ERISA: Plan Participant Remedies for Breach of Fiduciary Duty

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In Kenseth v. Dean Health Plan, Inc., 610 F.3d 452, 49 EB Cases 1652 (7th Cir. 2010), an ERISA claims administrator (empowered with discretionary authority) for a fully insured ERISA health care benefits plan (membership in the Dean Health HMO) refused to pay $78,000 in medical expenses related to plan participant Deborah Kenseth’s surgery, even though the HMO plan admitted that it had pre-authorized her treatment. After exhausting her internal appeals, Ms. Kenseth sued Dean Health Plan in federal court. Ms. Kenseth asserted three claims in her complaint, for breach of fiduciary duty under ERISA § 502(a)(3), for equitable estoppel under ERISA common law, and a claim for violation of a state insurance law that provided a time limit on exclusions for pre-existing conditions. Conspicuous by its absence, the complaint did not include a § 502(a)(1)(B) claim to recover benefits due under the plan.

Many people would think that Ms. Kenseth presented a sympathetic case for recovery in her lawsuit against the HMO plan; however, the Seventh Circuit Court of Appeals suggested that Ms. Kenseth may have no remedy, even though the court found that she stated a credible claim against the HMO plan for breach of fiduciary duty. Implicit in this brief description of Kenseth is the further suggestion that Ms. Kenseth’s remedies for breach of the plan contract under ERISA § 502(a)(1)(B), or for equitable estoppel, or under state law for bad faith breach of an insurance contract were also prohibited or somehow limited under ERISA.

Kenseth is a remarkable case, but not because ERISA may deny a remedy to a seemingly worthy claimant. Rather, the case is remarkable because Kenseth provides a vehicle to explore the current state of ERISA remedies law. Recall that Congress hailed ERISA as a great consumer protection achievement when it enacted the statute in 1974. Kenseth presents an opportunity to try to reconcile Congress’s stated purpose in adopting ERISA—to promote the interests of employees and their beneficiaries in employee benefit plans and to protect contractually defined benefits—with Supreme Court precedent that often makes ERISA plan participants worse off under ERISA than they were prior to the statute’s enactment.

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2 See, e.g., Catherine L. Fisk, The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism, 33 HARVARD J. ON LEGIS. 35, 38 (1006)(“It is ironic that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws.”).
3 See Firestone Tire & Rubber Co v. Bruch, 489 U.S. 101, 113-14, 10 EB Cases 1873 (1989)(rejecting the plan sponsor’s argument that courts should apply a deferential standard of review in ERISA benefit cases because to do so would make plan participant’s worse off under ERISA then they had been prior to the law’s enactment, contrary to Congress’s purposes)(citing ERISA §2. Findings and declaration of policy, 29 U.S.C § 1001).
ERISA’s breach of fiduciary duty remedy under § 502(a)(3) limits a plan participant to the recovery of equitable relief—money damages (the classic example of legal relief) for breach of contract arguably are not available under § 502(a)(3). See Great-West Life & Annuity Ins. Co., v Knudsen, 534 U.S. 204, 27 EB Cases 1065 (2002). The Seventh Circuit suggested in Kenseth that the plaintiff may have chosen to bring a breach of fiduciary duty action under ERISA § 502(a)(3), rather than a claim to recover benefits due under the terms of her ERISA plan, because she wanted to avoid the court-invented deferential standard of review applicable when plan participants challenge a discretion-empowered plan administrator’s claim denial under ERISA § 502(a)(1)(B). See Kenseth, 610 F.3d at 476. However, by making the choice to pursue a breach of fiduciary duty claim under (a)(3), and not a breach of contract claim under (a)(1)(B), the plaintiff put herself at risk for winning the battle (prevailing on the breach of fiduciary duty claim), but losing the war (on remand, the trial court may classify her requests for injunctive relief as really just an attempt to obtain money damages, which is likely unavailable relief under (a)(3)).

There are many underlying issues lurking in Kenseth that must go unaddressed in this short manuscript; for our immediate purposes, we address first, the remedies that may be available to Ms. Kenseth under her breach of fiduciary duty claim filed pursuant to ERISA § 502(a)(3); second, whether Dean Health Plan’s breach of fiduciary duty could provide the basis of a claim to recover benefits due under ERISA § 502(a)(1)(B), while avoiding deferential review; and third, whether the same facts that establish Dean Health’s breach of fiduciary duty also amount to a violation of an insurer’s duty of good faith and fair dealing, which could then provide the “rule of decision” and dictate the result of an ERISA § 502(a)(1)(B) claim for benefits due under the rationale of UNUM Life Ins. Co. v. Ward, 526 U.S. 358, 377, 22 EB Cases 2745 (1999). We first detail the Kenseth facts and holding, and then discuss these three remedies issues.

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5 For example, Kenseth could be utilized to critique the legal foundation for applying a deferential review standard based upon dicta in Firestone, and to ask whether Congress really intended donative trust law principles to govern claims for breach of contract presented under ERISA § 502(a)(1)(B); or to ask whether negligence in the course of advising an ERISA plan participant should establish a per se breach of fiduciary duty under ERISA, given that a fiduciary owes a higher standard of care than a mere negligence standard under the fiduciary’s duty of loyalty to act “solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries, see Kenseth, 610 F.3d at 465-66 (citing ERISA § 404(a)(1)); or whether the implied preemption of state law remedies inferred from ERISA’s civil enforcement scheme should trump the express exception to preemption in ERISA § 514 for state laws, including state remedies law, that regulate insurance. See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 377, 27 EB 2921 Cases (2002)(“Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the ‘reservation of the business of insurance to the States,’ we have anticipated such a conflict, with the state insurance regulation losing out if it allows plan participants ‘to obtain remedies . . . that Congress rejected in ERISA.’”)(citations omitted).
The Facts:

In 1987, many years before she became a member of the Dean Health HMO Plan, Deborah Kenseth underwent a surgical procedure called vertical band gastroplasty (VGB), commonly known as stomach-stapling, to treat her morbid obesity. Eighteen years later, and now a member of the Dean Health HMO Plan (through her employment at Highsmith, Inc.), Ms. Kenseth’s physician recommended additional surgery—a Roux-en-Y gastric bypass—to treat her “gastric outlet obstruction.” The gastric outlet obstruction was a complication from the old VGB surgery, which was now causing Ms. Kenseth to suffer severe acid reflux, erosion of the esophagus, and other complications.

The subject Dean Health Plan contains an exclusion for “any surgical treatment or hospitalization for the treatment of morbid obesity” and for “services and/or supplies related to a non-covered benefit or service. . .”

Apparently unbeknownst to Ms. Kenseth, her primary care doctor at the Dean Health HMO was worried that the proposed treatment may not be covered under the Dean Health Plan because the proposed surgery “related to” her old VGB surgery. The Dean Health surgeon, however, thought the procedure would be covered because the purpose of the new surgery was to treat Ms. Kenseth’s acid reflux and esophageal problems, and not to treat obesity—Ms. Kenseth was no longer obese. In fact, the Dean Health Plan had paid for an unsuccessful endoscopic procedure to treat these complications from the old VGB surgery just a year before the surgery subject of this case, and the operative notes from that procedure clearly indicate that the procedure was an attempt to remedy symptoms that resulted from the old VGB surgery.

Ms. Kenseth visited the surgeon at his office on November 9, 2005 to finalize a plan of treatment. The surgeon’s office note for that visit recites as follows:

I told [Ms. Kenseth] that basically she has an expected problem after vertical banded gastroplasty that has been more apparent after many years have passed following this procedure. That problem specifically is stricture at the site of the Marlex band placed to regulate the size of the outlet of the “neo-stomach” created with the VGB. I told her that I certainly felt that this was amenable to revision and would simply require conversion to a roux-Y gastrojejunostomy. I further told her that I felt that this was a procedure which was widely done 20 years ago and was a covered benefit even by Dean Health Plan until very recently. To that end I believe that this would be considered revision surgery and not bariatric surgery as the patient does not need surgery for weight loss. She simply needs a procedure to correct the situation which will continue to create increasing complications for her. . .”

*Kenseth*, 610 F.3d at 458-59.
After Ms. Kenseth consented to the procedure at the November 9, 2005 office visit, surgery was scheduled at a Dean-affiliated hospital for December 9, 2005. During the office visit, the Dean Health surgeon gave Ms. Kenseth a form used widely at Dean facilities, which instructed her that:

[It is] the patient’s responsibility to check on coverage whether prior authorization or pre-certification is needed prior to surgery. It is also the patient’s responsibility to check on coverage. Please call your insurance company and let them know the date and type of surgery you are having. If they need further information you may give them your nurse’s phone number and they can call with questions.

Kenseth, 610 F.3d at 459 (emphasis in original)\(^6\)

The form also provided the phone number for the Dean Health Plan Customer Service Representative to call to obtain pre-authorization for the surgery. Importantly, neither this form nor any other written document advised plan participants that they could not rely on the Customer Service Representative’s authorization as a commitment or guarantee that the Dean Health Plan would actually pay for the pre-certified treatment. Further, the agent was not trained to so inform plan participants, and she admitted that she did not so inform Ms. Kenseth that Ms. Kenseth should not rely on this pre-certification as a commitment by the plan to pay for the pre-certified surgery.

Later in the day on November 9, 2005, Ms. Kenseth called the Customer Service Representative at the number provided and spoke with a Dean Health Plan agent to obtain pre-authorization for the recommended treatment. She told the agent that she was scheduled for “a reconstruction of a Roux-en-Y stenosis,” which was the language filled-in on the form by her surgeon. The agent asked Ms. Kenseth to explain the nature of the surgery and Kenseth replied that “it had to deal with the bottom of the esophagus because of all the acid reflux I was having.” There was no discussion of Ms. Kenseth’s prior VGB surgery. After putting Ms. Kenseth on hold for several minutes, the agent returned to the phone and advised Ms. Kenseth that the surgery would be covered, except for a $300 co-pay.

The Dean Health Plan empowered the plan administrator with discretionary authority. Following Ms. Kenseth’s surgery, the plan administrator refused to pay the $78,000 in medical expenses charged to Ms. Kenseth by the Dean Health HMO, even

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\(^6\) The patient testified that she did not look at the Dean Health Plan Certificate; instead she followed the instructions given to her by her Dean-affiliated surgeon and on the form given to her by the surgeon. The Certificate included the following language:

**Specific Benefit provisions:** If you are unsure if a service will be covered, please call the Customer Service department at 1-608-828-1301 or 1-800-279-1301 prior to having the service performed.

Kenseth, 610 F.3d at 458 (emphasis in original)

No other means of ascertaining coverage was identified in the Certificate or in any written document provided to Ms. Kenseth, except for the above-described Dean HMO form, and no other means of ascertaining coverage was delivered orally to Ms. Kenseth or to her treating physicians.
though the Dean Health Customer Service Representative recorded in the Dean Health computer records that she had pre-authorized Ms. Kenseth’s surgery.7

The Lawsuit:

Unhappy with Dean Health Plan’s refusal to pay the medical expenses related to the surgery that Dean Health had pre-authorized, Ms. Kenseth sued Dean Health Plan in federal court. Ms. Kenseth asserted three claims in her complaint: first, for breach of fiduciary duty under ERISA § 502(a)(3); second, for equitable estoppel under ERISA common law; and third, a claim for violation of a state insurance law that provided a time limit on exclusions for pre-existing conditions. Again, the complaint did not include a § 502(a)(1)(B) claim to recover benefits due under the plan.

The District Court granted summary judgment against Ms. Kenseth on all claims. The Seventh Circuit upheld the dismissal of the estoppel claim and the state law claim. The Circuit Court also found that while the facts supported a breach of fiduciary duty claim, that issue should be remanded back to the district judge to determine whether Ms. Kenseth was “seeking any form of equitable relief that is authorized by [ERISA § 502(a)(3)], 29 U.S.C. § 1132(a)(3).” Kenseth, 610 F.3d at 483.

In particular, the Seventh Circuit upheld the trial court’s dismissal of Ms. Kenseth’s estoppel claim because estoppel claims require that the plaintiff prove that the party to be estopped knew the relevant facts at the time such party made a misrepresentation to the plaintiff. The Seventh Circuit found that Dean Health Plan did not know at the time its Customer Service Representative told Ms. Kenseth that her surgery would be covered that the recommended surgery arguably related to a non-covered service. See Kenseth, 610 F.3d at 463. While the plaintiff may have sound arguments to disagree with this ruling, we will not address the estoppel claim in this discussion of Kenseth.8

The Seventh Circuit also upheld the dismissal of plaintiff’s claim based upon the state insurance law limitation on pre-existing condition exclusions. This holding was not based upon preemption and did not depend on any application of the saving clause; rather, the court upheld dismissal of the state law-based claim simply because the plan

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7 The plaintiff asserts that the approximately $78,000 billed to Ms. Kenseth is significantly more than the charges would have been if the treatment were covered due to the substantial discounts the Dean Health HMO Plan negotiated with its parent company, Dean Health, Inc. The plaintiff has argued on remand that equitable principles prohibit Dean from recovering an unjust windfall under these facts.

8 For example, the plaintiff might argue that her physicians, who certainly knew all the relevant facts, were employees or agents of Dean Health and that the principal should be charged with the knowledge of its agents. Further, later in the opinion the Seventh Circuit arguably ruled that a fiduciary has a duty to investigate and determine relevant facts before it makes statements to its beneficiaries that they may be expected to rely upon—here almost a full month passed between the time Ms. Kenseth called to obtain pre-authorization and the date of her surgery. Regarding the estoppel claim, the plaintiff would likely argue that if Dean Health had done even a cursory investigation—for example, just obtaining a copy of her doctor’s office notes by fax, Dean Health would have known the relevant facts and therefore, given the fiduciary’s duty to investigate, Ms. Kenseth’s estoppel claim arguably should have survived summary judgment.
exclusion was not properly characterized as a pre-existing condition exclusion—the policy excluded all services related to a non-covered procedure, not impacted by timing. The Seventh Circuit held that the state law did not prohibit an insurer from “establishing limitations or restrictions on the amount, level, extent, or nature of benefits or coverage for similarly situated individuals enrolled under the plan.” See Kenseth, 610 F.3d at 464.

The Seventh Circuit’s ruling on Ms. Kenseth’s breach of fiduciary duty claim is the most notable part of the opinion. First, the Seventh Circuit held that the plan’s exclusionary language was ambiguous. That holding is well supported by Kenseth’s facts. Recall that two of Ms. Kenseth’s treating physicians, who were each employed by or affiliated with Dean Health and who were both familiar with the subject Certificate language, each interpreted the exclusion differently as it applied to the surgery recommended for Ms. Kenseth. Further, crucial to the interpretation in this case was a determination that the proposed surgery did or did not “relate to” Ms. Kenseth’s previous VGB surgery to treat morbid obesity. As we all know, in New York Conf. of Blue Cross & Blue Shield Plans v. Traveler’s Ins. Co., 514 U.S. 645, 19 EB Cases 1137 (1995), the Supreme Court found that the “relate[s] to” phrase in ERISA’s preemption clause was inherently ambiguous because, while the phrase was intended to provide some limitations on the reach of ERISA preemption, “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere.” Id. at 655 (internal quotations omitted); see also, California Div. of Labor Standards Enforcement v. Dillingham Constr. Co., 519 U.S. 316, 335, 20 EB Cases 2425 (1997)(Scalia, J., concurring)(“[A]pplying the ‘relate to’ provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.”).

Second, the Seventh Circuit held that an ERISA fiduciary “has an obligation to convey complete and accurate information material to the beneficiary’s circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire.” Kenseth, 610 F.3d at 466 (internal quotations omitted). The court also remarked that the ERISA fiduciary duty recognizes the disparity in training and knowledge existing between a lay worker and the trained fiduciary. Id. The Seventh Circuit found that Dean Health breached its fiduciary duty owed to Ms. Kenseth because of Dean’s failure, both in writing the Certificate and in training its customer service agents, to ensure that plan participants received complete and accurate information. Specifically, Dean Health breached its fiduciary duty owed to Ms. Kenseth by failing to take reasonable steps to ensure that plan participants like Ms. Kenseth understood that they could not rely upon the coverage advice of Dean Health’s customer service agents, and by failing to ensure that plan participants knew where and how they could obtain

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9 Here the plaintiff was apparently seeking relief under state law, and not under ERISA § 502(a)(1)(B). If the issue in Kenseth did involve a pre-existing condition exclusion that was contrary to state insurance law, perhaps the plaintiff’s best remedy would have been to pursue the claim for benefits due under ERISA § 502(a)(1)(B) and at the same time assert that the state insurance law prohibiting the pre-existing condition exclusion was saved from ERISA preemption and therefore should be read into the terms of the plan/policy under state insurance law. As such, the state insurance law would then provide the “rule of decision” and control the outcome of the § 502(a)(1)(B) claim, as in UNUM v. Ward. See discussion in sub-section III, infra.
coverage advice that they could rely upon. See id. at 472. The Plaintiff may assert that the Kenseth Court also held that ERISA fiduciaries owe a duty to their beneficiaries to investigate and to obtain available information before they provide misinformation to plan participants. See id. at 469-473 (the ERISA fiduciary must take reasonable steps in furtherance of an insured’s right to accurate and complete information).

Discussion of ERISA Remedies

I. Breach of Fiduciary Duty under ERISA § 502(a)(3):

In analyzing the breach of fiduciary claim, the Seventh Circuit seemed to take a step back from the holding in the Seventh Circuit’s decision in the Frahm v. Equitable Life Assur. Soc. Of U.S. 137 F.3d 955 (7th Cir. 1998) line of cases which hold that negligence in the course of advising a participant regarding their rights and obligations under a plan is not actionable as a breach of fiduciary duty.


In the Frahm case, a group of retirees who received copayments from their employer, Equitable, for payment of medical care plan premiums filed suit under ERISA when Equitable made changes in premium payments. The Plan document and the summary plan description both reserved the right to change the plan terms or end the plan altogether at any time. Plaintiffs had received oral statements that stressed the availability of lifetime benefits and omitted the qualifier that the rule was not cast in stone. Plaintiffs’ argued that those statements violated Equitable’s duty as a fiduciary because under Section 1104(a)(1), Plaintiffs were entitled to accurate information about their benefits at all times and any error in communicating plan terms violated the statutory duty and entitled them to the benefits promised orally, rather than those in the plan documents. The Seventh Circuit disagreed. The Seventh Circuit first analyzed Section 1104(a)(1) and held that the duty of care in Section 1104(a)(1)(B) was satisfied by a plan administrator who takes precautions “such as training the benefits staff and providing accurate written explanations – even if the precautions sometimes prove to be insufficient.” The Court further held that by treating Section 1104(a) as establishing a duty to give participants whatever benefits someone on the staff promised them orally would be to undermine the essential principle of ERISA that there are no variances from written plans. See Central States Pension Fund v. Gerber truck Service, Inc., 870 F.2d 1148 (7th Cir. 1989) (en banc); Central States Pension Fund v. Joe McClelland, Inc., 23 F.3d 1256, 1257-58 (7th Cir. 1994). The court noted that mistakes in any organization are inevitable and sometimes participants will be given inaccurate advice by plan representatives. Thus, the Court found that notwithstanding the fiduciary’s duty to

10 Id at 956.
11 Id at 959.
12 Id at 958-959.
13 Id. at 960.
14 Id. at 959-960
provide complete and accurate information to the insured, mistakes in advice which were attributable to the negligence of the individual supplying that advice, were not actionable as a breach of fiduciary duty.15

2. The Seventh Circuit refused to apply Frahm to the Kenseth case.

In holding that Frahm did not apply in the instant case, the Seventh Circuit analyzed the duty to disclose material information and held that based on prior precedent in Antweiler v. Am. Elec. Power Serv. Corp., 3 F.3d 986, 991 (7th Cir. 1993), fiduciaries must not only refrain from misleading plan participants but "must also communicate material facts affecting the interests of beneficiaries," whether the beneficiary asks for the information or not.16 The Court determined that the affirmative duty to disclose came into play because Dean encouraged participants to call its customer service line with questions regarding coverage and therefore, a participant could infer that Dean understood that those callers were seeking to determine in advance whether upcoming medical treatments could be paid for. The key to the Seventh Circuit was that callers were not warned that they could not rely on the advice given from the customer service line and that Dean might deny coverage, and they were not advised of any process where they could receive a binding determination of whether their treatments would be covered. The Court found that on this basis the fact finder could conclude that Dean had a duty to make these disclosures so participants could make appropriate decisions about their treatment.17

The Seventh Circuit then addressed the tension between the facts in Kenseth which require the fiduciary to disclose material facts and the circumstances to the insured, and the Frahm v. Equitable Life Assur. Soc. Of U.S. 137 F.3d 955, 958-60 (7th Cir. 1998) line of cases that hold that negligence in the course of advising a participant regarding their rights and obligations under a plan is not actionable as a breach of fiduciary duty. In Kenseth, the Court distinguished Frahm and its progeny, holding that those cases only absolve a fiduciary of liability for negligent misrepresentations made by an agent of the plan if the plan documents themselves are clear and the fiduciary has taken reasonable steps to avoid such errors.18 The Seventh Circuit held that the Frahm Court recognized that the duty of care also entailed a duty to take reasonable steps in furtherance of a participants’ right to complete and accurate information and that other decisions both before and after Frahm have recognized that the failure to take such actions can render a fiduciary liable. "Although negligent misrepresentations are not themselves actionable, the failure to take reasonable steps to head off such misrepresentations can be actionable" and the most important way the fiduciary complies with the duty of care is with accurate and complete written explanations of the benefits available.19 Therefore, the Kenseth Court concluded, Frahm held that only when the plan

15 Id. at 960
16 Kenseth, 610 F.3d at 468, citing to Antweiler 3 F.3d at 991 (citations omitted); Eddy v. Colonial Life Ins. Co. of Am. 919 F.2d 747, 750 (D.C. Cir. 1990).
17 Kenseth 610 F.3d at 469-481.
18 Id at 469-472.
19 Kenseth, at 471
documents are clear and the fiduciary exercised appropriate oversight over what its agents advise plan participants and beneficiaries as to their rights under the those documents, will the fiduciary not be held liable simply because a ministerial, non-fiduciary agent has given incomplete or mistaken advice to an insured.\(^{20}\)

In contrast, unlike the claims in *Frahm*, Kenseth's claims were based on both the ambiguity of the plan documents and on Dean's lack of care in training the customer service representatives. Dean failed both in writing the Certificate and in training the customer service representatives to ensure that the participants received accurate and complete information. Since the Court found that the documents were not clear and the fiduciary did not exercise appropriate oversight over what its agents advised plan participants as to their rights under the Certificate, the Seventh Circuit held that *Frahm* did not apply.\(^{21}\)

In analyzing the evidence submitted on the record before the Court, it concluded that a fact finder could determine that Dean had a duty to advise callers to its customer service line that they were not entitled to rely on any advice received, and inform callers how to obtain a binding determination of coverage. Dean could have avoided that liability by providing plan beneficiaries with a clear and unambiguous statement of benefits. Although the Court concluded that Dean's statement of benefits was clear that a procedure like the VBG was not covered, it concluded that the "related to" exclusion was not clear. In addition to the fact that the language itself was not clear, the Court also referred to the fact that Dean had already paid for a procedure to address a complication of the original surgery.\(^{22}\) Furthermore, the Court had no difficulty in finding an injury caused by Dean's breach of its fiduciary duty as Kenseth had already undergone the surgery, but had she known it would not be covered, she might be able to show that she could have pursued other treatment or could have undergone the same surgery elsewhere for less money or postponed the surgery until she had enough to pay for the procedure.\(^{23}\)

\(b. \) **Remedies available under ERISA § 502(a)(3) for Kenseth.**

There is a real question as to whether Kenseth has any remedy under ERISA § 502(a)(3) for Dean’s alleged breach of fiduciary duty. According to the Seventh Circuit, and Kenseth herself in her Second Amended Complaint, Kenseth’s suit is filed under § 502(a)(3), ERISA’s catch-all provision.\(^{24}\) Section 502(a)(3) specifically authorizes a civil suit by a plan participant or beneficiary (and also a fiduciary) “(A) to enjoin any act or practice which violates any provision or this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan[.]”\(^{25}\) The Section also imposes a prohibition on the type of relief that is available. It allows only injunctive relief and

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\(^{20}\) *Id.* at 469-472.

\(^{21}\) *Id.*

\(^{22}\) *Id.* at 479-481.

\(^{23}\) *Id.* at 481.

\(^{24}\) *Id.* at 482.

\(^{25}\) *Id.*
“other appropriate equitable relief;” compensatory damages and other forms of legal relief are beyond the scope of the relief authorized. See **Mertens v. Hewitt Assocs.**, 508 U.S. 248 (1993).

While the type of relief that Kenseth was seeking in her initial Complaint was somewhat vague, in her Second Amended Complaint she specifies what relief she is seeking and alleges that all of her relief is equitable and appropriate. Among those types of relief, she seeks an order requiring Dean to pay Kenseth’s care providers as if the treatment she received had been covered and requests an order requiring Dean to make whole all entities to whom Kenseth owes a debt for the treatment. See Second Amended Complaint, Case No. 08-C-1-C, Western District of Wisconsin. Based on Kenseth’s requests for relief, it is clear she is really trying to couch a claim for a denial of benefits which is properly brought under § 502(a)(1)(B), as a claim under § 502(a)(3) for other appropriate equitable relief. Kenseth is not really seeking injunctive or other equitable relief, what she is really trying to do is recover benefits she feels are due to her under the plan.

In remanding the case to the district court, the Seventh Circuit specifically explained that a denial of benefits claim may only be pursued under ERISA § 502(a)(1)(B).26 Furthermore, the Seventh Circuit’s opinion was clear that Kenseth may not obtain denial of benefits recovery under the guise of a claim for breach of fiduciary duty.27 Thus, a breach of fiduciary duty claim is not an alternative avenue to seek recovery for the denial of benefits claim that she elected to forego. See **Varity Corp. v. Howe**, 516 U.S. 489, 515 (1996). A majority of the circuits are of the view that if relief is available to a plan participant under subsection (a)(1)(B), then that relief is not available under subsection (a)(3). See **Mondry v. American Family Mut. Ins. Co.**, 557 F.3d 781, 805 (7th Cir. 2009).28

Thus, it remains to be seen whether Kenseth has any remedy at all for Dean’s alleged fiduciary breach to the extent she is asking for the Dean Health Plan to pay for her treatment. All of the briefing has been completed in the district court case with the DOL weighing in by **Amicus** and supporting Kenseth’s request for relief under § 502(a)(3).

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26 **Kenseth**, 610 F.3d at 482.
27 **Id.**
28 See, also, **Antolik v. Saks, Inc.**, 463 F.3d 796, 803 (8th Cir.2006); **Ogden v. Blue Bell Creameries U.S.A., Inc.**, 348 F.3d 1284, 1287-88 (11th Cir.2003); **Tolson v. Avondale Indus., Inc.**, 141 F.3d 604, 610-11 (5th Cir.1998); **Wilkins v. Baptist Healthcare Sys., Inc.**, 150 F.3d 609, 615-16 (6th Cir.1998); **Forsyth v. Humana, Inc.**, 114 F.3d 1467, 1474-75 (9th Cir.1997); **Wald v. Sw. Bell Corp. Customcare Medical Plan**, 83 F.3d 1002, 1006 (8th Cir.1996). All of these cases hold that a claimant whose injury creates a cause of action under § 1132(a)(1)(B) may not proceed with a claim under § 1132(a)(3).
II. Remedies Available under ERISA § 502(a)(1)(B) for Breach of Fiduciary Duty:

1. “But for” benefits answer to ERISA remedies conundrum.

ERISA practitioners take an unreasonably dim view of ERISA remedies. For years, plaintiffs’ lawyers and lawyers at the Department of Labor have banged their heads against the wall trying to expand the scope of “appropriate equitable relief” under ERISA § 502(a)(3). But it is going nowhere. Initial hopes raised by the Supreme Court in Varity Corp. v. Howe, 516 U.S. 489, 19 EB Cases 2761 (1996), that ERISA § 502(a)(3) would become a true “catchall” providing flexible relief for statutory breaches have been dashed to bits. But there is no need for despair. Another approach can be taken that has support in the text and the case law. That approach is for courts to turn to ERISA § 502 (a)(1)(B) and grant the benefits that would be due under the plan terms “but for” the statutory breach. Where the statutory breach is the inclusion of an illegal term, the benefits are those that would have been paid but for the illegal term. Where there is a breach of the statutory fiduciary duty, the remedy is to grant the benefits that would be due under the terms of the plan “but for” the breach. Despite defying conventional assumptions about what § 502(a)(1)(B) is about, this approach more neatly fits the statutory text and has considerable grounding in case law. Practitioners should also not worry unduly about courts deferring to plan administrators under the statute. Courts should defer to no one when deciding if a statute has been violated.

2. The text supports a broad reading.

ERISA § 502(a)(1)(B) allows suits "by a participant or beneficiary…to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” The common feature of the section is that each of the three subparts limits relief to relief “under the terms of the plan.” These words together with the reference to “benefits due” are clearly limiting words. They do not authorize suits for damages; they authorize suits to collect benefits and suits to clarify the right to benefits. But Congress did not further limit the words “the terms of the plan” to include the further assumption that the “terms of the plan” are “the terms of the plan as written by the plan sponsor” as opposed to those terms that comply with ERISA. Congress also did nothing to preclude courts from ordering payment of the benefits that would be due under the plan terms if plan fiduciaries had complied with ERISA.

This means that the statute can logically be read to require payment of the benefits due assuming compliance with the law. Indeed, to assume otherwise, would be to assume that plan fiduciaries could administer benefit plans inconsistently with ERISA. But ERISA § 404 plainly prohibits that by requiring plan fiduciaries to administer ERISA plans “in accordance with the documents and instruments governing the plan” but only “insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.” The existence of this language assumes that there will be instances where administering plans will be inconsistent with ERISA.
where the plan should then be administered to comply with the law, rather than the plan terms as written.

It is no stretch then to say that ERISA § 502(a)(1)(B) permits the recovery of the benefits that would have been paid “but for” a violation of the law.


Many ERISA practitioners assume that this interpretation flies in the face of a considerable body of respected precedent that presumably holds that ERISA § 502(a)(1)(B) permits recovery only under the plan terms as written and never permits recovery for breaches of fiduciary duty, which must be brought under ERISA § 502(a)(3). But that isn’t so either.

The assumptions probably came from perfectly reasonable readings of Varity Corp. v. Howe. In Varity the Supreme Court recognized that individuals harmed by breaches of the statutory fiduciary duty, could receive individual equitable relief under ERISA § 502(a)(3). The Court said that § 502(a)(3) operates as a catchall for cases like Varity where a breach of fiduciary duty deprived employees of welfare benefits and the six-member majority opinion written by Justice Breyer assumed that the employees could not proceed under ERISA § 502(a)(1)(B) because they had received everything due to them under the terms of the plan.29 But while the Court assumed the section did not apply, the plaintiffs in the case had not made a claim under that section and certainly not a “but for” claim under § 502(a)(1)(B). In any case, this dicta combined with the “catchall” characterization of § 502(a)(3) set off a wave of claims that § 502(a)(3) provided relief for all and sundry.

These hopes were short lived. In Great West v. Knudson, 534 U.S. 204, 27 EB Cases 1065 (2002), a new majority of the Court speaking through Justice Scalia, slammed the door on broad views of “appropriate equitable relief,” reducing the section to permitting the recovery of money only where the money was part of a res originally in the hands of the claimant and now wrongfully in the hands of the defendant.30 Lower court doors across the country began closing under orders typified by decisions like the Fifth Circuit’s 2007 ruling denying a recovery of insurance benefits for a breach of fiduciary duty in Amschwand v. Spherion Corp.31 As the Amschwand Court held, Great West prohibits the recovery of anything but a typical equitable remedy in a traditional equitable cause of action.32

Beyond Varity, the case law supporting the conventional wisdom is surprisingly thin. The most direct authority appears to be an old Sixth Circuit decision from 1988 called Hughes v. General Motors.33 Hughes and other former employees claimed GM

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30 534 U.S. 204, 211 (2002).
31 505 F.3d 342 (5th Cir. 2007).
32 Id. at 346.
33 852 F.2 568 (6th Cir. 1988).
misled them into retiring shortly before the adoption of a voluntary severance package that would have promised them a richer retirement benefit. The Sixth Circuit said that Hughes and the others could not claim under § 502(a)(1)(B) because it was “undisputed that each of the plaintiffs is receiving all the benefits due him ‘under the terms of his plan.’” 34 It appears to be the only Court of Appeals decision to directly address the question of “but for” relief under § 502(a)(1)(B):

It is evident that the plaintiffs have no "rights" to present or future benefits "under the terms of the plan." The plaintiffs allege, rather, that they would have been entitled to special early retirement benefits under the terms of the plan but for the fact that the defendants maliciously, falsely, or recklessly led the plaintiffs to believe that the terms of the plan would not be changed, after the date of their proposed retirements, to make special retirement benefits available to participants who might still be on the payroll after that date. The words of 29 U.S.C. § 1132, as we read them, do not give the district court jurisdiction to decide claims of this type; the claims cannot fairly be said to be claims by a participant seeking to recover benefits or enforce or clarify rights "under the terms of the plan." 35

4. A solid and growing body of case law suggests support for “but for” relief under § 502(a)(1)(B).

By 1994, courts had suggested another way to view § 502(a)(1)(B) and when the cases are viewed together, they form a more cohesive argument for expanding the section than case law like Hughes forms against it. The suggestion first came in the equally troubling area of standing in reaction to cases like Hughes where, in addition to undercutting ERISA remedies, the Court also held that a party’s standing to sue could be defeated because the wrongdoing alleged prevented the plaintiff from becoming a “participant” with a right to sue. 36

The first decision to challenge this result was the First Circuit’s 1994 opinion in Vartanian v. Monsanto. 37 Vartanian claimed he was misled into a premature retirement shortly before an incentive program was announced that was being considered before he left. Monsanto claimed that Vartanian had no standing to sue because he never participated in the program and the statute only permitted participants and beneficiaries to sue. 38 The First Circuit held that Vartanian had a right to sue under § 502(a)(1)(B) because he alleged that “but for” Monsanto’s breach of fiduciary duty he would have been a participant in the program and would have had a claim for benefits under the terms of the plan. 39

34 Id.
35 Id. The Court in Jordan v. Federal Express Corp., 116 F.3d 1005 (3d Cir. 1997) appears to take a similar view but implies that some fiduciary breaches might be addressed under § 502(a)(1)(B).
36 852 F.2d 568 (6th Cir. 1988).
37 14 F.3d 697 (1st Cir. 1994).
38 Id. at 699-700.
39 Id. at 702.
In far more recent years, several courts have directly applied § 502(a)(1)(B) as a remedy for statutory violations. In 2003, in *Leyda v. AlliedSignal*, the Second Circuit upheld a district court ruling that ordered a plan fiduciary to pay a beneficiary the life insurance benefits she would have received but for her husband’s employer’s breach of its statutory duty to distribute a summary plan description showing a benefit cut. The Court refused to consider a challenge to the relief because its propriety had not even been questioned below. In 2006, in *Frommert v. Conkright*, the Second Circuit considered the appropriate remedy for an undisclosed account offset that reduced pension benefits. The Court held that § 502(a)(1)(B) provided the correct mechanism under which the plan terms could be enforced without the illegal offset—the benefits due were those that would have been due “but for” the illegal term.

In *Leister v. Dovetail, Inc.* in 2007 the Seventh Circuit considered the subsection in the context of a fiduciary breach arising from the mismanagement of a 401(k) pension plan. Judge Posner wrote the decision for the Court, holding that “section 1132 [502] (a)(1)(B) authorizes suit only for benefits. But the benefits to which Leister was entitled were the assets that would have been in her 401 (k) account had the defendants complied with their fiduciary duties.” In other words, in a statutory breach of fiduciary duty case § 502(a)(1)(B) authorizes a remedy equal to the benefits the plaintiff would have realized but for the breach.

Another kind of statutory duty was considered by the Sixth Circuit in 2007 in *West v. A.K. Steel Corp. Ret. Accumulation Pension Plan*. In that case, a cash balance plan had an illegal feature that violated an IRS requirement concerning the actuarial equivalence of lump sum and annuities. Rushing past its previous decision in *Hughes* without so much as a nod of recognition, the Court held that while § 502(a)(1)(B) provided redress only for the recovery of benefits due under the terms of the plan, “those terms must nevertheless comply with ERISA.” The Court thus effectively held that the benefits due under the terms of the plan were the benefits due but for the incorporation of an illegal term. The Supreme Court thought about taking the case. It considered a petition for certiorari with the assistance of the solicitor general, but ultimately denied cert.

Cert. denial may have made particular sense to the Supreme Court. After all, Chief Justice Roberts had just written the year before in a concurring opinion in *LaRue v. DeWolf Bobruff Assoc.* that the breach of fiduciary duty claim in that case arising from a negligent failure to follow a participant’s investment instructions fit best under §

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40 322 F.3d 199 (2d Cir. 2003).
41 *Id.* at 204.
42 433 F.3d 254 (2d Cir. 2006).
43 *Id.* at 270.
44 546 F.3d 875 (7th Cir. 2008).
45 *Id.* at 878.
46 484 F.3d 395 (6th Cir. 2007).
47 *Id.* at 400-01.
48 *Id.* at 405.
502(a)(1)(B) rather than the majority decision’s solution of allowing recovery “on behalf of the plan” under § 502(a)(2).\(^50\) Indeed, shortly after that, the Chief Justice had the satisfaction of writing the majority decision in 2010 in *Frommert v. Conkright* in which the unchallenged proceeding in that case under § 502(a)(1)(B) led to a remand on the issue of the plan administrator’s right to interpret the plan document a second time to avoid a violation.\(^51\)

Courts high and low have unquestionably been taking a well-deserved second look at § 502(a)(1)(B). Practitioners should take notice of it and affected government officials would best serve their constituencies by embracing and shaping it rather than persisting with hopes for § 502(a)(3).

5. Section 502(a)(1)(B) should continue to develop as a solution.

Accepted as a solution instead of the source of new problems, resort to § 502(a)(1)(B) for “but for” relief may be far more productive than years of disappointing results for claimants seeking relief under § 502(a)(3). Belief that use of this subsection will mean greater deference for plan administrators and more time exhausting administrative remedies should not be overblown. Deference and exhaustion were not even certainties under the *Frommert* facts. The Court considered in an important footnote whether deference is ever due if a statutory violation is at issue and concluded that the question went to the merits and could be decided on remand.\(^52\) So it is by no means established that the courts would take the illogical position that the judiciary should defer to the laity when it comes to the exclusive expertise of the courts in interpreting and applying the law. In any case, the risk that this may be so is outweighed by the potential gain of clarity on a question that has cost all parties time, expense, and frustration.

III. Remedies Available under ERISA § 502(a)(1)(B) for Breach of State Insurance Law Duties:

1. Introduction and Summary of Argument

In addition to pursuing an ERISA claim for benefits under § 502(a)(1)(B), and relying upon a fiduciary breach to form the “but for” predicate to support the benefit claim, plan participants under fully insured plans may want to assert the *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 22 EB Cases 2745 (1999), rationale to make the case that a plan insurer’s breach of its duty of good faith and fair dealing establishes the “rule of decision” to control a § 502(a)(1)(B) claim for benefits. State insurance law suggests that an insurer owes a good faith duty to its insureds to interpret ambiguous policy language in favor of coverage.\(^53\) While the Supreme Court has ruled that ERISA impliedly

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\(^{50}\) 552 U.S. 248, 257 (2008).

\(^{51}\) 130 S. Ct. 1640 (2010).

\(^{52}\) 130 S. Ct. 1640, 1652.

\(^{53}\) See, e.g., Wolf v. Prudential Ins. Co. of Am., 50 F.3d 793, 799-800 (10th Cir. 1995)(upholding ins. bad faith award where insurer construed ambiguous term in policy in its own favor and against coverage in HDC/ABMT breast cancer treatment case); Employees’ Benefit Ass’n. v. Grissett, 732 So.2d 968, 976-77 (Ala. 1998)(the insurer cannot use ambiguity in the ins. contract as a basis for claiming a debatable reason
preempts any state law remedy for extra-contractual damages, even remedies limited to claims against the insurance industry, arguably state insurance laws which merely dictate an insurer’s standards of behavior in claims administration are saved from ERISA preemption. To the extent that an ERISA plan insurer violates its duty of good faith and fair dealing owed to its insureds by interpreting ambiguous policy language in its own favor and against coverage, a plan participant should urge ERISA courts to find that the state insurance standard of good faith is saved from ERISA preemption. This state insurance law duty may then provide the rule of decision to characterize a plan administrator’s claim denial in such circumstances as a per se abuse of discretion in the participant’s ERISA § 502(a)(1)(B) claim for benefits.

This theory presents an indirect argument; however, given the difficulty of prevailing in an ERISA § 502(a)(1)(B) claim under a deferential review standard, plan participants in fully insured plans should not forget that ERISA expressly saves their state insurance law consumer protections from ERISA preemption. In UNUM v. Ward, the Supreme Court held that the state insurance law “notice-prejudice” rule was effectively written into the terms of the insured ERISA plan and prevented the plan insurer from enforcing contrary plan language to deny an ERISA § 502(a)(1)(B) claim. Similarly, plan participants under insured ERISA plans should argue that the state law duty of good faith and fair dealing requiring insurers to interpret ambiguous policy language in favor of coverage is effectively incorporated into the terms of the insured ERISA plan. As such, this plan language should control any court decision where it can be established, as in Kenseth, that the plan insurer denied coverage by interpreting ambiguous plan language against the plan participant.

2. Pilot Life

ERISA’s express preemption language contains a saving clause, which exempts state laws that regulate insurance from ERISA preemption. In Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987), a plan participant under a fully insured ERISA disability benefits plan sued the plan insurer under Mississippi state law for bad faith breach of the insurance contract based upon asserted irregularities in handling the claims process. The Supreme Court ruled that under Mississippi law, every contract, not just insurance contracts, were imbued with a duty of good faith and fair dealing. Consequently, the Court held that the Mississippi bad faith remedies law upon which Dedeaux pursued his claim was not a law that regulates insurance. Consequently, the remedies law was not saved from ERISA preemption. Unlike Mississippi, however, most states limit the remedy for bad faith breach of contract to breaches of an insurance contract.

not to pay a claim under Ala. insurance law, otherwise insurer would have incentive to write ambiguous policies in order to create an absolute defense to a bad-faith claim); Sanders v. Home Indemnity Co., 594 So.2d 1345, 1351 (La. App. 1992)(insurer that misinterprets insurance contract in its own favor and against coverage is liable for penalties and fees under Louisiana insurance law). See generally, Stephen S. Ashley, BAD FAITH ACTIONS (2d ed.) (including in app. I-VI, reprints of the National Association of Insurance Commissioner’s (NAIC) Model Unfair Insurance Practices Acts).
55 Bad faith insurance laws come in many sizes and shapes. Some states apply their insurance bad faith laws entirely through the common law. The majority of states have enacted some version of the Model
The *Pilot Life* Court then held that in addition to ERISA’s express preemption of state laws, the statute contains a civil enforcement provision that provides the foundation for even further, implied preemption of state law. The *Pilot Life* Court characterized ERISA’s civil enforcement scheme as “comprehensive.” See *Pilot Life*, 481 U.S. at 53-54. Based upon that characterization, the Court determined that Congress intended ERISA to provide the exclusive remedies available for plan participants in claims arising from their employee benefit plans. *Id.* 56

Following *Pilot Life* most lower courts ruled that ERISA impliedly preempts all state law bad faith claims, even under state remedies laws directed exclusively against the insurance industry. 57 While it is arguable that *Pilot Life* did not require such holdings, the Supreme Court has subsequently ruled that where a state provides a remedy available exclusively against an insurance company, implied preemption under ERISA’s civil enforcement scheme trumps ERISA’s express saving clause exception to preemption for state insurance laws. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 32 EB Cases 2569 (2004); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

3. **UNUM v. Ward**

In *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 22 EB Cases 2745 (1999), the Supreme Court distinguished *Pilot Life* and found that the saving clause protects state insurance law from preemption when the state law is asserted in an ERISA §

Unfair Claims Settlement Practices Act. Some states hold insurance companies to their duty of good faith and fair dealing through a combination of statutory standards and common law claims. Many states authorize individual insurance consumers to enforce bad faith standards through civil actions for extra-contractual damages, including punitive damages. Other states grant statutory treble damage remedies to insurance consumers. Some states only allow the state Commissioner of Insurance or the Attorney General to enforce the state’s insurance law standards established in statutory unfair insurance practices laws. See Model Unfair Claims Settlement Practices Act, National Association of Insurance Commissioners (as amended, 1985) (hereafter “Model Act”). See also, *Ashely, Bad Faith Actions*, supra note 53, at 9-5 through 9-6.

56 *But see*, Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for Southern Cal., 463 U.S. 1, 25 (1983) (“Section 502(a) specifies which persons—participants, beneficiaries, fiduciaries, or the Secretary of Labor—may bring actions for particular kinds of relief. . . . It does not purport to reach every question relating to plans covered by ERISA. Furthermore, § 514(b)(2)(A) of ERISA, 29 U.S.C § 1132(b)(2)(A) [the saving clause], makes clear that Congress did not intend to pre-empt entirely every state cause of action relating to such plans. With important, but express, limitations, it states that ‘nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.’”).

502(a)(1)(B) claim for benefits due under an ERISA plan, rather than in action pursuing a state law remedy.

Almost two years after he stopped working due to a disability, Mr. Ward discovered that he was covered under an employment-provided disability insurance policy issued by UNUM Life Insurance Company. Mr. Ward filed a claim with UNUM, however, the UNUM policy required plan participants to submit a proof of loss within 18 months of the onset of a claimed disability. Since Mr. Ward failed to meet the policy deadline, UNUM rejected the claim. California, where Mr. Ward lived and worked, however, applied a state common law insurance regulation, known as the “notice-prejudice” rule, which offered Mr. Ward relief. Under the notice-prejudice rule, in order for an insurer to enforce a policy-imposed notice deadline, it had to show that the delay in presenting a claim actually prejudiced its ability to defend the action. After UNUM refused to reconsider Mr. Ward’s disability claim, Mr. Ward sued UNUM under ERISA § 502(a)(1)(B) to recover benefits due from the plan, invoking the California notice-prejudice rule to overcome the policy deadline.

UNUM advanced two arguments in defense of Mr. Ward’s pleas: first, that Mr. Ward could not avoid the notice provision in the insurance contract because ERISA expressly preempted the California notice-prejudice rule; and second, that ERISA impliedly preempted California’s notice-prejudice rule because application of the rule would allow a state law to interfere with ERISA’s civil enforcement provision. In UNUM v. Ward, the Supreme Court held that the California notice-prejudice rule is saved from preemption under ERISA § 514 as a law that regulates insurance. Further, the Ward Court found that California’s notice-prejudice rule did not provide an alternative state law remedy in conflict with ERISA § 502. Acknowledging that the state law notice-prejudice rule would control the outcome of the benefits claim, the Court nonetheless found that the state law did not provide a separate state law remedy because the plan participant was still required to sue under ERISA § 502 to recover his benefits. The Court held that the state insurance regulation—the notice-prejudice rule—provided the “rule of decision” that controlled the outcome of Mr. Ward’s ERISA § 502(a)(1)(B) claim for benefits.

4. Applying UNUM v. Ward to Kenseth

Arguably, a claims administrator in an insured ERISA plan abuses its discretion when the claims administrator interprets ambiguous plan/policy terms in its own favor and against the plan participant. ERISA’s duty of loyalty, which requires ERISA fiduciaries to discharge their duties with respect to a plan solely in the interest of the plan participants and their beneficiaries and for the exclusive purpose of providing benefits, see ERISA § 404(a), arguably requires plan administrators to interpret ambiguous plan provisions in favor of paying benefits. Unfortunately, ERISA courts facing plan language that grants the plan administrator absolute discretion to interpret plan terms have generally failed to enforce ERISA’s duty of loyalty in this manner when applying deferential review.

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58 Mr. Ward filed his lawsuit within the applicable statute of limitations. The UNUM policy imposed time limits to provide notice of claims that were shorter than the statute of limitations.
In particular, the Seventh Circuit has ruled that the statutory interpretation doctrine known as *contra proferentum* does not apply when courts apply deferential review in ERISA § 502(a)(1)(B) claims. See Hightshue v. AIG Ins. co., 135 F.3d 1144, 1149, 28 EB Cases 1273 (7th Cir. 1998). See also, Colucci v. Agfa Corp. Severance Pay Plan, 431 F.3d 170, 176-78, 36 EB Cases 1593 (4th Cir. 2005)(holding that “[w]hen a plan’s terms are ambiguous in the sense that its language gives rise to at least two different but reasonable interpretations and when a plan confers discretion on an administrator to interpret the plan and resolve ambiguities, a court defers to the administrator’s interpretation by reviewing it only for abuse of discretion”); Cagle v. Brunner, 112 F.3d 1510, 1519, 21 EB Cases 1113 (11th Cir. 1997)(“arbitrary and capricious standard of review would have little meaning if ambiguous language in an ERISA plan were construed against the Fund”). Consequently, plan participants seeking to enforce the assertion made herein that it is a breach of duty (insurance law good faith duty or the ERISA duty of loyalty), and a *per se* abuse of discretion for a claims administrator in an insured plan to construe ambiguous plan/policy terms against the plan participant may be better off presenting this assertion under state insurance law, and under the *UNUM v. Ward* rationale.

To enforce this assertion, however, it is essential to recognize that the insurance law duty of good faith as applied in the context of construing ambiguous policy terms is different than the *contra proferentum* doctrine. *Contra proferentum* is a statutory construction rule that requires a court (not a party to a contract) to interpret ambiguities in contract language against the drafter. The standard of good faith and fair dealing in insurance law imposes a duty on one of the parties to a contract—the insurance company—to interpret ambiguous policy terms against its own interests and in favor of coverage.

In the law of contracts when parties deal at arm’s length, each party can advocate for its own interpretation of contract language, and courts are asked to decide the correct interpretation (perhaps by applying *contra proferentum*). But the duty of good faith in insurance law, and arguably the duty of loyalty under ERISA’s fiduciary responsibility rules, apply to the insurer/plan administrator and require the insurer/plan administrator to abandon a *caveat emptor* approach to contract interpretation. The duty of good faith under insurance law imposes a higher duty on the insurer/plan administrator to place the interests of their insured/plan participants above their own interests. This duty controls the insurer/plan administrator’s behavior when dealing with the contract beneficiary during the claims process—that is, prior to even going to court.

Application of the insurance law duty of good faith and fair dealing as applied in *Kenseth* would allow the plan participant to recover monetary damages under ERISA § 502(a)(1)(B). The Dean Health HMO Plan is a fully insured plan; consequently, the state insurance law duty of good faith and fair dealing governs the claims administrator’s actions and impose state insurance law standards of behavior that are saved from ERISA preemption. As part of the duty of good faith, the Dean Health insurance claims administrator is required to construe ambiguous policy terms in favor of coverage—
because this good faith duty is effectively written into the policy language, as in *UNUM v. Ward*. Consequently, when the Dean Health claims administrator failed to interpret the ambiguous policy exclusion in Ms. Kenseth’s favor, the administrator violated its duty of good faith owed to Ms. Kenseth, and the administrator violated the express terms of the plan/policy. These violations on behalf of the claims administrator then establish a *per se* abuse of discretion and would entitle Ms. Kenseth to her benefits under § 502(a)(1)(B), even if the court applied a deferential review standard.