

A FIDUCIARY THEORY OF HEALTH ENTITLEMENTS

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The Affordable Care Act's "contraceptive mandate" continues to generate controversy in courts and academic literature. While a growing body of scholarship analyzes the merits of employers' religious freedom claims, claims presently before the Supreme Court, academics and commentators have overlooked a more fundamental tension illuminated by the Act but predating its enactment: Historically, the law has empowered employers to make almost all decisions relating to the cost, quality, and accessibility of health insurance on behalf of employees with virtually unlimited discretion, even when those decisions have subverted employees' interests. While contraceptives are the current source of controversy, tensions exist around a wider range of services.

Academic literature has not adequately recognized the conflicts that result when employers select employees' health insurance terms, and the law itself provides no current framework to resolve those conflicts. This Article contends that employees have an entitlement to health insurance, grounded in the Affordable Care Act's statutory guarantees and employer mandate, and in the inherent structure of employment-based health insurance financing. After all, employees pay for their health insurance either directly (through premium contributions) or indirectly (through a wage-benefit tradeoff). Nevertheless, the law undermines employees' rights by empowering employers to make coverage decisions on their behalf with broad discretion.

This Article introduces fiduciary law to re-theorize this relationship between employers and employees. It suggests that employers act as fiduciaries when they make coverage decisions on employees' behalf. Fiduciary law constrains fiduciaries with duties of care and loyalty, requiring that fiduciaries act in beneficiaries' sole interest and disregard their own social or other preferences. The fiduciary reframing accepts a

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world of dependent health care relationships, particularly given the complexity of health insurance decision-making. Yet it ensures that these third parties act in beneficiaries' interest with appropriate diligence and care. The Article concludes by analyzing doctrinal obstacles and opportunities in implementing the revised fiduciary account.

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INTRODUCTION

Who should make decisions regarding health insurance on behalf of the insured? Who should decide what services insurance will cover and under what terms? For the majority of Americans, employers make these decisions. In 2010, 55% of persons in the United States received their health insurance through their place of employment or that of a family member.¹ General Motors' executives used to quip: "We are in

¹ See BRIAN MAUERSBERGER, U.S. BUREAU OF LABOR STATISTICS, TRACKING EMPLOYMENT-BASED HEALTH BENEFITS IN CHANGING TIMES 2 (Jan. 27, 2012), available at <http://www.bls.gov/opub/mlr/cwc/tracking-employment-based-health-benefits-in-changing->

the healthcare provision business and make cars on the side.”² In certain respects, they were right. Employers are the primary health insurance providers in the United States. And yet, they are more than *providers*—they are also health insurance *deciders* on behalf of employees and their families.

Historically, the law has supported this structural arrangement, allowing employers to make all decisions about employees’ (and in many instances their families’) health insurance with virtually unlimited discretion.³ Employers make decisions affecting health insurance cost, quality, and accessibility—and the tradeoffs among them—even when their choices subvert employees’ interests. The contraceptive mandate litigation now before the Supreme Court is but one example of the tensions that can result from such decisions.⁴ In that litigation, employers effectively assert this same right—to make coverage choices regarding health insurance on behalf of employees based on their own set of values and preferences. Reframed in this way, the lawsuits evince broader and more fundamental conflicts that have long existed around health insurance decision-making—conflicts that the academic literature has not adequately recognized and that the law itself has no current framework to resolve.

This Article fills in these gaps by examining the tensions inherent in allowing employers to have unlimited discretion to purchase health insurance on behalf of employees. It starts by asking two questions:

times.pdf (citing CARMEN DENAVAS WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (Sept. 2011)).

² Christopher Stuart, Comment to Avik Roy, *Democrats’ New Argument: It’s a Good Thing That Obamacare Doubles Individual Health Insurance Premiums*, FORBES (June 3, 2013), <http://www.forbes.com/sites/theapothecary/2013/06/03/democrats-new-argument-its-a-good-thing-that-obamacare-doubles-individual-health-insurance-premiums> (internal quotation marks omitted).

³ Certain de minimis content controls exist, such as those related to pregnancy benefits. See, e.g., *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 685 (1983) (holding that under the Pregnancy Discrimination Act it is discriminatory to exclude pregnancy coverage from an otherwise inclusive benefit plan). However, by and large, employers have had almost unlimited latitude to select coverage and terms. See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 76 (1995); U.S. DEP’T OF LABOR, UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN 2 (May 2013), available at <http://www.dol.gov/ebsa/pdf/ghpfiduciaryresponsibilities.pdf>.

⁴ Presently, over ninety employers have filed lawsuits objecting to the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified primarily in scattered sections of 26 and 42 U.S.C.). See, e.g., *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114 (10th Cir. 2013), cert. granted, 134 S. Ct. 678 (2013). See also *HHS Mandate Information Central*, BECKETT FUND FOR RELIGIOUS LIBERTY, <http://www.becketfund.org/hhsinformationcentral> (last visited Apr. 18, 2014). In these lawsuits, employers allege that the mandate requires them to pay for drugs and services in violation of their religious freedom rights. Two of these cases are before the Supreme Court this term. This Article does not address the merits of employers’ claims, but rather elucidates the broader structural problem that the lawsuits reveal.

First, what entitlements do employees have to employment-based health insurance? And second, what protections exist to ensure that persons making decisions with respect to those entitlements represent employees' interests? The Article then re-theorizes the relationship between employers and employees as a fiduciary relationship, i.e. a relationship that forms when one party acts on behalf of another (the beneficiary) and exercises discretion over a critical resource belonging to the beneficiary.⁵ Employers, in this revised account, act as fiduciaries when they make coverage decisions with respect to employees' health insurance.

The fiduciary account clarifies that the critical resource of health insurance *belongs* to the employee. In the case of contraceptives, the employee's claim of right to health insurance is grounded in the series of health entitlements that the Affordable Care Act grants, as well as in the way that employment-based health insurance is financed. First, the Affordable Care Act creates a statutory entitlement to contraceptives and other preventive services for participants in all new health plans. Employees working for large employers—those with fifty or more full-time employees⁶—must access most of these entitlements through their employer-based health insurance plans. Second, the Affordable Care Act-based entitlements add to a broader claim that employees might make about their claim to *all* employment-based health insurance premium payments. In particular, employees pay for their health insurance either directly through premium contributions or indirectly through a wage-benefit tradeoff. When employers contribute to employees' health insurance plan premiums, their payments act as a form of employee compensation, supplementing—or, more aptly, substituting for—formal wages. The federal government also contributes to employment-based insurance costs by offering a tax-credit that accrues to employees' benefit. Collectively, these entitlements ground a normative claim of right to particular preventive health services, federal tax exclusions, and—most fundamentally—to the insurance purchased with employees' money.

Fiduciary law aims to protect the interests of employees with respect to these critical resources. As a field of law, it leverages the knowledge and expertise of fiduciaries to make decisions on behalf of beneficiaries, particularly with respect to complex matters like investments or, in this case, the purchase of health insurance. Fiduciary law also applies a deep and reasoned doctrinal approach to resolve tensions that emerge across diverse disciplines like investment management, guardianship, and corporate directorship. Common issues

⁵ See TAMAR FRANKEL, *FIDUCIARY LAW* 1–4, 7–12 (2011); see also D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1458–60 (2002).

⁶ See 26 U.S.C. § 4980H(c)(2)(A) (2012).

include how to delineate boundaries on discretion, how to make choices in the interests of collective groups with divergent desires, and how to resolve inherent conflicts of interest. Fiduciary law has substantive and procedural mechanisms to respond to these challenges, such as the use of the duties of loyalty and care as regulatory tools.⁷ Courts, in turn, have developed limiting mechanisms to constrain fiduciary actions when conflicts of interest are inevitable.⁸ For example, fiduciaries may create “walls” around conflicted parties, or engage independent third parties to act as unbiased decision-makers.⁹ In limited circumstances, a fiduciary may have to recuse himself from serving in a fiduciary role.¹⁰

Fiduciary law holds appeal among academics and practitioners, in part, due to its adeptness at resolving these types of conflicts.¹¹ This Article furthers fiduciary scholarship by considering employment-based health insurance purchasing through the fiduciary lens. It offers the first comprehensive account of the range of entitlements that employees have to health insurance¹² and then applies fiduciary law to clarify decision-making with respect to those entitlements.

⁷ See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 YALE L.J. 625, 642 (1995) (“Fiduciary law imposes two broad standards, loyalty and care, that regulate the exercise of the discretion that modern trustees’ powers law bestows.”); see also Smith, *supra* note 5, at 1458–60.

⁸ See FRANKEL, *supra* note 5, at 117–19.

⁹ *Id.*

¹⁰ SUSAN P. SHAPIRO, TANGLED LOYALTIES: CONFLICT OF INTEREST IN LEGAL PRACTICE 449 (2002).

¹¹ Law and economics scholars have highlighted the economic, contractarian model of fiduciary law grounded in notions of trust law and agency. See, e.g., Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045 (1991); Frank H. Easterbrook & Daniel R. Fischel, *Contract and Fiduciary Duty*, 36 J.L. & ECON. 425 (1993); Robert H. Sitkoff, *The Economic Structure of Fiduciary Law*, 91 B.U. L. REV. 1039 (2011). Others have explored the importance of trust and reposed confidence in guiding fiduciaries’ discretion. See, e.g., Frank B. Cross, *Law and Trust*, 93 GEO. L.J. 1457 (2005); Tamar Frankel, *Fiduciary Duties as Default Rules*, 74 OR. L. REV. 1209 (1995); Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795, 800 (1983) (using the word “entrustor” to describe fiduciary relationships); Claire A. Hill & Erin Ann O’Hara, *A Cognitive Theory of Trust*, 84 WASH. U. L. REV. 1717 (2006); L.S. Sealy, *Fiduciary Relationships*, 1962 CAMBRIDGE L.J. 69; D. Gordon Smith & Jordan C. Lee, *Discretion*, 75 OHIO ST. L.J. (forthcoming 2014), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2238287; Ernest J. Weinrib, *The Fiduciary Obligation*, 25 U. TORONTO L.J. 1 (1975). Across diverse relationships, scholars have applied fiduciary law to reconsider interactions with partners, see Larry E. Ribstein, *Are Partners Fiduciaries?*, 2005 U. ILL. L. REV. 209; judges, see Ethan J. Leib, David L. Ponet & Michael Serota, *A Fiduciary Theory of Judging*, 101 CALIF. L. REV. 700 (2013); friends, see Ethan J. Leib, *Friends as Fiduciaries*, 86 WASH. U. L. REV. 665 (2009); and elected officials, see D. Theodore Rave, *Politicians as Fiduciaries*, 126 HARV. L. REV. 671 (2013). But see Ethan J. Leib et al., *Translating Fiduciary Principles into Public Law*, 126 HARV. L. REV. FORUM 91 (2013) (documenting the complexities of mapping private fiduciary doctrine onto public figures like officeholders).

¹² Professor Timothy Jost offers an account of statutory-based health care entitlements for the time before the Affordable Care Act. See generally TIMOTHY STOLTZFUS JOST, *DISSENTMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A*

Offering this account is particularly important at this time. Employment-based insurance coverage will remain the dominant mode of health care financing in the United States for the foreseeable future, given the Affordable Care Act's employer "play or pay" mandate.¹³ The contraceptive mandate litigation before the Supreme Court provides a narrow window into conflicts that exist in this structure of health insurance decision-making, conflicts that academic literature to date has been unable to resolve.¹⁴

RIGHTS-BASED RESPONSE 30–34 (2003). This Article compares health entitlements under the Act with those entitlements that existed before the Act. *See infra* Part II.B.

¹³ HENRY H. PERRIT, JR., EMPLOYMENT LAW UPDATE § 3.01 (2013 ed.) (internal quotation marks omitted).

¹⁴ To date, scholars have generally assessed the legal challenges in two manners. First, certain scholars delineate the expressive freedom rights of different categories of faith- and non-faith-based employers. *See, e.g.*, Caroline Mala Corbin, *Two Easy Cases: Nonprofit and For-Profit Corporate Challenges to the Contraception Mandate*, 161 U. PA. L. REV. ONLINE 268 (2013) (contending that one need not oppose the Religious Freedom Restoration Act to conclude that it does not require exemptions from the contraception mandate); Paul Horwitz, *Defending (Religious) Institutionalism*, 99 VA. L. REV. 1049, 1049 (2013) (arguing that religious institutionalism, in the church and elsewhere, is important, and emphasizing concern about the "pulverising . . . tendency" of the state toward those institutions (quoting F.W. MAITLAND, STATE, TRUST AND CORPORATION 66 (David Runciman & Magnus Ryan eds., 2003)) (internal quotation marks omitted)); Mark Rienzi, *God and the Profits: Is There Religious Liberty for Moneymakers?*, 21 GEO. MASON L. REV. 59 (2013) (arguing that the act of earning money does not preclude profit-making businesses and their owners from engaging in protected religious exercise); Elizabeth Sepper, *Contraception and the Birth of Corporate Conscience*, 22 AM. U. J. GENDER & SOC. POL'Y & L. 303, 304 (2014) ("[A] dangerous doctrine of 'corporate conscience' may be born of the contraception controversy."); Edward Whelan, *The HHS Contraception Mandate vs. The Religious Freedom Restoration Act*, 87 NOTRE DAME L. REV. 2179 (2012) (contending that the contraception mandate violates the Religious Freedom Restoration Act). Alternatively, other scholars expand the analytical framework to highlight how contraceptives promote equality, autonomy, and progressive conceptions of family. *See, e.g.*, Naomi Cahn & June Carbone, *Family Classes: Rethinking Contraceptive Choice*, 21 U. FLA. J.L. & PUB. POL'Y 361 (2009) (highlighting tensions between models of family, and arguing that politicization of family issues through measures like cutting family planning funds produce a vicious cycle); R. Alta Charo, *Warning: Contraceptive Drugs May Cause Political Headaches*, 366 NEW ENG. J. MED. 1361 (2012) (arguing that objections to the mandate reject progressive, cross-subsidizing ways of structuring public space in order to promote affordable health care for varied citizens); Robin Fretwell Wilson, *The Calculus of Accommodation: Contraception, Abortion, Same-Sex Marriage, and Other Clashes Between Religion and the State*, 53 B.C. L. REV. 1417 (2012) (suggesting that religious accommodations qualified by hardship to others can promote both access and religious freedom). This Article offers a lens into the deeper structural problems that are now evident, problems that extend far beyond issues of contraceptive coverage. Doing so also contributes to academic analysis of relationships and decision-making within health care delivery. *See also* Jessica L. Roberts, "Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 U. ILL. L. REV. 1159 (identifying discrimination as endemic to long-standing practices of private, for-profit health-insurers); William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1818 (1999) (examining the utility of disclosure laws in regulating conflicts with health care providers and insurance organizations); Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501 (2012) (examining the role of individual and institutional health care providers in offering care consistent with their morals).

Importantly, this re-framing may have utility beyond this particular setting. Our system of health care delivery is replete with third-party relationships in which patients must rely on others (e.g., employers, unions, or insurers) to make decisions with respect to their critical resources on their behalf. Such fiduciary relationships are grounded in notions of dependency—of entrusting property or power to others with more knowledge, expertise, or authority in order to promote individual or public good.¹⁵ Such dependency can offer benefits—such as improved decision-making or risk pooling. Yet it also carries risks—such as paternalism or conflicts of interest—that allow third parties to exploit the patient’s vulnerability. Such structural arrangements may silently, without justification, undermine health care users’ choice and agency in health care decision-making. The fiduciary reframing accepts a world of dependent health care relationships, particularly given the complexity of health care decision-making. Yet it defines the limits of third parties’ discretion in order to ensure that these parties act in beneficiaries’ sole interest with appropriate diligence and care.

This examination also unearths and explores potential solutions to newly discovered tensions within fiduciary law. For example, fiduciaries may have double fiduciary obligations or they may exercise discretion in nuanced ways in rapidly changing environments. And traditional fiduciary remedies—typically, the disgorgement of profits—may be ill equipped to compensate for harms beneficiaries suffer when they are denied access to critical resources. This Article also suggests a potential new accountability framework for third parties administering public entitlements,¹⁶ rooted in fiduciary law.

The Article proceeds as follows. Part I introduces the historical account of employment-based health insurance, describing how it came to be the dominant mode of health care insurance delivery in the United States, as well as how it came to serve as a form of substituted wages. Under this system, employers make payment and coverage decisions on behalf of employees (and their family members who participate in

¹⁵ See FRANKEL, *supra* note 5, at 7–12.

¹⁶ See Alfred C. Aman, Jr., *Privatization and Democracy: Resources in Administrative Law*, in *GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY* 261, 281–85 (Jody Freeman & Martha Minnow eds., 2009); Gillian E. Metzger, *Private Delegations, Due Process, and the Duty to Supervise*, in *GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY* 291, 291 (Jody Freeman & Martha Minnow eds., 2009) (assessing the legal mechanisms needed to enable constitutional review of administrative delegation to private parties); Gillian E. Metzger, *Privatization as Delegation*, 103 *COLUM. L. REV.* 1367 (2003) (arguing that privatization acts as a form of administrative delegation and existing state action doctrine is functionally inadequate to address the constitutional challenge posed by such privatization); David Super, *Privatization, Policy Paralysis, and the Poor*, 96 *CALIF. L. REV.* 393 (2008) (suggesting high costs of dismantling subsistence benefits programs and advocating for an efficiency model of determining whether and how much to privatize).

health plans).¹⁷ From the outset, this relationship presented conflicts. Yet the law protected employers' ability make decisions despite these conflicts.¹⁸ There were also a range of justifications for employment-based coverage, including negotiating advantages, risk pooling, favorable tax treatment,¹⁹ and reinforcing employee values around risk sharing.²⁰ Overall, scholars and critics largely dismissed potential agency problems as theoretical²¹ and endorsed employment-based coverage,²² identifying it as the "Rodney Dangerfield" of health insurance—receiving no respect despite having many positive attributes.²³ Yet the structural faults undergirding battles like those in courts today were ever-present. The contraceptive mandate litigation exposes conflicts between employers' and employees' preferences, showing that they are not purely theoretical. Instead, the conflicts are extensive, and the stakes significant.

Against this backdrop, Part II contends that employees have entitlements to employment-based insurance coverage. The Affordable Care Act guarantees that new health plans will cover certain health services, including contraceptives. It also mandates that large employers provide coverage or pay a penalty, thereby requiring private parties to provide the entitlement. These entitlements are just the tip of the iceberg. Employers make a range of health coverage and payment decisions beyond those relating to preventive care. This broader

¹⁷ Employers also make these decisions on behalf of employees' family members when employees enroll in family health plans. In 2012, according to one survey, 17% of covered workers had single plus one coverage, and 36% of covered workers had family coverage. THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 49 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>. This Article focuses on tensions with employees, but the broader scope of potential conflicts should not be overlooked.

¹⁸ See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."); U.S. DEP'T OF LABOR, *supra* note 3, at 2 ("[T]he decisions to establish a plan, to determine the benefit package, to include certain features in a plan, to amend a plan, and to terminate a plan are employer business decisions [and not subject to fiduciary duties] . . ."); PETER J. WIEDENBECK, ERISA PRINCIPLES OF EMPLOYEE BENEFIT LAW 114 (2010) ("Judgments respecting the design, establishment, or modification of an employee benefit plan are not fiduciary acts, for they do not implicate program management.").

¹⁹ See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 30-35 (2001).

²⁰ See Sage, *supra* note 14, at 1818.

²¹ See Hyman & Hall, *supra* note 19, at 30 ("[T]he agency problems . . . often are more theoretical than real. . . . Surveys and focus groups indicate that employers do a reasonably good job reflecting their workers' values and preferences, just as one would expect in a reasonably competitive labor market.").

²² See *id.* at 23.

²³ David A. Hyman, *Employment-Based Health Insurance Coverage: Is Health Reform a "Game Changer?"* 2 (Univ. of Ill. College of Law, Ill. Law & Econ. Research Papers Series, Research Paper No. 10-17, 2010).

decision-making has taken place for decades, with employers using employees' financial resources—whether tax exclusions, employee contributions to health insurance premiums, or employer-made contributions to premiums that function as a form of wages—to make insurance decisions on behalf of employees.

Given this employee entitlement to workplace health insurance, Part III suggests that employers act as fiduciaries when they purchase health insurance on behalf of employees. It examines the fiduciary duties that would follow—namely, a duty of loyalty and a duty of care in decision-making. Where conflicts exist, as in employers' self-professed statements in the contraceptive mandate litigation, fiduciary law offers a set of solutions (through limiting mechanisms) to legal challenges presently before courts. This Part also considers and responds to shortcomings in the fiduciary model, including employers' double fiduciary duties to the corporation and to employees; employers' limited fiduciary "expertise" to make health coverage decisions; and the challenges in acting on behalf of diverse collectives.

Finally, Part IV provides an account of the doctrinal opportunities and challenges involved in implementing this revised fiduciary model. It explores the fiduciary model presented in the Employee Retirement Income Security Act of 1974 (ERISA)²⁴ and notes the tensions in ERISA's limited framing of fiduciary roles. Yet the Affordable Care Act has dramatically altered the nature of employment-based health coverage by making it mandatory for large employers and requiring minimum coverage. Therefore, this Part posits that the Affordable Care Act has created *at least* a limited set of entitlements to employer-provided health insurance. It suggests solutions to reconcile the Affordable Care Act (as a later-in-time statute) with ERISA, and to help ensure that employees' interests are protected in health insurance purchasing and related decision-making.²⁵ The Article concludes by suggesting implications of applying fiduciary law to this setting for health law and fiduciary law more broadly.

²⁴ The Employment Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.) (establishing minimum standards for pension plans, including health insurance plans, and aiming to protect the plan participants' interests).

²⁵ Notably, this Article argues that *Curtiss-Wright* no longer is apposite in holding that "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

I. EMPLOYMENT-BASED COVERAGE: THE HISTORICAL ACCOUNT

Employers provide health insurance to the majority of persons in the United States. While serving in this role, they also make almost all decisions regarding the terms of health insurance on behalf of employees, making them powerful arbiters of how individuals experience and access health services. This Part will offer a descriptive account of how employers came to occupy such a prominent role in health insurance financing and delivery, demonstrating that employment-based health insurance has come to serve as a form of substituted wages. It will then canvas the longstanding tensions in this mode of obtaining health insurance coverage, as well as the attendant justifications that have sustained it.

A. *Evolution of Employment-Based Coverage*

Employers became the dominant providers of health insurance in the United States over the course of many decades due to political, social, and market factors.²⁶ Employment-based coverage emerged in the 1930s as consumers increasingly demanded health insurance, and providing it through the place of employment proved convenient and efficient.²⁷ It mitigated concerns of adverse selection, as individuals generally do not join a place of employment (and, hence, qualify for and enroll in a system of employment-based health insurance coverage) because they are ill.²⁸ It also helped minimize marketing and underwriting costs by creating a pooled group of health plan

²⁶ See COMM. ON EMP.-BASED HEALTH BENEFITS DIV. OF HEALTH CARE SERVS., INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 49 (Marilyn J. Field & Howard T. Shapiro eds., 1993) [hereinafter EMPLOYMENT AND HEALTH BENEFITS].

²⁷ See TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 55 (2007). Jost's overview of the historical events surrounding the evolution of employment-based coverage challenges the popular narrative that this form of coverage is due to historical accident, concluding that "[t]he primary reason why we have employment-related health insurance in the United States . . . is [because] . . . [h]ealth insurance is a product that consumers want, and one of the most efficient ways to provide it is through places of employment . . ." *Id.*; see also William S. Custer et al., *Why We Should Keep the Employment-Based Health Insurance System*, 18 HEALTH AFF. 115, 120 (1999) ("The employment-based health insurance system is not a historical accident. Its characteristics flow directly from our society's desire to maximize access to health care, our commitment to voluntary private markets, and the market advantages of employer-sponsored health insurance."). But see Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 LAW & INEQUALITY 1, 33-34 (2010); Jon R. Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*, 18 HEALTH AFF. 62, 63 (1999).

²⁸ See JOST, *supra* note 27, at 55.

participants.²⁹ Employment-based coverage expanded dramatically over the next two decades in terms of the number of individuals covered and the range of services available under health plans. Labor unions lobbied for the expansion, pressuring employers to offer health insurance as part of richer benefit packages.³⁰ In non-unionized industries, the pressure to provide health insurance also increased. By offering these benefits, employers could discourage unionization, help keep workers healthy, and make it more difficult for employees to leave their jobs.³¹

World War II-era wage stabilization and tax policies contributed to the growth of employment-based coverage.³² In 1942, when the war made the supply of domestic labor scarce, Congress passed the Stabilization Act, but exempted a “reasonable amount” of insurance benefits, including health benefits, from the Act’s wage controls.³³ In addition, in 1943, the Internal Revenue Service ruled that workplace health and welfare benefits would not be considered as taxable income to employees, and businesses could deduct payments to health and welfare funds as business expenses.³⁴ These tax rulings provide key economic incentives to provide health insurance through the place of employment.³⁵ Employees functionally receive a subsidy for their insurance purchases—by one estimate, a savings of 10% to 35% depending on an employee’s marginal tax rate.³⁶ At the time, with the

²⁹ See *id.*

³⁰ See *id.*; Hyman & Hall, *supra* note 19, at 25–26. In 1948, the Seventh Circuit held that employee benefits were within the “terms and conditions of . . . employment” subject to collective bargaining agreements under the National Labor Relations Act. *Inland Steel Co. v. NLRB*, 170 F.2d 247, 258 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949); see also JOST, *supra* note 27, at 63 (providing a more expansive account of unions’ role in the growth of employment-based coverage).

³¹ See JOST, *supra* note 27, at 63; Hyman & Hall, *supra* note 19, at 25–26. Even today, employment-based coverage restricts workers’ labor mobility since there are no economic substitutes for employment-based coverage with its attendant tax subsidies. See *infra* Part I.B. Whether the Affordable Care Act, with its employer mandate, insurance exchanges, and attendant tax credits for qualifying employees, can mitigate these effects is yet to be seen.

³² Hyman & Hall, *supra* note 19, at 25–26. These two factors may have played a smaller role in promoting growth, given that most expansions in employment-based coverage took place before these policies came into effect. See JOST, *supra* note 27, at 55.

³³ See JOST, *supra* note 27, at 59.

³⁴ See *id.* at 60; Hyman & Hall, *supra* note 19, at 25. The IRS later withdrew this ruling, but Congress then amended the Internal Revenue Code to expressly exclude employment-based coverage from taxable income. See *id.* (citing 26 U.S.C. §§ 106, 3121 (2012); SHERRY GLIED, REVISING THE TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH INSURANCE 4 (1994)).

³⁵ See JOST, *supra* note 27, at 59–60; Hyman & Hall, *supra* note 19, at 25.

³⁶ See BOB LYKE, CONG. RESEARCH SERV., RL34767, THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE: POLICY ISSUES REGARDING THE REPEAL DEBATE 2 n.5 (2008) (“Since it reduces the after-tax cost of insurance in ways that are not transparent, it likely results in people with insurance obtaining more coverage than they otherwise would.”).

exception of some unionized groups, employees generally paid for benefits themselves.³⁷

In the decade following World War II, employment-based coverage grew dramatically. By 1954, 11.3 million workers had this form of coverage, as compared with just 0.5 million of such workers in 1945.³⁸ Employment-based coverage continued to expand rapidly; in 2009, employers provided health coverage to approximately 160 million individuals under the age of sixty-five, or 59% of that population.³⁹ For individuals aged sixty-five and older, Medicare is the principal source of health insurance—it covered approximately 93.5% of that population in 2009.⁴⁰

Coverage became more robust beginning in the 1960s—it increasingly included forms of preventive care, dental care, pharmaceuticals, maternity care, and mental health treatment.⁴¹ And employers' absolute and proportional contributions to workers' health premiums grew over time.⁴² In 2012, employers contributed an average of 82% towards premium costs for individual health plans, and 62% towards premium costs for family health plans.⁴³ Employers thereby became a powerful player in the health insurance marketplace: covering an expanding range of health services through employment-based insurance plans and contributing an increasing portion to plan premium costs.

³⁷ See JOST, *supra* note 27, at 61 (noting that by the end of World War II, only 7.6% of Blue Cross enrollees participated in groups that had employer contributions).

³⁸ *Id.*

³⁹ CONG. BUDGET OFFICE, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE 1 (Mar. 2012), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf; Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 886 (2011) (citing PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2010 CURRENT POPULATION SURVEY 4 (2010)). By way of comparison, in 2009, approximately 21% of individuals under the age of sixty-five were covered by public programs, 19% were uninsured, and 6% purchased insurance directly from an insurance company. *Id.* at 886 n.3 (citing FRONSTIN, *supra*, at 4).

⁴⁰ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 79 (2010). A significant portion of the group of individuals aged sixty-five and older—almost 35%—also maintains employment-based coverage. *See id.*

⁴¹ See JOST, *supra* note 27, at 61.

⁴² See *id.* at 61–62.

⁴³ See THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *supra* note 17, at 1, 72.

B. *Tensions in Employment-Based Coverage*

Most of the long-existing tensions in employment-based coverage relate to the fact that the employer, rather than the consumer, is making health insurance coverage and payment decisions.⁴⁴ Employers' decision-making impedes a pure free-market solution since individuals do not make their own cost-quality-accessibility tradeoffs; instead, employers dictate the level and nature of those decisions.⁴⁵ When employers select certain insurance products to offer their employees and omit others, they influence which services will be covered and under what terms and conditions.⁴⁶ Their decisions necessarily impact the financial accessibility of health care for participants in employment-based plans. Employers may ultimately ignore individual preferences and have fewer incentives to favor particular quality enhancements, since they only internalize part of the benefits of improved care.⁴⁷

That employment-based coverage extends not only to individual employees but also to groups of employees (and, potentially, to their family members) widens the potential scope of tensions.⁴⁸ The end result is a set of informational, preference, and incentive mismatches that exist between various permutations of actors—employers, individual employees, collective groups of employees, and employees' family members.⁴⁹ While some employees may be able to minimize the tensions by selecting from more than one available health insurance plan, approximately half of employees do not receive a choice among multiple plans from their employers, and—even with several insurance plan options—various actors would still confront preference and other mismatches. In practice, conflicts have been evident around a range of services, including bariatric surgery, in vitro fertilization, cosmetic surgery, and sex reassignment surgery.⁵⁰

⁴⁴ Hyman & Hall, *supra* note 19, at 26–27; *see also* Sage, *supra* note 14, at 1743 (“The risks of relying on these agents went largely unnoticed as long as consumers, employers, and taxpayers were willing to fund unlimited amounts of care . . .”).

⁴⁵ *See* Sage, *supra* note 14, at 1744–45.

⁴⁶ *See id.*

⁴⁷ *See id.* at 1724, 1744–45.

⁴⁸ This Article generally refers to conflicts between employers and *employees*. Yet the arguments made herein about employees' entitlements apply, by extension, to employees' family members covered under such plans.

⁴⁹ Notably, with respect to covered family members, employers may realize even fewer benefits of improved care, leading to adverse distributional consequences within family units. *See* Naomi Schoenbaum, *Mobility Measures*, 2012 BYU L. REV. 1169, 1175 (2012).

⁵⁰ *See* Norman Daniels & Marc Roberts, *Health Care Reform*, in FROM BIRTH TO DEATH AND BENCH TO CLINIC, THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS 83, 86–87 (Mary Crowley ed., 2008); *see also, e.g., BlueCare Disclaimer*, ANTHEM BLUE CROSS & BLUE SHIELD, http://www.anthem.com/wps/portal/ahprovider?content_path=shared/va/f3/s6/t0/pw_m008961.htm&state=va&rootLevel=2&label=BlueCare%20Disclaimer (last visited Apr. 17, 2014) (listing coverage exclusions for Anthem

Employment-based insurance coverage confronts other critiques as well. It leads to labor market dislocations and “job lock”—that is, employees may choose to stay in a current job because of fears of waiting periods or exclusions on preexisting conditions, or perhaps because a new, otherwise appealing employer does not offer health insurance coverage.⁵¹ There are also significant equitable concerns for those persons not covered by employment-based insurance. The current system of tax exclusions fosters a regressive form of health care financing in the United States. Tax exclusions provide the largest subsidies for the wealthy in the highest tax brackets, lower subsidies for those with lower incomes who pay little or no taxes, and no subsidies at all for those who cannot obtain employment-related insurance and, instead, must rely on the individual market.⁵²

And tax exclusions come at a high cost to the government. The Joint Committee on Taxation identified the income tax exclusion for employer-based care as the single largest government tax expenditure in fiscal year 2009.⁵³ The estimated lost tax revenue from the tax exemption that year was \$94.4 billion.⁵⁴

C. *Justifications for Employment-Based Coverage*

Despite these fundamental tensions in employment-based coverage, this system of financing endures and, indeed, even flourishes. As Timothy Jost noted, “[i]t is a system with many faults, but its great virtue is that it has extended insurance to 172 million Americans, far more than have been reached by the individual insurance market, and

health insurance plans); *Limitations and Exclusions*, AETNA, <http://healthinsurance.aetna.com/aetna-insurance/limitations-exclusions> (last visited Apr. 17, 2014) (listing coverage exclusions for standard Aetna health insurance plans). There are varied, and at times obscure, reasons that coverage for such services is often denied. According to one insurer, these services are “insufficiently effective, experimental, inappropriate or outside the practical scope of coverage.” *BlueCare Disclaimer*, *supra*. Employers may also exclude services, or not bargain on behalf of employees to include services, as part of their overall business strategy. *See, e.g.*, U.S. DEP’T OF LABOR, *supra* note 3, at 2. Although it is beyond the scope of this Article to consider the political economy surrounding particular coverage decisions, it is worth noting that stigmatized and/or politicized health services, such as treatments for mental disorders, obesity, and reproductive health, are often excluded.

⁵¹ Hyman & Hall, *supra* note 19, at 28–29.

⁵² JOST, *supra* note 12, at 185. Most other developed countries, in contrast, embrace progressive forms of health care financing, with more financial assistance being made available to persons who can least afford care. *See id.* at 198. Medicaid and Medicare support specific groups of individuals and, to some extent, counter this tendency towards regressive health care financing.

⁵³ Moore, *supra* note 39, at 891 (citing STAFF OF JOINT COMM. ON TAXATION, 111TH CONG., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2009–2013, at 3, 6 n.14, 41 (Comm. Print 2010)).

⁵⁴ *See* STAFF OF JOINT COMM. ON TAXATION, *supra* note 53, at 41.

even more than are covered by public insurance.”⁵⁵ Employment-based coverage provides an efficient solution to economic and negotiating challenges that employees would otherwise confront on their own.⁵⁶ Workers in large companies often accept notions of health risk spreading and redistribution around the place of employment.⁵⁷ In contrast, workers may not embrace these same values in the context of society-wide sharing and redistribution of health care costs.⁵⁸ Given employment-based coverage’s favorable tax treatment as non-taxable income to employees, and at the same time fully deductible as a business expense to employers,⁵⁹ it has emerged as a “second-best” option in a world of political constraints and no perfect solutions.⁶⁰ With respect to its shortcomings, scholars have generally acknowledged—but largely dismissed—potential agency problems in having employers negotiate coverage.⁶¹

Notably, where tensions exist in having employers negotiate coverage, they have been permissible from a legal standpoint, at least historically. Before the Affordable Care Act, while it was often economically and strategically advantageous for employers to offer coverage, employers had no obligation to do so.⁶² Employers could decide not only whether to offer coverage, but also the terms of coverage each plan year. This has long been the case under ERISA,⁶³ which governs employers’ conduct in providing benefit plans, including health insurance plans.⁶⁴ The Supreme Court, considering ERISA before the advent of the Affordable Care Act, stated, “ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.”⁶⁵ In other words, aside from de minimis content controls,⁶⁶ employers could select benefit packages to optimize their business advantage.⁶⁷

⁵⁵ See JOST, *supra* note 12, at 197.

⁵⁶ See Hyman & Hall, *supra* note 19, at 30–35.

⁵⁷ Sage, *supra* note 14, at 1818.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ See Hyman & Hall, *supra* note 19, at 24; see also Hyman, *supra* note 23, at 1.

⁶¹ See Hyman & Hall, *supra* note 19, at 30 (citing, among other sources, an Employee Benefit Research Institute study showing satisfaction rates of 68% with the mix of benefits and wages received at the place of employment).

⁶² See *id.* at 25–26.

⁶³ The Employment Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.).

⁶⁴ See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 75 (1995); U.S. DEP’T OF LABOR, *supra* note 3, at 1.

⁶⁵ *Curtiss-Wright Corp.*, 514 U.S. at 78; see also WIEDENBECK, *supra* note 18, at 114.

⁶⁶ For example, under ERISA, plans must provide for “continuation” of health coverage, group-plan-guaranteed issue and renewability, and certain pre-existing condition exclusions.

Yet, as Part IV will demonstrate, ERISA's statutory language, as interpreted by the Supreme Court, is superseded by the Affordable Care Act in key ways. In particular, the Act requires that large employers provide health insurance and enumerates particular health services that employment-based plans must cover free of cost sharing, creating a baseline entitlement to health care for employees.⁶⁸ In this sense, the Affordable Care Act changes employers' ability to have unlimited discretion over health insurance plan purchasing. Further, the Act may broaden the scope of employers' duties, at least under the more expansive view of health entitlements that this Article proffers.

II. EMPLOYMENT-BASED COVERAGE IN A LAND OF HEALTH ENTITLEMENTS

The Affordable Care Act, signed into law on March 23, 2010, has been controversial since its drafting. As of April 2014, House Republicans had made more than fifty attempts to repeal the legislation.⁶⁹ As Federal Policy Director of the Center for Health Transformation Vincent Frakes noted, "[n]ot only did the content of the more than 2,700 page bill illustrate the stark ideological differences between the two major political parties, but also the legislative process by which it became law further showcased both sides' entrenchment in their beliefs."⁷⁰ The Act reflects a range of strongly-held partisan viewpoints, as seen in its handling of traditionally contentious areas (such as abortion coverage),⁷¹ as well as in the nuanced ways in which it structures individuals' and employers' participation in the health insurance market.⁷²

29 U.S.C. §§ 1161–62, 1181–83 (2012).

⁶⁷ See U.S. DEP'T OF LABOR, *supra* note 3, at 2; WIEDENBECK, *supra* note 18, at 114.

⁶⁸ See *infra* Part IV.

⁶⁹ See Ed O'Keefe, *Boehner Takes Over Response to Obama, Focuses on Jobs and Health Care*, WASHINGTON POST (April 26, 2014), http://www.washingtonpost.com/politics/boehner-takes-over-response-to-obama-focuses-on-jobs-and-health-care/2014/04/26/74369bd4-cd78-11e3-93eb-6c0037d4e2ad_story.html?tid=hpModule_ba0d4c2a-86a2-11e2-9d71-f0feafdd1394.

⁷⁰ Vincent L. Frakes, *Partisanship and (Un)compromise: A Study of the Patient Protection and Affordable Care Act*, 49 HARV. J. ON LEGIS. 135, 135 (2012) (discussing the partisan nature of insurance regulation and employer penalties, as well as the bipartisan compromise evident in provisions on improving quality of care).

⁷¹ The Act extends historic federal abortion funding restrictions to newly created health insurance plans. Health plans cannot be required to cover abortions as part of their essential health benefits package, and federal tax credits and cost-sharing subsidies may not be used for abortions not permitted by the Hyde Amendment. See 42 U.S.C. § 18023; Exec. Order No. 13,535: Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act, 75 Fed. Reg. 15,599 (Mar. 24, 2010).

⁷² See Frakes, *supra* note 70, at 145–48.

This Part profiles two contentious and noteworthy components of the legislation: (1) the statutory entitlements to certain health insurance benefits and modes of coverage, which create claims of right for the vast majority of health insurance purchasers in the United States; and (2) the “play or pay” participation mandate for medium- and large-sized employers. When combined, these two legislative provisions functionally “privatize” the Act’s entitlements—that is, they require employees of these employers to access their entitlements through their employment-based health insurance plan.

The Part concludes by asserting a broader claim regarding employees’ entitlement to employment-based health insurance. Employees have a claim to their workplace health insurance in three ways: (1) employees generally make direct financial contributions to plan premium payments; (2) employers’ contributions to health premiums operate not as philanthropy but rather as a form of employee wages; and (3) the federal government’s system of tax exclusions accrue to the benefit of and on behalf of employees receiving health insurance.

A. *Health Entitlements Under the Affordable Care Act*

The Affordable Care Act creates entitlements—legally enforceable rights⁷³—to health for all participants in non-grandfathered or otherwise-exempt health plans.⁷⁴ These entitlements include the right to particular preventive health services free of cost sharing, as well as the right to certain modes of health care accessibility. The Act creates a statutory set of entitlements to a range of preventative services on a no-cost-sharing basis.⁷⁵ Specifically, the statute provides for mandatory and free minimum levels of preventive care coverage, with specific emphasis on evidence-based and evidence-recommended preventive services for children and women.⁷⁶ Of greatest controversy since the bill’s passage have been certain guidelines for women’s preventive health services.⁷⁷ Those guidelines provide that, beginning in the first plan year on or after August 1, 2012, health plans and issuers (if not grandfathered or

⁷³ See David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 638 (2004) (“To a lawyer, an entitlement is a legally enforceable right.”); see also Ian Ayres & Eric Talley, *Solomonic Bargaining: Dividing a Legal Entitlement to Facilitate Coasean Trade*, 104 YALE L.J. 1027, 1036–41 (1995).

⁷⁴ Fifty-eight percent of firms had at least one grandfathered health plan in 2012, and 48% of covered workers were enrolled in grandfathered health plans in 2012. THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *supra* note 17, at 7.

⁷⁵ See 42 U.S.C. § 300gg-13.

⁷⁶ See *id.* § 300gg-13(a)(3)–(4).

⁷⁷ *Women’s Preventive Services Guidelines: Affordable Care Act Expands Prevention Coverage for Women’s Health and Well-Being*, HEALTH RESOURCES & SERVICES ADMIN. (HRSA), <http://www.hrsa.gov/womensguidelines> (last visited Apr. 17, 2014).

otherwise exempt)⁷⁸ are required to provide coverage without cost sharing for women's preventive care, including:

- Annual preventive care visits for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care
- Maternal screening for gestational diabetes
- Counseling on sexually transmitted infections
- All contraceptive methods and sterilization procedures approved by the Food and Drug Administration (FDA)
- Patient education and counseling for women with reproductive capacity
- Comprehensive lactation support and counseling and costs for renting breastfeeding equipment
- Screening and counseling for interpersonal and domestic violence⁷⁹

While the contraceptive guidelines have received the most media and legal attention in the past year, the Act's entitlements are in fact much broader than this. By January 2013, the U.S. Preventive Services Task Force, responsible for promulgating a significant portion of the mandated preventive health services list, had delineated almost fifty types of preventive services required under 42 U.S.C. § 30gg-13(a)(1), such as obesity and cholesterol screening, sexually transmitted infection screening and counseling, and breast cancer screening.⁸⁰

⁷⁸ Group health plans sponsored by certain religious employers, and group health coverage in connection with such plans, are exempt from the requirement of covering contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization according to certain Internal Revenue Code definitions. See 45 C.F.R. § 147.130(a)(1)(iv)(B) (2013); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011) (codified at 45 C.F.R. § 147.130); HEALTH RESOURCES & SERVICES ADMIN., *supra* note 77.

⁷⁹ See HEALTH RESOURCES & SERVICES ADMIN., *supra* note 77. The HRSA—an agency of the U.S. Department of Health and Human Services that is responsible for improving access to health care for persons who are uninsured, isolated, or medically vulnerable—promulgated these guidelines.

⁸⁰ See *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVICES TASK FORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm> (last visited Apr. 17, 2014). The U.S. Preventive Services Task Force is an independent panel of non-federal specialists in prevention and evidence-based medicine, and is comprised of primary care providers, including internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists. *U.S. Preventive Services Task Force*, U.S. PREVENTIVE SERVICES TASK FORCE, <http://www.uspreventiveservicestaskforce.org> (last visited Apr. 17, 2014).

Employers must also abide by the Affordable Care Act's conditions, including non-discrimination, automatic enrollment, a ban on pre-existing condition exclusions, limited waiting periods, restrictions on annual coverage limits, and mandatory employer reporting and disclosure.⁸¹ These provisions individually and collectively impact the accessibility of health insurance, making it easier for groups such as women and those with preexisting illnesses to access health services of any sort, not only preventive health services.⁸² The Act thereby creates a minimum floor of coverage and accessibility for all new health insurance plan participants.

Notably, the Act creates user rights through indirect linguistic framing by targeting the duty-bearer rather than the rights holder in its language.⁸³ The Affordable Care Act, like many forms of U.S. insurance regulation, imposes requirements on the group health plans and health insurance issuers offering health insurance coverage. For example, the Act notes that these actors "shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for [a basic package of preventive services]."⁸⁴ The duty-bearers in this case are the health plan and health insurance issuers who must provide a minimum floor of benefits. Despite the Act's key focus—evident in the statute's title—on *patients* and their protection and access to affordable health care,

⁸¹ See 42 U.S.C. §§ 300gg to -9. These entitlements may be more or less robust depending upon the implementation of the legislation. For example, the right to non-discrimination, while prohibiting premium differentials based on preexisting conditions, allows health insurance issuers to set premium rates with consideration of the rating area, the participant's age, and tobacco use. See *id.* § 300gg ("Fair Health Insurance Premiums"). These remaining rating mechanisms allow issuers to approximate health status, likely disadvantaging many of the same persons who confronted more limited and expensive access to health care before the Affordable Care Act. See Roberts, *supra* note 14, at 1159 (suggesting that there is an unresolvable tension between the non-discrimination approach embraced by health care reform advocates and the ongoing practices of the private, for-profit health insurance industry).

⁸² *But cf.* Roberts, *supra* note 14, at 1159–60.

⁸³ Compared to international treaties regarding the right to health and their language of positive rights, the Act creates entitlements indirectly, largely through the language of third parties' obligations. The International Covenant on Economic, Social, and Cultural Rights, which contains the boldest statement of the requirements of the right to health, acknowledges "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." International Covenant on Economic, Social and Cultural Rights art. 12, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3. Other international treaties also create a right to health using language of positive rights. See, e.g., Convention on the Elimination of All Forms of Discrimination Against Women arts. 12, 14(2)(b), *adopted* Dec. 18, 1979, 1249 U.N.T.S. 13; International Convention on the Elimination of All Forms of Racial Discrimination art. 5(e)(iv), *adopted* July 3, 1966, 660 U.N.T.S. 195; U.N. Convention on the Rights of the Child art. 24, *adopted* Nov. 20, 1989, 1577 U.N.T.S. 3 (signed but not yet ratified by the United States).

⁸⁴ 42 U.S.C. § 300gg-13(a). Similarly, in removing lifetime limits on health insurance coverage, the Act states that "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish [a specified set of limits]." *Id.* § 300gg-11(a)(1).

Congress did not expressly articulate patient entitlements to health.⁸⁵ Nonetheless, the Act creates a robust and bold set of rights related to health.⁸⁶

B. *Comparing Pre-Existing Health Entitlements*

The Affordable Care Act is certainly not the first piece of legislation to create an entitlement with respect to health services. Other entitlement programs exist with different eligibility requirements and, hence, breadths of coverage. Medicare and Medicaid each create a claim of right for program beneficiaries or participants to health care goods and services,⁸⁷ as does the system of tax exclusions for persons obtaining health insurance through their place of employment.⁸⁸ And the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA)⁸⁹ requires any hospital participating in Medicare to provide standard emergency screening to any patient arriving at the emergency room.⁹⁰

In terms of eligibility, Medicare benefits accrue to beneficiaries based on age, among other requirements.⁹¹ In 2012, Medicare Advantage group plan enrollment, available to certain persons aged sixty-five or older, covered approximately thirteen million persons per

⁸⁵ The rights created by the Act are attendant to, and correlative of, the duties of those offering health insurance. As Wesley Hohfeld observed a century ago, rights are the necessary correlatives of duties, with individuals located within a matrix of relationships with other duty-bearing or right-holding individuals. *See generally* WESLEY N. HOHFELD, *FUNDAMENTAL LEGAL CONNECTIONS* (1923); Wesley Newcomb Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 *YALE L.J.* 16 (1913). Hohfeld considered substituting the word “claim” for “right.” *See* Arthur Corbin, *Rights and Duties*, 33 *YALE L.J.* 501, 501 n.2 (1924). Where duty bearers fall short of their statutory obligations, rights-holders have a claim of right. Yet, without some form of accountability—whether through formal legal recourse, government audits, or otherwise—those rights may be largely meaningless. *See* JOST, *supra* note 12, at 34.

⁸⁶ *See, e.g.*, *Atkins v. Parker*, 472 U.S. 115 (1985) (statutory entitlement to food stamps); *Mathews v. Eldridge*, 424 U.S. 319 (1976) (statutorily granted property right in social security benefits); *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002) (statutory entitlement to certain Medicaid benefits created when a state promises to provide services to private individuals in exchange for federal funding).

⁸⁷ *See* JOST, *supra* note 12, at 23.

⁸⁸ *See id.* at 184–98.

⁸⁹ 42 U.S.C. § 1395dd.

⁹⁰ *See id.*; Clark C. Havighurst, *American Health Care and the Law*, in *THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES* 1, 16–17 (Gregg M. Bloche ed., 2003).

⁹¹ *See* 42 U.S.C. § 426. The Medicare statute frames many entitlements using the language of positive rights. *See, e.g., id.* § 1395c (“The insurance program for which entitlement is established . . . provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care . . . [to persons entitled by virtue of their meeting program requirements].”).

month.⁹² Various other Medicare components, each with its own set of attendant benefits, had differing monthly enrollment rates.⁹³ In turn, the program generally known as Medicaid⁹⁴ creates its own set of means-tested, needs-based social welfare benefits.⁹⁵ In the year 2012, about fifty-five million persons were enrolled in the federal Medicaid program each month.⁹⁶

Under the federal tax code, employees receiving health insurance through their workplaces are entitled to income tax exclusions: Health benefits are not considered taxable income,⁹⁷ and employees can exclude from taxable income the value of medical benefits purchased with employment-based insurance.⁹⁸ The financial benefit to employees is significant.⁹⁹ Employment-based insurance tax exclusions are the largest of the existing federal health entitlement programs, in terms of the number of persons covered. Overall, in the year 2010, the U.S. Census Bureau reported that approximately 31% of individuals were covered by Medicare or Medicaid, compared to 55% of persons covered by employment-based coverage (and therefore eligible for federal tax exclusions).¹⁰⁰ EMTALA's benefits accrue to any person arriving at a qualifying hospital emergency room, without any consideration of the patient's ability to pay, citizenship, or legal status.¹⁰¹ But to be clear, EMTALA does not guarantee free treatment; hospitals can bill patients for the cost of their health care services after treatment.¹⁰²

The Affordable Care Act's entitlements, in comparison, vest to all new health plan participants and not just persons in defined age,

⁹² See CONG. BUDGET OFFICE, MARCH 2012 MEDICARE BASELINE 3 (Mar. 13, 2012), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf.

⁹³ See *id.*

⁹⁴ See 42 U.S.C. § 1396.

⁹⁵ See, e.g., *id.* §§ 1396b(k), 1396b(m)(2)(A)(vii), 1396e(a)(1) (classifying Medicaid recipients as persons "entitled to medical assistance" under Subchapter XIX of Title 42 or under a state plan approved under that Subchapter).

⁹⁶ See CONG. BUDGET OFFICE, MEDICAID SPENDING AND ENROLLMENT DETAIL FOR CBO'S MARCH 2012 BASELINE (Mar. 2012), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf.

⁹⁷ See Hyman & Hall, *supra* note 19, at 25; see also JOST, *supra* note 12, at 23, 34, 184.

⁹⁸ See JOST, *supra* note 12, at 184 (citing 26 U.S.C. §§ 105–106). Employers themselves have a legal claim to tax exclusions and deductions for employment-based coverage. See *id.* at 23. In particular, the payments that an employer makes to purchase health insurance for its employees are considered business expenses and, therefore, excludable from the company's taxable income. See *id.* at 184. Employers can also exclude the costs of self-insuring their employees' health care costs from their taxable income. See *id.*

⁹⁹ See LYKE, *supra* note 36, at 2.

¹⁰⁰ MAUERSBERGER, *supra* note 1, at 2 (citing CARMEN DENAVAS WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 23 (Sept. 2011)). A further 10% of Americans were covered by the direct purchase of health insurance, 4% had military health care, and 16% remained uninsured in 2010. See *id.*

¹⁰¹ See 42 U.S.C. § 1395dd (2012); Havighurst, *supra* note 90, at 16.

¹⁰² See 42 U.S.C. § 1395dd(h). EMTALA contains no reimbursement provisions. See *id.* § 1395dd.

income, or employment categories.¹⁰³ Notably, in order to access the entitlements, a person must be insured in a qualifying plan—health insurance coverage is thus a prerequisite to accessing specific coverage and accessibility rights guaranteed in the Act. The estimates vary,¹⁰⁴ but the Congressional Budget Office predicts that 250 million persons will be covered by the Act by 2017—and, hence, eligible for statutorily-granted health benefits—if they do not participate in grandfathered health plans.¹⁰⁵ In contrast, approximately twenty-nine million persons, including non-legal residents of the United States, will be uninsured by the year 2017.¹⁰⁶ Despite the fact that the Act’s entitlements accrue to all participants in new health plans, it is notable that many employees will only be able to access these entitlements through the workplace. This is due to the powerful role of the Act’s employer mandate, which solidifies employers as key actors in the health insurance financing arena and consolidates their authority to make decisions on behalf of employees in this space.

C. *The Affordable Care Act Employer Mandate*

The Affordable Care Act entrenches employers as the primary providers of health insurance for persons in the country. Whereas, prior to the Affordable Care Act, employers had the *option* of providing health insurance coverage to their employees, the Act formalizes the provision of health insurance around the site of employment for many persons in the United States.

The Act does not explicitly mandate that employers must offer health insurance. Similarly to the “individual mandate” that was

¹⁰³ See, e.g., *id.* § 300gg-13 (specifying minimum preventive health benefits for participants in any non-grandfathered group health plan, without regard to age or income requirements).

¹⁰⁴ This is due, in part, to the uncertainty in states’ Medicaid coverage decisions in the wake of *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012), which allows the states to choose whether or not to expand eligibility for coverage under the Medicaid program pursuant to the Act. While the Affordable Care Act’s insurance coverage provisions require most legal residents to obtain health insurance or pay a penalty tax, individuals’ decisions in that respect remain uncertain and will likely depend in part on Medicaid, tax subsidies, and other sources of financial aid. See CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION, 1–2 (July 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

¹⁰⁵ See *id.* at 20.

¹⁰⁶ See CONG. BUDGET OFFICE, CBO’S FEBRUARY 2013 ESTIMATE OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE 1 (Feb. 2013), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2013-02-ACA.pdf>. The estimated uninsured population includes unauthorized immigrants and individuals who are eligible for, but not enrolled in, Medicaid. *Id.* It also includes those persons who decide to not purchase health insurance despite the Act’s individual mandate, choosing instead to pay the Act’s penalty.

contested before the Court in 2012, the Act promulgates an “employer mandate” with tax penalties for non-compliance. Beginning in 2015, certain employers with at least fifty full-time employees¹⁰⁷ will face penalties if at least one of their full-time employees obtains a health insurance premium credit through a federal or state exchange.¹⁰⁸ Non-compliance with the mandate becomes evident when an employee working for a qualifying large employer that offers no coverage or unaffordable coverage purchases health insurance through a state or federal exchange. This outside purchase triggers a penalty.

The penalties assessed on large employers who do not offer adequate and affordable insurance are far from insignificant. In 2015, the annual penalty will amount to the number of full-time employees minus thirty multiplied by \$2000.¹⁰⁹ For example, a firm with fifty employees that does not offer insurance and has at least one employee purchase insurance from an exchange must pay an annual penalty of \$40,000: $(50 - 30) \times \$2000$.

Even employers who offer health insurance must pay a penalty if their plan is unaffordable.¹¹⁰ Employers who offer health coverage that is unaffordable pay an annual penalty of \$3000 for any applicable month for each full-time employee receiving a premium credit to purchase insurance on an exchange, with an upper limit of the amount the employer would pay if it did not offer insurance at all.¹¹¹ For example, if a fifty-person firm offers unaffordable coverage and has thirty persons purchase insurance from an exchange, the annual penalty would be \$90,000 $(30 \times \$3000)$ or \$40,000 $((50 - 30) \times \$2000)$. Thus, in this case, the firm would pay an annual penalty of \$40,000.

¹⁰⁷ “Large employers” are those that meet or surpass the threshold of fifty full-time employees. “Full-time employees” are those who work an average of at least thirty hours per week. The number of full-time employees excludes full-time seasonal employees who work for up to 120 days during the year, but part-time employees are included in the calculation on a monthly basis. HINDA CHAIKIND, CONG. RESEARCH SERV., R41159, SUMMARY OF POTENTIAL EMPLOYER PENALTIES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 1 (Jan. 13, 2011), available at <http://www.ncsl.org/documents/health/SumEmpPenalties.pdf>.

¹⁰⁸ *Id.* at 2. In July 2013, the Obama administration unexpectedly announced a delay in the commencement of the employer mandate, from January 1, 2014 to January 1, 2015. See Mark J. Mazur, *Continuing to Implement the ACA in a Careful, Thoughtful Manner*, TREASURY NOTES BLOG (July 2, 2013), <http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx>.

¹⁰⁹ See CHAIKIND, *supra* note 107, at 3. After 2015, the penalty payment amount will index by the premium adjustment percentage for the calendar year. See *id.*

¹¹⁰ See *id.* at 3–4. An employment-based plan is considered unaffordable if the employee’s required contribution for self-only coverage exceeds 9.5% of the employee’s household income or if the plan offered by the employer pays for less than 60% of covered expenses. According to the Congressional Budget Office, an estimated one million employees per year will receive a credit towards an exchange plan because their employer’s plan is unaffordable. See *id.* at 3.

¹¹¹ See *id.*

Employer mandates extend beyond the obligation to offer health insurance. Employers offering new health insurance plans must meet the minimum health plan content requirements outlined in the Affordable Care Act. If they do not provide a specified entitlement (such as contraceptives), employers can face fines, penalties, and potential civil enforcement actions by the Department of Labor and/or insurance plan participants for non-compliance.¹¹²

Overall, the Affordable Care Act guarantees minimum thresholds of coverage and affordability for health plan participants, including employees who receive employment-based coverage. In turn, it requires that employers providing health insurance meet these minimum legal requirements. And it limits employees' access to affordable, substitutable insurance coverage by restricting access to tax exclusions on the federal and state exchanges to those instances where employers do not provide adequate coverage. It thereby "privatizes" particular publicly-guaranteed entitlements to health around the site of employment. This privatization, in turn, heightens "job lock" concerns and other tensions around employment-based coverage that scholars have identified over the years.¹¹³

D. *Financial Entitlements to Employment-Based Coverage*

Beyond statutory entitlements to health, employees have a broader claim to employment-based coverage. They have a property-like interest¹¹⁴ in their workplace health insurance based on the fact that they functionally pay for it and are eligible for federal tax exclusions to subsidize it. This account raises additional critiques of labor market dislocation and illuminates the structural power imbalance in current health coverage decision-making.

In particular, workers have an interest in three separate components of the financial contributions to the cost of employment-

¹¹² See 26 U.S.C. § 4980D(a)–(b) (penalty of \$100 per day per employee for noncompliance with coverage provisions of the Affordable Care Act); 29 U.S.C. § 1132(a) (2012) (civil enforcement actions by the Department of Labor and insurance plan participants); *id.* § 4980H (annual tax assessment for noncompliance with requirement to provide health insurance).

¹¹³ See *supra* Part I.B (describing tensions in employment-based coverage).

¹¹⁴ Competing accounts of property rights view property as a right to exclude others from a particular thing, THOMAS W. MERRILL & HENRY E. SMITH, *PROPERTY: PRINCIPLES AND POLICIES* v (2007), or as an ad hoc bundle of rights, JESSE DUKEMINIER ET AL., *PROPERTY* 83 (7th ed. 2010). Property, at its core, endows owners with an *in rem*—and largely undifferentiated—right to exclude others from that thing. See *supra* MERRILL & SMITH, *supra*, at v, 16–17. In the most basic sense, employees have an interest in, and a corresponding right to exclude others from, the wages that they receive as the consideration within their employment contract. See 1 MARK A. ROTHSTEIN ET AL., *EMPLOYMENT LAW* § 4.1, at 333 (1994) (noting how most states also have laws that protect workers' rights to receive payment of their wages).

based health insurance. First, employees generally make direct contributions to their employment-based coverage premiums. In 2012, for example, employees contributed an average of 18% of premium costs towards individual health plans, and 28% of premium costs towards family health plans.¹¹⁵ Second, and as described earlier,¹¹⁶ workers who receive health insurance through their place of employment are entitled to a “subsidy” towards their health coverage—an estimated 10% to 35% of the health insurance premium cost depending on the employee’s marginal tax rate¹¹⁷—through the existing tax code, which excludes workplace insurance from taxable income.¹¹⁸ Third, employers’ contributions to monthly health insurance premium costs comprise part of the employee’s net compensation package. Indeed, since World War II, employee benefits other than cash wages have become an increasingly important aspect of employee compensation.¹¹⁹ Research suggests that the growing costs of health insurance have been responsible for dampened wage growth as employers have invested more money in the health benefit portion of an employee’s compensation and less in formal wages and salaries. For example, “[b]etween 1970 and 1991, the years of greatest growth in health-care costs, wages and salaries of American workers grew only four-tenths of 1% in inflation-adjusted dollars, while employer health expenditures grew 234.1%.”¹²⁰ More recently, economists have speculated that employers will respond to the “play or pay” mandate by passing the cost of the insurance onto employees in the form of reduced wages.¹²¹

Notably, the source of two of these entitlements is distinct from that in the Affordable Care Act. With the exception of the federal tax exclusions, which are enshrined in the federal tax code, these other entitlements are grounded in basic common law notions of property—either as items purchased with employees’ money or as part of the consideration supporting an employment contract. The distinction matters because, in the instance of the IRS tax code and the Affordable Care Act, the federal government has privatized the source of a federally

¹¹⁵ THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *supra* note 17, at 1, 72. Workers contributed an average of \$79 per month towards individual health plan premiums and \$360 per month towards family health plan premiums in 2012. *Id.*

¹¹⁶ *See supra* Part II.B.

¹¹⁷ *See* LYKE, *supra* note 36, at 2 & n.5.

¹¹⁸ *Id.* at 1; 26 U.S.C. § 105 (2012). Federal law provides employees with a claim of right to this tax exclusion. *See* 26 U.S.C. § 106.

¹¹⁹ *See* ROTHSTEIN ET AL., *supra* note 114, at 333.

¹²⁰ JOST, *supra* note 12, at 186.

¹²¹ *Cf.* Katherine Baicker & Helen Levy, *Employer Health Insurance Mandates and the Risk of Unemployment*, 11 RISK MGMT. & INS. REV. 109 (2008); Richard Burkhauser & Kosali Simon, *Who Gets What from Employer Pay or Play Mandates?* (Nat’l Bureau of Econ. Research, Working Paper No. 13,528, 2007). Economists have also predicted that workers will accept lower wages if they value the additional insurance coverage. *Cf. id.*

enumerated entitlement. This may have implications for public law analysis.¹²² By contrast, employees' and employers' financial contributions to plans are a private arrangement between non-state actors, albeit one facilitated by the Affordable Care Act's employer mandate.

Indeed, the Affordable Care Act heightens tensions between employers and employees by entrenching and mandating employment-based coverage, solidifying its role as a functional form of employee compensation. The Act also precludes employees that are *eligible* for affordable employment-based plans from receiving federal tax exclusions to purchase *other* plans.¹²³ Employees are locked into accepting the health insurance that their employer chooses if they wish to receive tax exclusions. Without attendant protections from employers' discretionary—and potentially adverse—choices, employees' needs may be ignored wholesale.

III. EMPLOYERS AS FIDUCIARIES OVER HEALTH ENTITLEMENTS

Identifying employees' property-like interest in employment-based insurance, in turn, clarifies the role of employers in making health coverage decisions on employees' behalf. Employers make decisions with respect to employees' resources and, therefore, act like fiduciaries. Fiduciary relationships describe a variety of interactions between individuals in which one party relies on another with more knowledge, skill, or power to act in her interest.¹²⁴ Across interactions as diverse as guardianship, investment management, corporate directorship, health service delivery, and lawyering, courts and legislatures have applied fiduciary law to frame—and legally constrain—relationships.¹²⁵ In the context of health service delivery, fiduciary law has framed physicians' dealings with patients for over 250 years.¹²⁶ The duty of loyalty—a cornerstone duty of fiduciary law—has helped outline boundaries around medical providers' conduct, constraining physicians' self-interested behavior.¹²⁷ Yet fiduciary law has not been applied to the

¹²² See *infra* Part IV.

¹²³ See BERNADETTE FERNANDEZ & THOMAS GABE, CONG. RESEARCH SERV., R41137, HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 5 (2012).

¹²⁴ See ETHAN J. LEIB, FRIEND V. FRIEND: THE TRANSFORMATION OF FRIENDSHIP—AND WHAT THE LAW HAS TO DO WITH IT 116 (2011).

¹²⁵ Scholars have considered the role of fiduciaries in an even broader array of relations, including partnerships. See *supra* note 11 and accompanying text.

¹²⁶ See 3 WILLIAM BLACKSTONE, COMMENTARIES *122.

¹²⁷ See, e.g., M. Gregg Bloche, Comment, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 927, 930–31 (2002); Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137 (2006). In the informed consent context, Mark Hall has been less optimistic

decisions that employers make on behalf of employees in selecting health insurance coverage. This Part provides an account of fiduciary doctrine and how employers act as fiduciaries when they make health coverage decisions on behalf of employees. It then examines what fiduciary law would require of employers, as well as the limitations inherent in applying the fiduciary framing to this relationship—limitations that may be under-recognized across other areas in which scholars and courts have applied fiduciary law.

A. *Fiduciary Law: The Doctrine*

While there are significant and unresolved academic disputes about fiduciary law,¹²⁸ most agree that trust and confidence are lynchpins of the fiduciary relationship. Commentators have defined trust as an optimistic view of others and “believing that others tell the truth and will keep their promises.”¹²⁹ Others have more directly referenced the inherent vulnerability of the beneficiary in a fiduciary relationship, defining trust in the fiduciary setting as “a willingness to make oneself vulnerable to another, based on the belief that the trusted person will choose not to exploit one’s vulnerability.”¹³⁰ Such deep trust tends to arise because of the fiduciary’s greater expertise, greater control over assets, or high degree of influence over the beneficiary’s decision-making process.¹³¹ Courts typically regard this as the fiduciary’s *discretionary control* over something in which a beneficiary has a legal interest.

Under the theory of fiduciary relationships that D. Gordon Smith proffers, one party (the fiduciary) acts on behalf of another (the beneficiary), exercising discretion with respect to a critical resource

about the utility of fiduciary law, finding it too varied across contexts to provide efficiency-promoting rules. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 490–91 (2002).

¹²⁸ Among other debates, some query whether it is a unified and coherent field of law at all. See, e.g., J.C. SHEPHERD, *THE LAW OF FIDUCIARIES* (1981) (identifying a unifying theory of entrustment); Austin W. Scott, *The Fiduciary Principle*, 37 CALIF. L. REV. 539 (1949) (maintaining that fiduciaries can be united through their voluntary undertakings); Smith & Lee, *supra* note 11, at 4 (viewing discretion around “critical resources” on behalf of less empowered parties as essential components of fiduciary relationships). But see Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879, 915 (arguing that an instrumental description of fiduciary obligations is the only unified thread).

¹²⁹ TAMAR FRANKEL, *TRUST AND HONESTY: AMERICA’S BUSINESS CULTURE AT A CROSSROAD* 49 (2006) (internal quotation marks omitted); see also Cross, *supra* note 11, at 1464 (Trust is the “confident expectation that, when the need arises, the one trusted will be directly and favorably moved by the thought that you are counting on her.” (quoting Karen Jones, *Trust as an Affective Attitude*, 107 ETHICS 4, 5–6 (1996)) (internal quotation marks omitted)).

¹³⁰ Margaret M. Blair & Lynn A. Stout, *Trust, Trustworthiness, and the Behavioral Foundations of Corporate Law*, 149 U. PA. L. REV. 1735, 1739–40 (2001).

¹³¹ See LEIB, *supra* note 124, at 116.

belonging to the beneficiary.¹³² The critical resource need not be a property interest (although, in trusteeship relationships, there is a need for a “res,” or property interest, about which the fiduciary makes decisions).

Notably, the determination of fiduciary status can be statutory, as in the case of ERISA, which draws on common law fiduciary principles in its definition.¹³³ Courts can also undertake a functional inquiry and apply common law principles to determine whether a fiduciary relationship exists.¹³⁴ In the latter approach, a court may find that an individual or entity behaves as a fiduciary in exercising certain functions but not others.¹³⁵

Fiduciaries act in the space for discretionary decision-making that remains after accounting for regulatory and contractual constraints on a fiduciary’s performance.¹³⁶ Discretion arises because contracts between the parties are necessarily incomplete about the fiduciary’s action with respect to the critical resource.¹³⁷ Such contractual incompleteness is not in and of itself a problem. It would be inefficient to try to perfectly contract for every potential discretionary use of power.¹³⁸ Many fiduciaries also execute their services in changing environments or in the context of unanticipated events, making perfect contracting unfeasible.¹³⁹ Fiduciaries exercise discretion by “us[ing] or work[ing] with the critical resource in a manner that exposes the beneficiary to harm that cannot reasonably be evaded through self-help.”¹⁴⁰

Fiduciary law helps ensure that fiduciaries do not misuse their discretion when managing a beneficiary’s critical resource.¹⁴¹ “[T]he critical resource theory reveals that the beneficiary’s vulnerability emanates from an inability to protect against opportunism by the fiduciary with respect to the critical resource. This insight suggests that fiduciary law can be justified on the grounds that it deters opportunistic

¹³² See Smith, *supra* note 5, at 1402; see also FRANKEL, *supra* note 5, at 6 & n.19 (citing the “critical resource” theory).

¹³³ See FRANKEL, *supra* note 5, at 184.

¹³⁴ See, e.g., *In re Elec. Data Sys. Corp. “ERISA” Litig.*, 305 F. Supp. 2d 658, 665 (E.D. Tex.) (identifying distinctions between expressly designated statutory fiduciaries and functional fiduciaries under ERISA), *class certification granted in part, denied in part* by 224 F.R.D. 613 (E.D. Tex. 2004), *vacated and remanded*, 476 F.3d 299 (5th Cir. 2007).

¹³⁵ See FRANKEL, *supra* note 5, at 184.

¹³⁶ See Smith & Lee, *supra* note 11, at 4–5.

¹³⁷ See Smith, *supra* note 5, at 1448.

¹³⁸ See Frankel, *Fiduciary Law*, *supra* note 11, at 813 (“[E]ven if [complete] contractual arrangements were feasible, the transaction costs involved in drawing up a detailed prior agreement covering all possible discretionary uses of power over the life of the relation would not only be enormous, but also would probably exceed the benefits of the proposed relation.”).

¹³⁹ See Tamar Frankel, *Fiduciary Law In the Twenty-First Century*, 91 B.U. L. REV. 1289, 1296 (2011).

¹⁴⁰ Smith, *supra* note 5, at 1449.

¹⁴¹ See generally FRANKEL, *supra* note 5; Smith, *supra* note 5.

behavior.”¹⁴² Fiduciary law is, thus, a field that enables more empowered, knowledgeable, or skilled persons to make decisions on behalf of others. It is also a body of law that aims to promote equity around presumably imbalanced relationships.

The law constrains fiduciaries’ discretionary actions by imposing duties as quasi-regulatory tools.¹⁴³ In particular, where there is a fiduciary relationship, the law imposes two duties: a duty of care, and a duty of loyalty.¹⁴⁴ While these duties vary in their enforcement according to the type of relationship at hand,¹⁴⁵ certain principles are relevant. The core fiduciary duty is the duty of loyalty:

The keystone of the duty of loyalty is the legal obligation that the fiduciary use her powers not for her own benefit but for the exclusive benefit of her beneficiary. It is highly improper—indeed proscribed—for a fiduciary to extract a personal benefit from her fiduciary position without her beneficiary’s consent, even when she can do this without harming her beneficiary.¹⁴⁶

The duty of loyalty has two components. First, a fiduciary must act for the sole benefit of the beneficiary.¹⁴⁷ Second, a fiduciary must not act in conflict with the interest of the beneficiary in the beneficiary’s property.¹⁴⁸ For instance, in the health care delivery setting, physicians generally have a duty to disclose material conflicts of interest to their patients when obtaining informed consent for treatment.¹⁴⁹

The beneficiary’s claims in this respect do not require a showing of actual loss. The *harm* caused by a breach of the duty of loyalty can be nothing more than an infringement on the beneficiary’s right to have the fiduciary act in her exclusive interest.¹⁵⁰ Where conflicts of interests between the fiduciary and beneficiary are inevitable, there are several

¹⁴² Smith, *supra* note 5, at 1404.

¹⁴³ See *id.* at 1402; FRANKEL, *supra* note 5, at 86.

¹⁴⁴ See Langbein, *supra* note 7, at 642.

¹⁴⁵ See Leib, Ponet & Serota, *supra* note 11, at 708.

¹⁴⁶ LEIB, *supra* note 124, at 113 (quoting Lynn A. Stout, *On the Export of U.S.-Style Corporate Fiduciary Duties to Other Cultures: Can a Transplant Take?*, in GLOBAL MARKETS, DOMESTIC INSTITUTIONS: CORPORATE LAW AND GOVERNMENT IN A NEW ERA OF CROSS-BORDER DEALS 46, 55 (Curtis J. Milhaupt ed., 2003)) (internal quotation marks omitted).

¹⁴⁷ FRANKEL, *supra* note 5, at 108. In recent years, some academic commentators have proposed relaxing the “sole interest” of the beneficiary rule to a more nuanced “best interest” of the beneficiary rule. See, e.g., John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 YALE L.J. 929 (2005). Under this reformulation, conflicts of interest are acceptable as long as they do not harm the beneficiary. See FRANKEL, *supra* note 5, at 148. Courts operationalizing this “best interests” standard create a rebuttable presumption of impropriety when there is a conflict, which can be rebutted upon a showing of no harm. See, e.g., *In re Am. Printers & Lithographers, Inc.*, 148 B.R. 862, 866 (Bankr. N.D. Ill. 1992) (adopting this rule); FRANKEL, *supra* note 5, at 148.

¹⁴⁸ See FRANKEL, *supra* note 5, at 108.

¹⁴⁹ BARRY R. FURROW ET AL., *HEALTH LAW* 332 (2d ed. 2000).

¹⁵⁰ See Smith, *supra* note 5, at 1411.

potential legal responses and limiting mechanisms that a fiduciary may employ. First, conflicts of interests are generally permissible if the fiduciary discloses the conflict and obtains the beneficiary's informed consent.¹⁵¹ In the absence of such consent, corporations can create a "wall" between units that might have a conflict of interest, leaving fiduciary roles to entities or persons who would not be divided in their loyalty to the beneficiary.¹⁵² In a similar manner, fiduciaries may delegate certain responsibilities prone to conflicts to third parties who can make decisions independently—although, in the corporate context, this solution has been criticized because conflicted parties often play a role in selecting the "independent" parties.¹⁵³ When conflicts involve all or almost all parties equipped to make decisions, fiduciaries may consult outside, independent experts and ask them to recommend decisions on their behalf.¹⁵⁴ In the absence of one of these solutions to limit conflicts of interests between fiduciaries and beneficiaries, there may be situations in which a fiduciary must withdraw from her role as fiduciary.¹⁵⁵ For example, in some circumstances, the relationship between a fiduciary and beneficiary may be too close to allow even the appearance of propriety and disinterested behavior. Judges who were formerly partners in law firms appearing before the bench are typically required to withdraw from sitting in judgment—the law deems them as "interested" in the action before the court and hence not objective with respect to both parties.¹⁵⁶ Similarly, interested directors who cannot resolve their conflicts or achieve the beneficiary's informed waiver should recuse themselves from decision-making.¹⁵⁷

A number of additional duties exist as correlatives of the duty of loyalty. These include the duty to follow and abide by the beneficiary's directives with respect to the entrusted property or power,¹⁵⁸ the duty to act in good faith,¹⁵⁹ the duty to treat beneficiaries fairly,¹⁶⁰ and the duty to account and disclose relevant information to the beneficiary.¹⁶¹

¹⁵¹ See FRANKEL, *supra* note 5, at 119; LEIB, *supra* note 124, at 113.

¹⁵² See FRANKEL, *supra* note 5, at 117.

¹⁵³ See *id.* at 117–18.

¹⁵⁴ See *id.* at 118–19.

¹⁵⁵ SHAPIRO, *supra* note 10, at 449.

¹⁵⁶ See FRANKEL, *supra* note 5, at 114; see also *Corradino v. Corradino*, 400 N.E.2d 1338, 1339 (N.Y. 1979) (“[N]o canon of judicial ethics . . . specifically requires disqualification . . . [but] it [is] the better practice for the court to have disqualified itself and thus to maintain the appearance of impartiality.”).

¹⁵⁷ See FRANKEL, *supra* note 5, at 178.

¹⁵⁸ See *id.* at 106.

¹⁵⁹ The duty of good faith requires more of fiduciaries than the duty of good faith would require of mere contracting partners. See LEIB, *supra* note 124, at 114.

¹⁶⁰ See *id.* at 107.

¹⁶¹ See *id.* at 113 (referring to this duty as one of “utmost candor and disclosure,” including disclosure of potential conflicts (emphasis omitted)).

Fiduciaries also have a duty of confidentiality to beneficiaries, which aims to promote trust and confidentiality between the two.¹⁶²

The duty of care is the lesser of the two duties—it is “not as weighty and prohibitory” on the fiduciary.¹⁶³ Under the duty of care, fiduciaries must “perform their services with prudence, attention, and proficiency.”¹⁶⁴ They must dedicate a reasonable amount of time to their services, which includes reasonably investigating relevant issues and conducting due diligence.¹⁶⁵ For example, an investment adviser should investigate an investment’s suitability to an overall class, and should be alert for investment “red flags” that would indicate lack of appropriateness for the class.¹⁶⁶ Industry custom and market practices inform the duty of care, as do the parties’ reasonable expectations of one another.¹⁶⁷ The duty of care has affirmative components, requiring action.¹⁶⁸ However, in practice courts allow fiduciaries to exercise substantial discretion in performing their responsibilities.¹⁶⁹

B. *Employers as Health Fiduciaries*

This Article makes a normative claim that employers act as fiduciaries when they purchase health insurance on behalf of employees. This argument contends that the employer (the fiduciary) acts on behalf of the employee (the beneficiary) with respect to decisions regarding health insurance, a “critical resource” that belongs to the employee, and exercises discretionary authority over that critical resource.¹⁷⁰

In the context of employment-based insurance, the first element of the fiduciary relationship is that employers (as fiduciaries) must act “on behalf of” employees (and other beneficiaries). The Restatement (Second) of Agency examines whether a fiduciary makes a decision

¹⁶² See FRANKEL, *supra* note 5, at 7; LEIB, *supra* note 124, at 114 (“[F]iduciaries commonly are required to maintain secrets and respect duties of confidentiality.”).

¹⁶³ FRANKEL, *supra* note 5, at 171. Some legal commentators do not view the duty of care as distinctly fiduciary in nature. See, e.g., DeMott, *supra* note 128, at 915; William A. Gregory, *The Fiduciary Duty of Care: A Perversion of Words*, 38 AKRON L. REV. 181 (2005). But in practice courts typically consider it an important duty. See *Lautenberg Found. v. Madoff*, No. 09-816 (SRC), 2009 U.S. Dist. LEXIS 82084 (D.N.J. Sept. 9, 2009); *In re Cook’s Trust Estate*, 171 A. 730 (Del. Ch. 1934); Smith & Lee, *supra* note 11, at 14.

¹⁶⁴ FRANKEL, *supra* note 5, at 169.

¹⁶⁵ See *id.* at 171.

¹⁶⁶ See *id.* at 172.

¹⁶⁷ See *id.*

¹⁶⁸ LEIB, *supra* note 124, at 113.

¹⁶⁹ *Id.* The duty of care, thus, appears as a weaker duty than the duty of loyalty. See *id.* at 112–14.

¹⁷⁰ See Smith, *supra* note 5, at 1402; see also FRANKEL, *supra* note 5, at 6.

“primarily for the benefit of” another.¹⁷¹ Health insurance decisions are, indeed, made for the primary benefit of employees who will participate in those plans. Employees are the primary beneficiaries of the employers’ decisions in this respect. While employers may participate in plans themselves, and may have residuary motives for making their coverage decisions—having healthy employees or attracting and retaining top talent, for example—their coverage decisions primarily impact employees and other persons who will be eligible for care under those plans. Ultimately, fiduciary law constrains employers’ ability to make decisions with these residuary or self-interested motives in mind.¹⁷²

Subsumed within this element are the power, knowledge, and expertise imbalances that typically characterize fiduciary relationships, with the beneficiary relying on the fiduciary to act on her behalf.¹⁷³ These imbalances—and potential inequities—are heightened in the case of employment-based insurance decisions. Employers already act as the dominant player in the employment landscape. Indeed, a host of employment laws have been developed to protect employees’ interests in the employment context.¹⁷⁴ That the employer has additional authority to make personal, often intimate, health insurance coverage decisions on behalf of the employee can potentially heighten the imbalance between an employer and employee. Further, employees have limited substitutes for this negotiating intermediary given the tax exclusions, and negotiating and risk-pooling benefits, that uniquely accrue to employment-based health coverage. Even under the Affordable Care Act, which offers state and federal exchanges as another site for health insurance purchasing, if an employer offers sufficiently comprehensive and affordable coverage, an employee is not eligible for a tax credit on the exchange system.¹⁷⁵ Thus, employees remain particularly beholden to employers and their decisions, with limited alternatives as economically viable (absent a career change).

The second element of the fiduciary relationship is that the employer (the fiduciary) must exercise control over a critical resource belonging to the employee (the beneficiary). Here, the health plans that

¹⁷¹ RESTATEMENT (SECOND) OF AGENCY § 13 cmt. a (1958); *see also* FRANKEL, *supra* note 5, at 8 (“Entrustors entrust property or power to fiduciaries not for the purpose of benefitting the fiduciaries but for the purpose of benefitting the entrustors (or their designates).”).

¹⁷² *See* Smith, *supra* note 5, at 1411.

¹⁷³ *See* LEIB, *supra* note 124, at 116.

¹⁷⁴ *See, e.g.*, Susan Stefan, “You’d Have to Be Crazy to Work Here”: Worker Stress, The Abusive Workplace, and Title I of the ADA, 31 LOY. L.A. L. REV. 795, 797–98 (1998) (noting protections under the Americans with Disabilities Act); *see also* 29 U.S.C. § 157 (2012) (protecting employees’ right to engage in concerted activity for “mutual aid or protection”); *id.* §§ 651–678 (protecting workers from occupational safety and health hazards).

¹⁷⁵ *See* CHAIKIND, *supra* note 107, at 1.

employers select—and their contents and terms—may be deemed a “critical resource.” An item is a critical resource if society has made a decision that such an item belongs to the beneficiary.¹⁷⁶ The “critical resource” theory differs from a conception rooted in property rights, where one would examine whether the owner has a “right to exclude” others from use of the property.¹⁷⁷ There are categories of “critical resources” (like confidential information) that are not subject to property rights, but which may fall under the umbrella of fiduciary law protections.¹⁷⁸ In the case at hand, the “critical resource” is a statutorily-granted and common law property-based interest in: (a) specific health services; and (b) the monies used to purchase employment-based health insurance, as well as the insurance purchased with that money. In the case of statutory entitlements, the relevant “resource” is akin to a form of “new property,” rather than one rooted in traditional understandings of property.¹⁷⁹

Employers exercise discretionary authority over this critical resource. It is through discretion that employers can misappropriate power to their own advantage, absent sufficient restrictions. Employers often execute their fiduciary duties in a rapidly changing environment, with unfolding health care advances as well as regulatory and legal changes.¹⁸⁰

In the case of statutory health entitlements, the room for discretion might, at first glance, appear small. The Affordable Care Act and the affiliated HRSA guidelines specify that health plans and issuers must provide (without cost sharing) certain services, including annual well-woman preventive care visits, and, in the case of the contraceptive mandate, all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.¹⁸¹ These entitlements are

¹⁷⁶ See Smith, *supra* note 5, at 1444. Determining what is a critical resource is similar to determining what property is, a subject that has generated voluminous academic literature. See *id.* As many academics have noted, property is not a fixed thing, but rather a bundle of rights with respect to a thing. See, e.g., Thomas W. Merrill & Henry E. Smith, *What Happened to Property in Law and Economics?*, 111 YALE L.J. 357, 357–58 (2001) (noting this conception’s roots in legal realism). Yet, in the case at hand, the determination need not be as difficult, given that the Affordable Care Act creates a clear statutory right to certain types and modes of health coverage.

¹⁷⁷ See, e.g., Thomas W. Merrill, *Property and the Right to Exclude*, 77 NEB. L. REV. 730, 730 (1998) (“[T]he right to exclude others is more than just ‘one of the most essential’ constituents of property—it is the *sine qua non*.”). Yet, as D. Gordon Smith has noted, the property theory of fiduciary law is inherently circular and, hence, less than useful. Smith, *supra* note 5, at 1442. In order to determine whether there is a right to exclude, one must first determine that property exists. *Id.*

¹⁷⁸ See Smith, *supra* note 5, at 1447.

¹⁷⁹ See, e.g., Charles Reich, *The New Property*, 73 YALE L.J. 733 (1964).

¹⁸⁰ See Frankel, *supra* note 139, at 1296.

¹⁸¹ See HEALTH RESOURCES & SERVICES ADMIN., *supra* note 77.

fairly determinate in content, leaving employers with minimal room for discretionary decision-making.

Yet if employers are successful in the contraceptive mandate cases and do not have to provide contraceptives despite the Affordable Care Act's guarantee of these benefits, then employers will maintain discretionary authority over even clearly-defined health entitlements. After contraceptives, employer contests could expand to include objections to other enumerated statutory benefits, such as immunizations, lactation support, or otherwise. It would be difficult for the government to limit employers' discretionary decisions over even clearly enumerated entitlements if employers were successful in these cases.

Further, even if the contraceptive mandate claims are unsuccessful, employers maintain a significant degree of residual discretion over the types of plans and coverage they select. For example, an employer has discretion to choose a Health Maintenance Organization (HMO) plan or a Preferred Provider Organization (PPO) plan,¹⁸² and the employer retains wide discretion in determining which specific insurance plan(s) to offer employees. Those decisions can dramatically affect the quality and accessibility of health care, with attendant cost implications. How much are premiums? How long will employees have to wait to schedule an appointment with a physician? How far must they travel to reach the physician? What is the physician's level of training? Will they attend community clinics or more specialized health centers with extensive referral networks? How integrated is the overall patient care? How up-to-date is the provider's technology? Is the care culturally accessible to a certain demographic of users? These decisions can have an enormous impact on the health care user's experience and overall health.¹⁸³

¹⁸² As to the difference between HMOs and PPOs, for the purposes of this Article, it is sufficient to note that HMOs generally mandate networks of doctors, hospitals, labs, and other care providers that plan participants must use. In contrast, PPOs also have networks but generally offer more options in terms of doctors, hospitals, labor, and other care providers. PPOs are also generally considered superior to HMOs in terms of patient choice, more limited medical management, accommodation of providers' preferences, and lower administrative expenses. See Robert E. Hurley et al., *The Puzzling Popularity Of The PPO*, 23 HEALTH AFF. 56 (2004). PPOs also tend to be more expensive. See *HMOs, PPOs & Other Health Insurance*, STATE OF CAL. OFF. OF THE PATIENT ADVOC., <http://www.opa.ca.gov/Pages/HMOsPPOsandOtherHealthInsurance.aspx#kindsofplans> (last visited Apr. 18, 2014).

¹⁸³ As an example, the State of California Office of the Patient Advocate released report cards for various state level PPOs and HMOs in 2013, which reflect a wide range of quality ratings (both within and between particular categories) for insurance plans. See *HMO Quality Ratings Summary: 2013 Edition*, STATE OF CAL. OFF. OF THE PATIENT ADVOC., <http://reportcard.opa.ca.gov/rc2013/hmorating.aspx> (last visited Apr. 18, 2014). PPO ratings showed similar diversity. See *PPO Quality Ratings Summary: 2013 Edition*, STATE OF CAL. OFF. OF THE PATIENT ADVOC., <http://reportcard.opa.ca.gov/rc2013/pporating.aspx> (last visited Apr. 18, 2014). HMO plans were rated from "excellent" to "poor" based on patients' feedback on their experience and, also, whether the HMOs actually delivered recommended care. See *HMO Quality Ratings Summary: 2013 Edition*, *supra*. An employer's discretionary decision to select a

Regardless of the outcome of the contraceptive mandate cases, the room for employer discretion around health coverage decisions—beyond those expressly mandated by the Affordable Care Act—is broad in another sense. Preventive care makes up a small portion of domestic health care expenditures and insurance plan costs.¹⁸⁴ Employers, acting as negotiating intermediaries, make a range of discretionary decisions about the non-preventive health services that will be covered in a particular insurance plan and the corresponding terms of that coverage. There are some oft-publicized areas of conflict between employees' and employers' preferences, such as in vitro fertilization coverage, cosmetic surgery, and sex reassignment surgery.¹⁸⁵ In these instances and others, employers have discretion over all coverage and payment decisions, raising the risk that they might not act in the interest of employees.

C. *Employers' Fiduciary Duties*

Given the inherent risk that employers will not act in employees' interest, this Part examines the corresponding fiduciary duties that would attach to employers acting as health fiduciaries. In particular, the fiduciary duties of care and loyalty would guide employers' conduct on behalf of employees. Conflicts wherein employers considered their own interests would be impermissible.

The duty of loyalty would require that the employer: (1) pursue employees' sole interest in making discretionary coverage decisions; and (2) refrain from acting in a self-interested manner. Under this fiduciary duty, employers' individual interests and beliefs could not interfere with decision-making. The breach of this duty would not require a showing of actual loss to the employee. The mere fact of the employer's divided loyalty would give rise to a claim of injury.¹⁸⁶

Of course, in practice, fiduciaries may have conflicts that create divided obligations between their own interests and those of beneficiaries. In the most basic example, many employers receive their own health coverage through employment-based plans, which makes them self-interested in the selection of coverage terms. Employers could use limiting mechanisms to respond to these situations. They could create "walls" between units that have these particular conflicts in decision-making, thereby allowing non-conflicted departments or persons to make decisions on behalf of the group of potential insurance

plan with a "poor" rating could have serious implications for how employees experience care around a given statutory entitlement.

¹⁸⁴ See J. Michael McGinnis et al., *The Case for More Active Policy Attention to Health Promotion*, 21 HEALTH AFF. 78 (2002).

¹⁸⁵ See *supra* note 50 and accompanying text.

¹⁸⁶ Smith, *supra* note 5, at 1410–11.

enrollees. They could also employ independent, third-party experts to make coverage decisions directly or to recommend employee coverage options.¹⁸⁷ As a method of fulfilling the duty of care and, relatedly, of due diligence, employers could ask employees to confidentially disclose their coverage preferences and ask independent experts to suggest health packages that best meet employees' desires and needs, including their own, in the aggregate.

Another option would be for the employer to disclose the inherent conflict in its decision-making and ask the employee to provide informed consent to the conflict.¹⁸⁸ Yet this option poses heightened risks in the employment context, where risks of coercion of employees might prevent consent from being meaningful. Generally speaking, conflicts in this space present more serious challenges than those in the corporate fiduciary model because of the heightened power imbalance between employers and employees, as well as employees' limited comparable and substitutable options.

As mentioned before, there may be situations in which the fiduciary's relationship with the beneficiary, by its very nature, gives rise to an inevitable appearance of partiality.¹⁸⁹ In that case, the fiduciary may need to withdraw from the role since the relationship cannot allow for disinterested behavior. In instances where conflicts of interest between employers' other duties—such as their fiduciary duties to the corporation—or personal values and views preclude them from acting in the *sole interest* of employees, recusal may pose a viable option.

As health fiduciaries, employers would also have a duty of care—this includes a duty to select health coverage plans with “prudence, attention, and proficiency.”¹⁹⁰ Employers would need to reasonably investigate relevant issues and dedicate time to discharging their duties. They would also need to investigate the suitability of health coverage plans to employees' needs—an investigation that presupposes knowledge of employees' health preferences. In practice, then, employers would have an affirmative duty to reasonably investigate the preferences of participants in employment-based plans. Doing so need not be a prohibitive task. For example, an employer could issue annual surveys to eligible employees asking them to convey their health coverage preferences. Actuaries could assist the employer in aggregating the surveys and reasonably approximating employees' overall preferences in the next year's available plan(s). Certainly, some individual preferences might not align with aggregate group

¹⁸⁷ See FRANKEL, *supra* note 5, at 117–18.

¹⁸⁸ See FRANKEL, *supra* note 5, at 119; LEIB, *supra* note 124, at 113.

¹⁸⁹ See, e.g., Dmitry Bam, *Making Appearances Matter: Recusal and the Appearance of Bias*, 2011 BYU L. REV. 943, 943 (referencing this standard in judicial recusal cases).

¹⁹⁰ FRANKEL, *supra* note 5, at 169.

preferences. Particular employees may favor more or less coverage, and employers would have to weigh cost versus coverage tradeoffs. As mentioned in Part III.D,¹⁹¹ these limitations need not be fatal. Employers can work to reasonably accommodate the aggregate group, taking into account the coverage and cost wishes of individuals as well as those of the overall group.

Further, within the duty of care, employers might have other affirmative obligations. These affirmative duties might require, for example, conducting due diligence reviews of insurance brokers, or seeking review of potential health coverage packages to ensure that they adequately diversify risk and protect against loss. Given the complexity of health insurance decision-making, as well as the fact that employers generally are not health “experts,”¹⁹² the duty of care in this context could require heightened due diligence in order to ensure that employers protect employees’ interests.

D. *Limitations of the Fiduciary Model*

Against this backdrop, this Part will explore potential limitations of applying a fiduciary model to employers in this context. There are several challenges: employers’ double, and potentially conflicting, fiduciary duties to both the corporation and to employees; employers’ limited fiduciary “expertise” to make health coverage decisions; the difficulty of making decisions in the interest of diverse collectives; and the limited nature of fiduciary remedies to adequately address harms from fiduciaries’ misconduct. And as Part IV will explore, there are doctrinal obstacles to reframing employers’ roles as fiduciary roles, although the Affordable Care Act has lessened—or perhaps even removed—these obstacles.

First, a significant question is how to resolve employers’ double fiduciary duties. Employers under this account have fiduciary duties to the corporation, as well as to employees in making health coverage decisions.¹⁹³ Each fiduciary role has an attendant duty of loyalty, which requires the fiduciary to act in the sole interest of the beneficiary. The questions follow: Can employers adequately serve the needs of both sets of beneficiaries? Or is the mere fact of these dual duties enough to warrant employers’ automatic recusal from serving as health fiduciaries?

In responding to this question, it is helpful to first consider the ways in which the two sets of beneficiaries’ interests align or diverge. In

¹⁹¹ See *infra* Part III.D.

¹⁹² See *id.*

¹⁹³ See, e.g., *Revlon, Inc. v. MacAndrews & Forbes Holdings, Inc.*, 506 A.2d 173, 179 (Del. 1986) (stating that directors owe fiduciary duties to the corporation and its shareholders).

many ways, the interests of the beneficiaries likely converge. For instance, it is generally in the interest of the corporation that employees enjoy good health, and employees would generally wish the same. Hence, if maximizing employees' health—in a broad sense—is the motivating desire of both sets of fiduciaries, the employer may not confront conflicts. However, there may be instances wherein an employee's interest diverges from that of the corporation. For example, employees with obesity challenges may desire insurance coverage for bariatric weight loss surgery; the corporation, in turn, may not wish to provide coverage because doing so may increase premiums or lead to additional employee leave in order to undergo this procedure. Or women and their partners may desire coverage for in vitro fertilization—an expensive procedure that may increase overall premiums as well as chances of employee leave. Subtle, or not so subtle, tensions may emerge.

What becomes clear is that there is a spectrum of potential conflicts between employers and employees (and even those employees' families).¹⁹⁴ In some instances, the interests of employees will align with those of the corporation and its shareholders; in others, they will not. Yet, under fiduciary law, the harm need not be quantifiable in terms of monetary loss. The harm is that a fiduciary acts outside the exclusive interest of the beneficiary.¹⁹⁵ Hence, if an employer has inherently divided loyalty—to the corporation and its shareholders, as well as to the employees—with both sets of beneficiaries having different motivating goals, then the employer likely should not serve in both fiduciary roles. Limiting mechanisms (such as the construction of walls between potentially conflicted parties or the use of independent agents) become especially important, then, to minimize risk of breach and help protect beneficiaries.

Second, unlike many fiduciaries, employers do not generally have heightened skill or expertise in their specific task—that is, in selecting health insurance coverage. While investment managers typically have the heightened acumen to make prudent investment decisions, employers do not necessarily have any greater skills to make health coverage decisions on behalf of users than the average person. Add to this the fact that health care is inherently complex,¹⁹⁶ and the fiduciary skill of the employer may come into question. Hence, the fiduciary's

¹⁹⁴ See, e.g., Schoenbaum, *supra* note 49, at 1174–75. As mentioned before, employers themselves are also frequently covered by the same benefit plans as their employees, which may create an additional conflict when an employer makes plan decisions based on his or her own personal interests.

¹⁹⁵ See Smith, *supra* note 5, at 1411.

¹⁹⁶ See *Report of the Working Group on Challenges to the Employment-Based Healthcare System*, U.S. DEP'T OF LABOR (Nov. 14, 2001), http://www.dol.gov/ebsa/publications/AC_1114b01_report.html.

heightened *skill* may simply be better *negotiating advantage* and ability to pool risk and minimize underwriting costs across a group of health care users.¹⁹⁷ Employers may play a further role in helping beneficiaries round out health coverage, beyond those services that an individual may select on her own, in order to diversify risk. In so doing, the employer minimizes the chances that an employee or her family will experience catastrophic loss from health events. Fiduciaries in many settings have a duty to diversify risk in order to avoid such loss.¹⁹⁸ In the health coverage context, there is a compelling reason to enlist fiduciaries' expertise to diversify coverage and control for anticipated areas of high risk.

Next, employers negotiate and act on behalf of a collective group of health care users rather than individuals, making strains between individual and collective coverage wishes inescapable. Certain employees may deeply desire more or less coverage for particular services, and those desires may conflict with the aggregate wishes of employees in a particular health pool. Even employers acting munificently can, at best, approximate the health coverage desires of the overall group, perhaps paying particular attention to the desires of those with the greatest health needs. This limitation need not be fatal to the application of fiduciary principles. In the corporate context, directors acting as fiduciaries have a duty to act in the sole interest of shareholders, who often represent a diverse set of constituents with different preferences. In these situations, directors who discharge their duties may act as arbitrators, clarifying the rights of the conflicted constituents, explaining their own role and, at times, resorting to general principles of law (such as maximizing fairness to all parties).¹⁹⁹ Fiduciaries should make decisions that best meet the aggregate interests of the group.²⁰⁰ By analogy, in the present context, employers can issue surveys that allow employees to confidentially identify their health coverage priorities. Based on the results of these surveys, employers can work with actuaries or other specialists to select the best health insurance plan, or set of health insurance plans, to meet the needs of the group.

¹⁹⁷ See JOST, *supra* note 27 at 55; *Report of the Working Group on Challenges to the Employment-Based Healthcare System*, *supra* note 196.

¹⁹⁸ See, e.g., Jeffrey A. Cooper, *Speak Clearly and Listen Well: Negating the Duty to Diversify Trust Investments*, 33 OHIO N.U. L. REV. 903, 906–10 (2007) (noting that the prudent trustee will diversify trust investments); see also 29 U.S.C. § 1104(a)(1)(C) (2012) (articulating the ERISA fiduciary duty to diversify trust investments, albeit not extending to health coverage decisions).

¹⁹⁹ See FRANKEL, *supra* note 5, at 178 (referencing the principle that fiduciaries must serve all masters, or at least the overall plan, with the utmost care and fairness).

²⁰⁰ See *id.* at 277.

And lastly, traditional remedies for breaches of fiduciary duties may be inadequate when the accessibility of life-protecting resources such as health services is at stake. This is true even though courts generally view remedies for breaches of fiduciary duties more strictly than they view those for contractual breaches.²⁰¹ Remedies generally require fiduciaries to disgorge profits, with such profits being measured by the amount of the fiduciary's gain rather than the amount of the beneficiary's loss.²⁰² The core underlying justification for this remedy is to deter future misconduct.²⁰³ Such a calculation of the fiduciary's gain is difficult to make in the context of health care coverage, where the fiduciary has made a coverage decision against the beneficiary's interest.

It would be slightly simpler to evaluate the harm to a beneficiary from the denial of desired medical coverage. However, even under that calculation, the harm may be attenuated and yet profound. Denying an employee coverage for a particular service—or offering coverage on more expensive terms—does not generally in and of itself render that service wholly inaccessible. The service typically remains accessible, albeit for a price that may be too high. It would be challenging to calculate damages to a beneficiary from financially inaccessible care—the harm may be enormous when individuals cannot access life-enriching and -preserving health services, and yet difficult to quantify. Traditional profits disgorgement calculations would not likely account for the full harm.

An equitable remedy would be preferable. For instance, an injunction could require a fiduciary to act, or not act, in a particular way or to reform a health insurance plan where a fiduciary has not done so.²⁰⁴ There is legal precedent for such injunctive relief.²⁰⁵ Such remedies may better serve the interests and needs of beneficiaries when the relevant critical resource is access to essential health care services.

Despite these potential limitations, the fiduciary framing of employers' role has advantages. It clarifies the underlying entitlements and interests. It also helps bound otherwise unlimited discretion around formative duties. And it illuminates the deeper structural role that employers play in this space.

²⁰¹ See *id.* at 249.

²⁰² See Smith, *supra* note 5, at 1493.

²⁰³ See *id.*

²⁰⁴ See FRANKEL, *supra* note 5, at 249.

²⁰⁵ Indeed, courts have allowed remedies under ERISA that reinstate particular medical plans for plaintiffs. See, e.g., *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.*, 579 F.3d 220, 236–37 (3d Cir. 2009), *cert. denied*, 559 U.S. 940 (2010).

E. *The Contraceptive Mandate Litigation as a Case Study*

The fiduciary approach also provides a helpful lens through which to view the contraceptive mandate litigation before the Supreme Court of the United States. This Article does not address the merits of employers' free exercise claims, but it does explore the broader and more fundamental tension raised by that litigation—whether employers should have to provide a service to which they object.

As of April 2014, over ninety lawsuits had been filed in federal courts contesting the HRSA-required contraceptive benefits and asking for injunctions against the enforcement of the contraceptive mandate, and the Supreme Court had accepted two for-profit cases for review.²⁰⁶ The litigants have included non-profit entities such as Catholic universities and hospitals, as well as for-profit businesses and their owners. Their core claim is that the regulations and penalties relating to an employer's obligation to cover contraceptives under employment-based health plans violates the business' and owners' rights under the Religious Freedom Restoration Act (RFRA),²⁰⁷ as well as the Free Exercise, Establishment, and Free Speech Clauses of the First Amendment of the U.S. Constitution.²⁰⁸ Certain employers have asserted that their non-compliance with the contraceptive coverage requirement, and the resulting penalties, would impose a significant financial burden, enough to require business closure.²⁰⁹

The government has responded that “[g]eneral business corporations . . . do not pray, worship, observe sacraments or take other religiously-motivated actions separate and apart from the intention and direction of their individual actors.”²¹⁰ The Court must examine the complex relationship between the free exercise clause and laws that are—like the contraceptive mandate—allegedly neutral and generally applicable. The most controversial question directly before the Court is whether secular corporations can exercise religion under the First Amendment and RFRA.²¹¹ As mentioned, the employers' religious freedom arguments are complex, and this Article does not engage them

²⁰⁶ See *HHS Mandate Information Central*, *supra* note 4.

²⁰⁷ 42 U.S.C. § 2000bb-1 (2012).

²⁰⁸ See, e.g., *Tyndale House Publishers, Inc. v. Sebelius*, 904 F. Supp. 2d 106, 109 (D.D.C. 2012).

²⁰⁹ See, e.g., *id.* at 113, 121 (noting plaintiff's contention that Tyndale House Publishers “cannot afford to sustain the fines threatened by the [contraceptive coverage mandate] at issue in this case” (alteration in original) (internal quotation marks omitted)).

²¹⁰ *Hobby Lobby Stores, Inc. v. Sebelius*, 870 F. Supp. 2d 1278, 1291 (W.D. Okla. 2012), *rev'd*, 723 F.3d 1114 (10th Cir. 2013), *cert. granted*, 134 S. Ct. 678 (2013).

²¹¹ The for-profit claims have been relatively successful in lower courts. As of April 2014, for-profit businesses and their owners had won thirty-three preliminary injunctions granting relief against the contraceptive mandate, and had been denied relief in six cases. See *HHS Mandate Information Central*, *supra* note 206.

directly. Indeed, if employers had rights protected by the Constitution or by federal law, then (under the Supremacy Clause) those rights would trump fiduciary claims.²¹²

However, this Article's fiduciary analysis helps clarify the structural problem underlying employers' claims. First, the analysis explains employees' interest in contraceptives as a guaranteed preventive care item under the Affordable Care Act. In order to access these entitlements, employees must rely on their employer to negotiate the terms of coverage. Historically, as this Article has described, the law has not limited employers' discretion in so doing, resulting in potential conflict between employees' preferences and employers' decisions on their behalf. Asking and answering this question again is even more important now given the Affordable Care Act's employer mandate, which consolidates employers' power in this space.

Fiduciary law constrains employer discretion through the duties of loyalty and care, which act as quasi-regulatory tools. Under the duty of loyalty, employers must act in the sole interest of employees in making decisions. And yet, in the contraceptive mandate lawsuits, employers have asserted a right to make health coverage choices based on *their own* set of values and preferences. Employers have claimed authority over the terms and contents of employees' health benefit packages, even if their choices contradict the desires of employees. The litigation exemplifies the risk that employers' motivations and interests may run counter to those of their employees—whether based on religion, values, economics, or broader business strategy.

Reframed in this light, the conflict between employers' obligations as fiduciaries and their actions becomes evident. Under principles of fiduciary law, these employers have a self-proclaimed conflict of interest. They cannot act in the sole interest of the beneficiary because their own interests and values preclude them from doing so. As referenced earlier, the *harm* to beneficiaries in such a breached duty is the mere fact that the employer considers its own interests. Notably, it is possible for an employer to fulfill the duty of loyalty while objecting to contraceptives if an employee herself—or a collective group of employees—objects to the coverage and financing of contraceptives. Employers then, as fiduciaries, would have standing as trustees to raise their objections on behalf of the beneficiaries. Absent this, employers do not act in employees' interest in objecting to contraceptive coverage.

The legal resolutions to such a conflict of interest include the use of limiting mechanisms. In the extreme case in which such mechanisms cannot suffice, employers may have to use absolute removal—i.e.,

²¹² See U.S. CONST. art. VI, cl. 2. If the fiduciary claims are grounded in the text of ERISA or the Affordable Care Act, which are themselves federal statutes, the analysis becomes more complex.

recusal—from serving in a fiduciary role. The Affordable Care Act itself envisions such “recusal”—an opting out of providing employment-based coverage, with employees then being eligible to purchase health care on a state or federal exchange. Yet employers have objected to the associated penalty, claiming significant financial harm.²¹³ It is important to note that, before arriving at this alternative, fiduciary law offers several other options to resolve conflicts that could meet employers’ needs. Employers could engage independent or third parties to make coverage decisions on behalf of employees in a disinterested manner. They could also consider disclosure and informed consent, although that mechanism may pose challenges in the employment context given the heightened power imbalance—indeed, employees generally have limited negotiating power when establishing the contractual terms of employment and might be deprived of meaningful choice in those negotiations.

Further, this Article’s fiduciary reframing, combined with its clarification of how employees pay for their employment-based health insurance, reveals a fault line in employers’ legal claims. In the litigation before the courts, many employers have objected to, among other things, what they allege is their compulsory *financing* of contraceptives, financing that they claim violates their rights to free exercise.²¹⁴ Yet they lack a claim to the underlying critical resources at stake. Employers make coverage decisions on behalf of employees and with employees’ money. In other words, it is employees who have a claim of right to the payments made towards their health insurance coverage, as well as items like contraceptives that the Affordable Care Act guarantees to them. Employers (as health fiduciaries) must make decisions regarding such critical resources in the *sole interest* of their employees (the beneficiaries).

IV. IMPLEMENTING THE FIDUCIARY ACCOUNT: DOCTRINAL OPPORTUNITIES AND OBSTACLES

The fiduciary account reinforces employees’ interests in various critical resources—the entitlements to health care outlined in the Affordable Care Act and in the U.S. tax code, as well as to the monies used to purchase employment-based insurance. It also affirms that employers’ role is to act in their employees’ interest in making decisions

²¹³ See *supra* Part II.C.

²¹⁴ See, e.g., *Korte v. Sebelius*, 528 F. App’x 583, 586 (7th Cir. 2012) (“The Kortes contend that the contraception mandate substantially burdens their exercise of religion by requiring them, on pain of substantial financial penalties, to provide and pay for an employee health plan that includes no-cost-sharing coverage for contraception, sterilization, and related medical services that their Catholic religion teaches are gravely immoral.”).

related to these critical resources. Thus far, this account has offered a normative case, with certain attendant positive claims. Yet there are doctrinal opportunities—as well as obstacles—in effecting such a fiduciary model in the wake of the Affordable Care Act. This Part examines those.

The Act sharpens existing tensions between employees' and employers' preferences in employment-based coverage by clearly delineating health entitlements, by mandating that certain employers must provide health insurance, and by thus limiting employees' alternative methods of accessing entitlements. Tensions between employees' desires and employers' coverage choices (which were once abstract) are now lucid and unmistakable.

As this Part demonstrates, historically, both public and private law have fallen short in protecting employees from employers' discretionary decisions in this regard. Yet ERISA has long recognized certain fiduciary duties with respect to employee benefit plans, and there is a colorable claim that the Affordable Care Act has altered ERISA to extend fiduciary obligations to employers' health insurance coverage decisions.

Federal law enshrines certain health entitlements outlined in this Article; namely (1) the Affordable Care Act's provisions guaranteeing particular health benefits, modes of coverage, and accessibility; and (2) the system of federal tax exclusions that accrue to, and on behalf of, employees. These entitlements have been "privatized" in the sense that employees must generally access them via their employment-based plans. Nonetheless, the legal framework through which beneficiaries can contest for and ensure adequate provision of their federal statutory entitlements is unclear. Constitutional law scholars have identified gaps in constitutional protection in other instances in which public benefits (such as welfare and public education) have been privatized.²¹⁵ They have pointed out how the "state action" doctrine is fundamentally inadequate to protect beneficiaries' interests in an era of increasing government devolution of power to private parties.²¹⁶ The government has given private actors wide discretion over a growing range of governmental programs, from welfare programs to prisons and public education.²¹⁷ While private parties wield increasing authority and

²¹⁵ See Metzger, *Privatization as Delegation*, *supra* note 16, at 1367 (arguing that privatization acts as a form of administrative delegation and existing state action doctrine is functionally inadequate to address the constitutional challenge posed by such privatization); see also Super, *supra* note 16, at 393 (suggesting high costs of dismantling subsistence benefits programs and advocating for an efficiency model of determining whether and how much to privatize); Symposium, *New Forms of Governance: Ceding Public Power to Private Actors*, 49 UCLA L. REV. 1687 (2002); Symposium, *Public Values in an Era of Privatization*, 116 HARV. L. REV. 1211 (2003).

²¹⁶ See Metzger, *Privatization as Delegation*, *supra* note 16, at 1370–71.

²¹⁷ See *id.* at 1379–80.

discretion over the delivery of statutory entitlements such as Medicare and Medicaid,²¹⁸ the public law framework for holding them accountable remains deficient.

In determining constitutional liability, courts test for “state action,” evaluating whether there is close government involvement in the administration of a particular entitlement.²¹⁹ In many situations, state action doctrine comes up short.²²⁰ Timothy Jost has written extensively about risks of “disentitlement” in the privatization of Medicaid and Medicare.²²¹ Jost has suggested statute-based private rights of action as an important alternative.²²² The Affordable Care Act creates no such private right of action for enforcement of health insurance reforms, although ERISA does.²²³ This Part now turns to ERISA to assess doctrinal opportunities under that statute.

Private law solutions could apply to the wider range of health entitlements described in this Article because the entitlements need not be grounded in federal statute in order for private law to apply. Any rigorous discussion of employment-based health coverage must grapple with ERISA,²²⁴ the primary statute regulating these health plans, as well as the private law enforcement actions around them. As the Supreme Court has acerbically stated, ERISA’s provisions are perhaps “not a model of legislative drafting.”²²⁵ A federal appeals court went further

²¹⁸ See *id.* at 1387.

²¹⁹ See *id.* at 1422–26; see also, e.g., *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40 (1999) (finding insurers who withheld workers’ compensation benefits without pre-deprivation notice were not liable under § 1983 because they were not state actors); *Blum v. Yaretsky*, 457 U.S. 991, 1008 (1982) (finding private nursing homes’ Medicaid eligibility and benefit decisions were not forms of state action because those decisions “ultimately turn[ed] on medical judgments made by private parties according to professional standards that are not established by the State”). Specifically, a court evaluates whether the government “exercised coercive power or has provided such significant encouragement . . . that the choice [to fire appellants] must in law be deemed to be that of the State.” *Id.* at 1004.

²²⁰ Professor Gillian Metzger has noted that “[t]o the extent constitutional law plays a role [in privatization], it is often the counterproductive one of creating incentives *against* close government oversight and supervision of private delegates.” Metzger, *Private Delegations, Due Process, and the Duty to Supervise*, *supra* note 16, at 291 (assessing the legal mechanisms necessary in order to support a new form of constitutional review of administrative delegation to private parties).

²²¹ See JOST, *supra* note 12, at 30–34, 93–96.

²²² See Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF. 145 (2003). Other scholars have recommended that privatized government contracts should be subject to more democratic and accountability processes, like the notice and comment procedures under administrative law. See Aman, *supra* note 16, at 281–85.

²²³ A U.S. Government Accountability Office (GAO) Study commissioned upon the PPACA’s passage reviewed several sections of the Act and concluded that it creates no private cause of action explicitly or implicitly. See U.S. GOV’T ACCOUNTABILITY OFFICE, B-322525, CAUSES OF ACTION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2012).

²²⁴ See The Employment Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.).

²²⁵ *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985).

and labeled provisions in the legislation a “veritable Sargasso Sea of obfuscation.”²²⁶ Yet because ERISA provides a set of largely exclusive remedies with respect to employment-based benefit plans, including health plans, it is an important part of the doctrinal discussion.

Congress passed ERISA in 1974 to regulate private employer pension plans.²²⁷ Congress aimed to both encourage employers to develop such programs and provide attendant legal protections for employees.²²⁸ The legislation applies to employee welfare benefit plans generally, including employment-based health insurance plans.²²⁹ Although employment-based health plans were not ERISA’s primary regulatory target, ERISA has had an enormous impact on these plans and on the course of American health care more broadly.²³⁰ In a paradoxical way, the statute’s most significant impact has been its preclusion of causes of action—i.e., its expansive preemption of state law actions pertaining to employee benefit plans.²³¹ “ERISA’s federal ‘presence’ thus tends to create an ‘absence,’ a regulatory vacuum that leaves the scope of employer-provided health care to employer decision or employer-employee bargaining.”²³²

ERISA displaces the ability of states to regulate employment-based health insurance. It also significantly limits employees’ and other beneficiaries’ ability to bring private causes of action against employers. ERISA preempts state laws “insofar as they may now or hereafter relate to any employee [health] benefit plan.”²³³ In practice, ERISA creates significant impediments to common law claims against employers or organized health plans, as well as to state legislative action in this arena.²³⁴ The scope of ERISA is complex, and it is unclear whether a

²²⁶ *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993).

²²⁷ See *EMPLOYMENT AND HEALTH BENEFITS*, *supra* note 26, at 82.

²²⁸ See 263 CONG. REC. S15, 762 (1974) (adopting ERISA to balance the need for reasonable limits on employers’ benefit plans while also protecting employees).

²²⁹ See *id.*; see also 29 U.S.C. § 1002(1) (2012).

²³⁰ See Havighurst, *supra* note 90, at 7–8.

²³¹ See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985) (rejecting arguments that implied private rights of action should accompany ERISA, and noting “[w]e are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA”); Richard A. Briffault & Sherry Glied, *Federalism and the Future of Health Care Reform*, in *THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES*, *supra* note 90, at 49, 55. Much of the motivation behind this preemption stemmed from the Congressional goal of avoiding distinct private law rules in different states. See *id.*

²³² Briffault & Glied, *supra* note 231, at 55.

²³³ 29 U.S.C. § 1144(a). The statute contains two other clauses that, combined with the preemption clause, define the contours of preemption. The statute’s “savings clause” excludes from preemption state laws that regulate insurance. *Kentucky Ass’n of Health Plans v. Miller*, 538 U.S. 329, 336 n.1 (2003) (citing 29 U.S.C. § 1144(b)(2)(A)). And the statute’s “deemer clause” provides that employee benefit plans shall not themselves be “deemed” to be an insurer or “engaged in the business of insurance.” *Id.* (citing 29 U.S.C. § 1144(b)(2)(B)).

²³⁴ See Briffault & Glied, *supra* note 231, at 59. The Supreme Court has found that state common law contract or tort doctrines, including breach of contract, fraud, and breach of

state could enact sweeping health reform including an employer mandate without being preempted.²³⁵ Academics have predicted that courts are unlikely to find that individual mandates—imposed on all health plan participants—are preempted by ERISA.²³⁶

ERISA itself imposes limited substantive requirements on employment-based health plans. ERISA does not mandate any particular health benefits,²³⁷ and unlike pension plans, health benefits plans are not subject to participation, vesting, or funding requirements.²³⁸ ERISA merely requires the periodic filing of forms related to plan participation and finances with the U.S. Department of Labor; disclosure of plan details to beneficiaries; the establishment of claim procedures; fiduciary obligations in certain circumstances (as described below); and remedies for violations of ERISA's minimal requirements.²³⁹

ERISA provides an exclusive set of private civil enforcement actions for benefit plan participants.²⁴⁰ Under ERISA, plan participants can bring lawsuits to clarify their rights to benefits, to recover benefits owed, and to ask for equitable relief for any act or practice that violates the terms of the plan or of ERISA itself.²⁴¹ Plan participants can also

fiduciary duty, “relate to” employee health plans within the meaning of ERISA, and thus are subject to preemption. *Pilot Life Ins. Co. v. Dedaux*, 481 U.S. 41, 47 (1987); *see also Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 61 (1987). On the legislative front, courts have found that ERISA preempts a wide array of state regulations. *See EMPLOYMENT AND HEALTH BENEFITS*, *supra* note 26, at 83. Employers can further insulate themselves from state regulation by self-funding—that is, having the plan bear the risk of health benefit claims itself, rather than transferring that risk to a third party. *See Briffault & Glied*, *supra* note 231, at 63. Unsurprisingly, an increasing number of employers have opted for self-funding. In 2011, 58.5% of workers with health coverage were in self-insured plans. Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, 33 EMP. BENEFIT RES. INST. NOTES 2 (2012).

²³⁵ *See* Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 86, 89–90 (2009). To date, no litigant has raised ERISA preemption challenges to the state of Massachusetts's health reform, which combines individual and employer mandates with government subsidies. Employers with more than ten employees are required to make a fair and reasonable contribution to workers' health premiums or else face a \$295 assessment per employee. *See id.* at 93.

²³⁶ *See id.* at 95.

²³⁷ *See Briffault & Glied*, *supra* note 231, at 58.

²³⁸ *See id.* ERISA's requirements for health plans are limited to periodic filing of forms pertaining to plan participation and finances with the U.S. Department of Labor, disclosure requirements to beneficiaries, claims procedures, remedies for violations of the Act's minimal requirements, and, as will be discussed later in this Part of the Article, fiduciary duties for employers engaged in particular functions. *See* U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS 95-167, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 30–31 (1995). Later legislation has amended ERISA to require continuation of health benefits for certain terminated employees. *See Briffault & Glied*, *supra* note 231, at 58 n.31.

²³⁹ *See Briffault & Glied*, *supra* note 231, at 58.

²⁴⁰ *See WIEDENBECK*, *supra* note 18, at 169.

²⁴¹ *See* Robert Rachal et al., *The Affordable Care Act and ERISA Litigation*, in ERISA LITIGATION (forthcoming 2012 Supplement).

bring causes of action against employers for their actions as fiduciaries.²⁴²

ERISA specifies fiduciary duties with respect to benefit plans, including health plans. Fiduciaries have a set of four duties to participants in benefit plans and their beneficiaries. The duties, derived from principles of trust law, are: (1) to act to the exclusive benefit of plan participants and their beneficiaries;²⁴³ (2) to exercise prudence;²⁴⁴ (3) to diversify investments, or by corollary to trust law, exercise reasonable care;²⁴⁵ and (4) to act in accordance with plan documents, insofar as they are consistent with ERISA's requirements.²⁴⁶ Where there is a breach of any fiduciary duty, fiduciaries must restore any illicit profits they have received and compensate for any plan losses.²⁴⁷ Courts may also impose equitable or remedial relief such as the removal of a fiduciary.²⁴⁸

ERISA statutorily defines persons who are "fiduciaries" as follows:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting *management* of such plan or exercises any authority or control respecting *management* or *disposition* of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the *administration* of such plan.²⁴⁹

This definition constrains the power of persons exercising certain types of discretionary or other authority over plan management, administration, or asset disposition. Courts have carefully crafted the

²⁴² See *id.*

²⁴³ See 29 U.S.C. § 1104(a)(1)(A) (2012); see also RESTATEMENT (SECOND) OF TRUSTS § 170(1) (1959).

²⁴⁴ See 29 U.S.C. § 1104(a)(1)(B); see also RESTATEMENT (SECOND) OF TRUSTS § 174.

²⁴⁵ See 29 U.S.C. § 1104(a)(1)(C); see also RESTATEMENT (SECOND) OF TRUSTS § 228.

²⁴⁶ See 29 U.S.C. § 1104(a)(1)(D); see also RESTATEMENT (THIRD) OF TRUSTS § 76(1) & cmt. b(1); WIEDENBECK, *supra* note 18, at 120–21. As the Supreme Court has explained:

[W]e recognize that these fiduciary duties draw much of their content from the common law of trusts, the law that governed most benefit plans before ERISA's enactment. We also recognize, however, that trust law does not tell the entire story. . . . Consequently, we believe that the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA's fiduciary duties.

Varity Corp. v. Howe, 516 U.S. 489, 496–97 (1996) (citation omitted).

²⁴⁷ See 29 U.S.C. § 1109.

²⁴⁸ See *id.* In general, the Supreme Court has limited relief to compensatory damages, disallowing punitive damages or extra-contractual compensatory damages. See EMPLOYMENT AND HEALTH BENEFITS, *supra* note 26, at 305.

²⁴⁹ 29 U.S.C. § 1002(21)(A) (emphasis added).

contours of those fiduciary functions.²⁵⁰ Significantly for the purposes of this Article's analysis, the Supreme Court has held that when an employer adopts, amends, or terminates a particular health benefit plan, the employer does not act in a fiduciary capacity under ERISA.²⁵¹

Yet that case, *Curtiss-Wright Corp. v. Schoonejongen*, predates the Affordable Care Act. The Act has dramatically altered the nature of employment-based health coverage, making it mandatory for large employers and requiring a minimum floor of coverage. Given this, *Curtiss-Wright* no longer seems apposite in holding that "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits."²⁵² There is a colorable claim that the Affordable Care Act, with its employer and coverage mandates, has created *at least* a limited set of entitlements to employer-provided health benefits, one grounded in statute, and that ERISA should be construed as such.²⁵³

As a matter of statutory construction, then, the Act itself supersedes ERISA in the areas in which the two conflict (given that it was passed later in time).²⁵⁴ Since the Act does not create a private right of action for health plan beneficiaries, health care users have no legal remedy outside of ERISA if employers do not provide them with their statutory entitlements under the Affordable Care Act, or if employers make decisions against their interest with respect to that entitlement. Reading ERISA and the Act together reveals at least a limited set of entitlements to employment-based insurance—namely, entitlements to services guaranteed under the Affordable Care Act (such as preventive care services). In turn, the two together could create attendant fiduciary duties with respect to those entitlements.

Further bolstering this argument, the Affordable Care Act itself amends ERISA to make the Act's coverage mandates applicable to individual and group health plans, including self-insured employment-based plans.²⁵⁵ If the Act's entitlements are *de facto* included in the

²⁵⁰ In one of the formative cases on this matter, *Pegram v. Herdrich*, the Court held that ERISA does not provide a remedy for a health maintenance organization's "mixed eligibility and treatment" decisions—that is, decisions that combine questions regarding an ERISA plan's "coverage of a particular condition or medical procedure for its treatment" with "choices about how to go about diagnosing and treating a patient's condition." 530 U.S. 211, 228–29 (2000). Such decisions are not fiduciary decisions under ERISA. *Id.* at 237.

²⁵¹ See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); U.S. DEPT OF LABOR, *supra* note 3, at 2; WIEDENBECK, *supra* note 18, at 114.

²⁵² *Curtiss-Wright Corp.*, 514 U.S. at 78.

²⁵³ This issue is ripe for litigation and judicial, or Congressional, resolution. In particular, if there is residual ambiguity, Congress could amend ERISA itself to clarify employers' roles as fiduciaries in making coverage determinations on behalf of employees.

²⁵⁴ See, e.g., Eric A. Posner & Adrian Vermeule, *Legislative Entrenchment: A Reappraisal*, 111 YALE L.J. 1665, 1668 (2002).

²⁵⁵ See 29 U.S.C. § 1185d.

terms of any employment-based plan, then employees could draw on ERISA's contract-type remedies to recover benefits owed to them under the terms of a plan.²⁵⁶ Employees could also invoke the fiduciary responsibilities outlined under ERISA to raise a claim that the plan fiduciary failed to conform the health plan to the Act's requirements.²⁵⁷ In these cases, a court may offer monetary damages or, perhaps, a reformation of the terms of the plan to include the denied benefits.

Yet that construction is limited, and would only secure employees' rights with respect to entitlements guaranteed on the face of the Affordable Care Act or its attendant implementing regulations. But the *de facto* and *de jure* outcome of the Affordable Care Act is that many employees must obtain health insurance from their employer in order to access the tax subsidies to which they are entitled.²⁵⁸ Employers thus have wide discretion to make all coverage decisions on employees' behalf using employees' entitlements (to tax exclusions or otherwise), as well as employees' very money or wages. The Affordable Care Act reinforces this as a matter of federal law.

Based on this, ERISA and the Act could be read together, and even consistently with *Curtiss-Wright*, to redefine employers' fiduciary duties to extend to all health insurance plan formation and amendment decisions, making employers the health fiduciaries this Article proposes. To the extent that ERISA and the Affordable Care Act prevent this interpretation, these statutes should be amended to impose such fiduciary duties and thereby protect employees' interests. In the absence of such amendments, the fault lines between employees' wishes and employers' discretionary decisions will remain—and perhaps even grow.

CONCLUSION

This Article re-theorizes the relationship between employers, employees, and government with respect to employment-based health insurance coverage. Employers have long made decisions on behalf of employees with almost complete freedom, and now employers are asserting additional rights to do so—even in contravention of federal law. This Article illuminates the thorny nature of decision-making in this space and thereby explores an area of the law that has been under-theorized. Employers act in a fiduciary-like manner when they make health coverage decisions on behalf of employees. Further, employees

²⁵⁶ See, e.g., 29 U.S.C. § 1132(a)(1)(B). Employees may also be able to bring an action against any "act or practice" that violates ERISA, including (by reference) the employers' violation of coverage mandates. See *id.* § 1132(a)(3).

²⁵⁷ See *id.* § 1104(a).

²⁵⁸ If an employer offers sufficiently comprehensive and affordable coverage, an employee is not eligible for a tax credit on the exchange system. See CHAIKIND, *supra* note 107, at 1.

have various entitlements to health insurance—to coverage of particular health services, modes of coverage, and financing; and yet in order to access these entitlements, they must rely on third parties who retain broad discretion in their decision-making. This Article endeavors to clarify this complex area of health law by reframing the role of employers vis-à-vis employees in this space. This clarification is particularly important at this moment as the United States undertakes a momentous health care reform program. The Affordable Care Act, which is certain to be the subject of more political controversy in the years to come, is also likely to remain a foundational part of the U.S. health care system. This Article recognizes employment-based health coverage as a flawed, yet durable, component of U.S. health insurance provision. It tackles one of the greatest flaws in employment-based insurance coverage, namely the unlimited discretion of employers to make coverage determinations on behalf of the majority of persons who access health insurance through this system. It also suggests doctrinal solutions to the negotiating problems that presently exist.

The fiduciary framing this Article proposes lacks the simplicity of a wholesale recommendation to eliminate employment-based coverage. Indeed, a more radical proposal would suggest that this form of coverage should be removed in favor of pure, consumer choice-oriented models like those offered in the nascent federal and state exchanges.²⁵⁹ Yet there are certainly advantages to employment-based coverage,²⁶⁰ including successful pooling of risk, collective negotiating advantages, employees' amenability to risk sharing around work communities, and, for the foreseeable future, favorable tax treatment.

It is also important to emphasize that health law and policy lack easy answers.²⁶¹ As other scholars have long noted, in health law, "legal and regulatory governance is the product of myriad, mostly uncoordinated power centers."²⁶² Several decades of legal accretion and thoughtful academic analysis of the same have revealed numerous

²⁵⁹ See 42 U.S.C. § 18031(c)(5)(B) (noting, among other obligations, the Secretary's obligation "to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices"). When it was originally launched, the government's consumer website on the PPACA stated, "take health care into your own hands." Nancy Scola, *Obama's New Healthcare.gov: A Look at What's Inside*, TECHPRESIDENT (July 1, 2010), <https://techpresident.com/blog-entry/obamas-new-healthcaregov-look-whats-inside>. The HHS Center for Consumer Information and Insurance Oversight website describes "State-based, competitive marketplaces, which launch in 2014, [that] will provide millions of Americans and small businesses with 'one-stop shopping' for affordable coverage." *Health Insurance Marketplaces*, CENTERS FOR MEDICARE & MEDICAID SERVICES: CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces> (last visited Apr. 18, 2014).

²⁶⁰ See *supra* Part I.C.

²⁶¹ See Havighurst, *supra* note 90, at 14–17.

²⁶² *Id.* at 16.

shortcomings in health law. Yet, as was evident in the years of negotiations and compromises that resulted in the Affordable Care Act, there are no simple solutions—legally, politically, economically, or culturally. The best solutions are necessarily second-best solutions that acknowledge the inherent complexity in designing a health care program that can equitably promote universal health.²⁶³

Applying fiduciary law in this context also offers a potential new framework for legal accountability around privatized public benefits. The government transfers public responsibilities to private hands in a range of arenas, including prisons, education, and health care.²⁶⁴ In recent years, there has been an expansion of government privatization, with privatized actors also receiving a greater range of discretion over the implementation of government's public programs.²⁶⁵ In the face of these expansions, it is important to revisit the long-mentioned academic argument that government benefits are as critical to individual liberty as traditional property—and, hence, should have the same substantive and procedural protection.²⁶⁶ This is particularly the case with benefits that are intrinsically linked to promoting livelihood and social welfare, like health benefits.²⁶⁷ And yet, decades later, there remains a legal blind spot with respect to protecting beneficiaries' rights to statutorily granted health entitlements. This Article's framework helps dissect, and perhaps resolve, the attendant problems. Lastly, this Article leaves room for further exploration of a host of relationships related to health care financing and provision that may benefit from a fiduciary framing.

²⁶³ See *id.* There is a certain path-dependency to the country's decision-making around health care. Yet, one could imagine that the country could still move in a different direction, away from the employment-based model, as the United Kingdom and Germany did. See JOST, *supra* note 12, at 204–35.

²⁶⁴ See Metzger, *Privatization as Delegation*, *supra* note 16, at 1376.

²⁶⁵ See *id.* at 1379.

²⁶⁶ See, e.g., Edward V. Sparer, *The Right to Welfare*, in *THE RIGHTS OF AMERICANS: WHAT THEY ARE—WHAT THEY SHOULD BE* 65 (Norman Dorsen ed., 1971) (advocating for an expanded recognition of legal rights to food and shelter in order to enhance dignity and social welfare); Reich, *supra* note 179 (arguing that certain benefits are so important to livelihood that they should be recognized as rights and, hence, should have substantive and procedural protections).

²⁶⁷ See Reich, *supra* note 179, at 785.