

Spring 2014

At the Intersection of Insurance and Tax: Equitable Remedies Under the Affordable Care Act, 47 J. Marshall L. Rev. 973 (2014)

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AT THE INTERSECTION OF INSURANCE AND TAX: EQUITABLE REMEDIES UNDER THE AFFORDABLE CARE ACT

JULIE A. LEWIS¹

INTRODUCTION

The Patient Protection and Affordable Care Act creates a social contract between individuals and their health plans. The Act guarantees minimum health care services at a cost that is affordable to most of us. It also embraces insurance as the means to pay health care providers and spread the cost of their services over the widest possible set of participants. This paper examines the role of health insurance in ensuring the social safety net.

Recently, courts have recognized insurers, employers and others who administer health insurance as benefits trustees with fiduciary responsibilities under ERISA akin to the trustees of pension and retirement plans. Plan participants, in the role of beneficiaries, have gained new rights to equitable relief intended to preserve their health care services and compensate for any loss.

ERISA section 1132(a)(3) equitable relief now includes a judicially recognized right to monetary damages—restitution, surcharge, unjust enrichment and disgorgement of profits—in response to a health plan’s breach of the fiduciary duty of loyalty. These recently articulated rights will be the critical avenue to remedial action under the Affordable Care Act.

This paper examines the Seventh Circuit’s recent line of cases addressing breach of a health plan’s fiduciary duty to individual plan participants beginning with *Kenseth v. Dean Health Plan, Inc.* Part I reviews the court’s 2009 *Kenseth* decision (*Kenseth I*) which sets out the parameters of a fiduciary breach. Part II looks how the court, post-*Amara*, addresses equitable remedies in its 2013 *Kenseth* decision (*Kenseth II*), including the Supreme Court’s evolution on the topic.

While Dean Health Plan is the named defendant in the *Kenseth* case, the situation to which Dean was responding is now universal. The fact pattern of the *Kenseth* case will be replicated until insurers, employers and other fiduciaries develop a system of providing health insurance coverage that meets the heightened statutory and judicial requirements for participant protection.

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I. DEBORAH KENSETH'S SURGERY

In 1987, Deborah Kenseth had a vertical banded gastroplasty to help her lose weight.² The group health plan she had at the time covered the procedure. In time, an obstruction developed, causing severe acid reflux, and by 2004, she was regularly experiencing painful symptoms related to gastric stenosis. She consulted a bariatric surgeon at Dean Health Systems in 2005, who recommended a surgical procedure known as Roux-en-Y to bypass the obstruction. His notes reference the 1987 gastroplasty, but indicate that the Roux-en-Y procedure would be revision surgery and not bariatric, as Kenseth did not need weight loss surgery.

Kenseth's group health insurer was the Dean Health Plan ("Dean"). The 2005 Dean Health Plan Certificate excluded surgical treatment for morbid obesity as a non-covered service. In addition, "services and/or supplies related to a non-covered benefit or service" were listed under "General Exclusions and Limitations." According to the Certificate, Dean was the claims administrator with "the [final and binding] discretionary authority to determine eligibility for benefits."

Kenseth's surgery was scheduled for December 6, 2005. The surgery instruction form directed patients to "check on" prior authorization, pre-certification requirements and insurance coverage and to inform their insurance company of "the date and type of surgery" scheduled.

Kenseth called Dean's customer service number on November 9, 2005. She informed the representative that she was scheduled

2. See *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452, 456 (2010) (*Kenseth I*) (detailing Kenseth's surgery).

for a Roux-en-Y esophageal reconstruction procedure to address severe acid reflux. She did not mention the 1987 gastroplasty. The customer service representative told her the procedure would be covered with a \$300 co-pay. Kenseth relied on this advice and proceeded with surgery on December 6, 2005.

By written notice dated December 8, 2005, Dean denied coverage for the surgery and all services “related to” the gastroplasty, a non-covered benefit. Coincidentally perhaps, the general exclusions section in Dean’s 2006 certificate was revised to read, “Services and supplies for, or in connection with, a non-covered procedure or service, *including complications . . .*” In the meantime, Kenseth suffered complications from the Roux-en-Y surgery, and was readmitted to the hospital for two weeks in January 2006. The final cost of the surgery and two hospitalizations was \$77,974. Kenseth exhausted her internal review rights and then filed suit under ERISA section 1132(a)(3).³⁴

As the court saw it, Kenseth alleged that Dean breached its fiduciary duty to her because 1) the Certificate was unclear regarding coverage of her 2005 surgery and misleading as to the process she should follow to determine coverage, and 2) Dean failed to provide her with a procedure by which she could obtain an authoritative preapproval of her surgery.⁵ Kenseth also argued that Dean was collaterally estopped from denying coverage under these circumstances because Dean’s representative advised her that the procedure would be covered and she relied on that advice.⁶

3. Kenseth also sued under Wis. Stat. § 632.746(1)(b), which limits pre-existing condition exclusions to 12 months. *Id.* at 463-64. The court upheld summary judgment for Dean on this claim. *Id.*

4. Under section 1132(a)(3), a civil action may be brought:

By a participant, beneficiary, or fiduciary, (A) to enjoin any act or practice which violates ... the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to address such violations or (ii) to enforce any provisions of ... the terms of the plan.

29 U.S.C. § 1132(a)(3).

5. *Kenseth I* at 461.

6. The district court dismissed Kenseth’s collateral estoppel claim for two reasons. *See id.* at 462 (detailing the district court’s decision). In light of Kenseth’s failure to disclose that the surgery was intended to remediate a complication from her gastroplasty, Dean’s advice was arguably accurate. In addition, Dean’s oral representations could not amend coverage terms, like the general exclusion for weight loss surgery and related services that were unambiguously set out in the certificate. The Seventh Circuit upheld summary judgment on this claim as well. *See id.* at 463 (holding that “given that Dean did not know a fact that was highly material to coverage under its policy, we do not think that it can be equitably estopped on the basis of an oral representation that its agent made on the basis of limited and incomplete facts”).

A. District Court

The federal district court for the Western District of Wisconsin granted summary judgment to Dean on each claim. The court did not find a duty for group health plans to provide an authoritative pre-approval process under section 1132(a)(3).⁷ As long as the certificate could reasonably be understood by the average person, the insurer-fiduciary is not obligated to explain it. Kenseth admitted that she did not read the certificate before proceeding with surgery. To the district court, the exclusion was clear (or clear enough) to put her on notice that the Roux-en-Y procedure would be excluded because it was related to a non-covered service.

B. Court of Appeals

On the breach of fiduciary duty claim, the appellate court held that a factfinder could conclude that Dean breached its duty of loyalty based on the following facts: 1) Dean provided Kenseth with “plan documentation that was unclear as to coverage for her surgery,” 2) Dean invited plan participants to call customer service to obtain coverage information but failed “to warn callers that they cannot rely on the answers they are given”, and 3) Dean failed “to inform participants how they might obtain answers from Dean they could rely on.”⁸

The court then evaluated the claim’s legal merits using the ERISA rubric. “A claim for breach of fiduciary duty under ERISA requires the plaintiff to prove: (1) that the defendant is a plan fiduciary; (2) that the defendant breached its fiduciary duty; and (3) that the breach resulted in harm to the plaintiff.”⁹ And, introducing the most complex element of its analysis, the court noted that section 1132(a)(3) limits a plan participant’s remedy to equitable relief if she is suing on her own instead of on behalf of the participant class.¹⁰

II. *KENSETH I*—A GROUP HEALTH PLAN’S FIDUCIARY BREACH

A. *Dean Health Plan’s Status as a Plan Fiduciary*

The customer service representative on whose advice Kenseth

7. *Kenseth v. Dean Health Plan, Inc.*, 568 F. Supp. 2d 1013, 1018 (W.D. Wis. 2008).

8. *Kenseth I* at 464.

9. *Id.* (citing *Kannapien v. Quaker Oats Co.*, 507 F.3d 629, 639 (7th Cir. 2007)).

10. *Id.* at 464.

relied was a ministerial employee with no discretionary authority over the plan terms. Dean was not, therefore, subject to a *respondeat superior* claim.¹¹ Dean was, however, a fiduciary in its own right as the claims administrator with discretionary authority to construe and apply the plan's terms and determine participants' entitlement to benefits.¹² The court squares up Dean's duty with that of a trustee at common law. This longstanding fiduciary/trustee identification enables the *Kenseth* court (and other courts that have ruled on these questions) to expand the equitable relief available to plaintiffs under section 1132(a)(3).

B. Breach of Fiduciary Duty

The court's analysis hones in on the trustee's duty to disclose material information.¹³ Breach of this duty can be one of commission—the duty not to mislead or misrepresent the plan terms—and one of omission—the affirmative obligation to disclose material facts when the participant requests information and “even when he or she does not.”¹⁴

The court relies on *Anweiler v. American Electric Power Service Corp.*,¹⁵ a crossover 1993 decision involving a life insurance policy, as precedent for the premise that an insurer has

11. This issue has been developed on a separate but parallel track to the evolving ERISA group health plan case law. The extent to which a plan fiduciary is responsible for communications made by its administrative employees is an open issue. Current decisions, including *Kenseth*, hold that plans will not be liable when the plan document is clear and an otherwise properly trained administrator makes an inadvertent mistake. However, a plan fiduciary can be liable for misrepresentation under ERISA when it fails to properly train the ministerial employees who are tasked with communicating and interpreting an unclear or ambiguous plan document to participants. *Kenseth I* at 470-71. This posture certainly raises the possibility of an extension of the “cat's paw” theory to fiduciary breach claims.

12. The court cites to section 1104(a)(1) for the controlling definition of the plan's fiduciary duties:

Dean is obliged to carry out its duties with respect to the plan “solely in the interest of the participants and beneficiaries and – (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; . . . [and] (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 and with like aims. . . .”

Kenseth I at 465 (quoting 29 U.S.C. § 1104(a)(1)).

13. The court relies on the Restatement of Trusts by noting that the trustee “is under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person.” *Id.* at 466 (quoting RESTATEMENT (SECOND) OF TRUSTS § 173 cmt. d (1959)).

14. *Id.* at 466 (quoting *Anweiler v. American Electric Power Service Corporation*, 3 F.3d 986, 991 (7th Cir. 1993)).

15. 3 F.3d 986.

a trustee's obligation to fully inform plan beneficiaries of all material facts. The plaintiff in the *Anweiler* case was a widow whose husband unwittingly agreed to make the insurer a beneficiary of his life insurance policy.¹⁶ Because Aetna, the insurer and putative beneficiary, did not inform Mr. Anweiler that this choice was optional, the court held that Aetna breached its fiduciary duty to the insured.¹⁷

In the Seventh Circuit, breach of a group health plan's duty to provide material information had already been recognized in the group health plan context in *Bowerman v. Wal-Mart Stores, Inc.*¹⁸ An employee who declined COBRA coverage during a one month leave from work found herself without group health insurance coverage for her pregnancy after she returned to work.¹⁹ The *Bowerman* court found that the plan documents were unclear about the break in service rules.²⁰ In addition, an administrative assistant in the benefits department told the employee that her coverage would be resumed when she returned to work.²¹ The court deemed Wal-Mart's actions to be a breach of its duty to disclose material information.²²

The *Kenseth* decision sets out some limits. First, the court declines to create a fiduciary obligation to provide a binding coverage opinion on every preauthorization request.²³ Second, there is a line, the court holds, between the duty to disclose material facts and fiduciary liability for negligent misrepresentation, particularly for comments made by ministerial employees. Examination of the trustee's state of mind to determine a degree of scienter is not consistent with trust law. In addition, since no plan document can address every fact permutation, communication errors will be made. Strict liability is not appropriate when the fiduciary's duty requires the exercise of reasonable care.²⁴

Instead, fiduciaries are bound by section 1104(a)(1)(b) to take

16. *Id.* at 988.

17. *Id.* at 991.

18. 226 F.3d 574, 590-91 (7th Cir. 2000).

19. *Id.* at 580.

20. *Id.* at 589.

21. *Id.* at 580.

22. *Id.* at 591.

23. *Kenseth I* at 472 (recognizing, however, that two courts have concluded that a health insurer has a good faith duty to advise the insured in advance of treatment whether the treatment is medically necessary and, as such, covered by the plan); cf. *State Farm Mutual Auto Insurance Co. v. Gueimunde*, 823 So. 2d 141, 144 (Fla. Dist. Ct. App. 2002) (noting that the insurer "does not have the obligation to preauthorize surgery in a situation in which the injury is within the coverage of the medical payments portion of the insurance policy"); *Eggiman v. Mid-Century Ins. Co.*, 134 Ore. App. 377, 847 P.2d 333, 335-37 (Or. Ct. App. 1995) (noting the good faith duty of insurer to advise insured of coverage in advance).

24. *Kenseth I* at 470.

reasonable steps to ensure that the insured receives accurate and complete information about his or her insurance coverage. Here, the *Kenseth* court pauses to distinguish *Frahm v. Equitable Life Assurance Society of U.S.*²⁵ In *Frahm*, the court declined to create a cause of action for fiduciary negligence when a plan agent gives incorrect information to a participant as long as the plan documents are clear and the fiduciary has implemented reasonable safeguards to avoid error.²⁶ In *Kenseth*, the caveat becomes the rule. Although *Kenseth* relied to her detriment on ultimately erroneous advice from Dean's representative, Dean's breach was not in the advice given but in its incomplete certificate and its failure properly to train its representatives to respond correctly to participant questions.

The fiduciary duty, therefore, has two components in the group health insurance context. One, "[t]he most important way in which the fiduciary complies with its duty of care is to provide accurate and complete written explanations of the benefits available to plan participants and beneficiaries."²⁷ Two, because no plan document can answer every question, mistakes by plan agents will not end in breach if the agents are properly hired, trained and supervised. When plan documents are silent or ambiguous on recurring topics, properly trained personnel become that much more important. The plan, as fiduciary, has an affirmative duty to disclose all material information, whether requested or not.²⁸

Although Dean's certificate of coverage excluded charges relating to a non-covered service, the court finds this language ambiguous regarding treatment "related to" a procedure completed 18 years earlier.²⁹ Dean instructs participants to call its customer service line for both preauthorization and eligibility questions. But the certificate does not warn participants that preauthorization is not binding and they cannot rely on the customer service representatives' advice. And consistent with its discussion of the positive and negative aspects of the duty to provide all material information, the court builds on the failure to warn by holding that, if Dean chose not to construe its plan with finality, it was obliged to instruct participants on how they "might otherwise obtain a definitive decision, in advance of [their] surgery, as to

25. 137 F.3d 955, 958-60 (7th Cir. 1998).

26. See also, *Brooks v. Pactiv Corp.*, 729 F.3d 758 (7th Cir. 2013) (an employer who is also a benefits plan administrator wears two hats such that termination of employment is not a fiduciary act even though that decision can affect a participant's benefits eligibility).

27. *Kenseth I* at 471.

28. *Id.* at 466.

29. The court notes that the gastroplasty was covered by *Kenseth's* insurer at the time. In addition, in 2004, Dean covered an endoscopic procedure *Kenseth* had to relieve stenosis which was identified in the medical record as a complication of the gastroplasty. *Id.* at 475.

whether Dean would cover it.”³⁰ ³¹ In a word, Dean’s role as a fiduciary obligated it to act at all times in Kenseth’s best interest.

The court recognizes a duty of care for health plan fiduciaries that requires them to offer a binding, authoritative declaration of coverage either in writing or on request, regardless of the plan’s reservation of rights. This expansion is critical in the health plan setting. If a health plan participant can demonstrate that the plan breached its fiduciary duty of care to the individual participant and caused her harm by providing inadequate coverage advice, the participant may seek an appropriate equitable remedy.

C. Harm

The court briefly touches on facts supporting the claim that Kenseth was harmed by Dean’s fiduciary breach. Because she offered evidence that there were alternatives not taken, including finding other coverage and continuing with ameliorative treatment in lieu of Roux-en-Y surgery, the court concludes that a factfinder could find harm.

D. Remedy

At this point, the court turns to the key question of remedy. Does ERISA offer Kenseth a remedy? Without one, she has no claim.³² The court acknowledges that Dean’s breach will not support an award of equitable restitution because she did not, and could not, file a section 1132(a)(1)(b) denial of benefits claim.³³ Navigating in a perfect factual storm, the court remands the case to the district court to determine whether Kenseth’s requested

30. *Id.* at 481. Dean’s certificate, of course, contained a standard disclaimer:

No oral statement of any person shall modify or otherwise effect [sic] the benefits, limitations, exclusions, and conditions of this contract; convey or void any coverage; increase or reduce benefits described within this Policy; or be used in the prosecution or defense of a claim under this Plan.

The court dismissed this term as useful only to lawyers. *Id.* at 479.

31. In *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013) (*Kenseth II*), the court refines this holding, stating that, by inviting participants to call customer service with preauthorization and eligibility questions, Dean created its own obligation to either provide a definitive coverage determination or instruct participants on how to obtain one. *Id.* at 873. Furthermore, if the certificate had clearly excluded coverage for complications arising from a procedure 18 years prior, there would be no need for a subsequent coverage determination. *Id.*

32. There is no right without a remedy. “[T]he main strength and force of a law consists in the penalty annexed to it.” 1 William Blackstone, *Commentaries on the Laws of England* 57.

33. Dean’s reservation of discretion to construe the plan would necessitate an arbitrary and capricious review. *Kenseth I* at 483.

remedy of compensatory damages is legal in nature and, therefore, beyond the scope of section 1132(a)(3) equitable remedies.

The district court finds that ERISA does not authorize the monetary damages Kenseth requests and dismisses the case. In the meantime, the Supreme Court issues its decision in *Cigna Corp. v. Amara*.³⁴

III. *KENSETH II*—EQUITABLE THEORIES AND REMEDIES UNDER SECTION 1132(A)(3)

The *Amara* decision famously recognizes a money payment as traditional equitable relief.³⁵ Courts may award monetary compensation for a loss resulting from a trustee's breach of duty or even to prevent the trustee's unjust enrichment. The fact that a group health plan fiduciary is analogous to a trustee means that a compensatory award or surcharge, in addition to the traditional remedies of reformation, estoppel, mandamus, injunctions and restitution, is available to individual plan participants under section 1132(a)(3). The plaintiff must be able to show causation and actual harm but does not have to prove detrimental reliance.³⁶

A. *The Availability of Make-Whole Monetary Relief*

In *Kenseth II*, the court observes the now fast-tracked transposition from life insurance decisions to group health insurance.³⁷ Previously, courts found a right to money damages under section 1132(a)(3) for plan administrator error causing loss of retirement medical coverage³⁸ and premium overpayment when the insurer mistakenly accepts life insurance premiums after coverage termination and then denies benefits.³⁹

The same conclusions should apply to group health insurance. The *Kenseth* court makes the point when evaluating the harm caused by the plan's actions. The health insurance participant:

[takes] an irreversible course of action in reliance on the approval given [by the health plan's] customer service representative, a reliance that [the health plan] invite[s] with its directive in the Certificate for participants to call with questions regarding coverage. The surgery could not be undone, the cost un-incurred. [The participant can] not seek insurance retroactively or negotiate with other providers for services that had already been performed. [The health plan's] actions [have] the singular effect of making it

34. *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011). By now, Kenseth's claim has been under review for six years.

35. *Id.* at 1880.

36. *Id.* at 1881-82.

37. *Kenseth II* at ?

38. *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448 (5th Cir. 2013)

39. *McCrary v. Metropolitan Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012).

impossible to put [the participant] back in the literal position she would have been in if the breach had not occurred, and also rendered very difficult the proof of viable alternatives.⁴⁰

In cases that have come this far, the health decisions in question are serious. The court's decision in *Killian v. Concert Health Plan* five months after *Kenseth II* was issued illustrates the point.⁴¹ On April 7, 2006, Mrs. Killian's doctors told her she would be dead in five days unless they immediately removed a large brain tumor. Mr. Killian called the provider participation number on the front of the insurance card to notify Concert Health Plan about the surgery. The representative could not find any information in Concert's system regarding the hospital where the procedure was scheduled. She told Mr. Killian to "go ahead with whatever needed to be done."

Mr. Killian called the Concert customer service line a second time the same day to confirm the details of the procedure including the name of the hospital. The representative said, "Okay." She did not inform Mr. Killian that the hospital was out of network or that there would be limits to his coverage.⁴²

When the claim was denied, Mr. Killian filed suit under section 1132(a)(3) requesting equitable relief for breach of fiduciary duty. The court *en banc* reversed the panel's decision to dismiss the claim. Relying on its *Kenseth* precedent, the court found that Concert Health was a statutory trustee under section 1104(a)(1)(b) with duties analogous to a trustee's common law duties of loyalty and care.⁴³

As the Killians had never received a summary plan description that included a current list of the provider network, the plan documents were not clear and complete. The Killians had to rely on the oral representations provided by the plan's customer service department to fill in the gaps. Concert then became responsible for its representatives' mistakes. Quoting *Kenseth*, the *Killian* court highlights the obligation—this is "*especially true* when the fiduciary has not taken appropriate steps to make sure that ministerial employees will provide the insured with complete and accurate information that is missing from the plan documents themselves."⁴⁴

B. Equitable Restitution—Unringing the Bell

Post-*Amara*, equitable restitution for health care claims takes on a new face in the Affordable Care Act era. The field of health care economics, once the provenance of a small group of insurance

40. *Kenseth II* at 885.

41. *Killian v. Concert Health Plan*, 742 F.3d 651 (7th Cir. 2013).

42. Mrs. Killian died shortly afterward from complications of her illness. *Id.* at 656.

43. *Killian I* at 34.

44. *Id.* at 51–52 (quoting *Kenseth I* at 472 (emphasis in original)).

specialists and Medicare analysts, is now under scrutiny as courts parse the meaning of equitable restitution for section 1132(a)(3) claims.

As *Amara* makes clear, a section 1132(a)(3) plaintiff can recover a fiduciary surcharge if she can show actual harm and causation.⁴⁵ Actual harm may result from detrimental reliance but may “also come from the loss of a right protected by ERISA or its trust-law antecedents.”⁴⁶ This would include compensation for the loss resulting from the trustee’s breach as well as compensation to prevent the trustee’s unjust enrichment.⁴⁷

Unlike a pension plan reformation; however, a health care plan’s fiduciary breach makes it impossible to return the parties to the positions they held before the breach and difficult to conceive of equivalent alternatives. The parties have most often made an irreversible choice in reliance on their understanding of their health care benefit.

C. Surcharge—A History

The surcharge remedy case law for health plan fiduciary breaches is not without its detractors. Justice Scalia’s majority opinion in *Great-West Life & Annuity Insurance Co. v. Knudson*⁴⁸ sought to maintain the boundaries between legal and equitable remedies under section 1132(a)(3).⁴⁹ Great-West was attempting to subrogate itself as beneficiary under a court-approved settlement for tort damages resulting from an auto accident.⁵⁰ The Court upheld the district court’s dismissal of Great-West’s claims.⁵¹

Justice Scalia begins by reiterating the adage that describes ERISA as a “comprehensive and reticulated statute.”⁵² He expands on this theme by limiting section 1132(a)(3) to express remedies.⁵³ Congress set out the remedies it intended to include in the statute.⁵⁴ Gaps in interpretation can be filled by reference to “standard current works.”⁵⁵ Even a remedy like restitution can be

45. *Amara*, 131 S. Ct. at 1881-82.

46. *Id.*

47. *Id.* at 1880-82 (describing the practice of courts of equity in granting monetary relief to compensate for losses “from a trustee’s breach of duty, or to prevent the trustee’s unjust enrichment” and including that among a plaintiff’s allowable recovery upon a showing of actual harm).

48. 534 U.S. 204 (2002).

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 209.

53. *Id.*

54. *Id.*

55. *Id.* at 217 (responding to the dissenting opinions of Ginsburg, J. and Stevens, J. by explaining that “the law-equity dichotomy” is not an outdated concept, those are the terms used in the statute, and questions regarding law and equity can easily be answered by consulting current legal texts).

legal or equitable.⁵⁶ Whether a particular request for restitution is authorized by section 1132(a)(3) “remains dependent on the nature of the relief sought.”⁵⁷ Equitable relief under section 1132(a)(3) is limited exclusively to relief that is not legal.⁵⁸

With a reference to Judge Posner’s opinion in *Wal-Mart Stores, Inc. v. Wells*,⁵⁹ Justice Scalia writes that lawsuits for money damages are legal in nature and may not be brought under section 1132(a)(3).⁶⁰ “[F]or restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant’s possession.”⁶¹

Justice Ginsburg’s dissent takes issue with the premise that what is not expressly stated in the statute is excluded under ERISA.⁶² She argues for a model that allows recovery through any means typical to equity.⁶³ From her perspective, Great-West was not suing to recover its loss. Great-West was suing as a subrogee to recoup the Knudson’s unjust gain.⁶⁴ If Congress can designate backpay as an equitable remedy under Title VII, why, the dissent wonders, would a similar make-whole compensatory award not be available under section 1132(a)(3)?⁶⁵ For Justice Scalia and Justice Ginsburg, “comprehensive and reticulated”⁶⁶ is either a limitation of or an invitation to interpretive breadth.

In 2004, Justice Ginsburg again called for greater ERISA clarity. In her concurring opinion in *Aetna Health Insurance v. Davila*,⁶⁷ she states:

The Court today holds that the claims respondents asserted under Texas law are totally preempted by § 502(a) of the Employee Retirement Security Act of 1974 (ERISA or Act), 29 U.S.C. 1132(a). That decision is consistent with our governing case law on ERISA’s

56. *Id.* at 212-14 (providing examples from legal articles and texts illustrating when restitution was considered a legal or equitable remedy).

57. *Id.* at 215 (referring to *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993), stating that it did not change the Court’s “well-settled principle” that restitution is only an equitable remedy or that “whether [restitution] is legal or equitable in a particular case (and hence whether it is authorized by § 502(a)(3)) remains dependent on the nature of the relief sought.”).

58. *Id.* at 218.

59. *Id.* at 210 (“A claim for money due and owing under a contract is ‘quintessentially an action at law’”) (quoting *Walmart-Mart Stores v. Wells*, 213 F.3d 398, 401 (7th Cir. 2000) (Posner, J.)).

60. *Id.*

61. *Id.* at 214.

62. *Id.* at 224 (Ginsburg, J., dissenting) (stating that Congress did not make a choice to limit available relief by relying on the word “equitable,” which is a concept “unrelated to the substance of the relief sought” and “obstruct[s] the general goals of ERISA.”).

63. *Id.* at 228.

64. *Id.* at 229.

65. *Id.* at 230.

66. *Id.* at 209.

67. 542 U.S. 200, 222 (2004).

preemptive scope. I therefore join the Court's opinion. But, with greater enthusiasm, as indicated by my dissent in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), I also join "the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime."⁶⁸

The opinion points out that, when interpreted to contain such narrow remedial limits, ERISA's "preemptive force" effectively eliminates most forms of relief for lost benefits.⁶⁹ "Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the 'equitable relief' allowable under § 502(a)(3), a 'regulatory vacuum' exists: '[V]irtually all state law remedies are preempted but very few federal substitutes are provided.'"⁷⁰

As *amicus curiae*, the Government suggested that section

68. *DeFelice v. AETNA U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J. concurring).

69. *Id.* at 222.

70. *Id.* at 456-57 (internal quotation marks omitted). Specifically, Justice Ginsburg observes:

A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief. First, in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985), the Court stated, in dicta: "[T]here is a stark absence-in [ERISA] itself and in its legislative history--of any reference to an intention to authorize the recovery of extracontractual damages" for consequential injuries. *Id.* at 148, 87 L. Ed. 2d 96, 105 S. Ct. 3085. Then, in *Mertens v. Hewitt Associates*, 508 U.S. 248, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (1993), the Court held that § 502(a)(3)'s term "equitable relief . . . refer[s] to those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* at 256, 124 L. Ed. 2d 161, 113 S. Ct. 2063 (emphasis in original). Most recently, in *Great-West*, the Court ruled that, as "§ 502(a)(3), by its terms, only allows for equitable relief," the provision excludes "the imposition of personal liability . . . for a contractual obligation to pay money." 534 U.S. at 221, 151 L. Ed. 2d 635, 122 S. Ct. 708 (emphasis in original).

As the array of lower court cases and opinions documents, *see, e.g., DiFelice*; *Cicio v. Does*, 321 F.3d 83 (CA2 2003), cert. pending sub nom, *Vytra Healthcare v. Cicio*, No. 03-69, fresh consideration of the availability of consequential damages under § 502(a)(3) is plainly in order. *See* 321 F.3d at 106, 107 (Calabresi, J., dissenting in part) ("gaping wound" caused by the breadth of preemption and limited remedies under ERISA, as interpreted by this Court, will not be healed until the Court "start[s] over" or Congress "wipe[s] the slate clean"); *DiFelice*, 346 F.3d at 467 ("The vital thing . . . is that either Congress or the Court act quickly, because the current situation is plainly untenable."); Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 Colum. L. Rev. 1317, 1365 (2003) (hereinafter Langbein) ("The Supreme Court needs to . . . realign ERISA remedy law with the trust remedial tradition that Congress intended [when it provided in § 502(a)(3) for] 'appropriate equitable relief.'").

Davila at 222-24.

1132(a)(3) would offer “some forms of make-whole remedies in equity “against a breaching fiduciary.”⁷¹ Justice Ginsburg encourages future plaintiffs to evaluate this approach. She writes, “[a]s the array of lower court cases and opinions documents, for example *DiFelice*; *Cicio v. Does*, 321 F.3d 83 (2nd Cir. 2003) (cert. pending *sub nom*) and *Vytra Healthcare v. Cicio*, fresh consideration of the availability of consequential damages under § 502(a)(3) is in order.”⁷²

D. Unjust Enrichment

Justice Ginsburg’s prescience is apparent in the Seventh Circuit’s *Kenseth II* decision. The *Kenseth II* opinion responds to *Amara* by holding that the plaintiff may bring a claim for make whole damages against Dean, the fiduciary, even though “the plan’s language *unambiguously* supports the fiduciary’s decision to deny coverage.”⁷³ The court can ignore the plan’s reservation of rights because it is reforming the plan document in equity to provide the compensatory relief now authorized, post-*Amara*, by the statute.⁷⁴

Following a line of reasoning developed by the Fifth Circuit in *Gearlds v. Entergy Servs., Inc.*,⁷⁵ and by the Fourth Circuit in *McCrary v. Metropolitan Life Ins. Co.*,⁷⁶ the *Kenseth II* court points out that make-whole damages are not limited to a return of premium or other strictly compensatory relief.⁷⁷ Judge Rovner observes that Dean “lulled Kenseth into believing that Dean would cover the cost of the procedure” by encouraging participants to call for coverage information, by telling her the procedure would be covered and by failing to inform her that she could not rely on that advice.⁷⁸ As the plan beneficiary, Kenseth could seek to surcharge Dean under section 1132(a)(3) to prevent unjust enrichment.⁷⁹

What does unjust enrichment look like in this new health plan context? Dean argued that Kenseth must produce evidence of a specific effective alternative not taken as the measure of damages.⁸⁰ The court rejects this argument.⁸¹ Instead, the court points to Kenseth’s lost opportunity to negotiate a lower price for her procedure with Dean or with another provider.⁸² In a footnote,

71. *Id.* at 223.

72. *Id.* at 222.

73. *Kenseth II* at 883.

74. *Id.*

75. 709 F.3d 448 (5th Cir. 2013).

76. 690 F.3d 176 (4th Cir. 2012).

77. *Kenseth II* at 883.

78. *Id.* at 882.

79. *Id.*

80. *Id.* at 884.

81. *Id.*

82. *Id.* at 884-85.

the court points to the district court's observation that, as with many healthcare systems across the country, Dean Health Systems (the hospital and medical providers) and Dean Health Plan (the insurer) share the same ownership.⁸³

If Dean Health Plan had approved the claim, Dean Health Systems would have collected the cost of the procedure, approximately \$35,000, from Dean Health Plan because Dean Health Plan would have the advantage of a lower negotiated rate with the health system.⁸⁴ Kenseth, without insurance, was billed \$77,000 for the procedure.⁸⁵ Her payment of the total billed amount, plus the full cost of her premium, would have unjustly enriched Dean Health Systems by more than 100 percent.

Further, and as is also common in the health care industry, the hospital where Kenseth had the surgery was owned by SSM Healthcare which owned five percent of Dean Health Systems and forty-seven percent of Dean Health Plan.⁸⁶ This ownership chain provided a cost recovery at the tail end of the transaction.⁸⁷

The potential for a conflict of interest in the fiduciary's chain of relationships and connections is well-established in ERISA case law.⁸⁸ Clearly, under the *Firestone* and *Metro Life* line of cases, a court could consider a health plan fiduciary's conflict of interest as a factor when weighing a section 1132(a)(3) fiduciary breach claim.

E. Other Theories—Plan as Contract

Judge Posner concurs with the outcome of the *Killian* decision but argues with its premise.⁸⁹ Just as an employer who is a plan administrator wears two hats, an insurer can also breach the plan as contract without a breach of trust.⁹⁰ Perhaps attempting to close Pandora's box, Judge Posner states that participant suits to recover benefits like Mr. Killian's should be brought under ERISA's section 1132(a)(1)(B) and analyzed under federal contract law where the participant can recover contract damages.⁹¹ Mr. Killian, for example, could sue for the cost difference between the

83. *Id.* at 882 n.4.

84. *Id.* at 884-85.

85. *Id.* at 885.

86. *Id.* at 871 nn. 1-2.

87. See *Rochow v. Life Insurance Company of North America*, 737 F.3d 415 (2013) (Exemplifying how the Sixth Circuit has gone so far as to order disgorgement of profits from a disability insurer who denied the plaintiff's claim for benefits after the plaintiff's expert found that the insurer earned a windfall of approximately \$2.8 million by retaining the plaintiff's disability benefits, using an annual return of between 11 percent and 39 percent).

88. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

89. *Killian* at 55 (Posner, J., concurring).

90. *Id.* at 57-59.

91. *Id.* at 60-62.

out of network fees he was charged and the in network fees he should have paid once Concert Health's representative "okayed" Mrs. Killian's surgery.⁹²

As he redirects the analysis of health insurance losses to contract law, Judge Posner asks two important questions: "How expansive is the fiduciary obligation to inform a plan participant of the differences in the plan's reimbursement for charges by alternative providers of medical treatment? What body of law supplies an answer to that question?"⁹³ The *Kenseth* decisions certainly do. Both the district and the appellate court intrepidly open the medical cost closet door. Both sets of decisions acknowledge the need for medical cost transparency, if for no other reason than to prevent a fiduciary from profiting when individuals have suffered serious economic consequences from the plan administrator's misapprehension of their health insurance coverage.

Looking back, again, to section 1132(a)(3) precedent, the seeds for equitable relief were planted early on. In a 1999 case, with that early common fact pattern, brought by an insurer wishing to subrogate itself as the recipient of the medical damages paid to a tort plaintiff, Judge Posner sanctioned the creation of a constructive trust on the insured's proceeds.

[W]hile the Ninth Circuit appears to believe that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust, *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997), it has given no reason for this belief and there is no basis for it either in ERISA or in the principles of equity. Granted that in times of yore the constructive trust was available only as a remedy against trustees and other fiduciaries, 1 *Dobbs*, *supra*, § 4.3(2), p. 597, there is nothing to suggest that ERISA's drafters wanted to embed their work in a time warp. In ordinary trust law the historical limitation of the remedy has been abandoned. *Id.* § 4.3(2), pp. 597-98, Austin Wakeman Scott & William Franklin Fratcher, *Scott on Trusts* § 462 (4th Ed. 1989). We do not think the motto of our law should be "let the dead bury the living." Alternative characterizations of Health Cost's claim (alternative to both restitution and constructive trust)—as seeking to impose an equitable lien on the escrow account or seeking a mandatory injunction directing Washington to sign over her claim to the money—are also permissible, moreover, and they reinforce our conclusion that Health Cost's claim is securely equitable and so within the jurisdiction conferred on the District Court by ERISA.⁹⁴

As participant-beneficiaries turn to the courts to enforce their rights under the Affordable Care Act, this expansionist view of

92. *Id.* at 62-66.

93. *Id.* at 62 (describing the Medicaid program).

94. *Health Cost Controls, Inc. v. Washington*, 187 F.3d 703, 711 (7th Cir. 1999).

ERISA's equitable remedies will surely shape the debate.⁹⁵

IV. CONCLUSION

We have just concluded an historic national debate on the affordable health care mandate. The Affordable Care Act creates the means by which health care will be delivered and paid for for anyone who is not already a government health plan participant. The details of this social program are being sorted out in real time through regulation and administrative guidance. The resulting rights and benefits will be judicially elucidated in the near future. Federal courts seem to agree that health plans, plan administrators, insurers, third party agents and even health systems must now step up to join pension, retirement, life insurance and other benefits trustees in protecting their beneficiaries. The remedies for failure to satisfy ERISA's high standards will be imposed in equity.⁹⁶

95. The Kenseth court's holding that the duty of loyalty includes an obligation to provide clear and accurate plan documents similarly expands on Judge Posner's impatience with the myriad documents Health Cost Controls aggregated to communicate its plan terms, none of which could be identified as the plan document. "This kind of confusion is all too common in ERISA land; often the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as 'the plan.'" *Id.* at 712.

96. The Act also contained a requirement that certain employers provide minimum coverage for their employees. 26 U.S.C. Sec. 4980H.