THERE IS NO PLAIN MEANING: THE JURISPRUDENCE OF ERISA AND THE "EXCLUSIVE BENEFIT" RULE

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On June 12, 2000, a unanimous Supreme Court, in Pegram v. Herdrich,¹ decided that a health maintenance organization ("HMO") that provides monetary incentives to doctors who increase profits by limiting patient care, does not violate the federal statute that governs employee health benefits—the Employee Retirement Income Security Act ("ERISA").² This decision was rendered despite ERISA's requirement that fiduciaries of benefit plans act exclusively in the interest of plan beneficiaries.³

The Court outlined its argument in familiar terms, using more of an economic efficiency or cost-benefit analysis than an enunciation of time honored legal principles or a sober statutory interpretation. Its reasoning was as follows:

1. HMOs are risk bearing organizations, and risk bearing organizations need to control costs.⁴

2. One way to control costs is to provide incentives to physicians, rewarding them for decreasing services and penalizing them for excessive treatment.⁵

3. "[I]n an HMO system, a physician’s financial interest lies in providing less care, not more."⁶


¹ 530 U.S. 211 (2000).
⁴ 530 U.S. at 219.
⁵ Id.
⁶ Id.

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

5. "The fiduciary is, of course, obliged to act exclusively in the interest of the beneficiary, but this translates into no rule readily applicable to HMO decisions or those of any other variety of medical practice."

6. "Any legal principle purporting to draw a line between good and bad HMOs would embody in effect a judgment about socially acceptable medical risk" that would turn on facts not readily accessible to courts and on social judgments not wisely required of courts unless there cannot be resort to the legislature.

On Labor Day in 1974, less than a month after President Richard Nixon resigned, President Gerald Ford signed ERISA into law. Pegram marks a little over a quarter of a century since the statute’s enactment and reflects a major policy pronouncement.

With a stock market boom then prevailing on Wall Street, baby-boomers aging, and the sunset of the Clinton administration, which was known for its efforts to reform healthcare, it is perhaps not surprising that the Supreme Court should issue this decision. Pegram embraces the ERISA statute as a marketplace phenomenon. Of course, failures of the market economy, including externalities such as the plundering of pension funds, led to Congress’s passage of ERISA. But the rhetoric of the market is invoked, whereby its risks and rewards will provide a necessary corrective to the effects of judicial excess in the form of judgments about "good" or "bad" HMO behavior.

7. Id. at 221.
8. Id. at 234.
9. Id. at 221.
10. 29 U.S.C. § 1001 et seq.
12. See generally The Federal Interagency Forum on Aging Related Statistics, Older Americans 2000: Key Indicators of Well Being, available at http://www.agingstats.gov/chartbook2000 (explaining how baby-boomers, comprising those born between 1946 and 1964, will begin to turn sixty-five in 2011, the size of the population aged sixty-five or older is projected to double over the next thirty years).
This article asks and seeks to answer how the current Supreme Court\textsuperscript{14} unanimously issued such a carefree, arguably extralegal, decision in the face of unambiguous statutory language imposing strict loyalty upon plan fiduciaries. That employers are obligated to operate an employee benefit plan for the exclusive benefit of employees is elusive in ERISA case law. Additionally, acknowledgment of the employees themselves as agents in the particular disputes is largely absent from the legal discourse.\textsuperscript{15} ERISA can be used to demonstrate how the meaning of laws are put forth and strategically resisted.\textsuperscript{16} It can also be used to demonstrate how the law not only reflects and accommodates the ideology of the private market and its accompanying social practices, thus supporting social stability, but likewise influences social and political life of which the debates over Social Security and patients’ rights are obvious examples.\textsuperscript{17}

This article addresses a cornerstone of traditional trust law, the trustee’s duty of undivided loyalty to the beneficiaries, which is enunciated in ERISA’s “exclusive benefit” rule.\textsuperscript{18} The rule mandates that “a fiduciary shall discharge his duties . . . solely in the interest of the participants and

\textsuperscript{14} Commentators and legal scholars have been actively observing the philosophical divisions on the Rehnquist Court. See, e.g., Bush v. Gore, 121 S. Ct. 512 (2000) (citing equal protection concerns and a lack of time to complete the presidential count as reasons to declare Governor George W. Bush the winner of the 2000 presidential election); Sven Erik Holmes, Symposium, 1999-2000 Supreme Court Review, 36 TULSA L.J. 1 (2000) (noting that many of the Court’s most high profile decisions reflect a 5-4 split). As to what is likely to be the Court’s most famous ruling, many suggested the decision was motivated by political or personal interest as much as driven by ideology. Ronald Dworkin noted, “the troubling question is being asked among scholars and commentators whether the Court’s decision would have been different if it was Bush, not Gore, who needed the recount to win — whether, that is, the decision reflected not ideological division, which is inevitable, but professional self-interest.” Ronald Dworkin, “A Badly Flawed Election,” THE NEW YORK REVIEW OF BOOKS, Vol. XLVIII, No. 1, at 53 (Jan. 11, 2001). Citing two witnesses, Newsweek magazine reported that at an election night party when returns were indicating a possible Gore victory, Justice O’Connor exclaimed, “This is terrible.” O’Connor’s husband, John O’Connor, explained that his wife was “upset because they planned to retire to Arizona” and a Gore win meant “they’d have to wait another four years” because she did not want a Democrat naming her successor. Evan Thomas & Michael Isikoff, The Truth Behind the Pillars, NEWSWEEK, Dec. 25, 2000, at 46. Many have argued that the five conservative justices, Chief Justice William Rehnquist, and Justices Kennedy, O’Connor, Scalia, and Thomas have “made this court the most activist Court in history.” Dworkin, supra. See also Robert G. Kaiser, Slim Majority Raises Fear of Court Partisanship, WASH. POST, Dec. 10, 2000, at A-32; Larry D. Kramer, No Surprise. It’s an Activist Court, N.Y. TIMES, Dec.12, 2000, atA33.

\textsuperscript{15} See generally ROGER COTTERELL, LAW’S COMMUNITY: LEGAL THEORY IN SOCIOLOGICAL PERSPECTIVE (1995).


\textsuperscript{18} ERISA § 404(a), 29 U.S.C. § 1104(a) (2001).
When Congress enacted ERISA it purportedly made its intent clear—that, under the common law of trusts, traditional principles of fiduciary obligations were to be applied to the administration of employee pension and welfare benefit plans. The law of trusts developed as a device for the wealthy to maintain ancestral land within the family, but under ERISA, trust principles provide a model for protecting benefits for working people. An ambiguity in the law of ERISA results, however, from a blurring of traditional trust law fiduciary functions and settlor (benefit plan sponsor) functions in two areas: (1) plan amendment and termination, and (2) the denial of health benefits under employee welfare benefit plans that utilize managed-care organizations for the delivery of healthcare services.

ERISA has never upheld the radical promises of labor democracy and democratic capitalism of the 1934 Wagner Act. Nor does it reflect substantive promises of providing a means and place of employment free from hazard and risk of death or serious physical harm, as did the Occupational Safety and Health Act of 1970 ("OSHA"). ERISA only provides procedural rights and some measure of government access. Social rights are not at stake and entitlements are not at issue. Therefore, I cannot argue that there is a “fundamental mismatch between the goals of the act and the approach taken.”

This article instead explores how recent judicial decisions could have been decided differently. It seeks to explain a doctrinal inconsistency in the federal courts’ interpretation of the duty of loyalty as applied to ERISA trusts (or plans) over the past twenty-five years. This article is divided into four major parts: two explanatory and two analytical.

Part I places ERISA in its social context and considers the events that led to the Act’s passage. Then it reviews the fundamentals of trust law, and

21. This irony, and problem, was suggested to me by a labor lawyer specializing in ERISA. Interview with Lowell Peterson, Attorney (Dec. 7, 2000) (on file with the author). Some argue that the “transferred usage of the trust” is problematic because “the statutory design neglects to adjust for the differences between a trust deal that implements a gratuitous transfer and a trust deal that is part of an exchange transaction.” John H. Langbein, The Contractarian Basis of the Law of Trusts, 105 YALE L.J. 625, 663 n.200 (1995).
the common law background and legislative history of ERISA, as it applies to both pensions and health benefits. I conclude Part I by explaining how and why Congress decreed that ERISA should preempt state causes of action. Although it probably was not the intent of Congress, some decisions have interpreted the preemption doctrine in ways that often leave employees worse off than they were before ERISA. Part II explains the "exclusive benefit" rule and the fiduciary obligations owed employees and beneficiaries under ERISA. The article then considers the tension between fiduciary duties and the settlor function, and the social relations that inhere in that tension.

I explore the legal decision-making process through the analyses of leading pension cases in Part III, and health benefits cases in Part IV. In both sections, I aim to reveal how ERISA jurisprudence both articulates and creates class relationships. In addition, these cases highlight an interpretive struggle at play, a kind of jurisprudential competition to determine the law of ERISA.

This article is not meant to be a primer on ERISA, nor strictly a doctrinal survey of this area of law. But it is necessary to focus on the language of the Act's relevant provisions, which can be tedious, in order to assess contested meanings of the statute.

One thing is certain about the Supreme Court's interpretations of the statute: the "plain meaning" rule has not prevailed in connection with the provisions of ERISA that require a fiduciary to "discharge his duties solely in the interest of participants and beneficiaries." If a cornerstone of


29. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A). Even if one takes into account that the text of the statute requires two things of the fiduciary, "to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and... for the exclusive purpose of... providing benefits to participants... and... defraying reasonable expenses of administering the plan," the latter clause should not trump the former clause. Id. (emphasis added). There is no ambiguity in the phrase "solely in the interest of participants and beneficiaries." Ambiguity could be argued in connection with the phrase "administering the plan." Does it mean administering in the sense of management of assets and the more back-office operations of providing participants with information, processing claims, mailing out benefits checks, and the like, or does it mean providing the benefits themselves? Such an argument would be grasping at a thin reed, however, because the
traditional trust law is the duty of loyalty, a basic tool of statutory
interpretation is to attribute to words in a statute their plain meaning.30 A
useful scholarly intervention would be to apply hermeneutic and linguistic
theory to a statutory interpretation of ERISA.31 Another article could
analyze Justice Scalia's schizophrenia with regard to ERISA, but perhaps
he is too easy a target. His criticisms of the decline of formalism, as
reflecting anti-democratic values that privilege judicial preferences over
formal enactments,32 seem like hollow posturing when one examines some
of the particular ERISA cases I review below. The text of the statute is
sometimes regarded as an inconvenience. This was certainly true of the
Pegram decision. Like any other law, however, the plain language of the
ERISA statute is a result of the type of Congressional decision-making that
characterizes the regulatory and democratic process. But its democratically
adopted text is often a mere springboard for judicial lawmaking.33

Instead, my project is limited to a first step in developing a
constitutive theory of ERISA law. Through an examination of judicial
decision-making, I aim to show part of the social relations at play in
classification and health benefit law. This kind of analysis may, in turn, be
useful in developing an understanding of the role of the law in how issues
concerning pension and health benefits are conceptualized, framed, and
debated politically in the future.

benefits are to be provided in accordance with the plan documents, so that any reduction in
benefits to defray expenses of the plan sponsor would hardly be "reasonable expenses," but
improper to "defray." See ERISA § 402(a)(1), 29 U.S.C. §1102(a)(1) ("Every employee
benefit plan shall be established and maintained pursuant to a written instrument.").

It is elementary that the meaning of a statute must, in the first instance, be
sought in the language in which the act is framed, and if that is plain, and if the
law is within the constitutional authority of the law-making body which passed
it, the sole function of the courts is to enforce it according to its terms. Where
the language is plain admits of no more than one meaning[,] the duty of
interpretation does not arise and the rules which are to aid doubtful meanings
need no discussion. There is no ambiguity in the terms of this act. . . . Statutory
words are uniformly presumed, unless the contrary appears, to be used in their
ordinary and usual sense, and with the meaning commonly attributed to them.
31. See, e.g., Paul F. Campos, This is Not a Sentence, 73 WASH. U. L.Q. 971 (1995);
William N. Eskridge, Jr. & Philip P. Frickey, The Supreme Court 1993 Term: Forward:
Law as Equilibrium, 108 HARV. L. REV. 26 (1994); Daniel A. Farber & Philip P. Frickey,
Legislative Intent and Public Choice, 74 VA. L. REV. 423 (1988); Philip P. Frickey, Faithful
Interpretation, 73 WASH. U. L.Q. 1085 (1995); Cass R. Sunstein, Interpreting Statutes in the
32. See, e.g., Antonin Scalia, Common-Law Courts in a Civil Law System: The Role of
the United States Federal Courts in Interpreting the Constitution and Laws, in A MATTER
33. Id.
I. COVERAGE, POLICIES, AND THE SOCIAL CONTEXT OF THE ERISA STATUTE

A. Background

As its name implies, the purpose of ERISA is to ensure that employees' retirement monies are secure. Yet, despite its noble title, ERISA is not to be mistaken for a mandatory social insurance program akin to Social Security that guarantees a stream of retirement income for workers. Instead, ERISA fits well within the voluntarist parameters of the economic order and constitutional structure of the United States.

ERISA reflects social organization through voluntary private ordering. It exemplifies ambivalence about the role of government in facilitating, much less providing, social insurance. ERISA also reflects a conception of law as a limiting device: legal rights protect us from the negative actions of the state that restrain our freedoms or cause us harm, not to ensure that the state will affirmatively protect us from the personal catastrophes that attend ill health or aging.

Unlike all of its industrial counterparts, the United States guarantees neither medical services nor health insurance as a right of citizenship. Similarly, unlike its Western European counterparts, the U.S. government does not require that private firms provide pension or medical benefits to their employees. Under the "contractual" model that governs U.S. labor policy, employees, or, if they are unionized, their unions, are "free" to bargain with employers for these types of compensation. Beyond that, whatever is provided by Congress is a matter of "statutory grace," not rights.

Since neither pension nor health benefit plans are required by U.S. law, ERISA is concerned essentially with administrative protections and procedures. It applies to all employee benefit plans maintained by any private employer or union. It does not cover government and church-sponsored plans. At its most basic, ERISA requires companies that sponsor employee benefit plans to: (1) disclose to participants the details of the plan; (2) report the plan to the federal government; and (3) honor fiduciary obligations in dealing with plan assets and the administration of

34. ERISA was supplemented in 1977, when provisions governing claims under employee health benefit plans were adopted. 29 U.S.C. § 1001 et seq. (2001).
37. Parmet, supra note 35, at 274.
benefits.\textsuperscript{39} Since providing a plan is a voluntary act in the first place, the decision to adopt a plan is a management or settlor decision. No fiduciary duty is implicated. Similarly, management may choose to end a plan at any time. The only time fiduciary duties are required is during the term of the plan; fiduciaries must honor the bible of the plan document, which ERISA purportedly enshrines. A company sponsor often wears two hats: that of the plan sponsor or settlor, who makes management decisions about what level of benefits to provide (arguably, what stockholders will allow), and that of a fiduciary in administering the plan, who should act with undivided loyalty to the participants and beneficiaries. These dual roles inevitably conflict.

This fiduciary/settlor dichotomy under ERISA is emblematic of income entitlements in the U.S. welfare state. ERISA promotes the notion of employee free choice, bargaining with equal power to management in a voluntary contractual exchange for benefits. The paradox of ERISA is that it promises unflinching loyalty to employees, while hiding a dagger that can carve out the benefits at any time.

Private pension funds represent the largest pool of investment capital in the United States (over five trillion dollars) and ERISA’s function as protective labor legislation “is tangled up with its function as a device to regulate capital formation and financial intermediaries.”\textsuperscript{40} Through tax breaks, ERISA provides an incentive to employers to provide benefits. But to justify these tax breaks, ERISA imposes Internal Revenue Service and Labor Department oversight of these plans to protect employees’ interests.\textsuperscript{41} ERISA also provides tax incentives to employees to participate in such plans, but it does not permit these benefits to be regarded as a “right” in the sense of being deferred, but earned, wages.\textsuperscript{42} How wages are

\textsuperscript{39} ERISA is governed by regulatory schemes administered by three federal agencies: the Department of Labor, the Internal Revenue Service, and the Pension Benefit Guaranty Corporation. The Department of Labor enforces the provisions of Title I of the Act, “Protection of Employee Benefit Rights,” 29 U.S.C. § 1001 \textit{et seq.} Title II of ERISA amended the Internal Revenue Code of 1954, 26 U.S.C. § 1 \textit{et seq.} Tax provisions “qualifying” employee benefit plans and deferred compensation are codified in the Internal Revenue Code. See I.R.C. § 401 \textit{et seq.} Title II contains the same requirements with regard to participation, vesting, and funding that are found in Title I, but in the context of provisions that must be satisfied to reap certain tax benefits. See, e.g., I.R.C. § 401 \textit{et seq.} Title IV of ERISA covers plan termination insurance, whereby the Pension Benefit Guaranty Corporation carries out the enforcement scheme. See 29 U.S.C. §§ 1301, 4002 \textit{et seq.}


\textsuperscript{41} See 29 U.S.C. § 1003(b)(1)-(2).

\textsuperscript{42} Some scholars contend that ERISA is primarily a tax vehicle. According to correspondence of James Klein, President of the Association Benefits Council:
conceived by ERISA and the relative power of labor and capital in this regard are a concern for courts attempting to reconcile the Act’s sanctioning of the dual and often conflicting roles of corporate officers with its stated policy objectives of protecting workers.

B. Fiduciary Duties vs. “Settlor” Function Under Traditional Trust Law

The inspiration for ERISA was traditional trust law, whereby a “settlor” sets up a trust (res), or property, for a trustee fiduciary to administer with undivided loyalty on behalf of a third party, the beneficiary. Before 1974, employees were left to enforce their pension or health benefit rights under general trust rules governed by applicable state law. In an express trust, or one that is voluntary, the owner of some property, known as the “settlor,” transfers it to some other person, known as the “trustee,” with the stipulation that the trustee not treat the money as his own, but handle it in some way for the benefit of a third person, the “beneficiary.” The essential features of a trust are: (1) a trustee; (2) a duty; and (3) property. Trusts come in many forms, but the root objective is to vest property in a trustee who is under an obligation to handle it in some particular way. It is presumed that this obligation is equitable and that the trustee has no interest of his own in the property. The overarching duty for the trustee is to exercise undivided loyalty in this undertaking.

Under the Restatement (Second) of Trusts, the duty of loyalty of a trustee is described as follows:

The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary.

(1) The trustee in dealing with the beneficiary on the trustee’s own account is under a duty to the beneficiary to deal fairly with him and to communicate to him all material facts in connection with the transaction which the trustee

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For much of the 1980s and early 1990s, with large federal budget deficits, we faced a situation where the tax policy tail wagged the retirement policy dog. So much legislative activity was based on how to extract more revenue from the pension system rather than what was sound retirement policy. As we entered an era of budget surpluses, the focus on tax revenue needs subsided.

(October 19, 2000) (on file with author).

43. Compare express trusts to constructive trusts, which, under contract, statute, or common law, are imposed between parties as a remedy for a breach of a duty or obligation under a pre-existing arrangement.

44. SIMON GARDNER, AN INTRODUCTION TO THE LAW OF TRUSTS 2 (1990).

45. Id. at 6.

46. Id. at 9.
knows or should know.\textsuperscript{47}

The comment to the Restatement notes that "[a] trustee is in a fiduciary relation to the beneficiary and as to matters within the scope of the relation he is under a duty not to profit at the expense of the beneficiary and not to enter into competition with him without his consent, unless authorized to do so by the terms of the trust or by a proper court."\textsuperscript{48}

Thus, implicit in the trustee's duty of loyalty is the duty to administer the trust solely in the interest of the beneficiaries, and to exclude from consideration one's own advantages and the welfare of third persons.\textsuperscript{49} The trustee "must refrain from placing himself in a position where his personal interest or that of a third person does, or may, conflict with the interest of the beneficiaries."\textsuperscript{50}

It is irrelevant whether a transaction was undertaken with the best of intentions. All of the trustee's conduct that:

has any bearing on the affairs of the trust must be actuated by consideration of the welfare of the beneficiaries and them alone. He is in a position of such intimacy with those he is representing and has such great control over their property that a higher standard is established by the court of equity than would prevail in the case of an ordinary business relation.\textsuperscript{51}

The standard texts even attribute the high standard of care to the vagaries of human nature and psychology. The loyalty rule is about "keeping all trustees out of temptation" so that the administration of the trust will proceed ethically and efficiently.\textsuperscript{52}

It is a well-known quality of human nature that it is extremely difficult, or perhaps impossible, for an individual to act fairly in the interests of others whom he represents and at the same time to consider his own financial advantage. In most cases, consciously or unconsciously, he will tend to make a choice which is favorable to himself, regardless of its effect on those for whom he is supposed to be acting. It is highly dangerous to fiduciary administration that the personal interests of the trustee come into play.\textsuperscript{53}

Accordingly, as Benjamin Cardozo observed when he was the Chief Justice of the New York Court of Appeals:

\textsuperscript{47} \textsc{Restatement (Second) of Trusts} § 170 (1959) (emphasis added).

\textsuperscript{48} \textit{Id.} at § 170 cmt. A.

\textsuperscript{49} \textit{See} \textsc{George T. Bogert, Trusts} § 341 (1987).

\textsuperscript{50} \textit{Id.}

\textsuperscript{51} \textit{Id.} at §§ 341-42.

\textsuperscript{52} \textit{Id.} at § 343.

\textsuperscript{53} \textit{Id.} at § 342.
Many forms of conduct permissible in the workaday world for those acting at arm's length are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of honor the most sensitive, is the standard of behavior.

Some see the trust concept as embedded in liberalism:

Liberalism takes it that everyone should be permitted the largest possible degree of autonomy regarding their actions. So the owner of some property is to be accorded the greatest possible freedom as to how he deals with it. The law provides the vehicle of the express trust in order to vindicate this liberty in him.

However, there is a contradiction between the greatest possible freedom in how the settlor “deals” with the assets and the essential concept of a trust. Although the settlor is “free” to establish the trust in the first place, these assets must be set aside and used only for carefully defined purposes—the traditional law of trusts frowns upon co-mingling.

While it draws on general principles of trust law, ERISA is more stringent in two respects. First, the Act prohibits the insertion of any exculpatory provisions in the creation of benefit plans. It states that, “[a]ny provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation or duty under this part shall be void as against public policy.” The second departure from trust law is that the statutory definition of a fiduciary extends beyond the formal or named trustee. It includes “functional fiduciaries,” meaning anyone who exercises discretionary authority in the administration of the plan or management of plan assets, including investment advisors. This departure from traditional trust law was effectuated to counterbalance ERISA’s permissive side.

55. GARDNER, supra note 44, at 14. Under trust law doctrine there are only four reasons for curtailing this unfettered right: (1) paternalism (the settlor must be prevented from acting against his own interests, as in someone who suffers a mental disability); (2) communitarian (perhaps the most ideological, i.e., a trust on condition someone does not marry would be disallowed as damaging the family and “humane influences like love”); (3) utilitarian (the trust’s effects should be beneficial, not deleterious, i.e., avoiding creditors; and (4) rights-oriented (the trust would infringe other people’s rights). Id. at 14-31.
56. Peterson, supra note 21.
57. Id.
59. So that employees may know who is responsible for operating and administering the plan, ERISA requires a “named fiduciary” to be provided in the plan document that employees have access to. 29 U.S.C. § 1102(a)(2) (1994), 29 C.F.R. § 2509.75-5 (1997).
ERISA is permissive in that under § 408(c)(3), it permits a fiduciary to be an officer, director, employee or agent of the plan's sponsor. As noted, traditional common-law trusts do not allow even the appearance of a conflict of interest on the part of fiduciaries. Under ERISA, however, fiduciaries do not breach their duty of loyalty when they hold a position in conflict with the plan or trust. It is only "when they [make] investment decisions out of personal motivations without making adequate provisions that the trust's best interests are served" that fiduciaries breach any duty.

C. Legislative History of ERISA

1. Pension Plans

In 1875, the American Express Company established the first U.S. pension plan, providing benefits for permanently disabled workers with twenty years of continuous service. The Revenue Act of 1921 provided the first tax incentives for private pension programs. In 1925, there were only about four hundred private pension plans in operation. Of these, approximately one-third were sponsored by four of the country's largest corporations. Most of the early plans, however, were bankrupted by the Great Depression. The subsequent growth of pension plans in the U.S. may be seen as rooted in a desire for financial security that "became part of the national psychology after the onset of the Depression." The Depression erased the lifetime savings of millions "and undermined American confidence in the historic tradition of self-reliance and in the virtue of individual thrift as a way to provide for old age."

62. Leigh v. Engle, 888 F.2d 361, 364 (7th Cir. 1988), cert. denied, 489 U.S. 1078 (1989). This is regarded as a seminal case in ERISA jurisprudence. In Leigh, investments made by the plan administrators who were also corporate officers resulted in large profits for the plan. Nevertheless, plan administrators were found to have breached their duty of loyalty to plan beneficiaries and participants because the profits were the result of investing plan assets in a number of corporate takeover targets that were either sponsors of the plan or related to those plan sponsors.
65. Unpublished asset data is on file with the Employee Benefit Research Institute. Id.
66. Munnell, supra note 63, at 72.
67. Id.
68. Id. at 73.
devastation made way for public and private savings plans, the passage of the Social Security Act of 1935, and fast growth in the number of private pensions. Neither Social Security nor employee-sponsored pensions alone provided adequate income, however, so each grew simultaneously.

The Revenue Act of 1938, which established the "nondiversion" rule and made pension trusts irrevocable, addressed the concern that a company could dissolve its pension plan immediately after it had made a sizable tax-deductible contribution. Under the 1938 Act, a pension trust is tax-exempt only if it is impossible, at any time prior to satisfaction of all employee liabilities, for any part of the contributions or income to be used for a purpose other than the exclusive benefit of employees or their beneficiaries.

By 1954, there were 25,000 pension plans with assets of $23.8 billion. This growth aroused concerns about the potential for fiduciary abuse, encouraging Congress to pass the Welfare and Pension Plans Disclosure Act of 1958 ("WPPDA"), which established certain disclosure requirements. Then, in the 1960s and early 1970s, evidence of misuse of employee benefit plans and the failure of the WPPDA to protect the rights of employees came to the attention of Congress. President Kennedy's Committee on Corporate Pension Funds expressed concern over unduly restrictive vesting, draconian forfeiture provisions, and the failure of some plans to accumulate sufficient funds to meet their benefit obligations.

The 1963 closing of the Studebaker automobile plant in South Bend, Indiana was the watershed event that influenced Congress to pass ERISA, even though it took eleven years. When the Studebaker plant closed, the company's pension plan covering 11,000 workers was terminated. The plan was so underfunded that 4,000 workers between the ages of forty and fifty-nine, with at least ten years of service, and whose pensions had vested, received only fifteen cents on the dollar of their accrued benefits. They were the lucky ones; those whose pensions had not vested got nothing.

The legislative history of ERISA reflects none of the explosive inter- or intra-class conflict that arose over other workplace-related legislation

69. Hubbard, supra note 64.
70. Id. at 43-44.
71. Id. at 44.
73. See Hubbard, supra note 64, at 44 (citing the President's Committee on Corporate Pension Plans and Other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans (U.S. Government Printing Office, 1965)).
75. Langbein & Wolk, supra note 74, at 62.
ERISA was not movement-generated; it was neither hailed as progressive nor decried as socialistic (as health care reform would be twenty years later). It was, however, constituent-driven and had moderate Republican Jacob Javits as one of its sponsors. Congress was well aware of prior abuses such as the pillaging of plan assets and tragedies such as the Studebaker plan, and blamed plan fiduciaries for underfunding, self-dealing, misappropriating plan funds, and imprudent investing. The year before ERISA was enacted, Ralph Nader and Kate Blackwell argued that “[m]ost people plan on [their] pension for retirement security and never know that pensions are no more certain than horseraces.”

Congress, therefore, pursued three primary objectives: (1) securing benefit promises to make sure plans were funded; (2) creating the Pension Benefit Guaranty Corp. (“PBGC”)—the only social insurance aspect of the Act—which provides minimum levels of insurance guaranteeing payments for vested participants; and (3) increasing benefit entitlement through greater participation and faster vesting. Some contend that all of these goals have been achieved.

The official Congressional findings and declaration of the policy of

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77. 120 Cong. Rec. 29,942 (1974). Senator Jacob Javits and Senator Harrison A. Williams were the two principal Senate sponsors. See also Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 156 (1985).

78. See Cong. Rec., supra note 77; Langbein & Wolk, supra note 75, at 62.


82. A fourth goal was to expand defined benefit plans, but the result has been just the opposite. The relative number of defined benefit plans is shrinking, while defined contribution plans such as 401(k)’s—referring to the Internal Revenue Code provision that renders these plans “qualified,” for specific tax treatment, I.R.C. § 401(k) (1994)—are increasingly prevalent.

Defined benefit plans typically pay monthly benefits at retirement with amounts based on the worker’s length of service and earnings. The benefits are usually financed with employer contributions based on actuarial estimates of the cost of future benefits. Defined contribution plans, on the other hand, provide for a fixed rate of contributions that are allocated to individual accounts for each worker. The benefits are based on the contributions (in almost half of these plans, participants contribute wages to the account) plus any gains, losses, and income expenses. In a defined contribution plan, the worker receives a lump-sum payout at retirement, or when he leaves the plan. See generally Hubbard, supra note 64, at 45-47; Thomas H. Paine, The Changing Character of Pensions: Where Employers Are Heading; Salisbury, supra note 81, at 33-58.
ERISA are that:

the continued well-being and security of millions of employees and their dependents are directly affected by [pension and benefit] plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations . . . ;

that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans;

that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits . . . ;

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

2. Health Benefits

In the legislative history of the Act, no such similar Congressional findings and declaration of policy concerning health care benefits are to be found. In contrast to pensions, little debate concerned health care, and Congress did not consider any in-depth instrumental action in this area. As Professor Catherine Fisk explains:

Congress gave relatively little thought to the problem of health

benefits, apart from joint union-employer Taft-Hartley funds, because the highly publicized problems in welfare benefits were mainly fraud . . . in the administration of union funds. . . . But the sharp increases in health care costs that would reveal the incongruence between employer and employee interests were still some years away.\(^{84}\)

Indeed, some have viewed ERISA’s regulations governing employee health coverage as an unintended consequence of the statute. Now, however, this is an area that has obtained a broad consensus for reform.

3. Preemption

ERISA has broad preemption language to guarantee interstate consistency, something the Supreme Court has called the legislation’s “crowning achievement.”\(^{85}\) ERISA’s preemption provision states: “[T]he provisions [of ERISA] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”\(^{86}\)

In fashioning federal common law under ERISA, the federal courts have borrowed from existing state common law fiduciary principles, but they do not apply state law to ERISA provisions. Federal courts apply the same principles to ERISA that they have to other federal labor statutes:

Federal interpretation of the federal law will govern, not state law . . . . But state law, if compatible with the purpose [of the Act], may be resorted to in order to find the rule that will best effectuate the federal policy . . . . Any state law applied, however, will be absorbed as federal law and will not be an independent source of private rights.\(^{87}\)

The practical application of preemption and its detrimental affect on employees are examined in Sections II and IV below in the discussions of fiduciary duties under ERISA, and health benefit cases, respectively.

\(^{84}\) Fisk, supra note 40, at 165-66.

\(^{85}\) See Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9-11 (1987).

\(^{86}\) ERISA § 514(a), 29 U.S.C. § 1144(a) (2001). Exempt from preemption is any state law that regulates insurance, banking, or securities. This is provided by the “savings clause” of ERISA, 29 U.S.C. § 1144(b)(2)(A) (1994). Yet this is also modified by what is called the “deemer clause,” which states that “[n]either an employee benefit plan . . . nor any trust under such plan, shall be deemed to be an insurance company or other insurer . . . for purposes of any law of any State purporting to regulate insurance.” 29 U.S.C. § 1144(b)(2)(B) (1994). Thus, even self-funded health benefit plans are wholly governed by ERISA. See generally ERISA § 514(d), 29 U.S.C. § 1144(d) (1994).

\(^{87}\) Textile Workers Union of Am. v. Lincoln Mills of Ala., 353 U.S. 448, 457 (1957).
II. **Fiduciary Duties Under ERISA**

A. *The “Exclusive Benefit” Rule: Solely in the Interest of Participants and Beneficiaries?*

Pension assets are to be invested solely for the benefit of the plan’s participants. As one certified financial advisor asserts adamantly, pension assets are to be invested: “[n]ot for the benefit of the company; not for the benefit of senior executives; and not to advance the careers or personal wealth of company employees”.  

Whether for pension plans or health plans, ERISA provides that:

[A] fiduciary shall discharge his duties with respect to a plan **solely in the interest of the participants and beneficiaries** and—

(A) for the exclusive purpose of:

(i) *providing benefits* to the participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the *care, skill, prudence, and diligence* under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims....

A dense body of law addresses fiduciary status, which is beyond the scope of this article. For present purposes, ERISA jurisprudence has divided its world into two spheres of action: fiduciary functions and administrative (including settlor) functions. The Act defines a fiduciary as a person who “exercises any discretionary authority or discretionary control respecting management” of a plan, or “exercises any authority or control respecting management or disposition of its assets.” Any person who does not exercise this control, and is not a “named fiduciary,” does not owe a fiduciary duty in his undertakings vis à vis the plan. Courts analyze fiduciary and administrative functions and apply this analysis to determine the status of the fiduciary or non-fiduciary. This status is outcome

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determinative because if a person is adjudicated to be a fiduciary under the functional test, a duty is owed to the employees as an expression of their rights. If that person’s actions do not confer fiduciary status, employees lack substantive rights.

As noted, under basic trust law, the owner of the property, or the settlor of the trust, may convey property to a third party or a trustee for the benefit of a beneficiary. Imposing a fiduciary duty prevents the trustee from engaging in self-dealing. Fiduciary duties were also imposed under the earliest benefit plans in the form of trusts. “Thus, ERISA in some respects was nothing more radical than a federal codification of the existing regulatory and contractual practices, not a dramatic reform.” However, unlike traditional trust practices, under ERISA there is no per se prohibition or presumption of wrong-doing in those instances where a fiduciary is also the settlor. The conflict of interest for employers is acknowledged, but given comparatively little attention. Although ERISA “occupies the field” and preempts state law, as noted above, the federal courts have had to fashion a federal common law of fiduciary duties where no specific provision of the act applies.

Once a position of dual loyalties is sanctioned, as it is under ERISA, it can be very difficult to determine whether: (1) a fiduciary breached his or her duty of loyalty to plan beneficiaries (an ERISA violation); or (2) a fiduciary has merely made a mistake in judgment or made a reasonable investment or taken a reasonable action that did not turn out as intended (probably not an ERISA violation). However, result measurement is not the appropriate test under ERISA, because even if self-dealing gives rise to substantially higher returns for a plan investment, a fiduciary breach may have occurred. Professor Wohl contends that “the yardstick by which behavior is determined appropriate or inappropriate under ERISA, as opposed to traditional trust law, is the measure of the impact that a fiduciary’s existing conflicts have on the decision-making process rather than the mere determination of the existence of a conflict of interest.” Wohl also laments that “ERISA legislation provides no mechanism for

92. Fisk, supra note 40, at 165.
93. See Central States, S.E. & S.W. Areas Pension Fund v. Central Trans., Inc., 472 U.S. 559, 570 (1985) (“Congress invoked the common law of trusts to define the general scope of [ERISA fiduciaries'] authority and responsibility.”); Milwaukee v. Illinois & Mich., 451 U.S. 304, 312-13 (1981) (“Federal courts. . . are not general common law courts and do not possess a general power to develop and apply their own rules of decision. . . . [However,] when Congress has not spoken to a particular issue . . . the Court has found it necessary, in a 'few and restricted' instances . . . to develop federal common law.”).
95. The leading case enunciating this rule is Eaves v. Penn, 587 F.2d 453 (10th Cir. 1978).
96. Wohl, supra note 94, at 52.
assessing the motivational factors of a plan fiduciary’s actions,” suggesting that the fiduciary labors under a cloud of mistrust that hinders his actions. Wohl believes that the fiduciary should be “assured a benign assessment by third parties of the motivational factors underlying the fiduciary’s act.”

The fiduciary has no reason to be concerned. The cloud of mistrust hovered initially because, historically, employers were motivated to control the supply and tenure of their workforce—before age discrimination was prohibited. But, even now, under ERISA, no one lays claim to pension plans being redistributive or altruistic in nature. Moreover, in the Pegram case, the Supreme Court has assured fiduciaries that the justices may disregard the conflicts of interest that may motivate a particular fiduciary act.

How benefits are characterized does, however, affect assessment of employer motivations. An inconsistency has prevailed in the identification of pension monies as either deferred wages earned by workers or something more akin to a voluntary perk gifted over by employers. Models of wage and benefit packages identify pension monies as deferred wages. Unless such monies are “vested,” the jurisprudence of ERISA refuses to confer beneficiaries’ substantive rights. Indeed, health benefits do not vest; otherwise, employers would be prevented from reducing

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97. Id. at 49.
98. Id.
99. Life expectancy in the U.S. has expanded tremendously, such that, until relatively recently, most people died while still working or after a brief incapacitation. Employers often seek to replace older workers through incentives such as early retirement, particularly now, since the Age Discrimination in Employment Act (“ADEA”) prohibits “arbitrary” age discrimination in employment and outlaws mandatory retirement. 29 U.S.C. §§ 621, 623, 631 (2001). See also Munnell, supra note 63, at 77-78.
101. According to a Bureau of Labor Statistics study, wage inequality understates compensation inequality. BROOKS PIERCE, COMPENSATION INEQUALITY 1 (Bureau of Labor Statistics, U.S. Dep’t of Labor, Working Paper No. 323, 1999). Pension and retirement savings plans are less prevalent than health insurance. Id. at 6. Defined benefit plans are present 35.7% of the time, while defined contribution plans, which include 401(k) plans and deferred profit sharing plans (with positive employer payments), are present 40.9% of the time. Id. The cost of pension plans is more difficult to project. For defined benefit plans, it is approximately $0.78 an hour. Id. at 7.

“Insurance consists primarily of health insurance, and accounts for 5.8% of compensation costs. The health insurance component itself accounts for $1.15 per hour in compensation costs, roughly comparable to average social security costs. The health insurance benefits coverage figure is 73.1% in these data,” which is somewhat larger than other statistics. Id. at 6. The Bureau of Labor Statistics study concludes, “[c]ompensation inequality rose of the past ten to fifteen years by a greater amount than did wage inequality. The differences are apparent mainly in the bottom half of the respective distributions, and are largely due to declines in health insurance coverage rates.” Id. at 31.
them. No fiduciary breach flows from a reduction in such benefits. From the employee’s perspective, the contributions to the pension fund are part of her compensation and the value flows from her to the extent it represents deferred compensation. From the employer’s perspective, the contribution flows from the employer, and cannot be equated with a separate investment by the employee. There is a dual rationale for a pension plan—deferred wages for employees and an incentive utilized by employers to retain workers in order to achieve their vesting periods. The dominant paradigm in ERISA jurisprudence endorses the latter.

For Professors Fischel and Langbein, law and economics adherents, this dual rationale makes ERISA chafe under the “exclusive benefit” rule. Law and economics promotes the view that judges should determine cases with a view towards economic efficiency, striving to imitate a perfectly operating market. Regulations, the theory goes, can hamper efficiency by placing too large a burden on business, which can always bargain with those affected (e.g., by pollution, or, here, fiduciary breaches). Here, Fischel and Langbein argue that, since both employees and employers benefit from the pension or welfare benefit plan, there is an “obvious” difficulty with interpreting the “exclusive benefit” rule. They contend that these plans are established for the mutual advantage of both employer and employee, not for the “exclusive benefit” of one. This renders the “exclusive benefit” rule “inconsistent with the economic realities of the plans.” If we consider the Supreme Court’s articulation of the economic realities of HMO-based employee welfare benefit plans in Pegram, it appears that the high court was influenced by such theories.

A concept related to the “exclusive benefit” rule is that of “prohibited transactions.” Under ERISA § 406:

(1) A fiduciary with respect to a plan shall not cause the Plan to engage in a transaction, if he knows or should know that such

103. Id.
104. Cf. International Bhd. of Teamsters v. Daniel, 439 U.S. 551, 560-61 (1977) (“[I]t seems clear that an employee is selling his labor primarily to obtain a livelihood, not making an investment. . . .”)
107. Id. See also Ronald H. Coase, The Problem of Social Cost, 3 J.L. & ECON. 1 (1960). The thrust of the Coase theorem is that except where transition costs are quite high, the role of law should not be setting rights and entitlements.
108. Fischel & Langbein, supra note 105.
109. Id.
transaction constitutes a direct or indirect—

(A) sale or exchange, or leasing, of any property between the plan and a party in interest;

... 

(C) furnishing of goods, services, or facilities between the plan and a party in interest;

(D) transfer to, or use by or for the benefit of a party in interest, of any assets of the plan; or

... 

(b) A fiduciary with respect to a plan shall not—

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party... whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries.\textsuperscript{110}

Section 3(14) of ERISA defines a party in interest as any fiduciary to the plan, any service provider to the plan, the employer sponsoring the plan, a union whose employees participate in the plan, or an owner of fifty percent or more of the company sponsor.\textsuperscript{111} The legal fiction of corporate personality operates here, in that a fiduciary may be an entity, and not a person.

B. The Tension Between Fiduciary Duties and the Settlor Function in ERISA Jurisprudence

The dichotomy between fiduciary duties and settlor functions under ERISA is based upon the voluntary nature of employee benefits under the statute.\textsuperscript{112} Employers, in their fiduciary capacity, have a duty to adhere to the "exclusive benefit" rule, and yet they have no duty to provide any benefits at all, which gives them broad discretion in their settlor or administrative capacities, with no duty to anyone but shareholders.

These conflicting duties have given rise to several tendencies in judicial decision-making. Since fiduciary breaches fall under the law of

\begin{itemize}
  \item \textsuperscript{110} 29 U.S.C. § 1106 (2001) (emphasis added).
  \item \textsuperscript{111} 29 U.S.C. § 1001(14) (2001).
  \item \textsuperscript{112} As of 1997, 69% of regular full-time workers received health insurance from their employers; 60.3% of regular full-time workers have an employer-based pension. THE STATE OF WORKING AMERICA 1998-1999 (1999).
\end{itemize}
According to some practitioners, federal judges have embedded in their decisions a fear that if they too enthusiastically extend protection to employees, increases in the cost of benefits to employers will result in a cancellation of benefits. Even if this approach is based on pragmatic concerns, it is reasonable to question the rationale behind these judicial decisions.

Although the Supreme Court directed the federal courts to develop a federal common law of rights and obligations in this area, the lower federal courts have resisted. They have ignored common law remedies and doctrines, such as implied contract, estoppel, fraud, and negligence, and determined that they are all state law remedies preempted by ERISA. The result is a narrow definition of rights, more procedural than substantive.

III. PENSION BENEFITS CASES

Because employee benefit trusts are freely revocable, the U.S. Department of Labor has taken the position that discretionary activities that relate to the formation, rather than the management of plans, including decisions concerning the “establishment, termination, and design of plans are not fiduciary activities subject to . . . ERISA.” For some, this is an obvious position to take. “There can be no doubt that applying fiduciary standards about plan design and termination—that is, demanding that such decisions be made for the ‘exclusive purpose’ of benefiting participants and beneficiaries—is radically inconsistent with ‘the voluntary nature of the private pension system.’” These same commentators disagree, however, with the Labor Department's position that certain actions normally taken in connection with plan termination do entail discretionary authority giving rise to fiduciary responsibility under the “exclusive benefit” rule. They contend that the Labor Department’s position “fails to observe the

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113. The Seventh Amendment of the Constitution provides that “in Suits at common law . . . the right of trial by jury shall be preserved.” U.S. CONST. amend. VII. Since breaches of fiduciary duties sound in equity, not the common law, there is no right to a jury trial in ERISA cases. This has additional adverse affects, such as precluding damages. See, e.g., Bair v. General Motors Corp., 895 F.2d 1094, 1096 (6th Cir. 1990) (there is no express statutory right to a jury trial and no evidence of congressional intent to grant the right to a jury trial on ERISA claims). See also Note, The Right to Jury Trial in Enforcement Actions Under Section 502(a)(1)(B) of ERISA, 96 HARV. L. REV. 737, 738, 741-43 (1983).


115. Id. at 322-33 and cases cited therein.

116. Id. at 331.


118. Id. at 330-31.

119. Id. at 331.
distinction between making judgments and following legal rules."\textsuperscript{120}

In the last three years, the Supreme Court has twice held that an amendment to an ERISA plan does not implicate fiduciary duties under the Act when it arguably should have. Moreover, the present Court decides few cases unanimously; it is often divided ideologically, with 5-4 decisions.\textsuperscript{121} Yet, in these two ERISA decisions, the Court ruled 9-0 and 7-2 (the two representing concurring opinions with only partial dissents). Even more remarkably, Justice Thomas, the least prolific opinion writer on the Court, authored both opinions.

A. \textit{Lockheed v. Spink: Take Your Gold Watch and Leave}

The 1996 Supreme Court case, \textit{Lockheed Corp. v. Spink},\textsuperscript{122} allowed the payment of benefits under an early retirement program to be conditioned on the participants' release of employment related legal claims against the company sponsor.\textsuperscript{123}

Paul Spink worked for Lockheed from 1939-50, and then departed. In 1979, when Spink was sixty-one, Lockheed persuaded him to return, however, Lockheed's defined benefit pension plan excluded employees over the age of sixty.

In 1986, Congress enacted the Omnibus Budget Reconciliation Act ("OBRA"),\textsuperscript{124} which prohibits age-based exclusions from participation in pension plans similar to Lockheed's.\textsuperscript{125} To comply with the law, Lockheed in 1988 amended its pension plan, but when Spink retired, Lockheed limited the years of service used in computing his benefit accruals to those after December 25, 1988, when it amended the plan. In short, the amended plan only credited those workers over sixty with their number of years of service commencing on December 25, 1988.

In 1990, before Spink's retirement, Lockheed pursued cost-cutting measures and offered incentives for early retirement. The company offered Spink and other older employees an extra three years of credited service if they would sign a general release in favor of Lockheed on all employment litigation claims they might have against the company, including claims

\textsuperscript{120} Id.
\textsuperscript{121} See, e.g., Printz v. U.S., 521 U.S. 898 (1997) (striking down, by a 5-4 vote, the Brady Handgun Violence Prevention Act on grounds Congress overstepped its bounds under the Commerce Clause of the U.S. Constitution, Art. I. § 8); see also Holmes, Kaiser, Kramer, and Dworkin articles cited supra note 14.
\textsuperscript{122} 517 U.S. 882 (1996).
\textsuperscript{123} Id. at 884.
\textsuperscript{124} Pub. L. 99-509 (1986).
\textsuperscript{125} ERISA had permitted these exclusions. ERISA was thus amended, and the statute now states that "[n]o pension plan may exclude from participation (on the basis of age) employees who have attained a specified age." 29 U.S.C. § 1052(a)(2) (2001).
under ERISA and the Age Discrimination in Employment Act ("ADEA").\(^\text{126}\) Spink refused to sign the waiver, and thus was deprived of these benefits—which were not insignificant at $10,000 a year.

The question presented to the Court was, "Can an ERISA plan require additional, non-incidental consideration from the employee running in favor of the employer in exchange for the payment of benefits from trust assets without violating ERISA’s prohibited transaction rule?"\(^\text{127}\) The prohibited transaction rule comes into play on the theory that Lockheed engaged in a self-interested transaction: the company dictated that the use of trust assets to pay the extra incentive benefits be conditioned on certain waivers. As the Ninth Circuit explained, Lockheed was offering to "writ[e] checks drawn on pension funds to buy the releases in question" for itself.\(^\text{128}\) It concluded, "Lockheed cannot avoid the prohibitions of ERISA by writing an amendment instead of a check."\(^\text{129}\)

In an amicus brief, the American Association of Retired Persons ("AARP") explained that it was illegal for the plan to pay for these releases:

> An early retirement incentive program provides the employer with the value of reducing its workforce. Payment of enhanced pension benefits to entice employees to leave is permissible as part of the employment paradigm. However, an employee’s release of employment claims is an additional and distinct benefit that is not inherent in the employee’s departure. Thus, if the employer wants a release of such claims, it can provide additional consideration from its corporate funds. The only issue here is who can legally pay for the releases—the employer or the plan.\(^\text{130}\)

Since Lockheed was the sponsor of the plan, it was a party in interest. The transaction was prohibited because Lockheed used pension monies to purchase something that inured only to its benefit, not to the benefit of participants and beneficiaries, nor to the trust itself. While the Supreme Court did not dwell on the issues, because the benefit was enjoyed solely by the employer sponsor, both the “exclusive benefit” rule and the duty of loyalty that are so unstable under ERISA were implicated.

Spink, who refused to waive any of his ADEA or ERISA claims against the company, brought suit alleging that Lockheed and its board of directors breached their duty of care to participants by making plan provisions conditional. Curiously, the case did not address in any

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\(^{127}\) Spink v. Lockheed, 60 F.3d 616, 623 (9th Cir. 1995).
\(^{128}\) Id.
\(^{129}\) Id. at 623-24.
\(^{130}\) Brief of Amicus Curiae AARP in Support of Respondent, 1996 WL 154237 at 28 (U.S. Amicus Brief).
significant way that the waiver could be invalid as violative of public policy.\footnote{131}{See, e.g., Brooklyn Sav. Bank v. O'Neil, 324 U.S. 697, 702-04 (1945) (noting that "the statutory right conferred on a private party, but affecting the public interest, may not be waived or released if such waiver or release contravenes the statutory policy," and ruling that employees could not waive their private rights to liquidated damages because of the public policy interest at stake).}

Reversing the Ninth Circuit, the Supreme Court observed, "[n]othing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan."\footnote{132}{Lockheed v. Spink, 517 U.S. 882, 887 (1996).} Despite citing language in a contemporaneous decision that would have supported the imposition of fiduciary duties based on Lockheed's uncontroverted actions alone ("it may be true that amending or terminating a plan . . . cannot be an act of plan 'management' or 'administration'")), the Court placed the burden of further proof on the beneficiary.\footnote{133}{Id. at 890 (quoting Varity Corp. v. Howe, 516 U.S. 489 (1996)).} Spink had to prove that Lockheed was engaged in self-dealing, a prohibited transaction under ERISA.\footnote{134}{Id. at 893-94.} This is a significant departure from traditional trust law doctrine, which requires the mere appearance of impropriety to be explained by a trustee. The Supreme Court said:

Spink concedes . . . that among the 'incidental' and thus legitimate benefits that a plan sponsor may receive from the operation of a pension plan are attracting and retaining employees, paying deferred compensation, settling or avoiding strikes, providing increased compensation without increasing wages, increasing employee turnover, and reducing the likelihood of lawsuits by encouraging employees who would otherwise have been laid off to depart voluntarily.\footnote{135}{Id. at 894.}

Justice Thomas continued, "[w]e do not see how obtaining waivers of employment-related claims can meaningfully be distinguished from these admittedly permissible objectives."\footnote{136}{Id. at 894.} In language reminiscent of early twentieth century labor cases,\footnote{137}{See, e.g., Coppage v. Kansas, 236 U.S. 1 (1915) (finding that a state law prohibiting employers from barring employees from joining labor unions violates the due process clause of the Fourteenth Amendment); Adair v. U.S., 208 U.S. 161 (1908) (striking down legislation forbidding employer discrimination against union members as interfering with liberty of contract); Lochner v. New York, 198 U.S. 45 (1905) (determining that a law limiting total work hours of bakers interfered with constitutionally protected liberty interest of freedom of contract between employer and employee).} Justice Thomas asserts, "[t]he employer can ask the employee to continue to work for the employer, to cross a
picket line, or to retire early."\textsuperscript{138} He concludes, "[t]here is no basis in . . . [ERISA] for distinguishing a valid from an invalid \textit{quid pro quo}."\textsuperscript{139} Justice Thomas adds, "[t]he private parties, not the Government, control the level of benefits."\textsuperscript{140}

In another context, Professor Catherine Fisk observes:

[w]hat remains is a legal guarantee of unrestrained managerial power . . . The irony is that the courts have resurrected contract in all its laissez faire and formalist glory under the aegis of legislation which was at least nominally supposed to protect employees against the exercise of private power that nineteenth-century contract law had allowed.\textsuperscript{141}

During the oral argument, Justice Scalia was preoccupied with the voluntarist aspect of ERISA, peppering the attorneys with questions about employer obligations and employee motivations:

He [the employer] doesn’t have to set up the plan anyway, and he can terminate it at any time, so he can make it conditional on anything that isn’t criminal.

How do you get that distinction out of Section . . . 406 [that a waiver for prior defamation claims, sex discrimination claims, toxic tort claims violates ERISA]?

The promise of benefits attracts the employee, but not the payment itself, because at the time payment is made the person is a former employee.\textsuperscript{142}

The arguments expose a fundamental disagreement about the definition of a pension. Congressional proponents of the legislation argued that pensions are part of an employee’s salary that may be collected later.\textsuperscript{143} But for Justice Scalia, the employee’s consideration should not figure into the equation because he is a former employee by the time he receives a

\textsuperscript{138} Lockheed, 517 U.S. at 894.
\textsuperscript{139} Id.
\textsuperscript{140} Id. (citation omitted).
\textsuperscript{141} Fisk, \textit{supra} note 40, at 155-56.
\textsuperscript{142} Official Transcript at 31-33, Lockheed Corp. v. Spink, 517 U.S. 887 (1996) (No. 95-809).
\textsuperscript{143} For example, in the brief for Mr. Spink, his counsel cited Congressional proponents of the legislation: "Pensions are not gratuities, like a gold watch bestowed as a gift by the employer on retirement. They represent savings which the worker has earned in the form of deferred payment for his labors" (Senator Williams); "The private pension plan is a means for transferring earnings during the working years into income for a decent living in the older years. The worker 'works' for that pension the same way he 'works' for his wages or salary" (Senator Javits). Brief of Amicus Curiae The National Employment Lawyers Assoc. at 3 n.2, Lockheed Corp. v. Spink, 517 U.S. 887 (1996) (No. 95-809) (supporting Paul Spink et al.).
Above all, actions related to the establishment, amendment, or termination of a plan are deemed to be administrative and therefore, non-fiduciary in nature. This has grave implications for numerous areas of law, including tort, contract, and civil rights. Under Justice Scalia’s construction of the statute, an employer could mandate, for example, that particular groups of employees who are more prone to suffer from particular diseases cannot file suit under a plan for violations of the ADA, that Blacks alone cannot sue for race discrimination, that women alone cannot sue for sex discrimination. Moreover, rather than being hostile to the legislation in the contractarian and traditional sense of laissez faire, it is apparent that the Court finds this legislation accommodating precisely because of its voluntaristic and contractual underpinnings.

B. *Hughes Aircraft v. Jacobson: The Company Benefits, Not You*

Again in 1999, the employees in *Hughes Aircraft* lost before the Supreme Court to another major defense contractor after attaining a temporary victory in the Ninth Circuit. The employees had hoped to steer clear of the problems created by *Lockheed*, where the plan was funded solely by employer contributions. In contrast, Hughes Aircraft’s plan was funded by both employer and employee contributions. The strategy was to argue that the “interest” (as in “solely in the interest of” participants and beneficiaries) was more pronounced since the participants’ stake in plan funds was a traceable ownership interest rather than a right based upon employer contributions. Unlike benefits earned from employer contributions, an employee is automatically vested in his or her contributions. Thus, where *Lockheed* failed, with stricter scrutiny, the *Hughes* plaintiffs might prevail.

The details of *Hughes* are as follows: Hughes had sponsored the pension plan since 1955, which required mandatory contributions from all participating employees, in addition to any contributions made by Hughes. By 1986, as a result of both employer and employee contributions and investment growth, the plan’s assets exceeded the then-present value of accrued benefits by almost one billion dollars. After Hughes was acquired by General Motors in 1987, it ceased making contributions, in part because of the over-funding. The employees, however, were required to continue

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146. Plaintiffs alleged that at the time General Motors acquired Hughes, the General
to make their contributions. According to the Ninth Circuit, as of January 1992, half the surplus in the Contributory Plan was attributable to employee contributions, and half to employer contributions.\(^{147}\)

The company used the plan’s surplus assets—again, attributable in part to the employees’ contributions—and amended the plan to fund an early retirement program for existing employees, while also allowing new employees who were not participants of the original contributory plan to participate on a different, non-contributory basis. The employees from the original plan charged Hughes Aircraft with violating its fiduciary duties, including the anti-inurement provision of ERISA. That provision states that “assets of a plan shall never inure to the benefit of any employer.”\(^{148}\) The provision reaches all employers, whether they are acting in a fiduciary capacity or not. There is no limiting language of the type explained above under fiduciary duties and prohibited transactions.\(^{149}\)

The district court dismissed the employees’ complaint, but the Ninth Circuit reversed.\(^{150}\) According to the appeals court, the amendment of the plan could have constituted the de facto creation of two plans because the plan before and after the “amendment” was considerably different.\(^{151}\) The Lockheed case was inapposite because ERISA's anti-inurement provision applies whether the employer is acting in a “settlor” or a “fiduciary” capacity.\(^{152}\) When both an employer and its employees contribute to a pension plan, limits are imposed upon the employer. It does not have sole discretion to use that part of the plan’s asset surplus attributable to employee contributions to benefit itself as well as employees who were never participants in the plan. Here, the Ninth Circuit addressed the real world economy: “Hughes, in effect, remained competitive in the labor market by using the asset surplus, created in part by employee contributions, to reduce its labor costs and increase new employees’ wages.”\(^ {153}\) The Court went on to observe that, “when an employer amends a plan to use for its own benefit an asset surplus attributable in part to employee contributions, the employer is wearing both its ‘fiduciary’ and its ‘employer’ hats.”\(^ {154}\)

The language of the dissent, portending the Supreme Court decision to

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Motors retirement plan was underfunded by over seven billion dollars. The Ninth Circuit noted that the Pension Benefit Guaranty Corporation “listed the GM plan as one of the most underfunded pension plans in the country.” \textit{Hughes Aircraft}, 105 F.3d at 1291 n.2.

147. \textit{Id.} at 1291.
149. \textit{Id.}
150. \textit{Hughes Aircraft}, 105 F.3d at 1288.
151. \textit{Id.} at 1291-95.
152. \textit{Id.} at 1296.
153. \textit{Id.}
154. \textit{Id.} at 1297.
come, was saturated with hostility towards the employees. Justice Norris, the author of the dissent, made the employees out to be gold-diggers. Notwithstanding that the case was certified as a class action, Justice Norris questioned whether the five bringing suit “among the 10,000-plus Hughes employees and retirees participating” could represent the class. Justice Norris stated that:

In the event that plaintiffs succeed in their quest for a judgment terminating the Plan...plaintiffs will receive not only the benefits which they are currently receiving but also a share of the $1 billion surplus. That is the pot of gold at the end of the rainbow that drives this litigation.

Justice Norris complained of limits upon employers’ unfettered discretion—limits that ERISA imposes: “[t]oday’s decision announces that in the Ninth Circuit there are severe, if vague and ill-defined, restrictions on the discretion of employers charged as plan settlors under ERISA with responsibility for the design of qualified pension plans.” Finally, Justice Norris appealed to Congress:

If ERISA is in need of clarifying or restricting amendments to the provisions relating to the authority of employers as settlors to design pension plans, that need should be addressed by Congress, not this court.

However, Judge Norris’s colleagues on the Ninth Circuit had no difficulty resolving the dispute by looking to the plain meaning of the statute:

At the heart of this dispute is whether Hughes is entitled to use and control for its own benefit the Contributory Plan’s one billion dollar surplus, approximately one half of which was generated by employee contributions. This is not a case in which the pension plan... was funded entirely by employer contributions. Nor is this a case in which the employer used the plan’s asset surplus solely to benefit participants of the plan. Because plaintiffs allege that the employer used the Contributory Plan’s asset surplus attributable in part to employee contributions for its own benefit and for the benefit of employees who were never participants in the Contributory Plan, we conclude that plaintiffs have stated cognizable claims under ERISA.

The Supreme Court eventually returned to the question whether under these facts a new plan had been created or one plan had been amended.

155. Id. at 1303.
156. Id.
157. Id. at 1312-13.
158. Id. at 1313.
159. Id. at 1292.
In a 9-0 decision authored by Justice Thomas, the Supreme Court snuffed out the possibility of distinguishing *Lockheed.*\(^{160}\) In ordering the case to be dismissed, the Supreme Court, an appellate tribunal, usurped the role of the fact-finder in making this determination. The Ninth Circuit had reversed the dismissal and remanded the case, effectively ordering the district court to proceed with discovery and trial; or at least determine at a future date, predicated upon the facts not being in dispute, whether summary judgment would be appropriate. The threshold to obtain one’s “day in court” is low. The Ninth Circuit concluded that the employees’ complaint alleged cognizable claims. Indeed, a party need not establish at the outset that it can win the case, only that it has pleaded the correct law to resolve the matter and that the facts alleged, taken in a light most favorable to the plaintiff, could support a claim for relief.\(^{161}\) Yet the Supreme Court ignored how different the “before” and “after” plans were and held that it was not even a question of fact whether two plans, disguised as one, were at issue. The Court avoided the facts and argued the law. It held that ERISA does not distinguish the type of plan involved when judging plan sponsors who alter the terms of a plan as settlors or administrators, not fiduciaries. The Court also rejected the employees’ suggestion that, since they contributed to the plan’s corpus, they should be regarded as co-settlers: “‘the settlor of a trust is the person who intentionally causes it to come into existence’... Certainly, respondents do not contend that they are responsible for the creation of the Plan.”\(^{162}\) The so-called liberals on the bench, Justices Stevens, Breyer, Souter, and Ginsburg,\(^{163}\) adhered not only to the result, but to this very reasoning; otherwise, they would have filed concurring opinions, if not dissents.

All of the justices thus aligned themselves with the employer, Hughes Aircraft. There may be a legitimate question whether ERISA enunciates or establishes a social or legal consensus as to whose expectations to protect, but the justices do seem to impose their own views, rather than any objective “law” as to whose rights take precedent.\(^{164}\) Yet the text of the

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\(^{160}\) Unlike in *Lockheed*, where it took a side, in *Hughes Aircraft*, the American Association of Retired Persons (“AARP”), of more than thirty million Americans age fifty or older, submitted a brief amicus curiae “in support of neither party.” Essentially, AARP asked the Supreme Court for more definitive guidelines for analyzing “fiduciary breach allegations arising from the employer’s plan amendment.” Brief of Amicus Curiae of AARP at 7, Hughes Aircraft Co. v. Jacobson, 525 U.S. 432 (1999) (No. 97-1287) (supporting neither party).

\(^{161}\) See, e.g., Conley v. Gibson, 355 U.S. 41, 45-46 (1957); 5 CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE §§ 1202, 1205, 1207, 1215-25, 1228 (2d 1990).

\(^{162}\) *Hughes Aircraft*, 525 U.S. at 445 n.5, (quoting G. BOGERT, LAW OF TRUSTS AND TRUSTEES §1 (2d ed. 1984)).

\(^{163}\) See, e.g., Dworkin, *supra* note 14, at 53-54 (discussing the alignment of the Court).

\(^{164}\) See Fisk, *supra* note 40, at 233.
statute itself provides a sufficient basis for a correct disposition without resort to such personal preferences. Justice Thomas must know that defined-benefit plans are likely to be funded by employees, not just their employer. However, he emphasizes the differences between a defined-benefit and defined-contribution plan by drawing our attention to the employer’s burden in defined-benefit plans: “[T]he employer typically bears the entire investment risk and—short of the consequences of plan termination—must cover any underfunding as the result of a shortfall that may occur from the plan’s investments.” Justice Thomas then states the obvious fact that if the plan is overfunded, the employer is free to reduce or suspend contributions. Justice Thomas asserts, “[employees’] vested-benefits and anti-inurement claims proceed on the erroneous assumption that they had an interest in the Plan’s surplus.”

The Court found that the employees enjoyed no such interest in the surplus because the “1991 amendment did not affect the rights of pre-existing Plan participants and Hughes did not use the surplus for its own benefit.” This rationale is emblematic of what Elizabeth Mensch has called the “justificatory language of the law.” ERISA cases may be decided through formalism, but that does not mean that the judge does not have discretion to make moral choices about the obligations of employer and employee.

These cases reflect a formalistic, if not circular, definition of what implicates a fiduciary duty under ERISA. And yet, they ignore formalism as to the “exclusive benefit” rule. Moreover, they overlook that one of the purposes of ERISA was to modify traditional trust law’s emphasis on settlor instructions, which is “insufficient to adequately protect the interests of plan participants and beneficiaries.” The Supreme Court swept aside the reasoning of the Ninth Circuit as if it were nothing but a panel of first-year law students laboring under misapprehension, or worse, foolish and untutored in ERISA law. To the Supreme Court, the “natural” and reasonable conclusion is that one plan exists. Whether the employer acted for the exclusive benefit of participants begs the question, “Could the Court have done anything different?” Obviously, it could have. It could have ruled that there were two plans.

165. Hughes Aircraft, 525 U.S. at 439.
166. Id. at 438.
167. Id. at 439.
169. See Fisk, supra note 40, at 233 (arguing that judges have the task to make value choices and factual inquiries in ERISA litigation).
To bolster the legitimacy of its one-plan holding and its invocation of employer objectives, the Court maintained that employees would be better off in the long run with the regime of an unfettered right of employers to amend a plan. Paternalism aside, these employees argued that they would, in fact, be worse off within such a regime.

In promoting a constitutive approach to the law, some scholars have addressed, in a parallel way, how legal practices “are a part of our culture, part of our nature,”172 and test the “reach of law into social and political life.”173 A constitutive approach argues against a claim “that laws either determine or fully encompass politics, but rather that they become part of politics in more than an instrumental way.”174 A constitutive approach to ERISA suggests that the power and legal meanings of pension security are produced within the acceptable paradigm of mobile capital and unlimited discretion to amend a plan. Here, the social and political relations of capitalist society are thus presented as not only natural and universal, but best for workers.175 At the same time, the theory claims that labor, with the ability to “enter and exit” has an equal role in determining its own security. In the next section, I explore ERISA cases involving health benefits and examine how the statute has become part of the politics of health care in the U.S., and has reached into our collective social, political, and moral life.

IV. THE DENIAL OF HEALTH BENEFITS AND THE “EXCLUSIVE BENEFIT” RULE

A. Individual vs. Corporate “Group” Rights

None of the following patients or their survivors would have make-whole remedies under ERISA. All of these wrongful death or malpractice claims would be preempted:

1. A woman had a history of difficult pregnancies. Her doctor recommended bed rest during the final months of her pregnancy. Toward the very end of her pregnancy, her doctor recommended hospitalization. The managed care plan’s pre-certification utilization reviewers determined that hospitalization was not necessary and only authorized ten hours per day of home nursing care. When no nurse was on duty, the fetus went into distress

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172. Brigham, supra note 17, at 3.
173. Id (citing Klare, supra note 26, at 122).
174. Id. at 4.
and died.176

2. A woman seeks a bone marrow transplant to aggressively treat advanced breast cancer. Her doctor recommends the treatment, but administrators in the HMO say the treatment is too experimental and refuse pre-certification. She cannot otherwise afford the treatment and haggles for months with the HMO until she dies.177

3. A sixty-two year-old man is on vacation 500 miles from his HMO. He suffers severe chest pains and is rushed to the emergency room. Expensive tests conclude he only had a severe case of indigestion. The HMO refuses to pay for the tests.

4. A woman has surgery on her aorta. The treating physician recommends an eight-day hospitalization stay. A consulting utilization review physician states that four days must suffice. The woman’s treating physician did not register a complaint for review of the denial and sends her home on the fourth day. She develops an infection in her leg and must have it amputated.178

5. A business cannot pay its debts. It continues to deduct health insurance premiums from employees’ paychecks, but falls back on its own contributions and fails to tell employees that their health coverage is in jeopardy. The HMO fails to notify all participants that it is canceling the group insurance. Meanwhile, an employee’s newborn baby suffers from a severe heart defect and requires expensive treatment, which he gets at an HMO-affiliated hospital. The HMO realizes its “mistake,” and cancels coverage retroactively. The HMO duns the employee for years. One collection agent even tells the man “you’d be better off if your baby had died.” The man’s credit rating is ruined, he files for bankruptcy and requires psychiatric care.

The 1993-94 Health Insurance Association of America’s “Harry and Louise” commercials were front-line weapons in the ideological war during

177. Several reported cases deal with a plaintiff’s challenge to a denial of a bone marrow transplant, and, in each, the court determined that the claims were preempted. See Bast v. Prudential Ins. Co., 150 F.3d 1003 (9th Cir. 1998), cert. denied, 528 U.S. 870 (1999); Turner v. Fallon Comm. Health Plan, 127 F.3d 196 (1st Cir. 1997), cert. denied, 523 U.S. 1072 (1998); Cannon v. Group Health Serv., Inc., 77 F.3d 1270 (1st Cir. 1996), cert. denied, 519 U.S. 816 (1996).
178. The actual case is Wickline v. State, 192 Cal. App. 3d 1630 (1986). Had this woman been receiving treatment through an employer-sponsored plan, any malpractice claim she may have had would have been preempted by ERISA.
the first Clinton administration’s attempt at health care reform.179 The advertisements, with their worried alerts of government intervention, helped characterize the Clinton plan as “socialized medicine” that would surely replace the Norman Rockwell family doctor with an inept, indifferent bureaucracy. These commercials helped derail any chances of reform. ‘Times have changed, and health care reform has gotten Congress’s attention—even the Republicans’.180 But the extent to which citizen agency and political organizing is responsible for this attention is unclear. Citizenship has been privatized, and the plight patients face is often a lonely test. Other than being plucked to serve as a prop at Congressional hearings or to appear in a political advertisement, there is “no public sphere in the contemporary United States, no context of communication and debate that makes ordinary citizens feel that they have a common public culture, or influence on a state that holds itself accountable to their opinions, critical or otherwise.”181 Even federal judges have decried their own powerlessness. In one wrongful death case involving a managed care facility’s refusal to provide alcohol treatment and the patient’s subsequent suicide, the judge pleaded:

Although the alleged conduct of Travelers [the insurance company] in this case is extraordinarily troubling, even more disturbing to this court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent. Does anyone care? Do you?182

The human interest story of a David/patient and Goliath/HMO may make for good television, but the agency, citizenship, and class relations operating “seem trite and unsexy.”183 Nevertheless, the anecdotes have had some impact, and Congress is listening, while some of its biggest campaign finance donors, insurance companies, are apprehensive.

In January 2000, the Health Insurance Association of America (“HIAA”) resurrected the Harry and Louise couple in new commercials. Louise exclaims, “Forty-four million Americans without health insurance.” Harry bemoans, “That’s huge. An epidemic.” The kinder, gentler image of

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183. Id.
HIAA is an unabashed effort to mute the call for HMO reform. The chief executives at fifteen of the largest managed-care companies have been "meeting regularly since last fall [1999] to explore ways to improve their companies' battered image. They are considering a $30 million to $40 million campaign [to]... help limit fallout if a patients'-rights bill passes. 'You need to have public approval and public trust,' says Roger Bolton, a senior vice-president at Aetna Inc." 

The hardest fought provision of any patients' rights legislation will be over whether to allow patients under employer sponsored health plans to recover against HMOs. All the players have lined up. For example, the Physician Insurers Association of America has urged Congress not to repeal ERISA's preemption feature that prevents self-insured health care plans from being sued for medical malpractice.

During the debates surrounding health care reform and patients' rights, discussion of the role of the courts, the law, ethics and morality has mostly been absent. It is the radical separation of law from morals. What is the distinction between the law that is and law that ought to be here? No penumbral question exists here. In the cases explored, judges could have appealed to the core meaning of a legal rule, the "exclusive benefit" rule, without resort to the ideas, intentions, or expectations subjectively held by the senators and congressmen who drafted and promulgated ERISA. The letter of the law applies and coincides with the spirit of the law. But unlike constitutional law, with its rich normative possibilities and penumbras, ERISA has no sex appeal.

184. This strategy is characterized as such by Lorraine Woellart, Suddenly, A Healthy Shot at Health-Care Reform, BUS. WEEK, Feb. 7, 2000, at 53.
185. Id.
186. Despite its name, The Federal HMO Act, 42 U.S.C. § 300e (1994), does not provide HMO subscribers with substantial recourse when medical procedures or reimbursement for outside treatment are denied. The Act's primary goal was to provide employees with the option to sign up with an HMO. The statute and accompanying regulations, 47 C.F.R. § 417.150 (1994), et seq., do require "meaningful" grievance procedures, but not the right to appeal for an impartial de novo review of an HMO decision. 42 U.S.C. § 300e-9(c)(5). Another piece of federal legislation, intended to prevent patient dumping, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), requires emergency rooms to treat patients, but does not require HMO reimbursement. 42 U.S.C. § 1395dd. So much for "managed care" meeting unplanned emergencies.
189. See Hart, supra note 188, at 615.
191. See Frederick Schauer, SPECIAL ISSUE: JUDICIAL OPINION WRITING:
Jonathan Simon has analyzed how seemingly neutral actuarial practices constitute components of a social ordering regime. The unobtrusiveness of these practices "is precisely why they have become so important; they make power more effective and efficient by diminishing its political and moral fallout." As shown in the next section, echoing the judge quoted above, a recurring theme of ERISA preemption decisions is that courts remain powerless to change the situation. Employers and employees are categorized into neutral-sounding "plan sponsors" and "plan participants." As Simon notes, "[s]ocial policy is inevitably ideological not only in its substantive goals, but in the techniques through which it is realized; every way of organizing and managing people produces representations of who they are."

B. ERISA Coverage and the Problems of Preemption

ERISA covers employee welfare benefit plans that are "plan[s], fund[s] or program[s] established or maintained" by an employer "for the purpose of providing for its participants... through the purchase of insurance or otherwise" medical or other benefits. ERISA preempts state laws that "relate to any employee benefit plan." Its preemptive effect is also felt because it provides a federal cause of action "to recover benefits due... under the terms of [the] plan, or to clarify... rights to future benefits." Thus, had the woman who needed the bone marrow transplant in the fact scenario above been receiving treatment through an employer-sponsored plan, any malpractice claim she may have had would be preempted by ERISA.

Common law causes of action to right the wrongs described in the narratives above might include: medical malpractice and negligence, tortious interference with the doctor-patient relationship, negligent or intentional infliction of emotional distress, breach of contract, loss of consortium, and fraudulent and deceptive trade practices. Yet, these are all preempted by ERISA. The effect of ERISA preemption is not to convert


Although I am sure there are people who find the intricacies of ERISA law fascinating, I am not one of them. If a poll were to be taken of American law professors (or even of American lawyers) as to which are the least interesting areas of the law, I am moderately confident that ERISA would get a few votes.

193. Id. at 772.
194. Id. at 798.
state law claims into federal questions, but to completely displace state law claims. Consequently, Medicare patients may have a better chance of prevailing with their claims than individual and employment-based subscribers. Because Medicare is a government program subject to elaborate statutory guidelines and due process requirements, those participants have access to well-structured and less costly appeal and grievance procedures.

The central theme of most cases brought in state court, in which the defendant files a motion to remove the case to federal court, is whether the state cause of action "relates to" employee benefits or is to "recover benefits due." In the malpractice area, the district courts are split as to whether ERISA preempts a vicarious liability action against an HMO. In 1995, two federal court of appeals decisions represented exciting developments. Dukes v. U.S. Healthcare, Inc. held that malpractice claims were not to recover benefits due under a plan—plaintiffs received benefits; the problem was with the quality of care and this presented a cognizable claim not preempted. The court contrasted its decision with cases involving utilization reviewers denying treatment, even though the actual harm to the patient might be similar. Pacificare of Oklahoma Inc. v. Burrage held that no reference to the plan is necessary in determining medical malpractice, so it allowed that claim, and also permitted the remand of the loss of consortium claim to state court in the wrongful death suit.

Other courts, including the lower Dukes court, have held that malpractice claims relate directly to the plan because the plan holds itself out in its literature as assuring a certain quality of services. It follows that allegations of negligence and fraud in administering a plan will be preempted. Cases often involve interpreting details of the plan document, the client’s medical condition, the disclosure and grievance provisions of ERISA, and potential claims of breach of fiduciary duties on the part of

199. For an excellent description of the remedies offered Medicare patients as compared to other HMO members, see Susan J. Stayn, Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures, 94 COLUM. L. REV. 1674 (1994).
203. Id. at 357-58 ("We are confident that a claim about the quality of a benefit received is not a claim under § 502(a)(1)(B) to ‘recover benefits due... under the terms of the plan.’").
204. 59 F.3d 151 (10th Cir. 1995).
205. Id. at 151.
HMOs (even their utilization review personnel). However, this is an expensive and time-consuming undertaking and ERISA offers no damage awards—its relief is purely equitable in nature. In theory, ERISA is a powerful tool on behalf of employees, but its limited relief and the narrow scope of judicial decision-making have compromised its effectiveness.

In fact, often the only thread patients under ERISA-sponsored plans can hang onto is an error on the part of the employer, sponsor, or other fiduciary in meeting its notice requirements. Again, since employee benefits plans are voluntary, the employer may terminate benefits at any time, provided adequate notice is given.207

Indeed, in Curtiss-Wright Corp. v. Schoonejongen,208 a harbinger of Lockheed, the Supreme Court proclaimed that "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."209 The amendments cannot, however, violate ERISA's substantive provisions. For example, an employer cannot amend a plan to require fifteen years of service in order to vest in a pension.210 Nor can an employer violate the express terms of a plan or other governing documents, or fail to provide proper notice to employees under ERISA.211 But, under ERISA, what constitutes a substantive provision in welfare benefits, even more so than in pension plans, is largely procedural.

To review, where the employer sponsoring the health benefits plan is a fiduciary, a weakness in the statute is that it exempts certain corporate settlor functions from the requirements of loyalty and proscriptions against self-dealing. ERISA permits the employer to wear two hats.212 Because employee benefit plans are voluntary, the employer is free to terminate such benefits anytime, provided only that it give adequate notice to participants. This falls under the rubric of implied contract rights that arise from the plan document. ERISA has an odd wrinkle: the employer is not obligated to pay the claims, per se, but, as a fiduciary, it is obligated to notify participants in time to seek alternative coverage or to forward deductions and not convert them to corporate use. Of course, if a beneficiary has a pre-existing condition and cannot get alternative coverage, that is not the employer's problem.

209. Id. at 78.
210. That would violate ERISA § 203(a), 29 U.S.C. § 1053(a) (2000), which prohibits denying accrued benefits. However, welfare plans are free of some of these restrictions upon pension plans. See, e.g., Schoonejongen, 514 U.S. at 1228; Groover v. Michelin N. Am., Inc., 90 F. Supp. 2d 1236, 1241 (M.D. Ala. 2000).
212. See Local Union 2134, UMW v. Powhatan Fuel, Inc., 828 F.2d 710, 713 (11th Cir. 1987).
ERISA requires that a plan’s claim procedures be reasonable, and described in an accessible manner for employees. Where a claim is denied, the participant must be told the specific reasons for the denial and the material or information needed to perfect the claim.\textsuperscript{213} Note, however, that these regulations are somewhat relaxed where a plan provides benefits through an HMO.\textsuperscript{214} There is a severe penalty, of up to $100 per day for the administrator’s failure to provide participants with requested information.\textsuperscript{215} Courts have generally required administrative remedies to be exhausted prior to filing suit. Most circuits apply a \textit{de novo} standard of review to benefits determinations,\textsuperscript{216} but have refused to apply the doctrine of \textit{contra preferentum} to resolve ambiguities against the companies that draft or adopt the plans and insurance policies.\textsuperscript{217} In applying \textit{de novo} review, courts should look to the conflicts of interest of the party determining benefits, but often, they just reluctantly acknowledge the conflict.\textsuperscript{218}

These cases truly combine tragedy and farce. For example, in \textit{Wilson v. Group Hospital & Medical Service, Inc.},\textsuperscript{219} an employee under a group health plan covered by ERISA was forced to sue her insurer, seeking an injunction to compel guaranteed payment for bone marrow transplant therapy together with high dosage chemotherapy. In granting the injunction, the district court dryly observed that the employee faced the “ultimate irreparable injury”—death—if therapy were discontinued. Moreover, the public interest would be furthered by having the notice requirements of ERISA plans complied with through the use of a preliminary injunction.\textsuperscript{220}

One could view the entire managed care scheme as poisoned by conflicts of interest and marked by prohibited transactions—the health care provider paying itself to review claims and to insure the entire undertaking. Each claim denied inures to the benefit of the HMO. The employee is not just at the mercy of the employer, who may terminate coverage at any time. She also, because of problems with preemption, might be better off as an individual subscriber to an HMO in seeking full compensatory damages. The barrier of the preemption edifice cannot be overstated here. These cases are expensive to try. The worst that can happen from the defendant’s point of view is that it will have to pay the claims originally due, and nothing more. There is no incentive to settle, but rather to drag the case on

\textsuperscript{213} 29 C.F.R. § 2560.03-1.
\textsuperscript{214} 29 C.F.R. § 2520.102-5(a).
\textsuperscript{216} Cf. Rodríguez-Abreu v. Chase Manhattan Bank, N.A., 986 F.2d 580 (1st Cir. 1993).
\textsuperscript{217} See Allen v. Adage, Inc., 967 F.2d 695 (1st Cir. 1992).
\textsuperscript{220} \textit{Id.} at 314.
as long as possible, which the plaintiff and her lawyers usually cannot afford.

C. Lawful Discrimination Under ERISA: The McGann Example

One of the most notorious cases in the short annals of ERISA jurisprudence is the Fifth Circuit's 1991 decision in *McGann v. H & H Music Co.* This case, too, foreshadowed the Supreme Court's reasoning in *Lockheed*. The case exposes the raw conflict among employees facing serious illness, their employers, and the employers' insurance carriers. Consequently, it affords us the opportunity to observe the discursive practices surrounding ERISA jurisprudence and, again, the justification by certain businesses and courts for their ethical and political choices.

The plaintiff, John McGann, an employee of H & H Music Co., discovered that he had HIV. Soon thereafter, he submitted his first claims for reimbursement under the company's group medical plan. At the time, the plan provided for lifetime medical benefits of up to one million dollars. Upon learning of McGann's illness and what its long-term costs might be, his employer, through its insurer, amended the plan to limit benefits payable for AIDS-related claims to a lifetime maximum of five thousand dollars. The amendment did not place this limitation on any other catastrophic illness, no matter how costly. McGann's suit under ERISA claimed that his employer, the plan administrator, and the plan insurer had all discriminated against him by reducing benefits for treatment of HIV and HIV-related illnesses. The United States District Court for the Southern District of Texas granted the defendants' motion for summary judgment and the Fifth Circuit affirmed, on the grounds that ERISA does not prohibit welfare plan discrimination between or among categories of diseases. This is the line of reasoning followed in the *Lockheed*.

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222. *Id.* at 403.
223. *Id.*
224. *Id.*
225. *Id.*
227. ERISA contains a nondiscrimination provision, § 510, 29 U.S.C. § 1140 (2001), which provides that, It shall be unlawful for any person to . . . discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of the employer benefit plan, . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

The "may," in the last part of this provision, is read as an "is" in cases such as *McGann*. 

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decision and reflected in Justice Scalia's concern during the oral argument that the employer's right to discriminate be preserved.

In McGann, the Fifth Circuit looked to a Second Circuit decision, *Moore v. Metropolitan Life Insurance Co.*, for guidance:

> With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. . . . medical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation.

As succinctly stated by the Fifth Circuit in *McGann*, to interpret ERISA § 510 “discrimination” so broadly as to preclude employers from placing a lifetime cap on a particular type of coverage would clearly conflict with Congress’s intent that employers remain free to create, modify and terminate the terms and conditions of employee benefit plans without governmental interference. The Court held that McGann had the burden of proving discriminatory intent directed specifically at him and then stated that there was “nothing in the record to suggest that defendants' motivation was other than as they asserted, namely to avoid the expense of paying for AIDS treatment. . . no more for McGann than for any other present or future plan beneficiary who might suffer from AIDS.” The *McGann* Court also professed concern for employees by noting that allowing the vesting of medical benefits and curtailing an employer's prerogative to change medical plans could lead to decreased protection for future employees and retirees in that it might force employers to cease offering welfare benefits coverage altogether. Businesses are hurt by the high cost of health insurance, but courts do not typically engage in such an analysis vis-à-vis other types of discrimination.

Aside from the particulars of the individual claim, these cases raise profound questions about the conflicts of interest at play in “managed care.” Imagine any other area involving fiduciary and ethical obligations to the welfare and care of third parties—trusts and estates law, corporate and securities law, the lawyer’s canon of ethics, or doctors’ Hippocratic

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In *Owens v. Storehouse, Inc.*, 984 F.2d 394 (11th Cir. 1993), the Eleventh Circuit reached the same conclusion relying on nearly identical facts.

229. 856 F.2d 488 (2d Cir. 1988).
231. Id.
232. Id. at 404.
233. Id. at 407.
Oath—and it is difficult to find a comparable example in which individuals and entities occupy conflicting roles so freely. The Pegram case, described in the following section, is the best example.

D. The “Exclusive Benefit” Rule is “Managed”: Cynthia Herdrich’s Appendix

As noted in the introduction, the Supreme Court has decided that an HMO that gives bonuses to doctors for limiting the cost of patient care does not violate the fiduciary duties imposed by ERISA. In Herdrich v. Pegram, plaintiff Cynthia Herdrich charged that an HMO’s physician failed to treat her appendicitis adequately because the physician failed to authorize a timely ultrasound procedure.

On March 7, 1991, Lori Pegram, Herdrich’s doctor, discovered a six by eight centimeter “mass” (later determined to be her appendix) in Herdrich’s abdomen. Although the mass was inflamed, Pegram delayed immediate treatment for Herdrich and forced her to wait eight days to obtain an ultrasound for purposes of determining the nature, size, and exact location of the mass. The ultrasound should have been performed immediately, but, in “non-emergency” situations, the Carle Clinic required plan participants to receive care from Carle-staffed facilities. Herdrich had to wait for an ultrasound at a Carle facility more than fifty miles away. Her appendix ruptured in the interim. According to the case:

The defendant-physicians managed the Plan, including the doctor referral process, the nature and duration of patient treatment, and the extent to which participants were required to use Carle-owned facilities. In fact, the board of directors consisted exclusively of the Plan’s physicians who were thus in control of each and every aspect of the HMO’s governance, including their own year-end

234. The Hippocratic Oath reads, in part:

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous . . . . With purity and with holiness I will pass my life and practice my Art . . . . While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

235. 154 F.3d 362 (7th Cir. 1998)
236. Id. at 365 n.1.
237. Id.
238. Id.
239. Id.
240. Id.
Moreover, "the defendants had the exclusive right to decide all disputed and non-routine claims." This means that under the functional test, the defendants were fiduciaries. The incentive structure at Carle was pernicious because the physician/administrators’ year-end bonuses were based on the difference between total plan costs (the cost of providing medical care) and revenues (payments by plan beneficiaries).

Herdrich sued the HMO and Dr. Pegram in state court under various tort law theories. The HMO successfully petitioned to have the case removed to federal court on grounds of preemption. In federal court, Herdrich also alleged that the HMO’s administrators breached their fiduciary duties under ERISA by accepting annual bonuses for restricting patient care, which depleted the plan’s assets. As noted above, there are no compensatory punitive damages under ERISA, but Herdrich still wanted the fiduciaries to make restitution to the plan for breach of fiduciary duties. Herdrich’s lawyers pressed the case that the defendants breached their fiduciary duty to all the plan beneficiaries by depriving them of proper medical care and retaining the resultant savings for themselves. Plainly, this was not acting “for the exclusive benefit” of the participants and their beneficiaries. The Court of Appeals for the Seventh Circuit overruled the Illinois Federal District Court’s dismissal of this count and reinstated the employee’s case.

In contrast to the Supreme Court’s action in Spink, which usurped the role of the fact-finder, the Seventh Circuit addressed the minimal requirements of stating a claim: (1) that the defendants are plan fiduciaries, (2) who breached their fiduciary duties, which (3) resulted in a cognizable loss.

In her complaint, Herdrich claimed that the “defendants breached their fiduciary duty to plan beneficiaries by depriving them of proper medical care and retaining the savings resulting therefrom for themselves." In reinstating Herdrich’s claim, the Seventh Circuit stated:

Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor

241. Id. at 370 (emphasis omitted).
242. Id.
243. Id. at 365-66.
244. Id. at 366.
245. Id. at 366 n.3.
246. Id. at 380.
247. Spink v. Lockheed, 60 F.3d 616 (9th Cir. 1995).
248. Herdrich, 154 F.3d at 366.
of 'loyalty' to his own financial interests. Tolerance, in other words, has its limits.\textsuperscript{249}

The dissent, invoking the law of the market, argued that dual loyalties and incentive schemes are per se valid without limitation.\textsuperscript{250} Only when there is a "breakdown in the market... [or a] serious flaw in the manner in which the incentive arrangement is established" can there be a breach of fiduciary duty.\textsuperscript{251}

Alluding to exit strategy, the dissent further argued, without proof:

[P]lan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to dangerous or undesirable levels... [J]udicial efforts to determine permissible levels of financial incentives through the vehicle of ERISA's fiduciary rules are unnecessary and ill-advised. No standards for conducting such an inquiry exist. Such a move would preempt legislative and regulatory efforts in this area and could seriously disrupt the ability of plan sponsors and beneficiaries to manage plan assets by agreeing to incentives that encourage cost-conscious medical decisionmaking... I fear that the decision today could lead, both in this case and in the future, to untethered judicial assessments of permissible incentive levels in health care plans.\textsuperscript{252}

In light of the Supreme Court's ruling in \textit{Lockheed} and \textit{Hughes}, it is perhaps not surprising that the Supreme Court adopted reasoning similar to the lower court dissent, and rejected Herdrich's claim—thereby rejecting the claims of all participants on behalf of the plan.

Whereas in \textit{Spink} and \textit{Hughes} the Supreme Court suggested that the employees were gold-diggers, during Herdrich's oral argument some of the justices mocked the plaintiffs act of class solidarity: \textsuperscript{253}

Q. What's really at stake for your client at this stage?

A. My client does not stand to profit individually or personally from this case. What we are seeking is to recoup the bonuses that we believe are paid in violation of fiduciary duties under \textit{ERISA}...\textsuperscript{254}

\textsuperscript{249} \textit{Id.} at 373.

\textsuperscript{250} \textit{Id.} at 380-84.

\textsuperscript{251} \textit{Id.}

\textsuperscript{252} \textit{Id.} at 383.


\textsuperscript{254} \textit{Id.} at *46.
... 

Q. ... may I go back to your answer to Justice Scalia? You were telling him [that] this case [is not]...a malpractice case... What is it?

A. It's a breach of fiduciary duty case.

Q. Resulting in what kind of harm? I mean, in a malpractice case we know what the harm is...What exactly is the harm?

A. The harm is that the money that is paid into the risk pool...50% of the premium is paid by the employee. The harm here is that the money, which is supposed to be used exclusively for health care, is not being used exclusively for health care.

Q. So you’re basically making a financial management claim. You’re saying they’re misapplying funds?

A. Yes, absolutely. They are breaching their fiduciary duties...You asked me what the harm is. What strikes me about this case, unusual about this case is that the courts zealously protect money for money’s sake with respect to pension plans... If you look at...other cases that are dealing with pension benefits, any fiduciary under one of those plans has never been able to deal with the funds in that plan if profit, self-profit from the dealing of—with those funds.255

... 

Q. Are you saying that it just happens to be a coincidence that you are bringing this financial mismanagement claim under the same—joined with the same pleadings that happen to make malpractice claims? Are you saying that out of the blue, even if you client had lived a totally healthy life and never been denied an immediate appendectomy, that you could still bring this claim...?

A. Essentially, that’s correct, Judge.256

The Supreme Court’s reasoning technique involved parsing the pleadings “very carefully.”257 They read Herdrich’s complaint not to allege a fiduciary breach with respect to administrative decisions about “pure eligibility,” but mixed eligibility and treatment decisions.258

Justice Souter reasoned that “any doubt” that Congress did not intend HMOs to be treated as fiduciaries “hardens into conviction” when the focus

255. Id. at ¶49-50.
256. Id. at ¶51.
258. Id. at 226-32.
shifts to the consequences of the alternative view.\textsuperscript{259}

But the “doubt” appears to have been just a rhetorical conceit of opinion-writing because the justices barely give pause to consider ERISA’s roots in trust law: “[t]he statute provides that fiduciaries shall discharge their duties with respect to a plan ‘solely in the interest of the participants and beneficiaries.’ . . . These responsibilities . . . have the familiar ring of their source in the common law of trusts.”\textsuperscript{260}

The Court explains the settled rule that ERISA permits the same actors to perform settlor functions as fiduciary functions:

ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions. . . . In every case charging breach of ERISA fiduciary duty, then, the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary’s interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.\textsuperscript{261}

Ignoring the legislative history of the Act and the plain meaning of the statute, the Court distinguishes the HMO from that of a “traditional” fiduciary:

Mixed eligibility decisions by an HMO acting through its physicians have, however, only a limited resemblance to the usual business of traditional trustees. . . . Traditional trustees administer a medical trust by paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well. Private trustees do not make treatment judgments, whereas treatment judgments are what

\textsuperscript{259} Id. at 232.
\textsuperscript{260} Id. at 222-24. The Court, quoting outside sources, then explains these duties:

The most fundamental duty owed by the trustee to the beneficiaries of the trust is the duty of loyalty. . . . It is the duty of a trustee to administer the trust solely in the interest of the beneficiaries.” 2A A. Scott & W. Fratcher, Trusts § 170, 311 (4th ed. 1987) (hereinafter Scott); see also G. Bogert & G. Bogert, Law of Trusts and Trustees § 543 (2d ed. 1980) (“Perhaps the most fundamental duty of a trustee is that he must display throughout the administration of the trust complete loyalty to the interests of the beneficiary and must exclude all selfish interests and all consideration of the interests of third persons.”); . . . Meinhard v. Salmon, 249 N.Y. 458, 464, 164 N.E. 545, 546 (1928) (Cardozo, J.) (“Many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.”).

\textsuperscript{261} Id. at 224; see also supra III A.
physicians reaching mixed decisions do make, by definition.... The settings bear no more resemblance to trust departments than a decision to operate turns on the factors controlling the amount of a quarterly income distribution.\textsuperscript{262}

The Court did not, however, distinguish Cynthia Herdrich from "traditional" beneficiaries. Despite the "two-hat" model federal courts have adopted under the developing federal common law of ERISA, Congress never chose to enact separate fiduciary provisions for health plan trustees. The Supreme Court substitutes its own reasoning that Congress "would have":

\begin{quote}
[W]hen Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits. . . . Its focus was far from the subject of Herdrich's claim. Our doubt that Congress intended the category of fiduciary administrative functions to encompass the mixed determinations at issue here hardens into conviction when we consider the consequences that would follow from Herdrich's contrary view.\textsuperscript{263}
\end{quote}

The consequences are hardships on HMOs. Thus, the Supreme Court abandoned plain meaning. Moreover, while invoking the market, the Supreme Court has arguably tinkered with that same construct: for hundreds of years the market has developed and adapted under the confines of the common law of trusts, but the Court fears the market under the regulatory hand of ERISA.

V. CONCLUSION

More than five trillion dollars are now invested in American pension and retirement income programs.\textsuperscript{264} Peter Drucker proclaimed almost twenty-five years ago that if "socialism" is defined as "ownership of the means of production by the workers," then the United States is the first truly socialist country. Through their pension funds, "employees of American businesses own at least 25% of its equity capital, which is more than enough to control."\textsuperscript{265} The figure is more like 30% now, but

\textsuperscript{262.} Id. at 231-32.
\textsuperscript{263.} Id.
\textsuperscript{264.} This is a 1994 figure. The current figure is probably much higher given the growth of the stock market these past five years. HUBBARD, supra note 64, at 45-47.
\textsuperscript{265.} PETER F. DRUCKER, THE UNSEEN REVOLUTION: HOW PENSION FUND SOCIALISM CAME TO AMERICA 1 (1976).
employees do not control these pension funds, and they reflect anything but social equality.266

In a global economy that best serves asset holders and highly skilled workers, the affluent will increasingly choose private market solutions over public goods and universal access to state-run programs.267 The private market solution with minimal state intervention is exemplified by ERISA, but the market can extend further, and employers can opt out of providing any benefits. Employers could tell employees to control their own destiny, get a computer, do some day trading, and invest for their retirement on their own.268 In staggering numbers, businesses, citing costs, are already opting out of providing health insurance.

ERISA has undergone growing pains as a body of law. Ironically, the invocation of trust law reflected Congress's commitment to a legal order founded on predictable, manageable doctrine. The judiciary's goal is developing legal doctrine so as to present it as rational, comprehensive, and coherent. Bourdieu uses the example of the legal status of labor unions to explain how the "juridical field is the site of a competition for monopoly of the right to determine the law."269 Beginning in the nineteenth century, the power relations shifted from a time when collective worker action was an illegal criminal conspiracy to the time in the twentieth century when unions received full recognition. However, under ERISA jurisprudence we see a more negative shift where the duty of undivided loyalty is diminished over time as applied to employee benefit plans.

Because of the complexity of ERISA legislation, this shift in the doctrine may be disguised by a technical view of the law intensified by the proliferation of legislation.270 Moreover, "the sources of law in governmental agencies are so numerous and varied that its formal rationality tends to appear merely as the requirement that a specific rule be traceable to some decision or procedure of an ostensibly authoritative governmental agency."271 The Treasury and Labor Department's multiplicity of rules and opinion letters interpreting ERISA provide ample authority. Further, although the Supreme Court did not cite its amicus briefs, the Labor Department in neither Lockheed nor Hughes supported the workers. Here we see one way in which legal ideology and state institutions mediate what, at bottom, is a political struggle.

266. Id.
267. NOBLE, supra note 36, at 136-37.
268. Of course, major changes in the tax system would be needed; for instance, individual retirement accounts would have to permit more than current levels of deductible income.
269. Bourdieu, supra note 29, at 817.
271. Id. at 228 (emphasis in original).
In a 1987 ERISA case addressing preemption, the Supreme Court observed that it was “obliged in interpreting” a particular clause under the preemption provision “to consider . . . the role [of the clause] in ERISA as a whole.” The Court might now say that in its decisions it has been considering the role of the “exclusive benefit” rule in ERISA as a whole: “[o]n numerous occasions we have noted that ‘[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.’” But how the exclusive benefit is to be read within the context of the “object and policy” of ERISA in a manner not detrimental to the interests of beneficiaries is precisely what is contested.

Under the “attitudinal model” of Professors Segal and Spaeth, judges vote because of their preferences, not because of what the “law” is. But the judge’s preferences are the law, and are so reflected in social practice. In all of the cases highlighted above, we saw the exercise of judges’ preferences in choosing among antagonistic interests and rights.

It is not a matter of questioning whether the old legal relations of trust law survived to the detriment of workers, for these relations should have helped workers (at least according to Congress’s enunciation of the purpose of ERISA). The relations have given way to a kind of modified “business judgment rule” under ERISA that permits dual loyalties. In doing so, has not ERISA’s enforcement scheme successfully mediated, in conjunction with judicial decision-making, the political struggle over the administration of pension and health care benefits?

The problem of mediating antagonistic rights is one that the law and economics adherents claim will be addressed by market forces—with a little help from enlightened courts. It would be politically impossible to require mandatory benefits and the cases imply knowledge as such with courts lending half-hearted support to employees’ claims for breach of fiduciary duty. *Lockheed, Hughes, and Pegram* all address the market forces that operate to maintain any benefits. Moreover, Congress, in enacting ERISA, and the courts, in enforcing it, have deployed the contract paradigm that has long advanced the theory that rational actors will do what needs to be done. “ERISA was enacted to ‘promote the interest of employees and their beneficiaries in employer benefit plans’ and ‘to protect

273. *Id.*
276. *Id.*
277. See generally ORRIN, *supra* note 76 (asking a related question concerning the National Labor Relations Act).
contractually defined benefits." 

ERISA is not an entitlement program at all, just an edifice of rules. Employers do not have to provide any benefits, so the "three-legged stool" approach to income security-Social Security, employer pensions, and personal savings—is not stable. ERISA jurisprudence is itself an integral element in constituting this political economy. ERISA reflects the idea that the American welfare state is "exceptional because it is so market conforming. After a hundred years of welfare-state building, Americans remain more vulnerable to the free play of market forces than do the people of nearly every other rich capitalist society."

While ERISA was purportedly enacted to ease the impact of market forces upon the employee, its jurisprudence has often invoked the theory of the market to resolve the tension within the statute between a purely voluntary legal order and strict fiduciary obligations to workers.

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279. ERISA is analogous to the Great Society's offering the poor an equality of "opportunity" rather than of "condition." NOBLE, supra note 23, at 10.


281. Id. at 3.