marilyn J. Field & Harold T. Shapiro eds., 1993); Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1647 (1992).

89. *See* INSTITUTE OF MEDICINE, *supra* note 88, at 212-16 (describing the evolution of employer cost containment measures over time); Pamela B. Peele, Judith R. Lave, Jeanne T. Black & John H. Evans III, *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 MILLBANK Q. 5, 6 (2000).

90. U.S. Dep't of Health & Hum. Servs., *National Health Expenditures Summary Including Share of GDP, CY 1960-2022*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical [https://perma.cc/J4JL-48TD] (providing data in an Excel file downloadable at the link).

the same threats to household finances or to macroeconomic stability as they do today.

Finally, while it was clear in 1974 how to apply ERISA's core principle—the assignment of fiduciary duties[91]—to ensure proper custodianship of pension plans, its application to healthcare benefits was less clear. The foundational fiduciary duties, such as the prohibition against self-dealing, obligation to make sound investments, and responsibility to act solely in the interest of plan beneficiaries, all had ready and intuitive applications to pension plans. None of these common-sensical prohibitions readily applied to health benefits that rested upon indemnity contracts, but they clearly apply to the health benefits industry of today.

Benefits markets are profoundly different fifty years later. In 2024, American employers are custodians to more annual health insurance dollars than retirement dollars, and the management of health benefits feature opportunities for self-dealing, profligate spending, and misbehavior that the duties of loyalty and prudence are designed to prevent. Thus, the failure to apply ERISA protections to health benefits is now a critical failure. Before detailing the development of the law as it applies to health plan fiduciary duties, we provide a brief overview of the employer health plan decision-making process and the points at which ERISA's existing fiduciary duties apply (even if not currently enforced).

1. Background on Employer Health Plan Decision-making

An employer's decision to offer health benefits to its employees is generally driven by labor market considerations.[92] For example, an employer would evaluate whether it needs to offer health benefits to be competitive with its peers and, relatedly, evaluate whether the employer's workforce values health benefits over an equal amount of cash wages. This initial decision regarding whether to offer a plan is purely a business decision and is not subject to any fiduciary obligations.[93]

91. *See* Natalya Shnitser, *Trusts No More: Rethinking the Regulation of Retirement Savings in the United States*, 2016 BYU L. Rev. 629, 640-43 (2016) (explaining how ERISA's reliance on the common law of trusts was thought to protect defined benefit plan participants from mismanagement); Peter J. Wiedenbeck, *Untrustworthy: ERISA's Eroded Fiduciary Law*, 59 WM. & MARY L. REV. 1007, 1010 (2018) (explaining that the "imposition of . . . fiduciary standards . . . rapidly rose to doctrinal and rhetorical prominence" after ERISA's passage).

92. *See generally* Jon B. Christianson & Sally Trude, *Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets*, 38 HEALTH SERV. RES. 357 (2003) (a six-year observational study finding that a "tight labor market" during the period under investigation was the key in decision making about employee health benefits); AMERICA'S HEALTH INSURANCE PLANS, THE VALUE OF EMPLOYER-PROVIDED COVERAGE IN 2023 (2023), https://www.ahip.org/resources/the-value-of-employer-provided-coverage-in-2023 [https://perma.cc/CWZ8-N46R] (reporting results of employee survey where 68% stated that their employer's health plan played a role in recruiting them, and 77% reported that the health plan has an impact on the employee's choice to stay in their current job).

93. *See* Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995) (recognizing that, under ERISA, an employer is generally free to "adopt, modify, or terminate" a plan at any time

Once the decision to offer a health plan has been made, the employer must decide how to finance those benefits. The two primary choices are purchasing a group insurance contract, where the financial risk associated with paying claims is transferred to an insurance company, or self-insuring benefits, where the employer pays claims out of its own assets. Employers are again free to make this financing decision based on business criteria, not fiduciary obligation.

The next decision for the employer is to select an insurer (if purchasing an insurance contract) or a third-party administrator (TPA) (if self-insuring) to operate the plan. The TPA is generally an insurance company that is willing to provide the administrative services for the health plan without taking on the risk-shifting function of insuring the benefits itself. TPAs typically charge a fixed per member per month fee for their services,[94] while the employer retains liability for paying the underlying claim expenses. (For ease of reference, we refer to these roles collectively as that of a "health plan administrator" or simply "administrator" and intend such term to capture both insured and self-insured plans). An employer's selection of a health plan administrator is a fiduciary act,[95] and therefore an employer must select the service provider solely in the best interests of plan participants and with the requisite care, skill, and prudence. The employer must research and consider all information relevant to selecting an administrator, and once selected, the employer has a further fiduciary duty to continually monitor the performance of the service provider.[96]

The employer's selection of an administrator has outsized significance on a health plan's ability to achieve its core purposes. When an employer selects a health plan administrator, one of the primary services the employer is purchasing is the administrator's network of medical providers and, with it, the reimbursement rates the administrator has negotiated with

and for any reason). This distinction between business decisions and fiduciary actions is not explicitly mentioned in statute; the distinction was first noted in a 1986 Department of Labor information letter. Information Letter 03-13-1986 from Dennis M. Kass, Assistant Sec'y, Dep't of Labor, to John N. Erlenborn, (Mar. 13, 1986), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/03-13-1986 [https://perma.cc/8VKD-7A2M]; *see* Muir & Stein, *supra* note 36, at 478, 487-88 (first quoting Beck v. PACE Int'l Union, 551 U.S. 96, 101-02 (2007); then quoting Hughes Aircraft Co. v. Jacobson, 525 U.S. 432, 444 (1999)). These business decisions are commonly referred to as "settlor functions" in the ERISA context, further borrowing from the language of trusts. Muir & Stein, *supra* note 36, at 488.

94. *See* Manoj Athavale & Stephen M. Avila, *The Selection of Competing Third Party Administrators*, 37 COMP. & BENEFITS REV. 51, 54 (2005).

95. U.S. DEP'T OF LAB., UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN 4-5 (2023), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf [https://perma.cc/6NWK-4B99]; Information Letter 02-19-1998 from Bette J. Briggs, Chief, Div. of Fiduciary Interpretations, Office of Reguls. & Interpretations, to Diana O. Ceresi, Assoc. Gen. Couns., Serv. Emps. Int'l Union (Feb. 19, 1998), https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/02-19-1998 [https://perma.cc/RLM7-TRS2] (hereinafter "DOL Information Letter").

96. U.S. DEP'T OF LAB., *supra* note 95, at 6.

these providers.[97] Nearly all health plans today either limit coverage to providers who are "in-network" or provide higher levels of coverage for in-network versus out-of-network providers.[98] Gone are the days when a health plan simply paid for any medically necessary care from any licensed provider.[99]

The result is that provider networks have a significant impact on nearly all facets of a health plan's operation. Since the selection of a plan's network amounts to the selection of the physicians that beneficiaries see, the decision has obvious patient-facing considerations regarding the availability of care offered: the provider network will influence or determine where a patient can receive care, the timeliness of that care, and the quality of care. There are also enormous financial implications associated with the structure and makeup of a provider network. In general, the broader a network is, the higher its reimbursement rates to providers will be, based on the assumption that providers in a broader network will see lower patient volume and therefore must charge higher rates.[100] Conversely, narrow networks typically have lower provider reimbursement rates because narrow network providers can be assured of a greater patient volume, and are willing to agree to lower reimbursement rates as a result.[101] These tradeoffs are central in assessing the value of any selected network.

Provider quality is also an important network component. While some networks seek to maximize quality of care, others seek to maximize value by including providers who deliver the best clinical outcomes at the lowest cost.[102] A prudent fiduciary, then, should carefully consider the provider network when selecting a service provider and understand the adequacy and clinical quality of the network. There is a clear analog between network choice for a health plan and an employer's selection of a retirement plan investment menu. Just as the underlying investments offered by a retirement plan determine the plan's ability to achieve its core

97. The choice of an administrator also implicates important compliance and customer service functions. The administrator is responsible for accurately communicating information about the plan to participants and must process claims promptly and accurately. The administrator should also have audit procedures in place to ensure oversight of major functions. While these functions are each important, we focus on provider network given its unique systemic effects.

98. *See* Employer Health Benefits 2023 Annual Survey, *supra* note 31, at 84, 85 fig. 5.1 (2023) (finding that only 1% of covered employees are enrolled in a "conventional" or indemnity plan that does not rely on a preferred network of providers).

99. *See generally* Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. R. 423 (2022) (documenting the various methods by which health plans limit or otherwise control coverage terms).

100. *See* Leemore S. Dafny, Igal Hendel, Victoria Marone & Christopher Ody, *Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth*, 36 HEALTH AFFS. 1606, 1607 (2017) (explaining that narrow-network plans can negotiate lower prices and lower reimbursement rates from providers because they provide greater patient volume and because they can threaten to exclude inefficient providers).

101. *See id.* at 1607, 1610-11.

102. JAMES T. O'CONNOR & JULIET M. SPECTOR, HIGH-VALUE HEALTHCARE PROVIDER NETWORKS 4-5 (2014).

purposes, so, too, does the selection of an administrator determine the ability of a health plan to achieve its core purpose of financing medical care.

Despite the importance of all these decisions to the success of a health plan, and despite the fact that such decisions are already subject to fiduciary standards, these decisions have to date received a shocking lack of regulatory attention and enforcement.

2. Little Guidance, Little Enforcement, Little Action

Even though the selection of a health plan service provider is functionally no different than the selection of a retirement plan custodian or retirement plan investment options, the Department of Labor has not engaged in any rulemaking addressing health plan fiduciary duties. To date, the only guidance regarding health plan fiduciary duties has constituted a single information letter[103] and a single employer pamphlet[104] describing the application of ERISA's fiduciary duties to health plans.

The clearest statement from the Department of Labor on health plan fiduciary duties came in 1998 with an information letter issued in response to a question from a union. The union asked whether it would be appropriate for a trustee of an ERISA health plan to "consider quality in the selection of health care services,"[105] and specifically whether it was permitted to prioritize quality over cost when contracting with or selecting among providers and plans.[106] In response, the Department first clarified that the selection of a "health care provider" for a plan is indeed a fiduciary act subject to fiduciary duties.[107] From there, the Department emphasized the importance of an "objective process" designed to carefully review the provider's qualifications, including the "quality of services offered, and the reasonableness of the fees charged in light of the services provided."[108] The letter emphasized that plans do not need to accept the lowest bidder for health services, and explicitly stated that "a plan fiduciary's failure to take quality of [health care] services into account" in selecting a health service provider "would constitute a breach of the fiduciary's duty under ERISA when . . . the selection involves the disposition of plan assets."[109]

103. *See* DOL Information Letter, *supra* note 95.

104. *See* U.S. DEP'T OF LAB., *supra* note 95.

105. DOL Information Letter, *supra* note 95; *see also* 75 Fed. Reg. 41603 (July 16, 2010) (Department of Labor states in preamble to retirement plan fee regulations that, while the regulations do not address health plans, ERISA § 404(a) "continues to obligate" health plan fiduciaries to "obtain and consider information relating to the cost of plan services and potential conflicts of interest.").

106. DOL Information Letter, *supra* note 95.

107. *Id*.

108. *Id*.

109. *Id*.

This 1998 guidance has been reinforced in the ensuing years but has not been promulgated more formally. Moreover, the Department has intentionally passed on opportunities to expound on its 1998 letter. In 2019 and again in 2023, for example, the Department of Labor published a compliance document for employers, *Understanding Your Fiduciary Responsibilities Under a Group Health Plan*.[110] The document explicitly states that fiduciary duties attach to the selection of any plan service provider, and further that employers are required to monitor the ongoing performance of any service provider "at reasonable intervals" through a formal review process.[111] The employer is also instructed to ensure that any fees charged by plan service providers are reasonable.[112] Notably, the document makes no effort to explicate what conduct amounts to compliance with or a violation of ERISA fiduciary duties.

The document similarly offers little specificity in guiding how plan administrators are to select among health plan service providers, which, as was noted above, is a critical decision that significantly determines the quality of the health benefits. Instead, the compliance document focuses only on the need for uniform evaluation criteria and on documenting the selection process.[113] Employers are advised to provide potential service providers with identical information about the plan and the services sought, and in return the service providers should each be asked to provide identical types of information.[114] Employers are instructed to, among other things, evaluate the quality of each firm's services, including the identity, experience, and qualifications of professionals who will be handling the plan or providing medical services, but they are not given any further guidance on how to complete such an evaluation, nor are they provided with definitions of key terms like "quality."[115] Moreover, since this guidance comes as an informal publication, it even lacks the force of law of formal rulemaking.

This regulatory inattention could be partially excused if the Department of Labor took other measures to safeguard health benefit dollars, but the Department has also been an inactive enforcer when it comes to health plans. While the Department of Labor regularly initiates actions that fall broadly within health plan fiduciary duties,[116] we have

110. U.S. DEP'T OF LABOR, *supra* note 95; U.S. DEP'T OF LAB., UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN (2019) (on file with authors).

111. U.S. DEP'T OF LABOR, *supra* note 95, at 6.

112. *Id.* at 5.

113. *See id.* at 4-5.

114. *Id.*

115. *Id.*

116. For example, the Department of Labor regularly pursues action against health plan fiduciaries that have withheld health plan premiums from employee wages but failed to use the collected funds to actually pay for health plan coverage. *See, e.g.*, Perez v. Harris, No. 12-3136, 2015 WL 12990189, at *1 (D. Minn. Jan. 14, 2015); Acosta v. Air LLC, No. 18-cv-235, 2019 WL 4670189, at *2 (W.D. Wisc. Sept. 25, 2019); Scalia v. Marzett, No. 1:19-cv-1164, 2020 WL 4365535, at *1 (E.D. Va. July 30, 2020).

located only a single case in which the Department of Labor pursued a breach of fiduciary duty claim challenging the selection of a health plan service provider.[117] In 2015, the Department of Labor initiated litigation alleging, among other things, that health plan fiduciaries paid excessive fees to the health plan's third party administrator and broker and failed to loyally and prudently administer the plan.[118] The court ruled against the Department of Labor on both issues, finding that the employer had "monitored the effectiveness of the TPA, regularly reviewing and evaluating options and alternatives."[119] Before selecting their TPA, the employer "engaged in an adequate investigative process, including contacting other organizations in similar circumstances and being informed that [the TPA] was a reputable, credible, and effective health and welfare plan manager."[120] The employer also periodically contacted peer organizations "to gauge whether the value they were receiving was reasonable in comparison to the fees they were paying."[121] The Department of Labor presented evidence showing that the plan's administrative expenses exceeded those of relevant benchmarks in the years at issue.[122] However, the defendant's expert used a different benchmarking methodology, which found that the plan's fees were within the 60 to 90% range of peers, and the court ultimately found the defense expert more persuasive.[123] The court noted that "ERISA does not require a fiduciary to 'scour the market' to find and offer the cheapest possible deal for participants"[124] and concluded that, compared to a prudent plan administrator under the same circumstances, the defendants acted prudently.[125]

Perhaps not surprisingly, given the Department of Labor's lack of formal rulemaking and lack of enforcement leadership, there is little private enforcement as well. In particular, our research discovered almost no enforcement of the Department of Labor's stated position that employers must consider both cost and quality in selecting health plan providers. There have been a small number of cases brought by private parties that have alleged a breach of fiduciary duty related to the

117. The Department of Labor has, however, brought breach of fiduciary duty claims against other types of welfare plans. *See, e.g.*, Secretary v. United Transp. Union, No. 1:17 CV 923, 2020 WL 1611789, at *2 (N.D. Ohio Mar. 30, 2020) (alleging disability plan trustees breached their fiduciary duty and engaged in prohibited self-dealing transactions).

118. *Acosta*, 2019 WL 931710, at *1-2.

119. *Id.* at *6.

120. *Id.*

121. *Id.* at *7.

122. *Id.* at *11.

123. *Id.* at *12.

124. *Id.* at *19.

125. *Id.* The Department of Labor also charged the defendants with self-dealing, alleging that the third-party administrator had made charitable contributions to the plan sponsor in return for being awarded the contract. The court found in favor of the defendants on this issue as well. *Id*. at *10-11.

management or administration of a health plan, but none other than the very recent cases described in Part III.A have been brought by a participant to challenge the employer's selection of a plan administrator. Other fiduciary lawsuits have been brought by health plan participants challenging aspects of plan design,[126] and by employers challenging administrator negotiations of provider rates[127] and fraudulent billing practices,[128] but those have generally been unsuccessful.

The lack of either public or private enforcement has many likely causes, but it seems highly probable that a lack of detailed regulatory guidance makes it difficult for any potential enforcer to make their case effectively. Moreover, health plan fiduciary lawsuits encounter additional barriers within the normal mechanism of litigation. Plan participants, who have a private cause of action for breach of fiduciary duty under ERISA, are unlikely to be in a position to evaluate the merits of a potential case prior to initiating litigation and discovery. Unlike retirement plan actions, where it is relatively simple to examine a plan's investment offerings and fees compared to what is available on the market, health plan fees are generally subject to an individualized bidding process. In part, this is because insurers treat negotiated provider reimbursement rates as confidential,[129] and because the size and composition of an employer's workforce typically affects pricing. A potential litigant cannot simply look up what competing insurers or administrators would have offered the employer plan. This issue is further exacerbated by the fact that there is no formal guidance on the information employers should consider, nor guidance on how employers should weigh cost and quality, along with the fact that the duty of prudence is largely process-based. The result is that a potential plaintiff may need to spend significant funds to determine if a viable claim exists. And ERISA's remedial limitations may make that type

126. For example, a lawsuit brought by plan participants who were charged a prescription drug copay that exceeded the actual cost of the drug was unsuccessful because they were complaining about plan design, a settlor function, not a fiduciary action. Alves v. Harvard Pilgrim Health Care Inc., 204 F. Supp. 2d 198, 210 (D. Mass. 2002), *aff'd*, 316 F.3d 290 (1st Cir. 2003) (finding no breach of fiduciary duty where prescription drug copays sometimes exceeded the drug's cost, because "there can be no breach of fiduciary duty where an ERISA plan is implemented according to its written, nondiscretionary terms"). Similarly, kickbacks paid out of health plan premiums to a local chamber of commerce were not governed by fiduciary rules because the premiums were agreed to in an arm's length transaction and what the insurance company chose to do with those premiums was not governed by ERISA's fiduciary duties. Depot, Inc. v. Caring for Montanans, 915 F.3d 643, 654-55 (9th Cir. 2019).

127. DeLuca v. Blue Cross Blue Shield of Mich., 628 F.3d 743, 747 (6th Cir. 2010) (holding that an insurer's rate negotiations where not fiduciary in nature because they were not specific to the individual employer's plan, but were instead applicable to insurer's entire book of business). While acknowledging that an individual is acting as a fiduciary when they engage in plan "management" or "administration," the court held that rate negotiation is "a business decision that has an effect on an ERISA plan [and is therefore] not subject to fiduciary standards." *Id.*

128. Peters v. Aetna, 2 F.4th 199, 210 (4th Cir. 2021) (alleging that self-insured plan's third-party administrator set up a dummy billing code to impermissibly pass administrative costs along to plan participants).

129. Michael Batty & Benedict Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFFS. 689, 694 (2017).

of investment unattractive for plan participants and even plaintiffs' counsel.[130]

Regardless of the precise cause, the past of low enforcement activity has coincided with little evidence that employers abide by their fiduciary duties with any meaningful rigor, as we discuss in Part II. Perhaps for this very reason, we might—at last—be on the verge of an upswing in litigation. We have found only two cases where a plan participant has attempted to challenge their employer's selection of a health plan administrator, with the first case filed mere days before this Article was submitted for publication, and the second while the Article was in production.[131] We review the current litigation in more detail in Part III, below.

3. ERISA Preemption and Its Restraints on States' Efforts to Improve Employer Health Plans

With the lack of federal rulemaking and enforcement just described, one might wonder why states have not stepped in to help protect employees. The answer is found in ERISA's broad preemption of state law, which effectively makes the federal government the only actor that can implement employer plan reforms. ERISA's preemption of any state law that "relates to" an employee benefit plan was part of ERISA's grand legislative bargain, a feature that was reportedly necessary to secure the bill's passage.[132] The practical result is that states are essentially powerless to compel employers to be better stewards of employee health plan dollars.[133] As a result, the current lack of federal rulemaking or enforcement around health plan fiduciary duties, combined with preemption of any state efforts to address the lack of federal action, has

130. While ERISA's remedial provisions are notoriously complex, it is sufficient for our purposes to note that there are two avenues of relief available for health plan participants. In the first, relief is sought under section 502(a)(2), where any recovery goes to the plan itself, not individual participants. Relief under this section could still benefit plan participants in the form of lowered premiums going forward, but such relief would not be automatic or direct. Plaintiffs' attorneys could, however, recover their fees in most cases if the action is successful, but such fee shifting is not automatic. *See* 29 U.S.C. § 1132(g). Participants could also seek relief under section 502(a)(3), but that section allows only those types of remedies that were typically available in a court of equity, such as injunction, mandamus, and restitution. Traditional money damages are therefore not available. Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc., 530 U.S. 238, 239-40 (2000).

131. Lewandowski v. Johnson & Johnson, No. 24-CV-00671 (D.N.J. filed Feb. 5, 2024), discussed *infra* in Section III.A; Navarro v. Wells Fargo & Co., No. 0:24-CV-03043 (D. Minn. filed July 30, 2024).

132. *See* Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109, 112-13 (1985).

133. *See, e.g.*, Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 401-10 (2020) (explaining the various ways in which ERISA preemption stands as an obstacle to state single-payer systems).

created what is commonly referred to in ERISA jurisprudence as "a regulatory vacuum."[134]

While ERISA allows states to regulate insurance,[135] that authority has its limits. States can (and do) regulate which insurance products may be offered for sale, specify contractual terms required to be included in insurance contracts, impose network adequacy standards, and regulate premiums and certain aspects of claims procedures. A state could not, however, place any legal requirements on employers when it comes to health plan design or the selection of an administrator, even when the administrator is also acting as an insurer.[136] Such actions are clearly and completely preempted by ERISA.

In addition, even if a state could cleverly devise an insurance regulation aimed at improving employer health plans that survives ERISA preemption, employers can easily avoid any such regulation by electing to self-insure their health plans.[137] ERISA explicitly provides that self-insured plans may not be regulated through state insurance regulation.[138] And while self-insurance may appear too large or volatile a risk for many employers to absorb, there is stop-loss insurance coverage easily available in most states that allows an employer to remain technically self-insured, while protecting itself from large medical plan losses.[139] In fact, the vast majority of large employers prefer self-insuring, and a majority of all employees with ESI have self-insured plans.[140]

In what could be a bitter irony, it is untrue to say that there has been no litigation regarding ERISA's application to health benefits. In fact, many lawsuits have been successfully brought by employers challenging the application of various state health care reform efforts to ERISA-

134. *See, e.g.*, Aetna Health v. Davila, 542 U.S. 200, 222 (Ginsburg, J., concurring) (internal citation omitted).

135. 29 U.S.C. § 1144(b)(2)(A) (2018) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . .").

136. New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995) (noting that ERISA preempts state laws that mandate "employee benefit structures or their administration").

137. 29 U.S.C. § 1144(b)(2)(B) (2018) (preventing states from regulating self-insured plans under the guise of state insurance law). 65% of all workers covered by an employer plan are covered by a self-insured plan. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 168. Nearly all large firms (93%) self-insure their health benefits, while rates of self-insurance among the smallest firms have increased somewhat from 13% in 1999 to 18% in 2023. *Id.* at 152.

138. 29 U.S.C. § 1144(b)(2)(B) (2018); *see also* Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 91, 97 (2005).

139. *See* Timothy Stoltzfus Jost & Mark A. Hall, *Self Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 546-50 (2013) (documenting the growing availability and feasibility of stop loss coverage for even small employers).

140. Frank Diamond, *As Large Employers Back Away from Self-Insurance, Small- and Medium-Sized Ones Embrace It: EBRI*, FIERCE HEALTHCARE (Aug. 31, 2023), https://www.fiercehealthcare.com/payers/large-employers-back-away-self-insurance-small-and-medium-sized-ones-embrace-it-ebri [https://perma.cc/23MR-HKTZ].

regulated health plans.[141] But, because that litigation has focused almost entirely on the preemption of state or local reforms, rather than the development and enforcement of substantive federal obligations, ERISA's role thus far has served only to erode consumer protections for health plan participants. The federal government has not only failed to monitor health benefits as Congress intended, but it has impeded efforts by states to fill the void.

The end result is that, even if a state had the political will to provide greater consumer protections to employer health plan participants—for example by allowing insurers to only offer provider networks that met certain minimum standards for quality or value—they would risk employers simply exiting the insured market and shifting to self-insurance.[142] The only governmental actor with the ability to effectively regulate employer health plans is the federal government.

II. The Regulation and Performance of Employer Health Plans

Employer-provided health plans are the primary financier of American healthcare, making its provision and regulation a central part of the nation's social policy. Although the link between employment and health insurance is now part of the nation's economic fabric, it came about from what has been called an "accident of history."[143] World War II employers started offering health insurance to their workers as a way to evade wage controls, and an IRS ruling shortly afterwards deemed that amounts paid for employer-provided health insurance were not subject to income tax.[144] Thereafter, employer-provided health plans enjoyed a hefty tax subsidy,[145] and human resources managers were suddenly thrust into becoming purchasers of healthcare for a heterogeneous workforce.

141. *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004) (Texas state law imposing liability for negligently processing health plan claims preempted by ERISA); Retail Industry Leaders Ass'n v. Fielder, 475 F.3d 180, 190 (4th Cir. 2007) (Maryland state law imposing tax on large employers that do not spend a minimum amount on employee health care preempted by ERISA); Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 315, 320 (2016) (Vermont state law requiring health plans to report certain information to state all claims payer database preempted by ERISA).

142. *See* Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1371-74 (2007) (discussing the phenomenon of employers electing to self-insure in order to evade state regulatory requirements).

143. Regina Herzlinger & Barak Richman, *Give Employees Cash to Purchase Their Own Insurance*, HARV. BUS. REV. (Dec. 9, 2020), https://hbr.org/2020/12/give-employees-cash-to-purchase-their-own-insurance [https://perma.cc/9JGL-KTSM].

144. CONGRESSIONAL RSCH. SERV., THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE 5 (2011). Such amounts are similarly excluded from state income and payroll taxes. *Id*.

145. I.R.C. §§ 106 (exempting contributions toward employer-provided health insurance from income taxation) and 125 (allowing employees a mechanism to pay their share of health insurance premiums on a pre-tax basis). States that impose an income tax uniformly follow this federal tax treatment.

While the federal government currently forgoes an estimated $262 billion per year in tax revenue to subsidize such coverage,[146] few regulations supervise the substance or quality of such benefits.[147] The lack of regulatory oversight is premised, in part, on the theory that employers act as effective agents for their employees, thereby blunting the need for much market intervention, but the reality is that employee health dollars are not necessarily being spent as those employees would want them spent. Premiums for employer health plans have risen substantially faster than both inflation and wages, and their offerings have become both more limited and subject to higher rates of cost-sharing over time.[148] Further evidence suggests that these cost increases are not just inevitable consequences of market pressures. To the contrary, research into how firms finance and construct their health plans suggest they expend little effort into conserving employee healthcare dollars and invest few resources into tailoring healthcare benefits to meet employee needs and preferences.[149] In other words, evidence from healthcare markets and from

146. The estimated cost of the federal tax expenditure for employer-provided health plans is $262.3 billion in fiscal year 2025, with additional revenue losses at the state level. *Tax Expenditures Fiscal Year 2026*, tbl.1 line 127, U.S. DEPT. TREAS., https://home.treasury.gov/system/files/131/Tax-Expenditures-FY2026.pdf [https://perma.cc/NQ3Y-MXMD]. While few estimates can be found regarding the nationwide cost of state income tax exclusions for employer-provided health benefits, one estimated that, in 2009, the value of such state exclusions was over $30 billion. Jonathan Gruber, *The Tax Exclusion for Employer-Sponsored Health Insurance* 15 (Nat'l Bureau of Econ. Rsch., Working Paper No. 15766, 2010), https://www.nber.org/system/files/working_papers/w15766/w15766.pdf [https://perma.cc/TU3M-HRNA]. Not surprisingly, in states that produce their own tax expenditure reports, the exclusion for employer-provided health care is among the most expensive preference. *See, e.g.*, *Tax Expenditure Report 2023-24* 14, CAL. DEP'T OF FIN. (2024), https://dof.ca.gov/wp-content/uploads/sites/352/2023/10/2023-24TaxExpenditureReport.pdf [https://perma.cc/SRN5-BBHP] (exclusion for employer contributions to health plans estimated to cost $9 billion in 2023-24, the second-highest personal income tax expenditure); *Georgia Tax Expenditure Report for FY 2025*, GA. DEP'T OF AUDITS & ACCOUNTS 9 (2023), https://opb.georgia.gov/budget-information/budget-documents/tax-expenditure-reports [https://perma.cc/FX98-X75H] (exclusion for employer-provided health plans has an estimated cost of $1.45 billion, the second-highest individual income tax expenditure); *State of Minnesota Tax Expenditure Budget Fiscal Years 2022-25*, MINN. DEP'T OF REVENUE 5, 32 (2002), https://www.revenue.state.mn.us/sites/default/files/2022-02/2022%20Tax%20Expenditure%20Budget_0.pdf [https://perma.cc/GTS2-3V83] (approximately $1.6 billion forgone revenue for employer-provided health plans in 2024, also the second-highest individual income tax expenditure).

147. Substantive health plan requirements have been added to ERISA since its passage in 1974 but remain modest in scope. *See* 29 U.S.C. §§ 1161-1191c (2018). More significant requirements were implemented by the Affordable Care Act, such as the requirement to cover preventive services without cost sharing. IRC § 4980H. However, even the Affordable Care Act exempted large employer plans from much of its health insurance regulation. *See* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 146-52 (2011).

148. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 41-42, 112.

149. *See, e.g.*, *id.* at 217 (reporting that employers most commonly plan on addressing high plan costs by "increasing workers' premium contributions" and "increasing cost-sharing," rather than changes that make the plan itself less expensive); *see also* Yiyan Liu & Ginger Zhe Jin, *Employer Contribution and Premium Growth in Health Insurance*, 39 J. HEALTH ECON. 228, 229-30 (2015) (finding that employer policies to partly pay premiums incentivize health plans to increase employer contributions, which in turn contributes to health plan premium growth).

internal firm deliberations suggests that many employers do not satisfy ERISA's requirement to act prudently and solely in their employees' best interest when managing their health benefit plans.

This Part provides a brief introduction to the current state, and the pervasive disappointments, of employer-provided health coverage. We highlight the impact that rising health plan costs have on worker take-home pay, as well as the lack of effective cost containment and the failure to adequately consider quality of care in employer plans. We then examine the mismatch between the task of selecting and managing a health plan administrator and the core competencies of human resources departments, along with various agency costs that impact employer health plan decision-making.

A. The Current State of Employer-Provided Health Coverage

Employer-provided health plans cover nearly 154 million people, or 58% of the entire population and more than 80% of those with private health insurance.[150] By comparison, Medicaid programs cover approximately 61 million people and Medicare covers 3.5 million.[151] It is the dominant form of health insurance coverage even as health insurance exchanges, individual coverage, and Medicaid expansion have caused the market share of employer-based plans to decline.[152]

Many consider employer-provided coverage to be the best-functioning piece of our dysfunctional system of health care finance,[153] but that perception might be due only to historically widespread dysfunction in other private health insurance markets and the fact that ESI hides its true costs. On paper, ESI is paid for by a combination of employer and employee contributions.[154] For example, an employer might require an employee to contribute $150 per month for health plan coverage, with the employer contributing the remaining $500 cost each month. The employee might think of her cost as limited to the $150 that is taken out of her paycheck each month. Economists generally agree, however, that the full cost of ESI—in our example $650 per month—is a compensation expense

150. *Health Insurance Coverage of the Nonelderly 0-64*, KAISER FAMILY FOUND. (2022), https://www.kff.org/other/state-indicator/nonelderly-0-64 [https://perma.cc/K27Q-H2E5] (showing that employer plans cover 58% of the U.S. nonelderly population, and that Medicaid is the second-largest source of coverage, at 23% of the nonelderly population).

151. *Id*.

152. Thomas C. Buchmueller & Robert G. Valletta, *Work, Health, and Insurance: A Shifting Landscape for Employers and Workers Alike*, 36 HEALTH AFFS. 214, 215, 217 (2017) (describing how the expansion of public insurance has reduced "the burden on employers to provide health insurance"). In 2000, 65.1% of all workers were covered by employer-sponsored insurance, compared to 55.7% in 2015. *Id.*

153. *See, e.g.*, Allison K. Hoffman, Howell E. Jackson & Amy B. Monahan, *A Public Option for Employer Health Plans*, 20 YALE J. HEALTH POL'Y L. & ETHICS 299, 311 (2021).

154. *See Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 88.

that reduces wages accordingly.[155] Assume that an employee in our example earns $3,600 per month before taxes. If that employee was not offered health insurance, we would expect her wages to increase by $500 per month, the amount currently contributed by her employer for health insurance, so that she would be paid $4,100 per month before taxes. In other words, total health insurance cost is part of an employee's earned compensation even though the dollars that finance it never fall into the employee's possession. And because the "employer contribution" to such coverage is largely invisible to employees, they are unaware of its impact, including the price of the health insurance they indirectly purchase and its effect on their cash wages.[156]

The costs and affordability of ESI impose enormous challenges for employers and employees alike.[157] In 2023, the average annual premium for employer plans for family coverage was $23,968 (equal to 23% of the median family household income of $102,800) and $8,435 for individual coverage (equal to 17% of median non-family household income of $49,600).[158] While the drivers of these premium levels are complex, they do not appear to be the inevitable consequences of healthcare cost inflation.[159]

155. *See, e.g.*, Gruber, *supra* note 27, at 694 ("[T]he results that attempt to control for worker selection, firm selection, or (ideally) both, have produced a fairly uniform result: the costs of health insurance are fully shifted to wages."); MARK V. PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEALTH INSURANCE 2 (1999) ("[E]mployer payments for health insurance premiums ultimately come out of what would otherwise have been money wages for workers.").

156. Some have argued that, if employees did know the true cost of their health insurance, many would decide to forgo it altogether. *See* Clark Havighurst & Barak Richman, *Who Pays for Health Insurance*, WALL ST. J. (Sept. 6, 2007), https://www.wsj.com/articles/SB118904358759518916 [https://perma.cc/QYM7-22U2]. The Affordable Care Act required employers to report the cost of health insurance to employees in their annual W-2 forms, in Box 12 using Code DD. *See* I.R.C. § 6055(b)(2)(B); Internal Revenue Service, General Instructions for Forms W-2 and W3 23 (2024), https://www.irs.gov/pub/irs-pdf/iw2w3.pdf [https://perma.cc/PUM5-WBK4]. Despite its well intentions, there is little evidence that this end-of-year report on the employee tax form makes employees more knowledgeable or cost-conscious of their health benefits.

157. Among those firms that do not offer health coverage, cost is most often cited as the most important reason for not offering coverage. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 62.

158. Health insurance premium data is available at *id.* at 33. Household median income data is available at Gloria Guzman & Melissa Kollar, *Income in the United States: 2023*, U.S. CENSUS BUREAU 2 fig.1 (Sept. 2024), https://www2.census.gov/library/publications/2024/demo/p60-282.pdf [https://perma.cc/A9UV-43X7].

159. Much of the literature about ESI cost drivers focuses on negotiating power, or the lack thereof. *See, e.g.*, Yang Wang, Mark K. Meiselbach, Jianhui Xu, Ge Bai & Gerard Anderson, *Do Insurers with Greater Market Power Negotiate Consistently Lower Prices for Hospital Care? Evidence from Hospital Price Transparency Data*, 81 MED. CARE RES. & REV. 78, 82 (2024) (finding that the largest insurers negotiated significantly lower hospital prices for "shoppable" services, but more modest discounts for emergency room visits); Anthony T. LoSasso, Kevin Toczydlowski & Yanchao Yang, *Insurer Market Power and Hospital Prices in the US*, 42 HEALTH AFFS. 615, 620 (2023) (finding that the market-leading insurer in the most concentrated insurance market pays 15% less to hospitals than the market-leading insurer in the least concentrated insurance market, but noting the lack of evidence that insurers pass along these savings to

Medicare payments to hospitals, which are calculated based on an accounting of costs, have remained much more stable over the past twenty years, whereas prices paid by private health insurers have rocketed upward. From 1996-2001, private insurers paid hospitals approximately 10% more than Medicare, but in 2012 private plans paid 75% more,[160] and the most recent data suggests that private plans now pay 224% of what Medicare pays hospitals for identical services.[161] The health insurers hired to insure and administer employer health plans have done a very poor job of negotiating prices that track actual costs of service, and employers thus far have not been effective in changing that result.[162]

The prices that health plans pay hospitals (which constitute the majority of medical spending—twice the amount spent on physicians and over three times the amount spent on pharmaceuticals[163]) and other providers determines the ultimate price of such plans, so the upward trend in prices paid to hospitals has caused average premiums to grow significantly over the past twenty years, outpacing both inflation and wage growth.[164] For example, from 2016 to 2021, average premiums for family coverage increased 22%, while inflation was 11% and wage growth was 18%. In earlier periods, the difference was even more stark. From 2001 to

employers); Eric T. Roberts, Michael E. Chernew & J. Michael McWilliams, *Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices*, 36 HEALTH AFFS. 141, 145-47 (2017) (finding that insurers with market shares of 15% or more negotiated prices for office visits that were 21% lower than prices negotiated by insurers with less than 5% market share, suggesting that health insurer consolidation could help counter the market effects of provider consolidation). At least one study found evidence that insurers negotiate better rates when they bear risk (as they do for fully insured employer plans) than when they negotiate as a third-party administrator (where the employer bears the underlying claims risk). Stuart V. Craig, Keith Marzilli Ericson & Amanda Starc, *How Important is Price Variation Between Health Insurers*, 77 J. HEALTH ECON. 102423, 102431 (2021); *see also* Leemore Dafny, *Does It Matter if Your Health Insurer Is For Profit? Effects of Ownership on Premiums, Insurance Coverage, and Medical Spending*, 11 AMER. ECON. J.: ECON POL'Y 222, 251 (2019) (suggesting that for-profit insurers are more likely than not-for-profit insurers to exercise market power when they possess it).

160. Thomas M. Selden, Zeynal Karaca, Patricia Keenan, Chapin White & Richard Kronick, *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, 34 HEALTH AFFS. 2147, 2147 (2015).

161. Christopher M. Whaley, Brian Briscombe, Rose Kerber, Brenna O'Neill & Aaron Kofner, *Prices Paid to Hospitals by Private Health Plans* 13, RAND (2022), https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1100/RRA1144-1/RAND_RRA1144-1.pdf [https://perma.cc/8QU7-GHHH].

162. There are, of course, complicated factors at play that affect an employer's ability to negotiate prices, including provider consolidation. For example, corporate giants Amazon, Berkshire Hathaway, and JPMorgan Chase joined forces in 2018 to try to lower health care prices, but the venture ultimately folded in 2021, unable to successfully achieve its aims despite representing over 1.5 million employees. Sebastian Herrera & Kimberly Chin, *Amazon, Berkshire Hathaway, JPMorgan End Health-Care Venture Haven*, WALL ST. J. (Jan. 4, 2021), https://www.wsj.com/articles/amazon-berkshire-hathaway-jpmorgan-end-health-care-venture-haven-11609784367 [https://perma.cc/5CQJ-X7J5].

163. *Trends in Healthcare Spending*, AM. MED. ASSOC. (2022), https://www.ama-assn.org/about/research/trends-health-care-spending [https://perma.cc/4ZRY-QXTV].

164. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 40.

2006, average family premiums increased 63%, compared to 13% inflation and 15% wage growth.[165]

Despite the rising cost of health coverage, most employer plans offer a diminishing degree of financial protection. After paying more for premiums, employees are also assuming heavier cost-sharing burdens through copayments, coinsurance, and deductibles.[166] Most workers with employer coverage are currently in a plan with an annual deductible, which on average is $1,735 and for 31% of covered workers is greater than $2,000.[167] Both the percentage of workers in plans with an annual deductible and the average dollar amount of such deductibles have grown significantly in recent years. From 2006 to 2022, deductibles have increased 162%, whereas inflation was 20% and workers' earnings grew by 26%.[168]

The appropriate market response to the pervasiveness of expensive health plans would be to encourage the availability of lower-cost alternatives, which could economize on care or coverage in various ways.[169] But workers' options are constrained by what their employers make available,[170] and most enjoy very limited choice. In 2023, only 21% of covered workers in all firms had a choice of more than two plan options, while 39% were offered only a single plan.[171] Among firms that only offer

165. *Id.* In addition to premium growth, underlying spending on health care for enrollees in employer plans has also grown. Over a ten-year period from 2007-16, total per enrollee spending in employer plans on health care increased by 44%, nearly twice the increase of inflation. Amanda Frost, Eric Barrette, Kevin Kennedy & Niall Brennan, *Health Care Spending Under Employer-Sponsored Insurance: A 10-Year Retrospective*, 37 HEALTH AFFS. 1623, 1623 (2018).

166. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 106-23. Where co-insurance is charged on such services, participants typically must pay 20% of the cost. *Id.* at 125.

167. *Id.* at 114 fig.7.10, 116 fig.7.14.

168. *Employer Health Benefits 2022 Annual Survey*, KAISER FAMILY FOUND. 95 (2022), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf [https://perma.cc/U2LQ-8W57] (explaining that in 2022, 88% of ESI enrollees faced an annual deductible, compared to 55% in 2006; the average amount of such deductibles was $584 in 2006, compared to $1,763 in 2022).

169. *See, e.g.*, Clark C. Havighurst, *Contract Failure in the Market for Health* Services, 29 WAKE FOREST L. REV. 47 (1994) (exploring the failure of the market to deliver lower-cost health insurance options).

170. While it is true that employees could forgo the coverage offered by their employer and seek coverage on the individual market, it generally would be financially disadvantageous to do so. First, an employee who purchases an individual health insurance policy must pay for such coverage with after-tax dollars, because the tax exclusion for health insurance premiums applies only to employer-provided coverage or coverage purchased by a self-employed individual. *See* IRC §§ 106, 162(l). In addition, an employee who is offered coverage by their employer has had their cash wages reduced to account for the "employer contribution" to such coverage. As a result, an employee who forgoes such coverage is losing the economic value of the employer contribution.

171. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 80 fig. 4.2. Lack of choice is especially prominent at small firms; over three-quarters of firms offering health benefits offer only a single health plan option. *Id.* Some employers express the worry that increasing choice also increases administrative costs, but substantial research indicates that expanding the selection of plans and insurers—especially offering options for narrow-network plans—increases employee welfare and controls costs. Jonathan Gruber & Robin McKnight, *Controlling Health Care Costs through Limited Network Insurance Plans: Evidence from Massachusetts State Employees*, 8 AM. J. ECON. POL'Y 219, 220-21 (2016).

one type of health plan, the most common offering is a higher-cost PPO plan rather than a more affordable plan such as an HMO.[172]

The burden of ESI's poor cost-containment falls disproportionately on lower-income workers. The diversion of employee money to pay for health insurance is a little-discussed factor in stagnant wages among wage-earning employees, but it is among the most important.[173] Because health insurance premiums are charged on a per employee or per family basis, and not adjusted for income level, such premiums effectively function as a "head tax."[174] The result is that lower-income employees have been hit especially hard, exacerbating income inequality. Heightened cost-shifting also disproportionally affects the finances and behavior of lower-income individuals.[175]

The high cost of ESI could be at least partially excused if the coverage was exceptionally high quality, such that one could argue that employers and employees were getting what they paid for. However, evaluating the quality of existing ESI offerings is difficult.[176] For example, quality could refer to the degree of financial protection the plan offers for unanticipated medical expenses. Or it could refer to the quality of claims processing and administration. It might also refer to the quality of the medical care that is financed by the plan, or the ability of covered individuals to access needed medical care in a timely manner. There is a reasonable argument that quality evaluations should include all of the above.

On some of these measures of quality, ESI performs reasonably well. The available data suggest that employer health plans do offer more generous financial protection than individual policies of health insurance.[177] Employer plans on average pay approximately 85% of

172. *Employer Health Benefits 2023 Annual Survey*, *supra* note 31, at 82, fig.4.5.

173. *See, e.g.*, Drew Desilver, *For Most U.S. Workers, Real Wages Have Barely Budged in Decades*, PEW RSCH. CTR. (Aug. 7, 2018), https://www.pewresearch.org/short-reads/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades [https://perma.cc/2RBQ-SN2V] (discussing the theory that "rising benefit costs – particularly employer-provided health insurance – may be constraining employers' ability or willingness to raise cash wages"); Jay Shambaugh, Ryan Nunn, Patrick Liu & Greg Nantz, *Thirteen Facts about Wage Growth*, HAMILTON PROJECT, at iv (2017), https://www.hamiltonproject.org/wp-content/uploads/2023/01/thirteen_facts_wage_growth.pdf [https://perma.cc/UC7L-LKJ7] (noting that benefit cost increases have outpaced wage growth; between 1991 and 2017, real wages have increased 15.71%, while the percentage of total compensation attributable to benefit plan costs has risen by 36.33%).

174. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L. & CONTEMP. PROBS. 7, 28 (2006).

175. *See* Collins et al., *supra* note 19, at 3 (explaining that for people with lower incomes, "minor out-of-pocket costs can comprise a large share of income").

176. For an overview of these issues, see generally John M. Eisenberg & Elaine J. Power, *Transforming Insurance Coverage into Quality Health Care: Voltage Drops from Potential to Delivered Quality*, 284 JAMA 2100 (2000).

177. *See, e.g.*, Paul Fronstin, Stuart Hagen, Olivia Hoppe & Jake Spiegel, *The More Things Change, the More They Stay the Same: An Analysis of the Generosity of Employment-Based Health Insurance, 2013-2019*, EMP. BENEFITS RSCH. INST. (Oct. 28, 2021), https://www.ebri.org/docs/default-source/pbriefs/ebri_ib_545_av-28oct21.pdf [https://perma.cc/4TY3-X3ZH].

covered expenses,[178] while the most commonly selected individual policy pays only 70%.[179] There is also some indication that employers pay attention to administrative or customer service quality in selecting plan administrators.[180]

But there is little to no evidence that a significant number of employers evaluate the quality or accessibility of medical care offered through the plan administrator's network.[181] Employees routinely report that quality medical care is among their highest priorities, yet evidence suggests that clinical quality is not a key metric used by employers in selecting a plan administrator.[182] For example, in one large 2019 survey, 36% of employers stated that "quality of providers" was the most important factor in selecting a health plan.[183] In follow-up focus group interviews, however, employer health plan decision-makers "were generally unable to identify any quality information available to them."[184] Similarly, a 2020 survey by the National Committee for Quality Assurance found that employers were not generally aware of how to compare health plan quality.[185]

178. Matthew Rae, Rebecca Copeland & Cynthia Cox, *Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage*, HEALTH SYS. TRACKER (2019), https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage [https://perma.cc/D2KZ-9MJ5].

179. 54% of individual market purchasers selected a "silver" level plan, which has 70% actuarial value; only 14% selected a plan with an actuarial value of 80% or greater. *Marketplace Plan Selections by Metal Level (2024)*, KAISER FAMILY FOUND. (2024), https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-metal-level-2 [https://perma.cc/T69W-JTNF] (detailing the percentage of individual market purchasers who select plans at the various metal levels); *How to pick a health insurance plan*, CTRS. FOR MEDICARE & MEDICAID SERV., https://www.healthcare.gov/choose-a-plan/plans-categories [https://perma.cc/SS9E-QR6X] (detailing the actuarial value of each plan).

180. Christianson & Trude, *supra* note 92, at 364-65.

181. *See* Robert S. Galvin, *An Employer's View of the U.S. Health Care Market*, 6 HEALTH AFFS. 166, 167 (1999) (noting that employers do not routinely engage their employees on issues of quality and value—keeping such tradeoffs obscured); McKinsey & Co., *Employers Look to Expand Health Benefits While Managing Medical Costs*, 4, May 25, 2022, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/employers-look-to-expand-health-benefits-while-managing-medical-costs [https://perma.cc/3874-39S3] (quality was not among the top five most important factors reported by employers).

182. While there are many ways to define quality of care, the Institute of Medicine uses six parameters—quality care is safe, effective, patient-centered, timely, efficient, and equitable. INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 39-40 (2001).

183. Gary Claxton, Daniel McDermott, Cynthia Cox, Julie Hudman, Rabah Kamal & Matthew Rae, *Employer Strategies to Reduce Health Costs and Improve Quality through Network Configuration*, PETERSON-KFF HEALTH SYSTEM TRACKER (Sept. 25, 2019), https://www.healthsystemtracker.org/brief/employer-strategies-to-reduce-health-costs-and-improve-quality-through-network-configuration [https://perma.cc/FNF4-VGQZ].

184. *Id*.

185. Kelsey Waddill, *Employers Unaware of How to Compare Health Plan Quality Measures*, HEALTH PAYER INTELLIGENCE (Sept. 2, 2020), https://healthpayerintelligence.com/news/employers-unaware-of-how-to-compare-health-plan-quality-measures [https://perma.cc/H2ZZ-Y3GQ].

The burdens and disappointments of ESI have led to a considerable decrease in lower-income employees accepting employers' health insurance altogether, which hardly is the preferred outcome for a polity aiming to achieve full coverage.[186] Even where such workers manage to find a way to afford premium payments, high cost-sharing requirements often result in such workers postponing necessary medical care or facing medical bankruptcy when care is received.[187] And even for those unaffected by financial barriers to care, there is no certainty that the medical care contracted for will be delivered by high-quality providers. These challenges illustrate the important role employer-provided coverage plays in achieving effective social policy and its general failure to perform well.

B. Explaining the Shortcomings of Employer-Sponsored Health Plans

ESI's shortcomings present something of a puzzle. A competitive labor market would suggest that employers would offer high-value health benefits to attract a talented workforce, and surveys consistently report that employers believe employer-provided health benefits are important in recruiting and retaining valued employees.[188] Moreover, employees also report in surveys that health benefits constitute the most important benefit that employers offer, far outranking retirement or other benefits.[189] Such evidence, along with rudimentary economics, indicates a mutual interest to have plan managers exercise fastidiousness and demand efficiencies in spending the very substantial sums dedicated to health benefits. This should be even more true given that employer-provided health care is part of a worker's total compensation, such that the amount spent on health benefits are borne by employees through lower wages.[190]

Perhaps this thinking is why employers have been subject to minimal regulatory oversight in their provision of employee health benefits. If a competitive labor market and other price pressures would discipline an employer that uses employee benefit dollars inefficiently, then stringent

186. Long-Term Trends in Employer-Based Coverage, PETERSON-KFF HEALTH SYS. TRACKER (2020), https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage [https://perma.cc/P2FJ-EFB3] (reporting that, among full-time workers, 88% of those with income at or above 400% of the federal poverty level were enrolled in employer health coverage, while only 48% of those with income between 100% and 250% of the federal poverty level elected such coverage).

187. *See* Saad, *supra* note 19; Himmelstein et al., *supra* note 19.

188. *See, e.g.*, Heidi Whitmore et al., *Employers' Views on Incremental Measures to Expand Health Coverage*, 25 HEALTH AFFS. 1668, 1670-71 (2006) (noting that over 90% of firms ranked health benefits as being somewhat or very important for retaining and attracting qualified employees).

189. Salisbury & Ostrew, *Value of Benefits Constant in a Changing Job Environment: The 1999 World at Work/EBRI Value of Benefits Survey*, EMP. BENEFIT RSCH. INST. NOTES 5-6 (2000).

190. *See supra* text accompanying notes 154-159.

regulation is unnecessary to monitor those employers.[191] An employer that fails to act as an effective agent for its employees will either have to increase total compensation to account for their less-than-ideal health benefits or face higher employee turnover than any competitors that properly account for employee preferences.[192]

The poor performance of ESI suggests, de facto, that this prevailing theory is problematic (would anyone think that employers who agree to prices that are more than twice that of Medicare are acting in accordance with their employees' wishes?), and some recent research has explored reasons why employers act as ineffective purchasing agents for their employees.

One hypothesis is that employers need only respond to the one or two highly salient plan features that employees focus on when evaluating health insurance offerings.[193] Evaluating a health insurance policy is notoriously complex, and, as humans routinely do with complicated decisions, employees satisfice by focusing on a small number of highly salient features to guide their decisions. For health insurance, the most important factors tend to be costs (premiums, deductibles, and copayments), followed by the availability of specific providers in-network.[194] With respect to employees' focus on costs, recall, as noted above,[195] that employees neither know how much their health benefits cost nor recognize the degree to which that cost directly reduces their take home pay. And even for those employees who might pay attention to cost, the tax subsidy provided to employer plan premiums further reduces employees' price sensitivity.[196] It therefore is not surprising that employers feel somewhat free to ignore premium costs when structuring their health benefits. The result is that employers may not be disciplined by the market so long as the "employee share" of premiums, as well as out-of-pocket spending amounts such as deductibles and copayments, are at or near market averages. And with respect to in-network providers, evidence

191. For a discussion of the employer's role as agent for its employees, see generally Gregory Acs & Eugene Steuerle, *The Corporation as Dispenser of Welfare and Security*, *in* THE AMERICAN CORPORATION TODAY: EXAMINING THE QUESTIONS OF POWER AND EFFICIENCY AT CENTURY'S END (Carl Kaysen ed., 1996).

192. *See* Peele et al., *supra* note 89, at 7.

193. Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 53-56 (1999).

194. *Id*. at 56. A large literature exists documenting the complexities individuals face when making health insurance enrollment decisions. For a summary of that literature, see Keith Marzilli Ericson & Justin Sydnor, *The Questionable Value of Having a Choice of Levels of Health Insurance Coverage,* 31 J. ECON. PERSP. 51, 58-59 (2017).

195. *See supra* text accompanying notes 154-156.

196. Both employer and employee contributions to employer-sponsored health plans can be paid with tax-free dollars, which results in health plan premiums being "cheaper" than an equivalent amount of cash wages. *See* I.R.C. §§ 106, 125.

suggests that employers respond to this preference by favoring broad networks.[197]

Taken together, this creates the perfect storm for a high-cost health plan. Employers respond to the employee preference for certain in-network providers by selecting a broad network, which they may do without much penalty because the true premium cost for that choice is hidden from employees. It is worth emphasizing that these choices do not appear to be consistent with true employee preferences. For example, a study by Ginsburg, et al., asked individuals to reveal their preferences for health benefits, but within a limited budget.[198] Respondents in the study placed a low priority on choice of provider, instead tolerating tight restrictions on provider choice in exchange for comprehensive coverage and reduced cost-sharing.[199] They also supported limiting benefits in accordance with "practice guidelines and standards of effectiveness . . . exclud[ing] high-cost and low-value interventions."[200]

Another explanation for the poor performance of ESI is derived from the political economy of the firm. In most firms, health benefits are overseen by the human resources (HR) department, whose primary role and core responsibility is to attend to employee needs, not conserve financial resources. This delegation not only means that benefits expenditures escape the typical scrutiny a company applies to its finances (in HR departments, accountability is often measured in terms of recruitment and retention, not the value of expenditures), but it also means that HR policies are not factored into a company's central business decisions. One former human resources executive put it starkly:

> [B]usiness leaders have not treated health care costs as a core business issue. They delegate the responsibility to their human resources department, which is measured on employee satisfaction and has no accountability for the company's financial performance. This makes little sense. HR professionals rely on insurance brokers to provide expertise. Brokers are rarely equipped to help employers develop effective health care strategies. Many states do not require a college degree for licensure, and brokers get commissions and hefty fees from the very health suppliers that employers hire them to select and manage.[201]

197. Christianson & Trude, *supra* note 92, at 364-65.

198. Marjorie Ginsburg, Susan Dorr Goold & Marion Danis, *(De)constructing 'Basic' Benefits: Citizens Define the Limits of Coverage*, 25 HEALTH AFFS. 1648, 1649 (2006).

199. *Id*. at 1652-53.

200. *Id.* at 1648, 1650-52, 1654; *see also* Marjorie Ginsburg & Kathy Glasmire, *Designing Coverage: Uninsured Californians Weigh the Options*, CALIF. HEALTH CARE FOUND. ISSUE BRIEF, https://www.chcf.org/wp-content/uploads/2017/12/PDF-DesignCoverageForUninsured.pdf [https://perma.cc/H26B-G445] (reporting the results of a study with similar findings).

201. Robert S. Galvin, *To Improve Your Company's Health Care, Get the CEO Involved*, HARV. BUS. REV. (May 29, 2019), https://hbr.org/2019/05/to-improve-your-companys-health-care-get-the-ceo-involved [https://perma.cc/QWL7-R4SK].

The above quote suggests additional inefficiencies that accrue from a delegation to HR departments. First, most HR executives lack the training and background necessary to scrutinize the purchasing of healthcare. They therefore outsource the job of selecting insurers/administrators to insurance brokers or benefit consultants.[202] And second, HR executives are generally poorly suited to monitor the wisdom of the brokers' or consultants' recommendations, who in turn and consequently are not held to terribly high professional standards.[203] A series of agency costs therefore accrue in the purchasing of healthcare benefits simply because HR departments are ill-equipped to demand value from their healthcare purchasing. Evidence suggests that when employers feel health plan cost pressure, they respond by shifting an increasing percentage of those costs to workers, rather than address the drivers of those costs.[204]

Of course, a lack of employer market power may also explain some ESI shortcomings. Certainly, there is evidence that employers believe they lack the ability to effectively negotiate prices, and the ongoing consolidation of U.S. healthcare providers dilutes any power that wise purchasers might have from exploiting competition. But other cost-containment strategies are available to many employers that do not depend on their ability to wield market power to secure lower prices, and those best practices likewise have had little take-up.

It might be understandable why employees have the errant belief that health benefits are a perk, rather than a displacement of wages and other compensation, and they therefore inadequately demand value from their employer health plans, as they would if they were purchasing the benefits directly. For similar reasons, employers place health benefits within the domain of human resources, where the skills and priorities of HR departments encourage an emphasis on broad networks and customer service, rather than clinical quality and value. But the emphasis on broad networks, which employers errantly believe responds to employees' desire

202. M. Susan Marquis & Stephen H. Long, *Who Helps Employers Design Their Health Insurance Benefits?*, 19 HEALTH AFFS. 133, 135 (2000) (finding that 54% of all surveyed employers use external consultants to advise them on health benefits, a figure that rises with employer size); Pinar Karaca-Mandic, Roger Feldman & Peter Graven, *The Role of Agents and Brokers in the Market for Health Insurance*, 85 J. RISK & INS. 7, 7-9 (2018) (summarizing the literature on the heavy use of insurance brokers by small firms purchasing health insurance contracts).

203. *See* Ge Bai, Angela Park, Yang Wang, Heidi N. Overton, William E. Bruhn & Martin A. Makary, *The Commissions Paid to Brokers for Fully Insured Health Insurance Plans*, 79 MED. CARE RSCH. & REV. 133, 133, 138 (2020) (noting the "substantial information asymmetry" employers face in the health insurance market, and the reliance on insurance brokers to recommend health insurance options, along with brokers' financial conflict of interest in advising on plan selection); Pinar Karaca-Mandic, Roger Feldman & Peter Graven, *The Role of Agents and Brokers in the Market for Health Insurance*, 85 J. RISK & INS. 7, 8 (2016) (noting that small firms "usually lack the expertise and human resource departments to evaluate large health insurance choice sets" and "rely heavily" on the advice of brokers).

204. *See, e.g.*, Jill R. Horwitz, Brenna D. Kelly & John E. DiNardo, *Wellness Incentives in the Workplace: Cost Savings Through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFFS. 468, 468 (2013); Hughes et al., *supra* note 30 (explaining that some employers address high costs by shifting those costs from premiums to workers' out-of-pocket expenses).

for quality care, merely shifts "responsibility for selecting 'quality providers' back to their employees"[205] and fails to control costs. Industry experts, in contrast, find that active benefits management, through narrow or tiered networks that explicitly consider quality while restricting choice, are far more effective in controlling costs and serving employee interests.[206]

None of this poor performance is irreversible. To the contrary, researchers regularly confirm that employers have an intense and genuine interest in promoting their employees' health, but the perceived barrier is simply a feeling of powerlessness in advancing their employees' health interests. One study concludes that "most companies and their senior leaders fail[] to appreciate their ability to intervene in ways that would improve the health of their employees."[207] Although prevailing mechanisms in providing employee health benefits suffer from a sequence of agency costs and misaligned priorities, the status quo is simply due to employers lacking both the imagination to craft the health benefits their employees crave and the legal requirements that they do so.

III. Using ERISA's Fiduciary Duties to Improve Employer Health Plans

Section I establishes that ERISA requires employers to abide by fiduciary standards when administering their health plans, and Section II illustrates the enormous need to hold employers to that standard. Together, the two Sections suggest that there is both a way and a will to bring relief to employees whose health benefits are being mismanaged.

The path forward offers both immediate and long-term implementation strategies. Some employees and employers are already pursuing immediate relief through litigation—this perhaps reveals both the broader recognition that ERISA imposes legal duties regarding health benefits and impatience with wasteful spending of health benefit dollars. However, despite the immediate need to demand more from ESI managers, imposing fiduciary duties on an area of economic activity as large as the entire French economy should be done deliberately. We offer a roadmap for how to apply ERISA's fiduciary obligations though a prudent rulemaking process led by the Department of Labor, aimed at

205. Christianson & Trude, *supra* note 92, at 365; *see also* Nicholas Tilipman, *Employer Incentives and Distortions in Health Insurance Design: Implications for Welfare and Costs*, 112 AMER. ECON. REV. 998, 1000 (2022) ("My principal finding is that the persistence of broad networks does not fundamentally reflect the preferences of the average employee.").

206. *See, e.g.*, Nicole Rapfogel & Emily Gee, *Employer- and Worker-Led Efforts to Lower Health Insurance Costs*, CENTER FOR AMERICAN PROGRESS (July 28, 2022), https://www.americanprogress.org/article/employer-and-worker-led-efforts-to-lower-health-insurance-costs [https://perma.cc/DZ7F-7BDD]; *Network Configurations May Help Improve Care Quality While Reducing Costs*, UNITED HEALTHCARE (2022), https://www.uhc.com/content/dam/uhcdotcom/en/BrokersAndConsultants/Tri1-Tiered-Network-article.pdf [https://perma.cc/Y8G5-W9NP].

207. Jeffrey Pfeffer, Stacie Vilendrer, Grace Joseph, Jason Kim & Sara J. Singer, *Employers' Role in Employee Health: Why They Do What They Do*, 62 J. OCCUPATIONAL & ENV'T MED. e601, e601-02 (2020).

improving the quality and reducing the wastefulness of health plans. This includes a regulatory safe harbor that would not only result in employers being better custodians of their employees' money but would also generate a more competitive healthcare market that would benefit all citizens.

A. Novel Litigation to Enforce Longstanding Fiduciary Duties

The secret is out. After more than forty years of ERISA litigation that almost exclusively hewed to enforcing fiduciary duties over retirement benefits, at least one employee was sufficiently exasperated with her employer's healthcare benefits to sue under ERISA, claiming that her employer failed to fulfill its fiduciary duties when selecting a plan administrator.[208] On February 5, 2024, Ann Lewandowski sued Johnson & Johnson, her employer, for selecting a health plan administrator (specifically, the pharmacy benefits manager) that charged the plan prices for prescription drugs that greatly exceeded market norms, a fiduciary decision that "cost[] their ERISA plans and their employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth."[209] To illustrate her complaint, Lewandowski alleged that the pharmacy benefits manager selected by Johnson & Johnson was charging an 800.72% mark-up on a generic HIV antiviral drug (the cash pay price for the drug ranged from $123.82 to $210 for a 90-day supply, while the plan agreed to pay $1,629.40).[210] One longtime observer of employee health plans remarked, "This is the first suit of its kind . . . . It definitely will not be the last."[211]

208. Lewandowski v. Johnson & Johnson, No. 24-cv-00671 (D.N.J. filed Feb. 5, 2024); *see also* Melanie Evans & Anna Wilde Mathews, *J&J Accused of Mismanaging Its Employees' Drug Benefits*, WALL ST. J. (Feb. 5, 2024), https://www.wsj.com/health/healthcare/j-j-accused-of-mismanaging-its-employees-drug-benefits-9da9a86e [https://perma.cc/863J-RMGF] (reporting on the novel nature of the case); Sara Hansard, *Johnson & Johnson Case Signals Employee Drug Price Suits to Come*, BLOOMBERG L. DAILY LAB. REP. (Feb. 9, 2024), https://news.bloomberglaw.com/daily-labor-report/johnson-johnson-case-signals-employee-drug-price-suits-to-come [https://perma.cc/YZ8U-ENF5] (noting that the case "appears to be the first case brought by an employee . . . alleging breach of ERISA fiduciary duty over mismanagement of health plan funds").

209. Complaint at 2, Lewandowski v. Johnson & Johnson, No. 24-cv-00671 (D.N.J. Feb. 5, 2024).

210. *Id.* at 33-34.

211. Evans & Mathews, *supra* note 208. The observer proved prescient. In July, a similar class action lawsuit was brought against Wells Fargo, challenging its selection of a pharmacy benefits manager that allegedly charged drug prices that in at least one instance exceeded the cash-pay price by fifteen times. Navarro v. Wells Fargo & Co., No. 0:24-CV-03043 (D. Minn. filed Sept. 27, 2024). Mark Cuban added, "If you work at a big company that is getting pharmacy rebates, your company will be getting sued. Guaranteed. It's not a question of if, it's a question of when. The inevitable class action suit will dwarf the tobacco settlements." Mark Cuban, X (July 24, 2024, 11:19 AM), https://x.com/mcuban/status/1815406400878825588 [https://perma.cc/32Y4-Z6RW]; *see also* Lauren Clason & Ben Miller, *Wells Fargo Ex-Workers Focus on Fees in Latest Drug Price Lawsuit*, BLOOMBERG L. (Aug. 2, 2024), https://www.bloomberglaw.com/bloomberglawnews/daily-labor-report/X83GAE1C000000 [https://perma.cc/DR5W-6FUV] (comparing the Johnson & Johnson and Wells Fargo lawsuits).

A victory for Lewandowski and her class of fellow employees would represent a sea change in the $1.4 trillion health benefits market and is precisely the litigation predicted in Parts I and II. While the Lewandowski lawsuit is the first of its kind because it has been brought by a *participant* challenging the *employer's* selection of a plan administrator, it builds on a still nascent but growing trend of litigation that is broadly exploring ERISA's application to health benefits management. In just the past few years, a small but important number of cases have been brought by *employers* against the very plan administrators the employers have contracted with, claiming that those administrators had breached their fiduciary duties to the relevant plans by, among other things, overpaying claims, approving fraudulent and improper claims, and failing to disclose plan information.[212] While it is undoubtedly a positive development that employers are beginning to question, on their employees' behalf, some of the financial behavior of their plan administrators, it obviously would be more productive to ensure that employers make better decisions in the first place.

These pioneering lawsuits do, however, offer some early lessons. The first is that they reflect deep dissatisfaction in both the structure and the administration of employer-sponsored health benefits. It is telling that so many of these early actions were brought by employers dissatisfied with the plan administrators they themselves had selected. Both the employers and the plan administrators they hire are subject to fiduciary duties under ERISA, but resorting to lawsuits reflects an incapacity or unwillingness among employers to effectively screen and monitor administrators or replace them; they instead reflect an exasperation that employers and the public have with an industry that is unaccustomed to being held accountable for its fees and quality of service. Somewhat cynically, the suits might suggest that employers now recognize that the failure of their plan administrators might expose them to liability as well.[213] However, it is unlikely that an employer meets its fiduciary duties under ERISA merely by suing the insurer that it hired for breaching ERISA's duties, and equally unlikely that an employer is excused if the administrator is deemed liable.

The second lesson is that recent medical price transparency requirements have enhanced the ability to enforce ERISA's health plan fiduciary duties. The most notable of these requirements is the "transparency in coverage" final rule, issued in October 2020 under the

212. *See, e.g.*, Clancy v. United Healthcare Ins. Co., 643 F. Supp. 3d 589 (E.D. Va. 2022); Trs. of the Int'l Union of Bricklayers Local 1 Conn. Health Fund v. Elevance, Inc., No. 3:22-CV-154 (D. Conn. filed Dec. 5, 2022); Kraft Heinz Co. Emp. Benefits Admin. Bd. v. Aetna Life Ins. Co., No. 2:23-CV-00317(JRG) (E.D. Tex. filed June 30, 2023).

213. ERISA imposes co-fiduciary liability where, for example, one fiduciary had knowledge of another fiduciary's breach and failed to take steps to remedy that breach. 29 U.S.C. § 1105(a)(3) (2024).

authority of the Affordable Care Act.[214] The rule requires health plans and insurers to disclose, among other figures, negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information to plan participants and beneficiaries.[215] Also important are the hospital price transparency rules[216] that require hospitals to disclose to the public the payer-specific negotiated charge for items and services.[217] The result is that, for the first time, employers selecting or monitoring a plan administrator can compare carriers' negotiated hospital rates, a key driver of health plan costs. The disclosure of negotiated prices has revealed to employees, plan administrators, and others whether certain ERISA fiduciaries are paying more than what a prudent purchaser should.

The third lesson is that the lawsuits are marching toward some new enforcement realities to vindicate employee rights. Most of the suits brought by employers have survived initial challenges and have settled, which suggests both that the claims have merit and that clear law is unlikely to emerge from the stream of lawsuits. And significantly, those within the industry sense that much more is to come. A longtime former Department of Labor attorney succinctly described the state of ERISA law:

> Fiduciaries and service providers to employee benefit plans [should] prepare now for what could be a new wave of class action ERISA fee and expense litigation—this one crashing down on health care plans. In the last two decades, hundreds of class action lawsuits have been filed against fiduciaries of ERISA retirement plans alleging their imprudence and lack of oversight of plan finances caused their plans to pay too much for investments and plan administration. . . . Some of the attorneys who spearheaded this retirement plan litigation tsunami may now be turning their attention to health care plans.[218]

One such attorney has already posted advertisements on *LinkedIn* with a simple message: *"Are you a current _____ employee who has participated in the company's healthcare plan? You may have a legal*

214. Transparency in Coverage, 85 Fed. Reg. 72158 (Nov. 12, 2020) (to be codified at 26 C.F.R. § 54).

215. 26 C.F.R. § 54.9815-2715A2 (2024).

216. *See* 42 U.S.C. § 300gg-18(e) (2024) (hospital price transparency requirements).

217. *See* 45 C.F.R. § 180.50(a)(3) (2024). In addition to making such information available in a machine-readable format, *id.* § 180.50(c), hospitals must also make such information available in a consumer-friendly format for certain "shoppable" hospital services, *id.* § 180.60(b)(3). There have, however, been indications that hospitals have failed to fully comply with these new requirements as of their effective date. *See* LoSasso et al., *supra* note 159, at 615.

218. Joanne Roskey, *Are You Ready for Class Action Health Care Plan Fee Litigation?*, PLAN ADVISER, (Sept. 1, 2023), https://www.planadviser.com/exclusives/ready-class-action-health-care-plan-fee-litigation [https://perma.cc/BB4Z-YUQ7].

claim—and we'd like to speak with you."[219] The company employees being targeted include Anthem, State Farm, PetSmart, and many more.[220]

The fourth lesson, and certainly the most important, is that these initial legal actions, whatever their outcome, illustrate the need for the Department of Labor to issue ex-ante regulations. Most lawsuits will result in settlements, which do nothing to clarify obligations for other employers, and even those that result in rulings will be hard to translate into rules of general applicability. For example, the plaintiff's success in *Lewandowski* may or may not have implications outside the domain of pharmaceutical benefits or for deciding whether an out-of-pocket payment is the only metric to determine plan overspending. Answering these questions, which have vital industry-wide importance and would meaningfully enhance needed accountability, predictability, and efficiency to the health benefits sector, requires the Department of Labor to exercise its authority under ERISA to promulgate regulations.

This is a common feature of lawmaking, as both scholars and legal authorities broadly agree that rules and rulemaking are generally superior over piecemeal adjudication, especially when a new wave of litigation raises industry-wide questions. Academic icons such as Merton Bernstein and David Shapiro, in the early years of administrative law scholarship, wrote conclusively about the general merits of rulemaking over adjudication,[221] and the Supreme Court has embraced it as a truism in multiple rulings.[222] Moreover, the Supreme Court on more than one occasion has criticized agencies that have delayed or refused to issue rules.[223]

In short, the recent filing of *Lewandowski v. Johnson & Johnson* and similar cases may be a harbinger of a new litigation wave, one that will squarely address the substantive fiduciary obligations that employers owe to their employees. It is unclear where these cases will lead and what rules they will generate, but the current trend will force courts to establish the parameters for ERISA's fiduciary duties. This puts the Department of Labor in a unique position and presents it with a unique opportunity.

219. *Schlichter Widens Net for Fiduciary Claims*, NAT'L ASSOC. OF PLAN ADVISORS (Aug. 9, 2023), https://www.napa-net.org/news/2023/8/schlichter-widens-net-fiduciary-claims [https://perma.cc/2XUT-25L4].

220. *Id.*

221. Merton C. Bernstein, *The NLRB's Adjudication-Rule Making Dilemma Under the Administrative Procedure Act*, 79 YALE L.J. 571, 578-82, 587-98 (1970); David L. Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 HARV. L. REV. 921, 929-942 (1965); *see also* KRISTEN E. HICKMAN & RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE 634 (6th ed. 2020) (reviewing the literature and listing "at least nine different advantages of rulemaking over adjudication as a source of generally applicable rules").

222. *See, e.g.*, Mohawk Indus., Inc. v. Carpenter, 558 U.S. 100, 114 (2009) ("Indeed, the rulemaking process has important virtues. It draws on the collective experience of bench and bar, and it facilitates the adoption of measured, practical solutions.").

223. *See, e.g.*, Allentown Mack Sales & Serv., Inc. v. Nat'l Lab. Rels. Bd., 522 U.S. 359 (1998).

Rather than watching a morass of case law develop, the Department could preemptively promulgate regulations that bring the clarity, farsightedness, and expertise that the industry requires.[224]

B. Regulatory Clarity and a Safe Harbor

ERISA's role in safeguarding employee retirement benefits has always relied on guidance from the Department of Labor. In giving the Department both rulemaking and enforcement authority, it was clearly Congress's intent to have the Department play an active role in ensuring compliance with ERISA. Moreover, in basing ERISA liability on the law of fiduciary duties, the statute contains significant ambiguities that Congress intended rulemaking by the Department of Labor to fill in.[225]

As noted in Part I, the Department of Labor has embraced this responsibility promulgating regulations regarding how employers should comply with their fiduciary duties in administering retirement benefits, but it has been virtually silent in doing the same for health benefits. Now, however, both the sector's failings (see Part II) and the recent emergence of litigation (see Part III.A) demand action by the Department.

In this Part, we offer a roadmap for how to apply ERISA's fiduciary obligations though a prudent rulemaking process led by the Department of Labor. We begin by offering suggestions for immediate steps the Department of Labor could take within their existing rulemaking authority to improve the quality of employer health plans. We then propose a regulatory safe harbor focused on health plan value that would cause employers to be better custodians of their employees' money and, consequently, would generate a more competitive healthcare market.

1. High-Return/Low-Risk Regulatory Actions to Improve Employer Health Plans

The obvious place to start in health plan fiduciary rulemaking is to specify the factors that an employer must consider when selecting a health plan administrator in order to comply with the duty of prudence. While precise details should be arrived at as part of a deliberative rulemaking process, at a minimum employers should be required to evaluate cost,

224. Such rulemaking is perhaps not without risk of judicial oversight following the Supreme Court's decision in *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024) (eliminating the so-called *Chevron* deference to agency rulemaking). However, the basic rulemaking we propose is not a stretch of statutory language and is squarely within the statutory authority granted to the Department of Labor by ERISA. *See* 29 U.S.C. § 1135 (2018) ("[T]he Secretary [of Labor] may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter."). As a result, we are comfortable that the rulemaking we propose remains a viable solution post-*Loper Bright*.

225. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987) (noting that Congress "expect[ed]" courts would develop "a federal common law of rights and obligations under ERISA-regulated plans").

clinical quality, network adequacy, claims processing accuracy and timeliness, and customer service functions. Cost considerations should include not simply administrative fees or premiums, but they should require employers to evaluate the provider reimbursement rates that will apply to covered medical services. Some of these factors (such as claims accuracy or customer service) require little explication and appear to receive appropriate attention from employers even in the absence of fiduciary rulemaking. We therefore limit our discussion below to those factors we have reason to believe receive a suboptimal level of consideration under the status quo and about which regulatory guidance could drive real improvement in employer health plans.

a. Medical Costs

When an employer selects a health plan administrator, it is purchasing access to that entity's provider network, along with the reimbursement rates that have been negotiated with those providers. Given that these reimbursement rates largely determine the plan's medical costs, which are far and away the most significant driver of overall plan expenses,[226] the choice of an administrator has a profound impact on plan premiums and those out-of-pocket expenses that are determined based on charged costs. Fiduciaries have a clear duty when selecting a plan administrator to determine if the administrator's negotiated provider rates are reasonable in light of the services provided, and rulemaking should make this requirement explicit.

Negotiated provider rates vary tremendously among payers. To begin with, private payers such as employer plans face rates that are significantly higher than the rates paid by public programs. Private payers on average pay twice as much as Medicare for hospital services and one and a half times more than Medicare for physician services.[227] But even when we

226. Fully insured employer plans are required to spend at least 85% of premiums on medical care and certain quality improvement efforts. 45 C.F.R. § 158.210(a) (2024). In 2023, one study found that, on average, such plans spent 88% on medical care. Jared Ortaliza & Cynthia Cos, *2024 Medical Loss Ratio Rebates* fig.2 (2024), https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates [https://perma.cc/7E9R-FXLG]. The proportion of premiums spent on medical care is even higher for self-insured plans, presumably because they do not need to account for insurer profit. U.S. DEP'T OF LAB., ANNUAL REPORT ON SELF-INSURED GROUP HEALTH PLANS 15 (2021) (self-insured health plans financed through a trust received $64 billion in contributions and paid $3.9 billion in administrative expenses in 2018, which, as calculated by authors, indicates 94% of plan contributions were spent on medical care), https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/self-insured-group-health-plans-report-2021.pdf [https://perma.cc/8RFA-DBRW].

227. *Report to the Congress: Medicare Payment Policy*, MEDICARE PAYMENT ADVISORY COMMISSION 9 (2024), https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf [https://perma.cc/M5WY-QK4B]; *see also* Mark Katz Meiselbach, Yang Wang, Jianhui Xu, Ge Bai & Gerard F. Anderson, *Hospital Prices for Commercial Plans are Twice Those for Medicare Advantage Plans When Negotiated by the Same Insurer*, 42 HEALTH AFFS. 1110, 1114-15 (2023)

focus solely on rates faced by private payers, we see substantial variation not only between geographic regions, but also *within* geographic regions. For example, the costs for a common surgical procedure in a given metropolitan area might vary by tens of thousands of dollars among various hospitals, [228] in a manner that is not correlated with quality.[229] Similarly, prices at a single hospital for the same service often vary dramatically by payer.[230] There is even evidence that, in some cases, the "negotiated" rates for services exceed self-pay cash prices for those same services.[231] While the causes of these disparate rates are complex, the important fact for our purposes is that prudent fiduciaries would inform themselves about these price differences as well as relevant market averages, and be prepared to justify the selection of any plan administrator that pays above-average provider rates.

Historically, employers have had limited ability to determine or compare negotiated reimbursement rates prior to entering into a contract with an insurer (and, in certain circumstances, even after entering into such a contract). Prior to the recent implementation of price transparency requirements, insurers and administrators treated negotiated rates as confidential and proprietary. While employers were able to request certain information about rates during the bidding process, that information was incomplete and was of course limited to those who submitted bids.[232]

Given the recently enacted price transparency requirements, plan fiduciaries now have much better information on reimbursement rates available to them, and they should be explicitly required to use this information when selecting a plan administrator. To use hospital prices as an example, a prudent fiduciary should be required to examine plan administrators' hospital reimbursement rates as part of the plan

(finding that insurer-negotiated medical hospital prices for private health plans were more than twice their Medicare Advantage prices in the same hospital for the same service).

228. *See, e.g.*, Nisha Kurani, Matthew Rae, Karen Pollitz, Krutika Amin & Cynthia Cox, *Price Transparency and Variation in U.S. Health Services*, PETERSON-KFF HEALTH SYSTEM TRACKER (Jan. 13, 2021), https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services [https://perma.cc/9JPN-VU67] (finding that, in the San Diego metropolitan area, the average allowed charge for knee and hip replacement surgery was $33,554, but the 25th percentile of the range was $20,305 and the 75th percentile was $51,995).

229. For a summary of the existing literature on this complex topic, see Michael E. Chernew & Richard G. Frank, *What Do We Know About Prices and Hospital Quality?*, HEALTH AFFS. FOREFRONT (July 29, 2019), https://www.healthaffairs.org/content/forefront/do-we-know-prices-and-hospital-quality [https://perma.cc/VHF7-A3TZ].

230. LoSasso et al., *supra* note 159, at 618.

231. Gerardo Ruiz Sánchez, *Variation in Reported Hospital Cash Prices Across the United States and How They Compare to Reported Payer-Specific Negotiated Rates*, 211 ECON. LTRS., at 3-4 (2022).

232. For examples of the types of rate information requested by employers as part of the bidding process, see PIERCE COUNTY WASHINGTON, REQUEST FOR PROPOSAL: THIRD PARTY ADMINISTRATOR FOR SELF INSURANCE MEDICAL PLAN AND STOP LOSS 1-3 (submissions due June 19, 2015) (on file with authors); and STATE OF NORTH CAROLINA, THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES REQUEST FOR PROPOSAL #270-20220830TPAS: THIRD PARTY ADMINISTRATIVE SERVICES 83 (submissions due Sept. 12, 2022) (on file with authors).

administrator selection process, particularly given the highly significant role hospital expenses play in overall health plan costs. Because there are innumerable types of hospital charges, it may be helpful to limit the required analysis to some manageable basket of services, such as the top-five hospital-based cost drivers for the plan. In reviewing potential plan administrators, the employer would be expected to compare hospital prices (among those hospitals most frequently used by plan participants) for those five services not only as compared to other bidders, but also as compared to all payers. If Company A's negotiated rates for knee replacement surgery are on average two times higher than all other private payers, a prudent fiduciary would take that into account in evaluating Company A's bid. Obviously, hospital rates are only one piece of a complex decision, but hospital rates significantly above competitors should at the very least require further consideration (and, hopefully, negotiation).

Regardless of the particular form the rulemaking might take, we believe that explicitly requiring employers to consider negotiated provider reimbursement rates and compare hospital reimbursement rates in selecting a plan administrator is one of the highest-return actions the Department of Labor could undertake.

b. Administrative Expenses

In addition to payments for plan participants' underlying medical expenses, plans face administrative expenses that cover what is characterized as overhead costs, such as payments for claim administration and call centers, as well as marketing and profits. Recent research has estimated administrative costs to consume 25% to 31% of total health care expenditures in the United States,[233] a proportion approximately twice that found in Canada and significantly greater than in all other OECD member nations.[234] The rate of growth in administrative costs in the United States has outpaced that of overall healthcare expenditures,[235] and these costs

233. Phillip Tseng, Robert S. Kaplan, Barak D. Richman, Mahek A. Shah & Kevin A. Schulman, *Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System*, 319 JAMA 691, 692 (2018)*; see also* Aliya Jiwani, David Himmelstein, Steffie Woolhandler & James G. Kahn, *Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence*, 14 BMC HEALTH SERV. RES. 556, 562 fig.3 (2014); David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet & Steffie Woolhander, *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFFS. (MILLWOOD) 1586, 1586-94 (2014).

234. Barak Richman, Albert S. Kaplan, Japees Kohli, Dennis Purcell, Mahek Shah, Igna Bonfrer, Brian Golden, Rosemary Hannam, Will Mitchell, Daniel Cehic, Garry Crispin & Kevin A. Schulman, *Billing and Insurance-Related Administrative Costs: A Cross-National Analysis*, 41 HEALTH AFFS. 1098, 1099 (2022); Steffie Woolhandler, Terry Campbell & David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND J. MED. 768, 772 (2003).

235. Himmelstein, et al., *supra* note 233, at 1586 (explaining that administrative costs are increasing, and that the ratio of administrative costs to hospital expenditures is increasing).

themselves have been blamed for contributing to excess health spending in the United States.[236]

Escalating administrative costs have likewise burdened ESI, though its impact has been hidden from most observers. Self-insured health plans have no oversight with respect to their administrative expenses, while regulation of insured plans' administrative expenses actually serves to incentivize increased costs. The culprit is the *medical loss ratio (MLR)*, which is the share of total health care premiums spent on medical claims, with overhead expenses constituting the remainder.[237] The Affordable Care Act (ACA), in an effort to limit the profits and administrative costs of health insurers, established floors for the MLR, thereby limiting administrative expenses.[238] For fully insured plans, these administrative expenses are capped under federal law as a percentage of premiums. Administrative expenses may not exceed 15% of total premium for large group plans or 20% for small group plans.[239] If the insurer spends less than 85% or 80%, respectively, on medical expenses (including health improvement efforts), the carrier must refund the excess premium to keep administrative expenses below the permitted maximum.[240] The problem is that the MLR is a ratio, so a health plan's profits—which are included in the 15% that excludes medical costs—can be increased if total expenditures increase.[241]

As with medical expenses discussed above, explicitly requiring employers to consider administrative expenses—for both insured and self-insured plans—could help strengthen price competition. Moreover, efficient management of medical expenses is inherently connected both to the amount paid in administrative expenses and to how administrative expenses are calculated. Although there are clear problems with calculating administrative expenses, including plan fees and profits, as a percentage of the overall spend, few employers scrutinize how plans are paid. Currently, employers with fully insured plans are often quoted premiums that represent an all-in price, but employers should, as part of

236. Laura Tollen, Elizabeth Keating & Alan Weil, *How Administrative Spending Contributes to Excess US Health Spending*, HEALTH AFFS. FOREFRONT (Feb. 20, 2020), https://www.healthaffairs.org/content/forefront/administrative-spending-contributes-excess-us-health-spending [https://perma.cc/U4FH-VHWN].

237. *See* 45 C.F.R. §§ 158.130, 158.140 (2024), 158.150 (2024), and 158.221 (2024) for definitions of the medical loss ratios, applicable premiums, medical claims, and other factors.

238. 42 U.S.C. § 300gg-18(b) (2018).

239. *Id*. § 300gg-18(b)(1)(A)(i)-(ii).

240. *Id*.

241. David Scheinker, Arnold Milstein & Kevin Schulman, *The Dysfunctional Health Benefits Market and Implications for US Employers and Employees*, 327 J. AMERICAN MED. ASSOC. 323, 323-24 (2022). ("[R]egardless of whether an insurer is managing or assuming financial risk for employee health benefits spending . . . lower spending for health care may weaken insurer financial performance."); Steve Cicala, Ethan M.J. Lieber & Victoria Marone, *Regulating Markups in US Health Insurance* 11 AMER. ECON. J. 71, 71 (2019) ("While intended to reduce premiums, we show [the medical loss ratio rule] creates incentives to increase costs.").

their fiduciary duties, pay attention to the administrative expenses embedded in premiums.

Of course, administrative expenses hold the particular feature of not adding any value to health care delivery, and even as the health sector frets over 15% caps, other industries manage financial transactions at far lower costs (for example, paying for services with a commercial credit card adds only 2% to the cost of the transaction).[242] Though an employer is not obligated to select the administrator with the lowest administrative fees, fiduciaries of health plans—like those of retirement plans—should be expected to reduce these expenses, and the key test is whether the fees charged be reasonable in light of the services provided. Specifying in rulemaking that employers explicitly consider these fee levels should not create an uncritical race to the bottom but instead result in employers documenting the factors that support a higher administrative fee level where lower cost options were available.

c. Network Adequacy

In addition to evaluating costs, health plan fiduciaries should also be explicitly required to evaluate network adequacy when selecting a plan administrator (except in the truly rare case where the health plan is offered on an indemnity basis and does not rely on a network of providers). This requirement is not proposed as a means to require plans to adopt a broad network; it is simply to ensure that employers are informed of the network structure they are purchasing when they select an administrator.

There are no agreed upon standards for network adequacy, nor consensus on how best to measure such adequacy. In part, the lack of standards and consensus in this area reflects the trade-offs between network size and price. In general, the broader the network, the less leverage an administrator has to negotiate on price, and therefore the higher the cost.[243] So while the effectiveness of coverage obviously depends on the ability of participants to access care, it is often difficult to determine the ideal network scope given price trade-offs.[244]

242. Jack Caporal, *Average Credit Card Processing Fees and Costs in 2024*, THE ASCENT (Aug. 28, 2024), https://www.fool.com/the-ascent/research/average-credit-card-processing-fees-costs-america [https://perma.cc/B8KY-FK9V].

243. *See* Paul B. Ginsburg & L. Gregory Pawlson, *Seeking Lower Prices Where Providers are Consolidated: An Examination of Market and Policy Strategies*, 33 HEALTH AFFS. 1067, 1069 (2014).

244. There are also well documented challenges in measuring network adequacy, such as the problem of "phantom networks"—where providers are listed as members of a network, but those providers are not actually accepting patients. For studies documenting these challenges, see Howard H. Goldman, *How Phantom Networks and Other Barriers Impede Progress on Mental Health Insurance Reform*, 41 HEALTH AFFS. 1023 (2022); Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills,* 39 HEALTH AFFS. 975 (2020); Simon F. Haeder, David L. Weimer & Dana B. Mukamel, *Secret Shoppers Find Access to Providers and Network Accuracy Lacking for those in Marketplace and Commercial Plans*, 35 HEALTH AFFS. 1160 (2016).

There are, however, federal regulations addressing network adequacy for individual marketplace plans[245] and private Medicare Advantage plans[246] that are helpful in illustrating various methods of evaluating network adequacy that might be borrowed in ERISA fiduciary rulemaking. These requirements include time and distance standards,[247] minimum provider-to-enrollee ratios,[248] and maximum appointment wait times.[249] To be clear, we are not suggesting that these standards be imposed on employer plans—only that these existing standards can be helpful in identifying data employers might gather for purposes of fiduciary network evaluation.

d. Medical Care Quality

It should be self-evident that a prudent fiduciary would evaluate quality when selecting a health plan administrator. But it is important to specify that this means not only administrative quality (i.e., customer service and claims processing accuracy), but also the quality of the medical care delivered by the administrator's network of providers. Evidence suggests that employers routinely consider administrative quality, but often overlook clinical quality or are unaware of how it can be measured.[250] To respond to employee preferences for quality care, employers often

245. The ACA has been interpreted to require individually-purchased marketplace plans to have networks that are "sufficient in number and types of providers…to ensure that all services will be accessible without unreasonable delay." 45 C.F.R. § 156.230(a)(ii) (2024). For studies of the breadth of marketplace plan networks, see Simon F. Haeder, David Weimer, & Dana B. Mukamel, *A Consumer-Centric Approach to Network Adequacy: Access to Four Specialties in California's Marketplace*, 38 HEALTH AFFS. 1918 (2019); Aditi P. Sen, Lena M. Chen, Donald F. Cox & Arnold M. Epstein, *Most Marketplace Plans Included At least 25 Percent of Local-Area Physicians, But Enrollment Disparities Remained*, 36 HEALTH AFFS. 1615 (2017); and Leemore S. Dafny, Igal Hendel, Victoria Marone & Christopher Ody, *Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth*, 36 HEALTH AFFS. 1606 (2017).

246. 42 C.F.R. § 422.116 (2024).

247. *Id.* § 156.230(a)(2)(i) (2024); Ctrs. for Medicare & Medicaid Servs, *Letter from Ctr. for Consumer Info. & Ins. Oversight*, U.S. DEPT. OF HEALTH & HUMAN SERV. 10-14 (Apr. 28., 2022), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf [https://perma.cc/A985-956C] (requiring that at least 90% of enrollees live within the maximum time and distance to at least one provider of each type). These maximum time and distance thresholds vary based on type of service and geographic location. For example, when it comes to primary care, the maximum time and distance is ten minutes or five miles in a large metro area, while it is forty minutes or thirty miles in rural locations. *Id*.

248. U.S. DEP'T OF HEALTH & HUM. SERV., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ADVANTAGE NETWORK ADEQUACY CRITERIA GUIDANCE 8-9 (2017).

249. U.S. DEP'T OF HEALTH & HUM. SERV., *supra* note 247, at 15 (noting that carriers need to attest that their contracted providers can meet wait time standards of ten calendar days for behavioral health, fifteen calendar days for primary care, and thirty business days for non-urgent specialty care).

250. *See* Claxton et al., *supra* note 183 (finding very low adoption rates or even unfamiliarity with a variety of quality-based plan features such as tiered networks, narrow networks, and dropping poorly performing hospitals or health systems, and noting that "focus group participants were generally unable to identify any quality information available to them"); Waddill, *supra* note 185 ("Employers . . . are not aware of how to compare health plan quality measures using the National Committee for Quality Assurance (NCQA) tools.").

simply provide broad provider networks and leave it to employees to determine which providers are delivering quality outcomes.[251]

To a certain extent, employers' discomfort measuring quality is understandable. Measuring the quality of medical care is difficult even for experts, let alone human resources professionals. But human resources professionals have much better resources available to them to evaluate quality than do individual plan participants. In fact, it is remarkable that the quality of health benefits, which arguably is much harder for the layperson to assess than financial instruments, was never subject to ERISA scrutiny while retirement benefits consistently are. There is a strong case for an explicit requirement that health plan fiduciaries evaluate medical quality when selecting a plan administrator.

The primary challenge of requiring consideration of clinical quality is determining the appropriate method or methods to use in such evaluation. We suggest, as a starting point, that fiduciaries be required to consult the pre-existing Healthcare Effectiveness Data and Information Set (HEDIS) when selecting a plan administrator, which provides quality ratings for over 90% of health plans.[252]

Health plan quality ratings such as HEDIS are a relatively new tool, having been developed beginning in the 1990s following the rise of managed care plans. When indemnity plans were the norm, there was no need to rate the quality of a plan's network because there was no network—covered individuals could go to any provider of their choosing. But in a managed care environment, where the administrator's provider network exerts a significant influence on how and where enrollees access care, quality ratings were and are thought to be necessary.[253] Today, health plan quality is typically evaluated using a combination of measures that take into account patient safety, clinical effectiveness, member satisfaction, and the timeliness of care.[254] HEDIS, the leading quality measurement set, produces scores that are based on data reporting that is subject to external audit.[255] The overall HEDIS performance score is based on an aggregation

251. Peele et al., *supra* note 89, at 13-15.

252. Off. of Disease Prevention & Health Promotion, *Healthcare Data and Information Set (HEDIS)*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/healthcare-effectiveness-data-and-information-set-hedis [https://perma.cc/RXN8-FCPL].

253. Agency for Healthcare Rsch. & Quality, *Measuring the Quality of Health Plans*, U.S. DEP'T. OF HEALTH & HUM. SERVS. (Mar. 2016), https://www.ahrq.gov/talkingquality/measures/setting/health-plan/index.html [https://perma.cc/PWY7-GFQG].

254. Agency for Healthcare Rsch. & Quality, *Examples of Health Plan Quality Measures for Consumers*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Dec. 2022), https://www.ahrq.gov/talkingquality/measures/setting/health-plan/examples.html [https://perma.cc/9RMQ-8EE8].

255. Agency for Healthcare Rsch. & Quality, *Major Health Plan Quality Measurement Sets*, U.S. DEP'T. OF HEALTH & HUM. SERVS. (Dec. 2022), https://www.ahrq.gov/talkingquality/measures/setting/health-plan/measurement-sets.html [https://perma.cc/3EWE-HKQP].

of compliance scores across six domains of care and includes over ninety individual measures of quality.[256] For example, one measured domain is the effectiveness of care. Within that domain, HEDIS measures whether certain care targets for specific patient populations have been met, such as whether women 50-74 years of age have had at least one mammogram within the past two years,[257] whether adults who have suffered acute myocardial infarction receive persistent beta blocker treatment for six months after hospital discharge,[258] and whether adults diagnosed with major depression were prescribed an antidepressant and remained on that medication.[259]

While HEDIS may not be a perfect measure, its current availability and general acceptance make it a good first choice for health plan fiduciary rulemaking. Moreover, the objective in ERISA quality assurance is not to guarantee beneficiaries receive the highest quality care but merely are not steered towards negligent caregivers. To be sure, the burgeoning industry of healthcare quality metrics will continue to produce new measures, and regulations may account for innovations in measurement or data availability, but the ERISA fiduciary duty requires attention and deliberation, not perfection.

e. Value

After examining relevant costs and quality, a prudent fiduciary should combine those measures to evaluate the value offered by prospective plan administrators. Metrics of quality tend to be independent from price, and thus the value offered by a particular administrator refers to assessing quality and efficiency of care given a particular price.[260]

The structure of ERISA's fiduciary duties precludes the Department of Labor from mandating selection of the highest-value administrator, but gains are likely to result from simply requiring plan fiduciaries to measure and consider value in selecting alternatives. An employer might rationally desire the highest quality plan available, irrespective of price, and such a choice is clearly permitted under ERISA as a business decision. But by requiring consideration of value, the employer might be better able to distinguish between two equally high-quality administrators. They might also become more open to tradeoffs that would otherwise be opaque

256. *Id*.

257. *Breast Cancer Screening (BCS-E)*, NAT'L COMMITTEE FOR QUALITY ASSURANCE, https://www.ncqa.org/hedis/measures/breast-cancer-screening [https://perma.cc/95TK-QCDW].

258. *Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)*, NAT'L COMMITTEE FOR QUALITY ASSURANCE, https://www.ncqa.org/hedis/measures/persistence-of-beta-blocker-treatment-after-a-heart-attack [https://perma.cc/6W32-Z3BM].

259. *Antidepressant Medication Management (AMM)*, NAT'L COMMITTEE FOR QUALITY ASSURANCE, https://www.ncqa.org/hedis/measures/antidepressant-medication-management [https://perma.cc/5LWP-UPSA].

260. JAMES T. O'CONNER & JULIET M. SPECTOR, MILLIMAN REPORT: HIGH-VALUE HEALTHCARE PROVIDER NETWORKS 4 (2014).

without value information. For example, if choosing between Administrator A, with a quality score of 99 and a cost of $5 million and Administrator B, with a quality score of 98 and a cost of $3 million, the employer might re-think its best-at-any-cost approach.

f. Disclosure to Participants

The last element in our high-return/low-risk proposal may be the most controversial, which is to require employers, as part of their fiduciary duties, to disclose to participants the relative cost, quality, and value of bidders, including the insurer or administrator ultimately selected. The goal of this requirement is to increase transparency to workers, so that they can better understand the trade-offs that their employer is making on their behalf and lobby for desired changes.

Recall that health plan expenses represent a significant percentage of employee wages and that, unlike the typical retirement plan scenario, employees have relatively little choice (if any) in the type of health coverage they receive from their employer. Ideally, an employer would be responsive to employee preferences and structure their health plans accordingly. But requiring disclosure may help improve responsiveness to employee preferences and help employees monitor their employer's fiduciary compliance.

For example, assume the employer received bids from three separate health plan administrators, Companies A, B, and C. After reviewing the factors identified above (and any others included in rulemaking), the employer selects Company C to administer the plan. The final step would be a "Notice of Health Plan Service Provider Selection" that would contain basic information about the bid process, including how many companies responded to the request for proposals. It would then list each bidder—and this could be done anonymously for those companies not selected—along with the HEDIS scores, network adequacy assessments, and quoted costs. The employer would then state a brief rationale for selecting Company C.

In many cases, the disclosed information would show an easy case for selecting Company C. Company C might have by far the best quality scores and a cost that does not exceed the other bidders. Or Company C might have the only adequate network. But the idea is that by making the employer's trade-offs transparent, employees can better communicate their desires to their employer, helping the employer to act as a more effective agent. And most importantly, such disclosure would aid both participants and regulators in ensuring employer compliance with health plan fiduciary duties.[261]

261. A helpful example is provided by the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), which broadly prohibits employer health plans from covering mental health and substance use disorder benefits in a manner that is more restrictive

2. A Modest Safe Harbor Proposal to Reward Value

While required consideration of specified factors is a good place to start, we believe even more could be achieved by encouraging employers to maximize value when selecting an administrator, and that this could be effectively accomplished through the use of a regulatory safe harbor. Such safe harbors are common in employee benefits rulemaking,[262] and seek to give employers comfort where they might otherwise face compliance uncertainty—as is frequently the case with fiduciary duties that inherently involve fact-specific determinations. They are by their very nature voluntary, and employers are free to take advantage of the protection they provide or simply proceed under the general legal standard.

We propose a regulatory safe harbor that deems an employer to have satisfied the duty of prudence in selecting a plan administrator if the employer has selected a high-value network option, even if other plan options continue to be offered alongside the high-value choice. To be eligible for the safe harbor, the employer would need to document selection of an administrator whose care network delivers the highest clinical quality at the lowest price, provided certain minimum standards are satisfied on the other relevant factors, such as network adequacy, claims processing accuracy, and customer service quality. In addition, in order to prevent the employer from undermining the purpose of a high-value option, where an employer offers multiple health plan options and seeks protection under our proposed value-based safe harbor, the employer's contribution to premiums must be an equal percentage of the cost of coverage across all options. In other words, the employee's required contribution for the high-value option must be the same percentage of total cost as it is for all other health plan options offered by the employer,

than the plan's coverage for medical or surgical benefits. *See* Pub. L. No. 110-343, §511 et seq., 122 Stat. 3765 (2008); 29 C.F.R. § 2590.715-2715 (2024). Several years after its passage, at least partly in response to concerns about a lack of compliance with the parity requirements, Congress amended the MHPAEA to require employers to undertake and document their analyses of the parity between mental health and substance use disorder benefits and medical/surgical benefits. Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020). The ability to track and review employer compliance through these analyses has created a helpful enforcement tool. *See* DEP'TS OF TREASURY, LAB., & HEALTH & HUM. SERV., MHPAEA COMPARATIVE ANALYSIS REPORT TO CONGRESS 26-33 (2023).

262. *See, e.g.*, DEP'T OF LAB., EMP. BENEFITS SEC. ADMIN., BULL. NO. 2015-02, SELECTION AND MONITORING UNDER THE ANNUITY SELECTION SAFE HARBOR REGULATION FOR DEFINED CONTRIBUTION PLANS (2015) (providing a safe harbor related to the selection of an annuity provider); 29 C.F.R. § 2510.3-1(b)-(l) (2024) (providing a safe harbor that deems certain types of "payroll practices" exempt from ERISA's requirements); 42 C.F.R. § 2510.3-2(b) (2024) (providing a safe harbor for certain severance plans to be considered welfare plans rather than pension plans); 29 C.F.R. § 2520.104b-31 (2024) (providing a safe harbor for compliance with certain retirement plan notice requirements); 29 C.F.R. § 2550.404a-2 (2024) (providing a safe harbor that deems fiduciary duties satisfied in connection with certain automatic rollovers to IRAs); 29 C.F.R. § 2550.404c-5 (2024) (providing a safe harbor for qualified default investment alternatives).

allowing the employee to enjoy the financial benefits of opting into a high-value network.

This safe harbor could be made even more effective by requiring employers taking advantage of the safe harbor to disclose relevant information to participants. Specifically, employers could be required to notify participants of the selection of a "Safe Harbor High-Value Health Plan Option." This notice should provide a brief explanation of high-value health plans and, if other options are offered in addition to the high-value plan, provide comparative cost and quality metrics for each option.

Because this is merely a safe harbor, employers are under no obligation to provide a high-value option but will simply receive a modest benefit—in the form of reduced fiduciary risk—if they choose to do so. We believe that the significant value in this proposal comes not from strong-arming employers into structuring their plans in a particular way, but by raising awareness of an effective cost control mechanism. Creating this regulatory incentive is likely to result in a reduction in health plan premiums, given that few employers currently offer high-value options, a benefit of particular value to low- and moderate-income workers for whom health plan premiums represent a significant percentage of total compensation. In addition, by creating a market-wide incentive for administrators to compete on the basis of value, the nature of competition in the employer market should begin to shift in favor of constructing provider networks that deliver the highest quality care at the lowest cost, rather than the current trend of broad networks at high prices, with the consumer left to attempt to ascertain quality.

Conclusion

Those immersed in American health policy are intimately familiar with the shortcomings of our current healthcare system and are rightly frustrated by escalating costs that have not translated into improvements in population health. The good news is that many of the system's deficiencies are attributable to the poor performance of ESI managers, and that existing law under ERISA can force them to do better. It is increasingly evident that many managers of employer sponsored health plans are likely in violation of their ERISA fiduciary duties, and a growing wave of private litigation will soon target them. Although this new scrutiny is welcome after many decades of nonfeasance, a better solution is to encourage the Department of Labor to do for the health benefits sector what it has done for the retirement benefits sector, which is to promulgate regulations that articulate the basic obligations that employers must fulfill in their capacity as fiduciaries. Their employees expect, and the law properly requires, employers to act as responsible custodians to the benefits their employees have already earned.

It is worth emphasizing the enormity of the gains that this regulatory guidance could generate for the entire U.S. economy. Employee benefits in the United States approximate the world's 7th largest economy, and employers purchase health care for a majority of Americans. Both the nation's economy and the nation's ailing health sector would experience widespread gains from even modest efficiencies. Even relatively modest guidance and regulatory attention could drive such efficiencies. It is not often that large problems have simple solutions, but ERISA—no longer hiding in plain sight—offers a powerful, albeit partial, remedy.