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Kathryn J. Kennedy

*UIC John Marshall Law School*, [kkenned@uic.edu](mailto:kkenned@uic.edu)

Melissa Travis

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## Notable Employee Benefits Articles of 2018

by Kathryn J. Kennedy and Melissa Travis

Kathryn J. Kennedy is a professor of law at the John Marshall Law School in Chicago. Melissa Travis is an employee benefits legal consultant at Mercer LLC in Chicago. They thank Raizel Liebler and Jessica Frothingham for their assistance in compiling more than 70 employee benefits law review articles for consideration.

In this article, Kennedy and Travis summarize 10 noteworthy law review articles published in 2018.

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- the author must be a full-time law professor, or, for a coauthored piece, the first-, second-, or third-listed author must be a full-time law professor;
- the article was published or expected to be published during calendar 2018 or the academic 2017-2018 term or forthcoming in the 2018-2019 term; and
- the article must appear or be expected to appear in a student-edited law journal or student-edited law review (or faculty-and-student-edited law journal or law review) affiliated with an American Bar Association-accredited law school or a Federation of Law Societies of Canada-accredited law school.<sup>2</sup>

### I. Introduction

This is the ninth year *Tax Notes* has extended an invitation to write an article summarizing the 10 law review articles that employee benefits scholars and practitioners should have read (but possibly didn't) in 2018.<sup>1</sup> In recent years, healthcare reform and executive compensation have dominated the field of employee benefits law. However, we continue to see a renewed interest in scholarship regarding retirement plans, especially in the areas of state IRA initiatives and public pension plans. The bulk of the scholarship produced last year focused on retirement and welfare plans. This trend will undoubtedly change during 2019 as Congress continues to dabble in healthcare reform and retirement benefit issues.

### II. Criteria

The pool of law review articles to be considered had to satisfy the following criteria:

Those criteria excluded several excellent articles written by practitioners, as well as academics who published in practitioner journals.

The exercise of reading all the 2018 published law review articles on employee benefits law was daunting, but refreshing. Excellent scholarship is being written in this area of law; it will assist the courts, the regulators, and the bar alike, especially because new legislation will be enacted affecting employee benefits. It was refreshing to see so many students' comments and notes on employee benefits issues as more law schools are adding employee benefits to their curricula.<sup>3</sup>

As Kathryn J. Kennedy is one of the faculty advisers to *The John Marshall Law Review*, she reads all the notes and comments published in the law review over a given academic year and recommends a single piece to nominate for the national Scribe's award. The task for this article

<sup>1</sup>Bridget J. Crawford began this tradition in 2009 with her article "Law Review Articles You Should've Read (but Probably Didn't) in 2009," *Tax Notes*, Jan. 18, 2010, p. 397, relating to estate planning issues.

<sup>2</sup>Kathryn J. Kennedy's articles published in 2018 were excluded from consideration.

<sup>3</sup>The John Marshall Law School in Chicago continues to provide the only LL.M. and M.J. in Employee Benefits degree in the nation.

was not much different; it just involved slightly different criteria for evaluation.

With more than 70 articles under consideration, our criteria were diverse:

- Did the article force us to think about a given area of employee benefits law in a novel way?
- Did the author undertake a difficult topic, and if so, did the author provide us with the necessary background information to understand the topic? Were original ideas posed?
- Did it rely on legal analysis as opposed to policy arguments to suggest new proposals?
- Did it use empirical data to decipher whether the law was accomplishing its objectives, and if not, did the author recommend alternative solutions?
- Did it provide us with a historical perspective, if necessary, to ascertain how the law was evolving?
- Was it clear and persuasive in its recommendations?
- Did it provide a meaningful contribution to academic scholarship?

While not all these factors were present in every article, we used them to gauge how creative and substantive an author's proposals would be for legal scholarship. We may not have agreed with all the authors' conclusions, but we felt their approaches to be innovative and thought provoking. The following is not a list of what we perceive as the 10 best employee benefits law review articles of 2018, but rather a list of what we consider the 10 most noteworthy law review articles on employee benefits law published in 2018 that a broad audience of employee benefits scholars and professionals would find relevant and worthy of significant attention.

### III. The Chosen Ones

While it is typical to review the articles alphabetically by the first author's last name, we changed tradition a few years ago and began categorizing the articles into three areas: retirement plan issues; healthcare reform and welfare plan issues; and executive compensation issues.

## A. Retirement Plan Issues

### 1. Benjamin P. Edwards, "The Rise of Automated Investment Advice: Can Robo-Advisors Rescue the Retail Market?" 93 *Chi-Kent L. Rev.* 97 (2018).

Edwards addresses the issue of new technology used to offer automated investment advice (referred to as robo-advisers). Honest Dollar, a start-up company, made employee retirement plans accessible to small and early-stage businesses beginning in 2015. It embraced the use of robo-advisers in its platform of low-cost passive funds by offering investment advice through its digital platforms. By completing surveys regarding a participant's investment strategies and financial wellbeing, the automated system devised a personalized portfolio for the participant investor.

Since the company's adoption of robo-advisers in 2015, the market for those services continues to grow, with one source estimating the use of automated investment advisers for \$2 trillion in assets by 2020. This article examines the potential market disruption that automated investment advisers face, as well as the challenges and barriers that lie ahead. Edwards begins with a discussion of the current conflicted-advice phenomenon that dominates the retail market, which relies primarily on shares in funds. It is the institutional intermediaries that market those funds. In Edwards's view, this market and the institutional intermediaries have contributed to a retirement crisis. It is estimated that a third of Americans have no retirement savings, and those that do have less than \$10,000 in savings. For those who save, most do not rely on advice from financial professionals. This may be because many financial advisers are compensated by commissions, which direct investors into high-fee products, and do not have sufficient incentives to provide financial counseling and planning services. Hence, the retail investment market has a void that automated investment advice firms could fill to alleviate the conflicted-advice problem and expand investment advice to many more participants because of lower costs. These robo-advisers could have the added advantage of forcing institutional intermediaries to steer investors toward passive investment strategies.

Edwards then examines the regulatory control over advice-givers in the retail market, in which their duties vary by the type of product marketed, the type of compensation received, the source of the investor's funds, and other considerations. For commission-compensated brokers, they are held to the suitability standard under the Financial Industry Regulatory Authority rules, which is not a client best interest standard. Investment advisers registered under the Investment Advisers Act of 1940 are held to a client best interest standard. And lastly, insurance brokers that are regulated under a wide array of state laws have no uniform standard of care.

Finally, Edwards discusses both the potentials and pitfalls of robo-advisers. Robo-advisers have the potential to alter the retail market by forcing down costs on asset allocation advice. This will have the benefit of having institutional intermediaries steer investors away from underperforming actively managed funds. That in turn will make additional capital available for investors to invest. But the perils facing robo-advisers include new cybersecurity risks as well as changing regulatory standards. The Department of Labor introduced its new fiduciary standards for advice regarding retirement accounts, only to be told to rethink that rule under a presidential order. The SEC is also asking for comments on the standards of care for investment advisers and brokerage firms. Finally, robo-advisers face conflict of interest issues: If they direct large amounts of capital to themselves, Wall Street firms may be encouraged to change algorithms used to allocate funds.

## **2. Anita K. Krug, "Investors' Paradox," 43 *Iowa J. Corp. L.* 245 (2018).**

In the first scholarship article to address the topic, Krug examines a growth of new funds (referred to as alternative funds) that attempt to close the gap between retail investors and private and more sophisticated investors. Krug examines the set of factors that make up alternative funds and evaluates their potential for retail investors. She then critiques the SEC's regulatory tool for protecting investors — that is, disclosure — and concludes that it is ineffective for these types of investment. Thus, she says the regulators should focus on the processes by which these mutual fund shares are marketed and sold to investors.

This new investment of alternative funds (also referred to as liquid alternative funds) replicates a mutual fund that uses investment and trading strategies typically found in hedge funds, private equity funds, and other types of privately offered funds. Because these strategies go well beyond the strategies seen in publicly traded securities, they are referred to as alternative strategies. The statute that regulates mutual funds is the Investment Company Act of 1940, which requires mutual funds to accept investor redemptions daily and to pay any proceeds from a redemption immediately, giving rise to the "liquid" component of these funds. These liquid alternative funds allow investors to take investment and trading positions that were previously available only to private and more sophisticated investors (for example, commodity futures, swaps, options, and derivatives).

Another new product seen in the marketplace is a subset of liquid alternative funds — that is, the multi-manager series trust. These trusts have sprung out of changes in the private fund market that have allowed investment advisers who manage private funds to move into the retail space. While the cost of previously sponsoring such funds had been prohibitive, the series trust answers the cost problem by changing the traditional model in which the investment adviser of the mutual funds (that is, the fund's manager) sponsors the funds it manages, to one in which a third party serves as the sponsor. The third party creates each fund, registers it under securities laws, and bears much of the expense that the previously manager-as-sponsor would accept. This series trust permits the manager to accomplish efficiencies that would exist if each fund were managed as a stand-alone mutual fund. But the complexity of these investments and trading activities demand sophisticated investor knowledge.

These alternative funds present an investor paradox: The usual standard is to minimize investment risk by diversification of one's portfolio, whereas these new alternative funds allow greater diversification but may undertake unduly increased investment risk. To solve this tension, Krug examines the existing regulatory tool of disclosure and concludes that it is ineffective. She focuses instead on reforming the

mutual fund distribution process, which should focus on a standard of fiduciary advice. Such advice should obligate a financial adviser to notify the investor about the appropriateness of a mutual fund and whether the mutual fund results in diversification of the investor's investment portfolio. In light of this standard, Krug discusses the Department of Labor's proposed fiduciary standards applicable to brokerage firms and their representatives.

Krug notes that the retirement plan channel as a possible venue for marketing the alternative funds may not be suitable because such funds offered via a retirement plan are regulated by securities laws and ERISA. Given that most defined contribution provide for "self-direction" of the investments by the plan participants, participants may not be in a position to evaluate the suitability of using alternative funds, nor are they typically provided advice from a financial professional because of the co-liability an employer sponsor would assume in selecting such professional. Thus, there may have to be other distribution channels to market these alternative funds. Krug concludes that the future of these alternative funds will require greater education by retail investors about the risk and reward of such funds, including how they relate to the diversification of the investor's overall portfolio.

**3. Kathryn L. Moore, "State Automatic Enrollment IRAs After the Trump Election: Are They Preempted by ERISA?" U. Ill. Elder L. J. (coming 2019).**

As states begin to close the gap between saving for retirement and the lack of employer retirement plans, especially for small and medium-size employers, they have been enacting legislation to mandate that employers that do not sponsor plans automatically enroll their employees in a state-administered IRA plan. The article examines the legal challenges for such plans, namely ERISA's preemption clause. Section 4(a) of ERISA defines what is an "employee benefit plan" for purposes of the law, and section 514(a) of ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." So Moore addresses two central issues: whether the state automatic enrollment IRA plans are employee benefit plans for purposes of ERISA, and if so, whether they are

preempted by ERISA. And alternatively, if such plans are not employee benefit plans under ERISA, whether they are still preempted by ERISA.

To answer those issues, Moore begins with a straightforward overview and comparison of the state automatic enrollment IRA programs — namely, the initiatives offered in five states: California, Connecticut, Illinois, Maryland, and Oregon. She then moves to the Department of Labor's 2016 regulations that provided that state automatic enrollment IRAs would not constitute employee benefit plans under ERISA if they satisfied 11 separate requirements, thereby creating a safe harbor. Shortly after Trump's election, Congress passed resolutions disapproving of the safe harbor, which caused the Department of Labor to remove the regulations — hence why Moore named her article accordingly. The removal of the regulations clearly left open the issue of whether state automatic enrollment IRAs were covered under ERISA. In the absence of regulations, Moore discusses whether such state plans are covered under ERISA under prior Department of Labor guidance, and if such state plans are not ERISA plans, whether they nevertheless relate to employee benefit plans such that ERISA's preemption clause would negate them. The latter analysis also applies to whether such state plans are said to be ERISA plans. Finally, Moore considers the merits of the two legal complaints that have challenged the state laws. Given the timeliness of this article, it is one that all benefits attorneys should read because the courts will be making legal determinations regarding the various state initiatives.

**4. Paul Rose, "Public Wealth Maximization: A New Framework for Fiduciary Duties in Public Funds," 18 U. Ill. L. Rev. 892 (2018).**

Rose questions the application of the standard fiduciary duties that public pension funds should be managed solely for the benefit of plan participants and beneficiaries. By viewing the public and current and future taxpayers, not the plan participants and beneficiaries, as the true risk bearers of public pension funds, the fiduciary duties owed by public pension fund trustees should be altered. This will have important consequences for the investment policies of these funds.



Rose advocates a change in the fiduciary duties for public pension trustees to embrace a public wealth maximization framework. While trustees of private pension funds generally focus on “participant wealth maximization,” which looks to the most favorable rate of return on their investments, a public wealth maximization standard would allow public pension trustees to consider socially responsible investment initiatives that benefit the public, who will be the true recipients of the investment choices of the public fund trustees. This new framework would allow fund managers to take into account fully the externalities that accompany these investments, which in turn will assist them in fully and accurately pricing these investments.

Rose makes his case for a change in the fiduciary standards for public pension trustees in four parts of his article. First, he examines the existing fiduciary standards applicable to private pension funds under ERISA and how the public pension funds are influenced by those standards even though ERISA does not apply to them. He then questions the application of those trust-law-derived standards — developed under common law, ERISA, or trust law — to public pension funds. The reason for this is that public pension funds have much different claimants and liabilities than private pension funds. Given the differences, Rose examines how shifting the fiduciary duties to the true risk bearers of public pension funds — the public — should change how these pension funds invest. By broadening the fiduciary standards for pension funds, the trustees will have a wider range of investments to choose from and will be able to focus on sustainable, long-term projects for the public good, rather than a short-term rate of return on the investments. He concludes by stating that by shifting the fiduciary duties to public wealth maximization, public pension trustees will be able to fully consider the externalities that accompany their investments because it is the public that funds the government who will be absorbing the costs of these externalities. By allowing these trustees to take positive externalities into account in their investment decisions, they will be able to invest in more sustainable enterprises and long-term projects.

## B. Healthcare Reform, Welfare Plan Issues

### 1. John Aloysius Cogan Jr., “Does Small Group Health Insurance Deliver Group Benefits?” 93 *Wash. L. Rev.* 1121 (2018).

While other scholarship exists discussing the decline of the small group market, little scholarship makes such a direct recommendation to kill the market because of its continued decline. However, this is exactly what Cogan argues in this article. Cogan begins his argument with basic facts — less than 30 percent of small employers (that is, those employing fifty or fewer employees) offer health insurance to their employees, and the number of people covered by small group insurance continues to drop. In lieu of stabilizing the market via reform or regulatory efforts, Cogan questions whether it is worth saving at all, focusing on whether the small group market is delivering group insurance benefits. That is, is it offering insured individuals a better deal through the available group health plan coverage than would be available on an individual basis? To Cogan, the small group market is not achieving this goal.

As expected, his article takes issue with further intervention in the small group insurance market. It first provides a history of group insurance, noting that this insurance traditionally provides four core benefits: (1) reduced adverse selection; (2) lower administrative costs; (3) greater access to insurance; and (4) tax-subsidized premiums. Based on a review of these core benefits, Cogan posits that such advantages are not being provided and that the small group market generally offers no better deal than the individual market.

He draws two additional conclusions from such a review. First, because of size and the actuarial limits of experience rating, small groups are unable to be priced or administered in the same way as large groups. Inevitably, this leads to small groups being exposed to adverse selection not unlike that experienced in the individual insurance market. Second, and coupled with the existing problem of adverse selection, because the Affordable Care Act actively worked to improve benefits within the individual market, it further marginalized any benefit that could be brought by selecting the small group market over the individual market. In recognition of these

conclusions, Cogan argues that allowing for the demise of the small group market could simply result in more participants moving to the individual market, which would help the individual market with little to no detriment to individual plan participants.

With a push by the current administration to encourage more flexibility in individualized healthcare — for example, although recent Health Reimbursement Arrangement proposed regulations — and in making the large group market incentives available to smaller groups — that is, through the administration’s push to expand Association Health Plans — there is support for the argument that the small market has lost its footing and will only continue to decline naturally. Attempts to dismantle the ACA may affect the arguments raised, but even with concerns about the future of the ACA, a shift of millions to the individual market would serve as a reason to encourage its stabilization. For those reasons, Cogan’s approach here, raising the question “whether small group markets are doing what they are aimed to do, and if not, why continue them,” is certainly worth considering.

## 2. Wendy Netter Epstein, “The Health Insurer Nudge,” 91 *S. Cal. L. Rev.* 595 (2017).

Epstein’s article focuses on the reality of rising healthcare costs and suggests a fairly straightforward approach to addressing these issues. By no means has this subject been overlooked in healthcare law scholarship. In fact, much scholarly attention has been paid to how patients and providers contribute to increased healthcare costs, including scholarship by Epstein herself; however, payors’ role in contributing to the problem is underexplored.

Epstein argues that lawmakers are looking for ACA savings in the wrong place. Common recommendations — for example, removing sick people from risk pools, reducing health plan benefits — are not the answer because they would effectively harm vulnerable patients. To that end, Epstein recommends more action on the payor side, arguing that they should “nudge” providers away from needless expenditures by requiring electronic alerts intended to deter unnecessary care.

Epstein had written another article (“Nudging Patient Decision-Making,” 92 *Wash. L. Rev.* 1255

(2017)) focusing on a similar “nudge” intended to affect patient decision-making. While reasonable to encourage more patient autonomy and help patients recognize the viability of any suggested treatment, this subsequent article recognizes that putting the onus on the payors instead may ultimately better affect patients’ decision-making because of the impact that such nudges may have on the providers. This is in part because of Epstein’s recognition of the importance of both patient and physician autonomy in making medical decisions. Also, this focus on provider behavior recognizes that high-tech imaging and laboratory tests are often overused. Absent any sort of “nudge” on the providers, most patients will assume that any recommendations by their doctors are necessary.

Here, Epstein proposes a nudge on the providers that instead protects the autonomy of doctors and patients and steers decision-makers toward appropriate, less-costly care. The nudge recommended is fairly straightforward: It could be communicated as a computerized nudge in the form of an automated warning before a physician’s order for a commonly used intervention is submitted. Such a nudge would have to be federally mandated, because otherwise intervening factors — that is, market failures, contract negotiations, and industry norms — would likely dictate the omission of such nudges. These electronic nudges would notify doctors of the possibility of unneeded or overly expensive care before recommending it.

Presumably, there will be pushback on such recommendations, but those best suited to address the costs are not the patients and providers by themselves; the insurer implementing a nudge may take a less politically problematic approach than outright refusing to reimburse for care post hoc. The nudge, via an electronic warning, could respect both patient and physician autonomy while also managing to curb unnecessary care. While no empirical evidence exists to support such a proposition, the mere suggestion warrants further consideration. And to the extent that nudges can be supported by empirical evidence, such a nudge without any sort of intervening law would be ineffective; thus, a mandate for a provider nudge would have to be required to give the policy any force.

**3 and 4. Abbe R. Gluck and Nicole Huberfeld, “What Is Federalism in Healthcare For?” 70 *Stan. L. Rev.* 1689 (2018); and Gluck and Huberfeld, “The New Health Care Federalism on the Ground,” 15 *Ind. Health L. Rev.* 1 (2018).**

In an impressive undertaking, Gluck and Huberfeld performed a five-year study in which they reviewed how federalism has affected the ACA’s implementation, namely to see how states and the federal government were sharing power in putting the law into place through Medicaid expansion and health insurance exchanges. This study culminated in two articles published this past year — one that focused on the findings, and one that focused on the interviews the authors conducted with about 20 high-ranking former federal and state officials who were heavily involved with the early years’ implementation of the ACA. Because such important information stemmed from the interviews, it seemed inadequate to highlight the *Stanford Law Review* article alone.

These articles tracked the details of the ACA’s federalism, focusing on progress from 2012 to 2017. Given the pure scale of the ACA, Gluck and Huberfeld saw the opportunity to investigate federalism-related implementation from the ground level and provide the concrete detail often wanting in federalism scholarship. Key questions motivating the project were: Does the ACA actually effectuate “federalism,” and what are federalism’s key attributes when entwined with national statutory implementation? More directly, the pieces discuss exactly what the title of the *Stanford* article posits — that is, the purpose of federalism within the ACA, because the interviewees unanimously concluded that federalism was the focal point of its implementation — as well as the consequences inherent in being unable to quantify this question.

While the results of this study were vast, some of the more interesting findings by Gluck and Huberfeld were that common theories in both federalism and healthcare were not supported by the study. While common conceptions of federalism exist, posited by a broad spectrum of theorists, those most commonly attributable to federalism — for example, autonomy, cooperation, experimentation, and variation — have been generated in ACA implementation

across almost every kind of governance model. What this means is that whether there was state expansion of Medicaid, state-run exchanges, federally run state exchanges, or the implementation of a state innovation waiver (established through section 1332 of the ACA),<sup>4</sup> these attributes of federalism were seen. Those results, Gluck and Huberfeld argue, make it increasingly difficult to point to a specific implementation design and determine one to be the most “federalist.” Such a determination directly challenges the argument that federalism goals can only be achieved through specific state-federal structural models.

Moreover, Gluck and Huberfeld’s study questions how we can know if healthcare federalism is best meeting its ends with a lack of clear consensus as to the end goals for U.S. healthcare in and of itself. Whether the goals are policy or structurally focused directly affect which ACA implementation arrangements best effectuate those goals. That illustrates that traditional expectations of federalism simply do not reveal themselves in this study of the ACA to the extent anticipated — that is, while there may be more support that federalism preserves state power in ACA implementation, the question whether federalism has achieved good health policy outcomes has been left unresolved. And to the extent that good health policy may not have been achieved, the lingering question remains whether federalism and the need to advance and preserve state powers was really necessary if the ends fail to justify the means.

These articles illustrate that there exists no bright-line determination on whether federalism is the right choice for healthcare policy. ACA implementation effectively illustrates that measuring federalism was not quantifiable despite five years of detailed study. The lack of definitive answers opens the possibilities of what federalism should mean in the future and raises questions regarding what is best for healthcare in

<sup>4</sup> See 42 U.S.C. section 18052 (allowing states to implement innovative ways to provide access to quality healthcare — while waiving the need to comply with some ACA requirements — as long as the care is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit).



the United States in the future. Ultimately, these articles by Gluck and Huberfeld provide excellent scholarly contributions even beyond their value to employee benefits scholarship.

**5. Rachel E. Sachs, “Delinking Reimbursement,” 102 *Minn. L. Rev.* 2307 (2018).**

This article recognizes that prescription drug costs are too high potentially because of the direct “link” between government approval and reimbursement. With existing proposed legislation focused on finding different ways to lower drug prices or, at a minimum, illustrate the reason for such high costs — for example, the Biologic Patent Transparency Act and the Drug Price Transparency Act — there exists a compelling interest in increasing drug price transparency. Similarly, there have been other approaches, focusing on curbing costs, from calls for the Food and Drug Administration (FDA) to approve pharmaceuticals at a faster rate to giving Medicare authority to negotiate drug prices. This article notes the deficiencies in those approaches alone, noting that a problem exists in doing so: FDA approval and insurance reimbursement are directly linked because insurers generally must cover most FDA-approved drugs.

Sachs uses the article as an opportunity to explain this linkage, arguing that understanding the link between FDA approval and insurance reimbursement is necessary in order to help policymakers understand a possible system in which the two can be delinked, at least in part. Sachs discusses the implications for innovation and access if approval and reimbursement were delinked, including three potential consequences: (1) reduction in access to these medicines, as Medicare and Medicaid would no longer be legally required to cover some drugs; (2) the possibility for more innovation in offerings in the event that these companies know that they must earn not only FDA approval, but prescription coverage; and (3) a direct way to address high prescription costs attributable to (1) and (2) above.

Sachs also discusses other possible consequences, as evidenced through some real-world examples of delinking (for example, the Department of Veterans Affairs’ ability to construct its own formularies, national payers in European countries negotiating on behalf of

citizens, and medical device approval in the United States). From a review of these examples, Sachs admits that while their facts illustrate some effects of delinking (that is, decreased costs but also lack of access), their review is more so to proffer policy-based assessments from the impact of delinking.

Finally, Sachs suggests several policy options that would include some form of partial delinking. While empirical analysis is needed, Sachs’s suggestions recognize a need to consider the possibilities of delinking if there is an interest in curbing the costs of healthcare, and prescriptions in particular. While this article’s focus is more on healthcare law, its suggestion, if enacted, would directly and greatly affect employer-sponsored group health plans.

### C. Executive Compensation Issues

**1. Rebecca N. Morrow, “Noncompetes as Tax Evasion,” 96 *Wash. U. L. Rev.* 265 (2018).**

Morrow studied the use of noncompete clauses typically found in executive compensation agreements. These clauses create a contract between an employer and an employee such that the employee agrees not to work for a competitor or enter into a competitive business for a specified period following termination of employment. Restricted periods are often 12, 18, or 24 months after employment. Noncompete clauses can be entered into before employment commences with the employer, or while the employee continues in the employer’s employment, such as an induction to receive a promotion or bonus. Their goal is to limit “the post-employment mobility of an employee.”<sup>5</sup>

Courts, federal policymakers, and state legislatures have tried to limit the harm caused by noncompete clauses, typically by relying on contract law. Most states will enforce the legitimacy of a noncompete based on its reasonableness in duration, scope, and geographic range. As the courts inevitably uphold noncompete clauses if supported by adequate

<sup>5</sup> Quoting from J.J. Prescott, Norman D. Bishara, and Evan Starr, “Understanding Noncompetition Agreements: The 2014 Noncompete Survey Project,” 2016 *Mich. St. L. Rev.* 369, 371 n.1 (2016); see also Bishara and David Orozco, “Using the Resource-Based Theory to Determine Covenant Not to Compete Legitimacy,” 87 *Ind. L. J.* 979, 986-987 (2012).

consideration, attempts to curtail their use through contract law have failed. In fact, a large study of noncompete clauses demonstrates their continued popularity regardless of the ability to enforce them.

Thus, Morrow suggests a new and more effective approach to curtail the use of noncompete clauses: a tax-law-based approach. When using a tax approach, a noncompete clause is not simply a contract between the employer and employee, it is also an intangible asset of the employer because it promotes the employer's future market share and business prospects. When viewed as an intangible asset that benefits future years, starting when the employment relationship ends, the payments for such an asset should be capitalized over the determined useful life, and not expensed over the employee's working years. However, employers routinely violate this principle because they immediately deduct the full amount of compensation as an exchange for current wages.

Morrow recommends that the IRS change its policy and view a noncompete as an intangible asset that should be future valued and partially expensed gradually over the restricted period that begins after the employment relationship ends. The IRS's current policy prompts the continued use of noncompete clauses by employers, while a tax-law-based approach would curtail their use. When employers take a current deduction for wages subject to noncompete clauses, their position in tax law does not coincide with the position they are taking under contract law. Under contract law, the compensation exchanged for the noncompete clause forms the consideration necessary to have a contract. But this admits that such compensation is partially consideration for the contract; the rest is compensation in exchange for future benefits. Hence, employers should not be allowed to fully deduct compensation, but instead should value the portion of the compensation that represents future benefit and amortize that over the period that begins when the employment relationship ends. Hence the tax-law-based approach holds "unique promise"<sup>6</sup> to curtail the use of

noncompete clauses when the contract-law-based approach has failed.

Morrow advocates a change in the IRS's tax policy because its current policy results in a sizeable subsidy for employment noncompete clauses. Such a change would provide another "tool of resistance"<sup>7</sup> for the continued use of those clauses. ■

<sup>6</sup>Morrow, "Noncompetes as Tax Evasion," 96 *Wash. U.L. Rev.* 267, 273 (2018).

<sup>7</sup>*Id.* at 325.