
ERISA REMEDIES, WELFARE BENEFITS, AND BAD FAITH: LOSING SIGHT OF THE CATHEDRAL

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After many years of study and debate, Congress enacted the Employee Retirement Income Security Act of 1974¹ (“ERISA”). Although born from concerns about pension security,² ERISA governs both pension *and* welfare plans.³ ERISA defines a “pension plan” to include “any plan, fund, or program . . . established or maintained by an employer” that “provides retirement income”⁴ or “results in a deferral of income by employees.”⁵ Its importance in protecting the retirement security of Americans can hardly be overstated.⁶

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1. 29 U.S.C. §§ 1001-1461 (2006).

2. In the words of a fellow Symposium participant, “ERISA was Congress’s attempt to devise a comprehensive regulatory program to protect millions of American workers who looked to private pension plans for financial support in their retirement years.” JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, A POLITICAL HISTORY* 1 (2004).

3. ERISA § 3(3) (“The term ‘employee benefit plan’ or ‘plan’ means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.”).

4. *Id.* § 3(2)(A)(i).

5. *Id.* § 3(2)(A)(ii).

6. ERISA-governed “retirement plans are the single largest source of income [other than Social Security] for aged Americans.” WOOTEN, *supra* note 2, at 1-2 (citations omitted). As of

ERISA defines a “welfare plan” to include “any plan, fund, or program . . . established or maintained by an employer” that provides “medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.”⁷ As of 2002, these welfare plans covered 137 million workers, retirees, and their families.⁸ The statute has extraordinary influence on the delivery of healthcare⁹ and other non-retirement benefits such as disability insurance, life insurance, and severance pay.¹⁰

Notable commentators have long expressed the concern about ERISA that is the subject of this Symposium. In her 2004 concurrence in *Aetna Health Inc., v. Davila*,¹¹ Justice Ruth Bader Ginsburg described that concern as follows:

2003, “[a]bout fifty million private-sector employees, including a majority of year-round, full-time workers, participate[d] in a retirement plan regulated by ERISA.” *Id.* at 2 (citations omitted). And as of the end of 2006, these retirement plans held more than \$5.5 trillion in assets. Bd. of Governors of the Fed. Reserve Sys., *Flow of Fund Accounts of the United States: Flows and Outstandings*, 113 (June 7, 2007), <http://www.federalreserve.gov/releases/z1/20070607/z1.pdf>.

7. ERISA § 3(1).

8. See Brief of the Sec’y of Labor as Amicus Curiae in Support of Qualchoice’s Petition for En Banc Rehearing at 13, *Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6th Cir. 2004) (No. 02-3614).

9. The majority of private health insurance in the United States is provided through ERISA-governed welfare plans. In 2006, for example, non-elderly Americans received health insurance from the following sources: 62% (162.7 million people) from an employer; 18% (46.5 million people) had no insurance; 15% (39.1 million people) from public programs, and 5% (12.5 million people) from some other source. See SARA R. COLLINS, CHAPIN WHITE & JENNIFER L. KRIS, WHITHER EMPLOYER-BASED HEALTH INSURANCE? THE CURRENT AND FUTURE ROLE OF U.S. COMPANIES IN THE PROVISION AND FINANCING OF HEALTH INSURANCE, THE COMMONWEALTH FUND 7, fig.1 (Sept. 17, 2007) available at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2007/Sep/Whither-Employer-Based-Health-Insurance--The-Current-and-Future-Role-of-U-S--Companies-in-the-Provis.aspx>. This is particularly significant because most healthcare expenditures in America are made by those with private insurance. See, e.g., GARY OLIN, MEDICAL EXPENDITURES OF THE NON-ELDERLY BY AGE AND INSURANCE STATUS, 2004 (Jan. 2008), http://www.meps.ahrq.gov/mepsweb/data_files/publications/st197/stat197.pdf (noting that 79% of all medical expenditures were made by those with private health insurance in 2004).

10. For example, “[s]hort- and long-term disability benefits were available [in 2004] to 39 and 30 percent of workers, respectively, and nearly all participated.” U.S. DEP’T OF LABOR, BUREAU OF LABOR STATISTICS, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN PRIVATE INDUSTRY IN THE UNITED STATES, MARCH 2004 1 (Nov. 2004) available at <http://www.bls.gov/ncs/ebs/sp/ebsm0002.pdf>. See also Letter from Barbara D. Bovbjerg, Associate Director, Education, Workforce, and Income Security Issues for the United States General Accounting Office, to the Honorable Robert E. Andrews, Ranking Minority Member of the Subcommittee on Employer-Employee Relations Committee on Education and the Workforce of the United States House of Representatives (Nov. 5, 1999), <http://archive.gao.gov/pdf/163015.pdf> (noting that, according to 1996-97 data, approximately 36% and 26% of all employees in the private sector had short- and long-term disability insurance, respectively).

11. 542 U.S. 200 (2004).

Because the [Supreme] Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the . . . relief[] allowable under [ERISA], a "regulatory vacuum" exists: "[V]irtually all state law remedies are preempted but very few federal substitutes are provided."¹²

As such, Justice Ginsburg joined what another noted jurist had described as "the rising judicial chorus urging that Congress . . . revisit what is an unjust and increasingly tangled ERISA regime."¹³

It is easy to appreciate the concern articulated by Justice Ginsburg and others.¹⁴ When a statutory violation has been committed, we expect that those injured by the violation will have an appropriate remedy.¹⁵ At the same time, however, reasonable minds often differ in their

12. *Id.* at 222 (Ginsburg, J., concurring) (quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003) (Becker, J., concurring)).

13. *Id.* (quoting *DiFelice*, 346 F.3d at 453 (Becker, J., concurring)). *See also* *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting), *rehearing after remand*, 385 F.3d 156 (2d Cir. 2004) ("[T]he injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end."); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997) ("This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA . . . [which] has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.") (footnote omitted); Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1091 (2001) ("Although the intent of the preemption clause was to provide uniformity regarding the administration of plan benefits, it is now being used as a shield for plan fiduciaries and insurers to limit their liability under these plans. Such a result is inconsistent with ERISA's overall objective to protect participants' rights.") (footnote omitted).

14. A now-infamous memorandum written by a disability insurance executive almost fifteen years ago is often cited to illustrate the importance of that concern. The memorandum, which was produced during the course of litigation, observed that:

[t]he advantages of ERISA [to a litigation defendant] are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review. The economic impact . . . from having policies covered by ERISA could be significant. As an example, [we] identified 12 claim situations where we settled for \$7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.

Memorandum from Jeff McCall to IDC Mgmt. Group & Glenn Felton (Oct. 2, 1995), *available at* <http://www.erisa-claims.com/library/Provident%20memo.pdf>.

15. This expectation was specifically expressed by Congress when it described ERISA as "providing for *appropriate remedies*." Employment Retirement Income Security Act (ERISA) of 1974 § 2(b), 29 U.S.C. § 1001(b) (2006) (emphasis added). And the civil enforcement provisions of the statute themselves use the word "appropriate" several times. *See id.*; ERISA § 409(a) ("equitable or remedial relief as the court may deem appropriate"); ERISA § 502(a)(2) ("appropriate relief"); *id.* § 502(a)(3) ("appropriate equitable relief").

conception of what remedies are *appropriate*.¹⁶

The debate over what civil remedies should be available under ERISA has long captured the attention of commentators¹⁷ and the courts.¹⁸ This Article addresses one of the most hotly contested questions in that debate: what remedies should be available in litigation against a welfare plan and its fiduciaries when a litigant has been injured by the wrongful handling of her benefits claim? It has a modest goal: to illustrate that the conflict that has raged over this question is nothing more than an age-old consequentialist battle over liability rules which, for several often misunderstood reasons, is not amenable to simplistic legislative or judicial resolution.¹⁹ By ignoring this reality and failing to reach a thoughtful compromise, we ensure that an important body of liability rules will continue to develop by default rather than by design.

I. EXISTING REMEDIES

As explained above, employer-sponsored welfare plans are regulated by ERISA.²⁰ Although several different types of employee

16. For example, those who disagree with the viewpoint espoused by Justice Ginsburg believe that market pressures coupled with existing legal rules already provide sufficient protections to participants and beneficiaries. See CAROLE ROAN GRESENZ ET AL., A FLOOD OF LITIGATION? PREDICTING THE CONSEQUENCES OF CHANGING LEGAL REMEDIES AVAILABLE TO ERISA BENEFICIARIES, 2, tab.1 (1999), http://www.rand.org/pubs/issue_papers/2006/IP184.pdf (table 1: column entitled "opponents of changing remedies"); see also *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222-24 (2004) (Ginsburg, J. concurring). They also believe that "[i]ncreased exposure [under ERISA] will result in defensive practices [that, in turn] will result in large increases in health care costs [that, in turn] will result in higher premiums [and] reductions in employer-sponsored insurance coverage." GRESENZ, *supra*, at 2 tab.1.

17. See, e.g., John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1321 (2003) ("examining the purposes and main features of ERISA . . . [and] then turn[ing] to the three Supreme Court decisions that have contorted ERISA remedy law."). See also Colleen E. Medill, *Resolving the Judicial Paradox of "Equitable" Relief Under ERISA Section 502(A)(3)*, 39 J. MARSHALL L. REV. 827, 831 (2006) ("develop[ing] a statutory and policy-based theory"); Dana M. Muir, *ERISA Remedies: Chimera or Congressional Compromise?*, 81 IOWA L. REV. 1, 3 (1995) ("concentrat[ing] on the scope of relief available in ERISA fiduciary and Section 510 claims after *Mertens*.").

18. For example, the United States Supreme Court has decided several statutory interpretation cases involving the precise scope of ERISA section 502(a). See *LaRue v. DeWolff, Boberg, & Assocs., Inc.*, 128 S. Ct. 1020, 1026 (2008) (interpreting section 502(a)(2) of ERISA); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361-63 (2006) (interpreting section 502(a)(3)); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 220-21 (2002) (interpreting section 502(a)(3)); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 260-63 (1993) (interpreting section 502(a)(3)); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 (1985) (interpreting section 502(a)(2)).

19. Throughout this Article, I use the term "liability rules" to encompass the rules governing what civil remedies are available to an aggrieved litigant.

20. See *supra* notes 7-8 and accompanying text.

benefits may be provided by such plans,²¹ most welfare benefits take the form of insurance.²² In other words, an employee who chooses to participate in her employer's welfare plan²³ is promised something of value (e.g., medical care, a monetary payment) if and when a contingent

21. The term "employee benefit" is commonly used to describe any non-wage compensation provided by an employer to an employee. This conception of employee benefits (i.e., as deferred compensation) has long been advanced by some economists. See, e.g., Albert de Roode, *Pensions as Wages*, 3 AM. ECON. REV. 287, 287 (1913) ("A pension system . . . is really paid by the employee, not perhaps in money, but in the foregoing of an increase in wages which he might obtain except for the establishment of a pension system."). Its adoption by American courts, however, is comparatively recent. See Peter M. Rehon, *The Pension Expectation as Constitutional Property*, 8 HASTINGS CONST. L.Q. 153, 168 (1980) ("[M]ost courts in the late nineteenth and early twentieth centuries viewed noncontributory private pensions plans as mere gratuities."). See generally A. Norman Somers & Louis Schwartz, *Pension and Welfare Plans: Gratuities or Compensation?*, 4 INDUS. & LAB. REL. REV. 77 (1950). Even today, there is disagreement regarding the extent to which employee benefits are truly deferred compensation rather than "status benefits." This disagreement animates the debate over whether, and under what circumstances, an employee-benefit that ERISA permits to be "non-vested" (e.g., retiree healthcare benefits) may be terminated. Although the issue is quite important, it is beyond the scope of this Article.

22. Insurance is simply a form of risk management used to hedge against the risk of a contingent loss. Typically, a consumer (i.e., the insured) directly enters into a contract with another party (i.e., the insurer). Pursuant to the contract, the insured pays a fixed sum (the premium). In exchange for this premium payment, the insurer assumes the financial risk of a contractually defined peril for an agreed period of time. A peril is any risk the likelihood of which can be quantified. In the case of employer-sponsored insurance benefits, an employer may enter into a contract with an insurance company on behalf of its employees and/or their beneficiaries (i.e., spouses, dependents). Alternatively, it may self-insure by agreeing to pay covered benefits once they are earned (either out of a segregated fund or out of the company's general accounts). If an employer chooses to self-insure, it may nonetheless purchase what is commonly referred to as "stop-loss insurance" which pays the employer for costs incurred above an agreed upon level. As commentators have long noted, the decision to self-insure—either fully or with the purchase of stop-loss insurance—is often influenced by ERISA. See, e.g., Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 110-12 (2005) (defending employers' decisions to avoid state-level regulation by purchasing stop-loss insurance but arguing that state regulators can exploit the "savings clause loophole" by directly regulating stop-loss insurance companies); see also Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 235-36 (1997) (arguing that ERISA should not be construed to preempt states from enforcing insurance laws against a stop-loss plan's insurer); L. Darnell Weeden, *Tactical Self-Funded ERISA Employers Unnecessarily Threaten Employees' Right to an Independent Review of an HMO's Medical Necessity Determination with Preemption*, 77 ST. JOHN'S L. REV. 867, 884 (2003) (arguing that ERISA preemption jurisprudence "may lead some employers to change to unfunded employee benefit plans to avoid ERISA's insurance saving clause").

23. ERISA refers to such an individual as a "participant" and defines that term to include "any employee or former employee . . . who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer." Employment Retirement Income Security Act (ERISA) § 402(7), 29 U.S.C. § 1002(7) (2006). A welfare plan may also promise benefits to the "beneficiary" of a participant. ERISA defines a "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *Id.* § 402(8).

event should occur (e.g., sickness, disability, death).²⁴

Each year, there are millions of recorded disputes regarding the scope of coverage under employer-sponsored insurance arrangements.²⁵ Typical disputes involve questions such as the following:²⁶ Is a particular medical treatment experimental and, therefore, not covered by the plan?²⁷ Is a particular treatment medically necessary?²⁸ Is an individual disqualified from receiving a particular medical or disability benefit because her illness is the result of a pre-existing medical condition?²⁹ Does an individual satisfy her plan's definition of disabled?³⁰

24. There are three important perils that are commonly covered by employer-sponsored insurance: illness (health insurance), debilitating injuries (disability insurance), and death (life insurance). An enormous portion of insurance against such perils in the United States today is currently provided by employer-sponsored welfare plans. See *supra* notes 9 and 10.

25. See, e.g., *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008) (noting that approximately "1.9 million beneficiaries of ERISA plans have health care claims denied each year") (citing GRESENZ, *supra* note 16, at 8). This statistic only includes healthcare benefit denials. It does not include denials of claims for disability benefits, life insurance benefits, and other welfare benefits.

26. The existence and magnitude of such disputes is neither surprising nor temporary. This is true for three reasons: First, any system that insures well over 100 million Americans against a broad range of perils will necessarily result in many disagreements regarding the scope of coverage. See *supra* note 8 and accompanying text. See also Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625 (2001). Second, welfare insurance benefits are typically defined in subjective terms. For example, most health insurance benefits are defined in terms of "medical necessity." Conventional wisdom is that "contractual precision [in defining health insurance benefits] has not occurred because . . . [t]he coverage decision-making enterprise is fundamentally resistant to *ex ante* elaboration." David M. Studdert et al., *Expanded Managed Care Liability: What Impact on Employer Coverage?*, 18 HEALTH AFF. 7, 18 (1999). And, third, there is an inherent conflict between the financial interests of the benefit decision-maker and the benefit applicant in virtually every coverage dispute involving welfare insurance benefits. See generally John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297 (2008).

27. See JAYNE E. ZANGLEIN & SUSAN J. STABILE, *ERISA LITIGATION* 542 (2d ed. 2005) ("Medical plans typically exclude experimental and investigational treatments. There has been a significant amount of litigation regarding treatments that insurers have characterized as experimental and therefore not reimbursable.").

28. See *id.* at 544 ("Many cases involving medical benefit denials concern the issue of whether a treatment is medically necessary."). See also William M. Sage, *Managed Care's Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 599 (2003) ("explor[ing] the concept of medical necessity as it has evolved in the judicial and administrative oversight of managed care.").

29. See ZANGLEIN & STABILE, *supra* note 27, at 545 ("Because many medical plans contain some exclusion of coverage for preexisting conditions, the question of whether a particular medical condition arose before the coverage under the plan is one that is litigated with some frequency.").

30. See *id.* at 554 ("Courts have frequently addressed the question of whether a particular condition qualifies as a disability entitling a participant to receive benefits under a plan.").

If a claim for benefits is denied, ERISA requires that the plan “provide adequate notice in writing . . . setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant.”³¹ The statute also mandates that the plan “afford a reasonable opportunity . . . for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”³²

In addition to mandating administrative review, however, ERISA also permits civil litigation to redress violations.³³ In this regard, the relevant part of the statute is section 502(a).³⁴ As interpreted by the Supreme Court, it sets forth the exclusive remedies that are available to a civil litigant.³⁵ Although section 502(a) currently has several parts, “[s]ubsections (1)-(3) . . . constitute the three remedy provisions upon which virtually all claims by ERISA participants and beneficiaries are brought.”³⁶ Only sections 502(a)(1)(B) and (a)(3) are significant in the welfare plan setting.³⁷

Disputes over benefits are squarely addressed by section 502(a)(1)(B) which authorizes a participant or beneficiary to file a civil action 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.”³⁸ Because of the nature of

31. Employment Retirement Income Security Act (ERISA) of 1974 § 503(1), 29 U.S.C. § 1133(1) (2006). As contemplated by this section of the statute, the Department of Labor has promulgated regulations setting forth many procedural requirements for administrative review of denied claims. See 29 C.F.R. § 2560.503-1 (2009).

32. ERISA § 503(2).

33. See ERISA § 502(a) (entitled “Civil enforcement”). See also ERISA § 2(b) (entitled “Congressional findings and declaration of policy” and providing that “[i]t is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by providing for . . . ready access to the Federal courts.”); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (“The civil enforcement scheme of § 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA.”).

34. ERISA § 502(a).

35. See, e.g., *Pilot Life*, 481 U.S. at 54 (“The deliberate care with which ERISA’s civil enforcement remedies were drafted . . . argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (“The . . . carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.”).

36. Langbein, *supra* note 17, at 1334 (footnotes omitted).

37. Section 502(a)(2) permits litigation against a breaching plan fiduciary in order to recover plan losses or disgorge fiduciary gains. ERISA § 502(a)(2). In either event, the lawsuit must be brought on behalf of the plan. Section 502(a)(2) can apply in litigation involving the handling of welfare benefits but only if the plan is funded and the dispute involves the mismanagement of its assets.

38. ERISA § 502(a)(1)(B). Two technical points about section 502(a)(1)(B) are worth

welfare insurance benefits, however, the denial or delay in the provision of such benefits often leads to non-economic injuries (i.e., pain and suffering) and extra-contractual economic injuries (i.e., lost wages due to a worsened medical condition). But section 502(a)(1)(B) merely allows “the successful plaintiff [to obtain] an order directing the plan to provide the benefits in dispute, plus attorneys’ fees or, if the employee has paid for the covered benefits out of his own pocket, he can obtain reimbursement.”³⁹ In other words, “consequential damages are not allowed.”⁴⁰

Section 502(a)(3) authorizes participants and beneficiaries, *inter alia*, to bring a civil action “to obtain . . . appropriate equitable relief” to enforce any provisions of the statute or to redress violations of the statute or the terms of the ERISA plan at issue.⁴¹ As interpreted by the Supreme Court, this statutory provision has proven to be of little help to victims of improper benefits handling.⁴² Although litigation continues

mentioning: First, “those that may be held liable in an action seeking recovery of benefits under Section 502(a)(1)(B) include not only the plan but also its administrators and trustees.” ZANGLEIN & STABILE, *supra* note 27, at 536 (citing *Crocco v. Xerox Corp.*, 137 F.3d 105, 107 (2d Cir 1998)). Second, a lawsuit to recover benefits pursuant to section 502(a)(1)(B), unlike other civil litigation authorized by ERISA, may be filed in either federal or state court. *See* ERISA § 502(e)(1) (“Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction . . .”). Of course, only a small fraction of benefit denials actually result in litigation in any court. *See, e.g.*, Susan M. Mangiero, *ERISA Fiduciaries Beware: Risk Is More Than a Four-Letter Word*, 19 PROB. & PROP. 65, 65 (2005) (“According to the Administrative Office of the U.S. Courts, new [ERISA] cases [numbered] 9,167 . . . in 2000 [and] 11,499 . . . in 2004.”).

39. Epstein & Sykes, *supra* note 26, at 632 (footnote omitted); *see also* ERISA § 502(g)(1) (authorizing “the court in its discretion [to] allow a reasonable attorney’s fee and costs of action” in various circumstances including litigation under section 502(a)(1)(B)).

40. Epstein & Sykes, *supra* note 26, at 632; *see also* Dana M. Muir, *Fiduciary Status as an Employer’s Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391, 436 (2000) (“Without exception, the benefits enforcement section has been construed to permit only the recovery of benefits due under a plan.”) (footnote and citations omitted).

41. ERISA § 502(a)(3)(B).

42. The Court first addressed the meaning of section 502(a)(3) in *Mertens v. Hewitt Assoc.*, 508 U.S. 248 (1993). In *Mertens*, the beneficiaries of an ERISA plan sought monetary compensation from a third party who allegedly participated in the plan fiduciaries’ breach. *Id.* at 250-51. Although “[m]oney damages are, of course, the classic form of legal relief,” *id.* at 255, the beneficiaries—joined by the United States as *amicus curiae*—argued that they sought “equitable relief” under section 502(a)(3) because, “at common law, the courts of equity had exclusive jurisdiction over virtually all actions by beneficiaries for breach of trust.” *Id.* at 256 (citations omitted). Put simply, the government argued that participants and beneficiaries were entitled to seek compensatory damages under the statute. A deeply divided Court rejected the argument. *Id.* at 257 (“Since all relief available for breach of trust could be obtained from a court of equity, limiting the sort of relief obtainable under § 502(a)(3) to ‘equitable relief’ in the sense of ‘whatever relief a common-law court of equity could provide in such a case’ would limit the relief *not at all*.”). Instead, the Court held that the phrase “equitable relief” was intended by Congress to limit the

over the precise meaning of “equitable relief” in this provision of ERISA, the Supreme Court has continuously interpreted the phrase in a manner which does not permit the recovery of extra-contractual or punitive damages by participants or beneficiaries who are injured by wrongful coverage determinations.⁴³

The fact that consequential and punitive damages are not available to a litigant under ERISA means that they are not available *at all*. Any state law cause of action permitting a litigant to challenge a benefit determination made by an ERISA plan is expressly preempted by section 514(a) of the statute.⁴⁴ And, even if a state law cause of action somehow managed to survive preemption under section 514,⁴⁵ it would be deemed preempted by section 502(a) if it permitted consequential or punitive damages.⁴⁶ For this reason, many welfare plan participants and beneficiaries who suffer serious or fatal injuries allegedly caused by the wrongful handling of a benefits claim have been left with no meaningful judicial remedy.⁴⁷

remedies available under section 502(a)(3) to “those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages).” *Id.* at 256.

43. It is now clear that the list of remedies set forth in *Mertens* was intended to be illustrative, not exhaustive. *See, e.g., Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 356 (2006) (recognizing the remedy of equitable lien by contractual agreement as “*typically* available in equity”). To date, however, the Court has failed to accept the characterization of any remedy as equitable that could be used by participants or beneficiaries to recover monetary compensation for consequential injuries caused by the improper denial or delayed provision of welfare benefits.

44. *See* ERISA § 514(a) (“Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .”). *See also* Epstein & Sykes, *supra* note 26, at 631 (“All courts seem to agree that disputes over the coverage of an employee benefit plan relate to the administration of the plan and thus come within ERISA’s general preemption clause.”).

45. This could happen either because the law at issue was somehow deemed not to “relate to” an employee benefits plan or because it qualified for an exception in section 514(b) of ERISA which saves from preemption “any law of any State which regulates insurance, banking, or securities.” ERISA § 514(b)(2)(A).

46. As Professors Epstein and Sykes explain, “state law is preempted unless it is part of the state law ‘regulating insurance.’ Even then, it will be preempted to the extent that it purports to provide any ‘remedy’ for the denial of benefits (as distinguished from, say, a rule of insurance contract construction).” Epstein & Sykes, *supra* note 26, at 631-32. “The practical consequence of this convoluted structure is that a civil enforcement action under ERISA is presently the sole legal remedy available to a patient who challenges the denial of coverage by an MCO [managed care organization] under a plan covered by ERISA.” *Id.* at 632.

47. *See, e.g., Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1010 (9th Cir. 1998) (finding no remedy for death allegedly caused by delayed authorization for bone marrow transplant); *Turner v. Fallon Cmty. Health Plan*, 953 F. Supp. 419, 424 (D. Mass. 1997), *aff’d*, 127 F.3d 196, 200 (1st Cir. 1997) (finding no remedy for death allegedly resulting from the denial of a bone marrow transplant); *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270, 1277 (10th Cir. 1996)

II. THE DEBATE OVER LIABILITY RULES

Even critics of expansive judicial remedies admit that “[i]t is not difficult to fashion an argument that this current ERISA remedy [for wrongful denial of coverage] is inadequate.”⁴⁸ In the commonly used language of law and economics, the argument is simply that current liability rules do not provide sufficient incentives for welfare plans to internalize the negative externalities of wrongfully handling benefits claims.⁴⁹ The argument is predicated on the uncontroversial notion that a self-serving or careless welfare plan is better off financially whenever it denies or delays coverage if the amount of money immediately saved by failing to pay the insurance benefit is greater than the expected present value of (i) the amount of money the plan will be required to ultimately pay the claimant plus (ii) any additional expenditures that the plan will likely incur as a result of the denial or delay (e.g., legal fees, an award of fees to the claimant’s attorney) plus (iii) the reputational cost of the wrongful denial.⁵⁰

Proponents of expanding liability in cases of wrongful benefits handling maintain that there are compelling reasons to believe that ERISA has created incentives that cannot possibly maximize the overall welfare of players in the system.⁵¹ First, they claim that many victims of

(finding no remedy for death allegedly caused by delayed authorization for treatment); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (finding no remedy for suicide allegedly resulting from refusal to authorize psychiatric benefits under the plan); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 132 (9th Cir. 1993) (finding no remedy for death allegedly caused by withdrawn authorization for surgery); *Kuhl v. Lincoln Nat’l Health Plan, Inc.*, 999 F.2d 298, 305 (8th Cir. 1993) (finding no remedy for death allegedly resulting from delayed authorization for surgery); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1339 (5th Cir. 1992) (finding no remedy for wrongful death of unborn child allegedly caused by denial of authorization for hospitalization).

48. Epstein & Sykes, *supra* note 26, at 641.

49. The mitigation of negative externalities has long been recognized as an essential objective in setting liability rules. See, e.g., Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1111-12 (1972). As recognized by Professor/Judge Calabresi and Professor Melamed’s reference to Claude Monet’s paintings of the Rouen Cathedral, one need not analyze liability rules from a consequentialist perspective. But there are few, if any, advocates of expanding ERISA remedies who are approaching the debate from a non-consequentialist perspective. To be sure, proponents of expanding remedies often make their *initial* arguments on different terms. But when opponents respond with consequentialist arguments, virtually all proponents accept the consequentialist framework and engage the debate as such.

50. Of course, it is also predicated on the notion that expanding the remedies available to civil litigants will affect the behavior of welfare plans and their fiduciaries. See, e.g., GRESENZ, *supra* note 16, at 4 (“Advocates of expanding liability [under ERISA] implicitly assume that private litigation is an effective deterrent mechanism.”).

51. As a fellow Symposium participant has noted, the Fifth Circuit articulated this position in

wrongful coverage decisions currently do not have the financial incentive to pursue legitimate claims to the point of settlement or judgment.⁵² The availability of more robust remedies, the argument goes, would result in a greater number of these claims proceeding to resolution.⁵³ Second, they argue that many victims of wrongful benefits handling currently accept a less costly benefit than the one that they initially requested.⁵⁴ The availability of more robust remedies, the argument goes, would result in a greater number of these claims being settled for fair (or close to fair) value. Finally, proponents of expanding liability suggest that courts get some cases wrong (i.e., affirm improper denials or delays) and that this is a particularly significant risk under the current system because ERISA has been interpreted by the Supreme Court to require judicial deference to the administrative decisions of welfare plan fiduciaries.⁵⁵ Stronger remedies, the argument goes, are a means to discourage welfare plan fiduciaries from engaging in strategic play in questionable cases.

Opponents of substantial expansion of liability maintain that there are compelling reasons to believe that such expansion will actually

a well known ERISA case when it stated that “bad medical judgments will end up being cost-free to the plans that rely on [utilization review] companies to contain medical costs” because, under ERISA, “the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored in utilization review companies’ cost of doing business.” Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. (forthcoming Dec. 2009) (manuscript at 33, on file with author) (quoting *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992)).

52. See, e.g., Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1068 (1996) (noting that patients often “find it too expensive or too difficult to pursue their objections through the costly and time-consuming judicial process”).

53. This is true because the potential for a greater ultimate recovery will have two likely effects: First, it will cause some victims of wrongful coverage determinations to bring lawsuits who otherwise would have avoided the litigation process entirely. Second, it will cause other victims of wrongful coverage determinations to continue the litigation of their claims until settlement or judgment who otherwise would have dismissed their claims prior to resolution. In either case, this might occur because the prospect of a greater ultimate recovery will influence whether—and to what extent—attorneys are willing to bear the costs of such litigation (e.g., by accepting contingency-fee compensation and/or by advancing costs).

54. As Professors Epstein and Sykes concede, “the calculus may be even more favorable toward wrongful denial if the plan anticipates that it can settle the cases that are brought quickly with minimal expenditures necessary to compensate plaintiffs’ attorneys.” Epstein & Sykes, *supra* note 26, at 641. In this regard, it is worth noting that settlements for less than 100% of the earned insurance benefit not only save the plan money, but also permit advertisement of a high rate of “coverage” because the patient does, ultimately, receive some treatment.

55. See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1321 (2007).

reduce overall welfare.⁵⁶ To be sure, they concede that the availability of extra-contractual damages “may be beneficial in theory”⁵⁷ but caution that “[i]f the standards applied in the courts for finding [a violation] are too lax and/or if damage awards are too high relative to the actual costs incurred by [those] whose claims have been denied, substantial incentive distortions may arise.”⁵⁸ Three potential distortions, in particular, are regularly identified: First, there is a concern that providing excessive remedies will incent participants and beneficiaries to file illegitimate or questionable claims.⁵⁹ Second, there is a concern that providing excessive remedies will incent plans to settle (rather than investigate and, in appropriate cases, dispute) illegitimate or questionable claims.⁶⁰ Finally, there is a concern that providing excessive remedies will result in the “over-invest[ment] in claims processing bureaucracy, procedures,

56. As a preliminary matter, they suggest that reputational costs already present a substantial barrier to widespread misconduct and negligence in the coverage decision-making process. See, e.g., Epstein & Sykes, *supra* note 26, at 642 (asserting that “the usual market constraints associated with repeat dealing and reputation are operative to a significant degree” and maintaining that “the notion that ERISA-covered plans can deny benefits willy-nilly without significant penalty is plainly exaggerated.”). Of course, the extent to which market forces affect the behavior of welfare plan fiduciaries is an empirical question. There is certainly evidence that market forces deter wrongful coverage decisions. See, e.g., Dahlia K. Remler et al., *What Do Managed Care Plans Do to Affect Care? Results from a Survey of Physicians*, 34 INQUIRY 196, 200 (1997) (finding that few physician-recommended services are ultimately denied by managed care organizations). At the same time, there is much evidence to suggest that market forces are woefully insufficient. See, e.g., Press Release, Mass. Office of Consumer Affairs & Bus. Regulation, Landmark Multi-State Settlement in Effect Nat’l Remedy Grants Claims Review for Thousands (Dec. 21, 2004), available at http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Government&L2=Our+Agencies+and+Divisions&L3=Division+of+Insurance&L4=Archive+of+DOI+News+%26+Updates&L5=2004+DOI+Press+Releases&sid=Eoca&b=terminalcontent&f=doi_Media_media_press59&csid=Eoca (describing a landmark agreement in which the largest disability insurer in the U.S. agreed (i) to pay a \$145 million settlement, (ii) to pay a \$15 million penalty, and (iii) to reexamine more than 200,000 disability benefit claims). At the end of the day, it is undeniable that one’s world view unquestionably colors his or her perspective regarding the extent to which reputational costs deter wrongful conduct. Compare Epstein & Sykes, *supra* note 26, at 642, with Bronsteen, Maher, & Stris, *supra* note 26, at 2312 n.58.

57. Sharon Tennyson & William J. Warfel, *First-Party Insurance Bad Faith Liability: Law, Theory, and Economic Consequences*, NAT’L ASS’N MUTUAL INS. COMPANIES, Sept 2008, at 7, available at www.namic.org/insbriefs/080926BadFaith.pdf.

58. *Id.*

59. “If damage awards are sufficient to create a ‘windfall’ for the insured, this may encourage insureds to file illegitimate claims.” *Id.* at 14. See also Epstein & Sykes, *supra* note 26, at 642 (“Given the diversity of medical opinions on the proper course of treatment for particular patients, it may not be difficult for a plaintiff to find an expert willing to opine that some treatment was necessary or nonexperimental.”).

60. “Excessive damage awards will in addition discourage insurers from questioning claims that may be potentially illegitimate.” Tennyson & Warfel, *supra* note 57, at 14. Cf. KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 178 (1986).

or technology” by welfare plans.⁶¹ Because of these potential distortions, the argument goes, the careless expansion of liability “will [result in] unwarranted increases in claim costs that are ultimately distributed to the insuring public in the form of higher insurance premiums.”⁶² As with any question about the economic efficiency of legal rules, the proper answer to the question of whether, and in what fashion, existing laws regarding liability for wrongful coverage determinations should be altered turns on complex empirical considerations. And empirical work to date on this question is, at best, inconclusive.⁶³

III. THE COMPLEXITIES OF LEGISLATIVE REFORM

The late 1990s and early 2000s saw many proposals advanced by prominent Democrats and Republicans to enact what is often referred to as a Patients’ Bill of Rights (“PBR”)—federal legislation designed to address the perceived regulatory vacuum created by ERISA in the context of managed healthcare.⁶⁴ Although they differed in specifics,

61. Tennyson & Warfel, *supra* note 57, at 14.

62. *Id.* at 14. One common example used to illustrate this argument is the assertion that expanding the remedies available for wrongful coverage decisions will cause welfare plans to authorize expensive high-tech diagnostic procedures (e.g., MRIs) in circumstances where the plan reasonably believes that the procedure is not medically necessary. The plan will do so, the argument goes, because the expected cost of litigation (in light of the expansion of available remedies) now exceeds the cost of, what the plan believes to be, an uncovered procedure. If we believe that welfare plan fiduciaries (i) usually act in good faith and (ii) exercise judgment that is not materially worse than that of judges and juries in making cost-benefit decisions about the appropriateness of welfare benefits, then expanding remedies available in cases involving allegations of wrongful coverage decisions is certainly “unwarranted.” Put simply, it will drive up healthcare costs without meaningfully improving care quality. Again, it is undeniable that one’s world view unquestionably colors his or her perspective regarding the relative integrity and competence of welfare plan fiduciaries (on the one hand) and judges/juries (on the other hand). Compare Epstein & Sykes, *supra* note 26, at 642 (focusing on concerns with the latter), with Bronsteen, Maher, & Stris, *supra* note 26, at 2311 (focusing on concerns with the former).

63. There is, of course, some literature devoted to empirical analysis of the likely effects of changing ERISA’s liability rules. See Studdert, *supra* note 26, at 8 (concluding that “the direct costs of [expanded] liability are uncertain but that the prospect of litigation may have [important] effects on coverage decision making, information exchange, risk contracting, and the extent of employers’ involvement in health coverage”); GRESENZ, *supra* note 16, at 4. Cf. Tennyson & Warfel, *supra* note 57, at 14.

64. See generally Edward A. Zelinsky, *Against a Federal Patients’ Bill of Rights*, 21 YALE L. & POL’Y REV. 443 (2003). In the words of Professor Zelinsky, a fellow Symposium participant, “For many years, ERISA Section 514 was interpreted to displace state regulation of medical care provided via employer-sponsored plans. Since ERISA itself supplies no regulation to replace the state regulation ERISA was believed to preempt, there appeared to be a ‘regulatory gap.’” *Id.* at 443 (citations omitted).

many proposed reform bills expanded, in some meaningful way, the remedies available for the wrongful handling of benefits claims by the fiduciaries of an ERISA-governed welfare plan.⁶⁵ The differences between these proposed bills highlight several important and challenging issues on which consensus must be reached before the law governing civil remedies in this area can be reformed.⁶⁶

A threshold question that must be answered, of course, is whether to permit *any* consequential damages as a remedy for improper handling of a benefits claim. This question is hardly new or unique to ERISA.⁶⁷ For years, states have grappled with the question in the process of establishing rules of liability for the improper handling of various first party insurance claims.⁶⁸ As explained above, the argument in favor of permitting consequential damages is a straightforward one. In the words of one scholar:

In first-party insurance, the cost to the policyholder of bringing suit for breach of contract makes it possible for the insurer to deny legitimate claims because the traditional rules governing damages award the successful claimant only the amount to which she is entitled under the policy. By threatening insurers who wrongfully deny claims with liability for extracontractual damages, bad faith liability has the potential to correct such underenforcement⁶⁹

Except for incumbent rent seekers, there are no commentators who strongly advocate for maintenance of the status quo regarding civil remedies for the improper handling of benefits claims by ERISA-

65. Studdert, *supra* note 26, at 8.

66. "Provisions involving judicial remedies and access to courts . . . proved to be the most difficult to resolve during the debates in both of the chambers." Jean P. Hearne & Hinda Ripps Chaikind, Patient Protection and Managed Care: Legislation in the 107th Congress, Issue Brief for Congress 11 (June 18, 2002), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/IB98017a.pdf>.

67. See, e.g., Alan O. Sykes, "Bad Faith" Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405, 409-10 (1996); Phyllis Savage, *The Availability of Excess Damages for Wrongful Refusal to Honor First Party Insurance Claims—An Emerging Trend*, 45 FORDHAM L. REV. 164, 166 (1977).

68. "A first-party insurance contract is at its heart a promise to pay a sum or sums of money to the insured (or heirs of the insured) when covered contingencies materialize and certain conditions have been met." Sykes, *supra* note 67, at 408. "The minimum remedy for breach of such a promise, available in all jurisdictions, is an action to recover the amounts owing under the terms of the insurance policy. At one time courts generally held that no further remedy was available." *Id.*

69. Kenneth S. Abraham, *The Natural History of the Insurer's Liability for Bad Faith*, 72 TEX. L. REV. 1295, 1309 (1994).

governed welfare plans (i.e., no consequential damages regardless of whether or not such damages were foreseeable).⁷⁰

Once a decision has been made to permit some consequential damages as a remedy for benefits mishandling, the next consideration is under what circumstances to permit such damages. Again, this is hardly new or unique to ERISA; states have long been forced to confront the issue in establishing liability rules for the improper handling of various first party insurance claims. And, as their experience illustrates, resolution of the issue necessarily turns on whether one conceptualizes the statutory violation (i.e., the benefits mishandling) as more analogous to breach of contract or tort.⁷¹ Division over which approach to take has been a significant, and somewhat misunderstood, obstacle to the passage of any federal patient protection legislation.

If a contract approach is adopted, then the accompanying liability rules would expand the remedies available in *some* ERISA cases because:

Under state [contract] law . . . consequential damages may be recoverable as long as they are “foreseeable” by the party who breaches the contract The foreseeability hurdle seems likely to be a modest one where [for example, a managed care organization] has been denied coverage for some treatment of medical importance to the

70. To be sure, there are respected commentators who stop far short of aggressively urging reform. See, e.g., Epstein & Sykes, *supra* note 26, at 641-42 (concluding that the argument that existing remedies under ERISA for wrongful coverage denials are inadequate “has considerable force and may in the end be convincing”). “[W]e cannot rule out the possibility that a broader remedy for wrongful denial of coverage, coupled with a cap on recoverable consequential damages, steers a reasonable course between the competing concerns.” *Id.* at 642.

71. See Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions After Two Decades*, 37 ARIZ. L. REV. 1153, 1153 (1995) (“The tort of bad faith for breach of an insurer’s obligation in the area of first-party insurance was first recognized by a court of last resort in 1973 in *Gruenberg v. Aetna Insurance Co.* In doing so, the Supreme Court of California created an entirely new cause of action against insurers regarding first-party coverages.”) (citation omitted). By 1995, “at least twenty-four other state courts of last resort ha[d] also recognized that an insurer may be liable to an insured or policy beneficiary for damages beyond the contract benefits under a tort theory” *Id.* “Today, a majority of jurisdictions permit a tort action based solely on breach of the implied covenant of utmost good faith (i.e., bad faith). . . . [In these states,] the injured party may recover for all harm or injuries incurred, regardless of whether they could have been anticipated.” Tennyson & Warfel, *supra* note 57, at 3. On the other hand, “nine states confine the good faith/bad faith inquiry to the realm of contract, but broadly define damages to include [all damages that were] . . . reasonably foreseeable by, the parties at the time the contract was made.” *Id.* See also Jason C. Brown, *Extra-Contractual Damages Stemming From a First-Party Insurer’s Bad-Faith Breach: Will Minnesota Adopt the Tort or Contract Theory of Recovery?*, 26 WM. MITCHELL L. REV. 525, 527 (2000) (arguing that if Minnesota courts are to follow national trends “first-party bad-faith will become a recognized cause of action”).

patient.⁷²

For two reasons, such expansion would be limited. First, “insurers may escape liability on the grounds that any economic losses were beyond their contemplation at the time of contract formation.”⁷³ And, second, “damages for mental anguish [i.e., non-economic consequential damages] are usually not recoverable in contract actions”⁷⁴ On the other hand, the accompanying liability rules would expand the remedies available in *many* ERISA cases if a tort approach is adopted.⁷⁵ The extent to which remedies would be expanded would likely depend upon the standard of culpability selected.⁷⁶ And, yet again, this is hardly new or unique to ERISA.⁷⁷

Irrespective of the choice between tort and contract, numerous additional questions must be resolved. Will recoverable damages be limited to those that are economic or will non-economic and punitive damages be available?⁷⁸ Would the availability of such newly permitted

72. Epstein & Sykes, *supra* note 26, at 632.

73. Sykes, *supra* note 67, at 410.

74. *Id.* Although some have argued that insurance contracts fall within an exception to the general rule, “a number of jurisdictions have rejected that assertion or otherwise denied damages for mental anguish on grounds of unforeseeability.” *Id.* (citing *Kewin v. Mass. Mut. Life Ins. Co.*, 295 N.W.2d 50 (Mich. 1980)).

75. Opponents of federal PBR legislation were (and are) well aware of this fact. *See, e.g.*, John S. Hoff, Remarks at Heritage Lecture #720, The Heritage Found.: The Right Prescription? Assessing the Patients’ Bill of Rights (Oct. 29, 2001), available at <http://www.heritage.org/research/healthcare/HL720.cfm> (“The House and Senate health care bills are turning contract actions, which are suits over what is covered under a health care plan, into tort cases, which have much more extended types of recovery This is done by letting state law apply under some of the bills and in some circumstances. Curiously, even where federal action would be created, they do not phrase issues of coverage in *coverage* terms.”).

76. It is worth noting, however, that at least one scholar has argued that the standard of culpability chosen is *not* particularly significant when viewing liability from a consequentialist perspective. Abraham, *supra* note 69, at 1310 (“Whether first-party bad faith includes reckless or even negligent disregard of the legitimacy of the policyholder’s claim for coverage and whether the liability insurer’s duty to settle is governed by a negligence or a strict liability standard matters little, because liability for bad faith serves a largely *ex ante* function.”).

77. *See* Dominick C. Capozzola, *First-Party Bad Faith: The Search for a Uniform Standard of Culpability*, 52 HASTINGS L.J. 181, 182 (2000) (noting that the various laws in this area are “in a state of confusion” because even those states that do recognize the tort “apply different standards of culpability”); *see also* Henderson, *supra* note 71, at 1156-59 (discussing the approach used in various states); Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. MICH. J.L. REFORM 1, 26 (1992) (“Although a number of jurisdictions have recognized a cause of action . . . the rationales for doing so have not been entirely consistent.”).

78. Some proposed PBR legislation would have permitted economic, non-economic, and punitive damages without limitation. *See, e.g.*, Patient’s Bill of Rights Act of 1999, H.R. 358, 106th Cong. § 302 (1999); Patient’s Bill of Rights Act of 1999, S. 6, 106th Cong. § 302 (1999); Access to

damages be limited in any way?⁷⁹ To what extent should *employers* be subject to liability for arguably making or exercising control over coverage decisions?⁸⁰ And to what extent should key players (i.e., plans, doctors, and employers) be prohibited from contracting around liability rules through anti-indemnification, anti-retaliation, and anti-waiver rules?⁸¹

Resolution of such questions requires substantial compromise between stakeholders with strikingly different interests and ideologies. As such, meaningful legislative reform is necessarily a complex and difficult undertaking. By ignoring this reality and failing to reach a thoughtful compromise, however, we ensure that an important body of liability rules will continue to develop by default rather than by design.

IV. THE COMPLEXITIES OF JUDICIAL RESOLUTION

As is often the case, obstacles to legislative reform have led many to search for a judicial resolution.⁸² Broadly speaking, proposed judicial resolutions address four primary subjects: the extent to which state law is preempted by ERISA,⁸³ the extent to which common law remedies may be implied under ERISA,⁸⁴ the meaning of “appropriate equitable

Quality Care Act of 1999, H.R. 216, 106th Cong. § 302 (1999). Yet other proposed legislation would have permitted economic damages for wrongful coverage decisions but not non-economic or punitive damages. *See, e.g.*, Promoting Responsible Managed Care Act of 1999, S. 374, 106th Cong. § 302 (1999).

79. Some proposed legislation would have permitted economic, non-economic, and punitive damages but with a safe harbor against punitive damages for coverage denials in which the plan timely followed the recommendation of an external review panel. *See, e.g.*, Managed Care Reform Act of 1999, H.R. 719, 106th Cong. § 302 (1999).

80. *See, e.g.*, Am. Benefits Council, Issue Brief, *Kennedy-McCain Patients' Bill of Rights Proposal (S. 872) Leaves Employers Vulnerable to Lawsuits* (June 2001), available at http://www.americanbenefitscouncil.org/documents/kennedy-mccain_s872_stmt.pdf.

81. *See, e.g.*, Epstein & Sykes, *supra* note 26, at 644-48.

82. To be fair, most commentators who propose judicial resolutions believe that ERISA has been misinterpreted by the courts. *See, e.g.*, George Lee Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 665 (1994) (“Congress intended that the remedies provided by ERISA include . . . those available under then current state contract law and trust law . . . [and] . . . those bodies of law . . . permitted recovery of both consequential damages . . . and punitive damages under certain circumstances . . .”).

83. *See, e.g.*, Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 460-61 (2003) (“ERISA, meant to govern relationships between employers and employees, should never have been interpreted to govern the relationships between employees and third parties By correcting this single error, the Supreme Court could rationalize the law of managed care immediately.”).

84. One of my fellow Symposium participants has focused on this issue. Andrew L. Oringer, *A Regulatory Vacuum Leaves Gaping Wounds—Can Common Sense Offer a Better Way to Address*

relief” in section 502(a)(3) of ERISA,⁸⁵ or the availability of consequential damages under section 502(a)(1)(B) of the statute.⁸⁶

Preemption and Federal Common Law. For years, much has been written about ERISA preemption, federal common law, and ways in which existing jurisprudence should be changed.⁸⁷ Modest proposals would have virtually no effect on the litigation of disputes over the improper handling of benefits claims. And those proposals which would significantly affect the liability rules available in such disputes—or find new implied causes of action under ERISA—have little, if any, chance of adoption.⁸⁸

Section 502(a)(3). By far, the most commonly advanced judicial resolutions address the meaning of the phrase “appropriate equitable relief” in section 502(a)(3) of ERISA. Clarification or reinterpretation of the phrase is regularly urged by commentators.⁸⁹ And the United

the Pain of ERISA Preemption?, 26 HOFSTRA LAB. & EMP. L.J. (forthcoming 2009) (manuscript at 16, on file with author) (arguing that “the development of federal common law . . . by providing appropriate causes of action where the legislature intended for ERISA to preempt state law is not only appropriate in light of historical development, but it is called for by the legislative history.”). See also, Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 667-68 (1994) (arguing that “courts must be willing to develop [federal] common law where state law is ousted” and that if leaving a litigant “without a remedy would contravene the purposes of ERISA, it would follow that, upon preemption, the court should recognize a federal remedy.”).

85. Another of my fellow Symposium participants has focused on this issue. Secunda, *supra* note 51 (manuscript at 47) (arguing that “Section 502(a)(3) should be interpreted by future Supreme Courts to permit traditional trust law remedies of ‘make-whole’ relief to rectify ‘any’ act or practice that violates ‘any’ provisions of ERISA”). See also Langbein, *supra* note 17, at 1321; Medill, *supra* note 17, at 831.

86. See, e.g., Flint, *supra* note 82, at 666 (“The impact on employee benefit plans of using the proper rule for awarding extracontractual damages should be another tool to reduce improper plan administrator behavior.”); Muir, *supra* note 40, at 461 (“[P]ermitting claims for foreseeable consequential damages against plan actors who engage in opportunistic or careless behavior will ensure that benefit plan participants and beneficiaries are compensated for injuries caused by inappropriate benefit administration.”).

87. See, e.g., Larry J. Pittman, *A Plain Meaning Interpretation of ERISA’s Preemption and Saving Clauses: In Support of a State Law Preemption of Section 1132(a) of ERISA’s Civil Enforcement Provisions*, 41 SAN DIEGO L. REV. 593, 612-13 (2004); Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951 (2000); Rebecca S. Fellman-Caldwell, *New York State Conference of Blue Cross & Shield Plans v. Travelers Insurance Co.: The Supreme Court Clarifies ERISA Preemption*, 45 CATH. U.L. REV. 1309 (1996); Seema R. Shah, *Loosening ERISA’s Preemptive Grip on HMO Medical Malpractice Claims: A Response to PacifiCare of Oklahoma v. Burrage*, 80 MINN. L. REV. 1545 (1996).

88. For example, it hardly seems possible that the Supreme Court will choose to revisit the core holding of its unanimous 2002 decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). And it seems equally unthinkable that the Court would adopt the conception of ERISA preemption advanced by Professor Korobkin. See Korobkin, *supra* note 83, at 460-61.

89. See, e.g., Secunda, *supra* note 51 (manuscript at 5-6); Langbein, *supra* note 17, at 1321;

States Department of Labor continues to aggressively pursue clarification by filing amicus briefs with the Supreme Court and various Courts of Appeals.⁹⁰ To be sure, there are many reasons to doubt that the Supreme Court's interpretation of section 502(a)(3) is faithful to Congressional intent.⁹¹ At the same time, however, there are fundamental limits on the ability to achieve meaningful reform through the clarification or reinterpretation of this provision.

In order for consequential damages to be available under section 502(a)(3), the interpretation of the statute advanced by the federal government in *Mertens*, or some variant thereof, would need to be adopted by the Supreme Court. Many will object to such an interpretation of the statute because, as a practical matter, it allows federal judges to determine liability rules on a case-by-case basis. As opposed to legislative reform (which might include damages caps or safe harbors), awarding consequential damages whenever they are deemed to be "appropriate" will, to many, be perceived as failing to balance competing systemic concerns.⁹²

Section 502(a)(1)(B). As explained above, federal courts have unanimously held that ERISA does not permit the recovery of consequential damages for the improper handling of a benefits claim.⁹³ This interpretation of the statute can be traced back to the Supreme Court's 1985 decision in *Massachusetts Mutual Life Insurance Co. v.*

Medill, *supra* note 17, at 831.

90. See, e.g., Brief of the Sec'y of Labor as Amicus Curiae in Support of LaRue for Rehearing and Rehearing en Banc, *LaRue v. DeWolff, Boberg & Associates, Inc.*, 458 F.3d 359 (4th Cir. 2006) (No. 05-1756); Brief of the Sec'y of Labor as Amicus Curiae at 1, *Coan v. Kauffman*, 457 F.3d 250 (2d Cir. 2006) (No. 04-5173); Brief for the Sec'y of Labor as Amicus Curiae Supporting Farace's Petition for Panel and En Banc Rehearing at 1, *Pereira v. Farace*, 413 F.3d 330 (2d Cir. 2005) (No. 03-5035); Brief of the Sec'y of Labor as Amicus Curiae in Support of Callery and Reversal of the District Court at 1, *Callery v. United States Life Ins. Co.*, 392 F.3d 401 (10th Cir. 2004) (No. 03-4097).

91. Justice Ginsburg forcefully communicated this point during oral argument in *Sereboff* when she asked, "Do you really think that Congress had in mind the distinction that you are now drawing in the ring case based on 15th and 16th century English precedent?" Transcript of Oral Argument, *Sereboff v. Mid Atl. Med. Servs., Inc.* 547 U.S. 356 (2005) (No. 05-260), available at http://www.oyez.org/cases/2000-2009/2005/2005_05_260/argument/.

92. This issue is further complicated by the fact that ERISA's civil enforcement provisions apply to both pension and welfare plans. For this reason, there is no way to selectively interpret the phrase "appropriate equitable relief." Yet it is undeniable that the calculus regarding whether (and when) to award consequential damages is quite different in cases where the disputed benefit is a monetary payment (a retirement, or even life insurance, benefit dispute) as opposed to those where the disputed benefit is medical care.

93. See *supra* note 42 and accompanying text.

Russell.⁹⁴ According to the *Russell* Court:

The question presented for decision [was] whether, under . . . (ERISA), a fiduciary to an employee benefit plan may be held personally liable to a plan participant or beneficiary for extracontractual compensatory or punitive damages caused by improper or untimely processing of benefit claims.⁹⁵

Although the Court's holding only applied to section 502(a)(2) of ERISA, the majority opinion contained the following dicta:

Significantly, the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan – [section] 502(a)(1)(B) . . . says nothing about the recovery of extracontractual damages, or about the possible consequences of delay in the plan administrators' processing of a disputed claim. Thus, there really is nothing at all in the statutory text to support the conclusion that such a delay gives rise to a private right of action for compensatory or punitive relief.⁹⁶

Over time, it has become settled law that *none* of the civil enforcement provisions of ERISA authorizes the recovery of consequential damages for the improper handling of a benefits claim.⁹⁷

As one ERISA scholar has previously noted, the Supreme Court's characterization of section 502(a)(1)(B) in *Russell* is "curious."⁹⁸ While the Supreme Court justified its rationale in *Russell* as one grounded in the language of ERISA, "the term 'extracontractual' never appears in the statute."⁹⁹ Prior to *Russell*, "no reported court decision had ever used the term in the ERISA context."¹⁰⁰ Moreover, the Supreme Court "never used the term before in the ERISA context" or "in any other context either."¹⁰¹ Nonetheless, the *Russell* Court relied on the phrase

94. 473 U.S. 134, 148 (1985). *See also* Flint, *supra* note 82, at 621 ("The difficulty with recovery of extracontractual damages under the benefits-due lawsuit arises because of some disparaging Supreme Court dicta [i]n *Massachusetts Mutual Life Insurance Co. v. Russell* . . .").

95. *Russell*, 472 U.S. at 136.

96. *Id.* at 144.

97. *See* Flint, *supra* note 82, at 621 (noting that, as a result of dicta in *Russell*, "many subsequent courts have concluded, without examining the legislative history, that ERISA forecloses traditional contractual remedies permitting recovery of extracontractual damages in the benefits-due lawsuit").

98. Muir, *supra* note 40, at 436.

99. *Id.*

100. *Id.* at 437.

101. *Id.* at 436.

“extracontractual damages” and, perhaps more importantly, failed to define its scope.¹⁰² This was significant because the phrase “is used in a variety of contractual contexts to describe damage requests that exceed the traditional measure of contract damages.”¹⁰³

As explained above, the traditional measure of contract damages permits recovery for one important category of “consequential” injuries (i.e., those economic injuries that were foreseeable by the breaching party at the time the contract was formed). The contrary rule (i.e., that absolutely no consequential damages are recoverable by a victim of contract breach) was unique to the insurance context.¹⁰⁴ But, as explained above, that exception for insurance contracts has now been abandoned by every state.¹⁰⁵ Thus, the Supreme Court’s use of the phrase extra-contractual damages (and the subsequent adoption by all federal courts of an outmoded interpretation of the term) has led to a limitation on contract damages under ERISA that is peculiar.

The Supreme Court could re-interpret section 502(a)(1)(B) to permit the recovery of foreseeable non-economic damages that result from the wrongful handling of a benefits claim. This is probably the most sensible interpretation of section 502(a)(1)(B). There is nothing in the text, legislative history, or purpose of ERISA to suggest that Congress intended to limit the contractual remedies available under section 502(a)(1)(B) to those available in traditional first-party insurance cases.¹⁰⁶

Such reinterpretation would undoubtedly be an improvement over

102. *Id.* at 437 (explaining that the lack of explicit statutory language led the *Russell* Court to leave its references of “extracontractual damages” undefined).

103. *Id.* “For example, Professor Dobbs refers to emotional distress damages and punitive damages as extracontractual damages.” *Id.*

104. “The most common use of the term extracontractual to refer to a limitation on damages, however, probably occurs in the insurance context.” *Id.* “In the past, because insurance policies were viewed as contingent contracts to pay the amount specified under the policy, remedies frequently were limited to the terms of the policy—generally its face value.” *Id.* (citing Sykes, *supra* note 67, at 408).

105. *See* Muir, *supra* note 40, at 437-38 (“More recently, traditional contract law principles have been applied in the insurance context. The line drawn in contract-based causes of action is between those ‘ordinary remedies for breach [of contract],’ which would include foreseeable damages . . . and those additional consequential and punitive damages traditionally recoverable in tort but not contract.”).

106. “Employee benefit claims may or may not be similar to traditional insurance actions. The Supreme Court, though, gave no reason for its characterization of *Russell*’s claim as one seeking extracontractual damages and drew no parallels with traditional insurance law. Nor did it cite any statutory provisions or legislative history analogizing employee benefit plan remedies to those available in insurance law or otherwise justifying its choice to speak in terms of extracontractual damages.” *Id.* at 439.

the status quo. As an analytical matter, this is precisely what courts regularly do in order to permit the recovery of prejudgment interest when benefits are wrongfully denied or delayed.¹⁰⁷ There is little, if any, principled reason to treat such interest payments as different from many other types of consequential damages in the welfare benefit context (e.g., the foreseeable costs of medical bills incurred in treating a condition that worsened because of a wrongfully denied or delayed medical procedure).

At the same time, however, this judicial solution does not address the three questions that largely drive the policy debate at issue: Should recovery be permitted for consequential economic injuries which are not foreseeable? Should recovery be permitted for non-economic injuries? And should punitive damages be available in the most egregious cases of benefits mishandling? As such, it is not surprising that most litigation and commentary on this issue is directed at the interpretation of section 502(a)(3).

107. "It is fair to say that prejudgment interest appears to be a widespread, acceptable remedy that was simply not written into ERISA, which should legitimately be included within the federal common law of ERISA, which is contrary to the approach courts otherwise take with respect to the remedial provisions of ERISA." ZANGLEIN & STABILE, *supra* note 27, at 254. Although Professors Zanglein and Stabile characterize the awarding of prejudgment interest as an implied remedy under federal common law, they admit that most courts have pointed to section 502(a)(3) of ERISA as authorization for such an award. *Id.* As many courts have noted, it is far from clear whether a section 502(a)(3) theory is still valid after *Great-West*. See, e.g., *Flint v. ABB, Inc.* 337 F.3d 1326, 1330-31 (11th Cir. 2003) (leaving open the question of whether interest of delayed payments is still available after *Great-West*). In my opinion, the near-universal availability of pre-judgment interest is actually motivated by the belief of most courts that the loss of the time-value of money is a foreseeable consequence of contract breach. See, e.g., *Fotta v. Trs. of the United Mine Workers of Am., Health and Ret. Fund of 1974*, 165 F.3d 209, 213 (3d Cir. 1998) (permitting pre-judgment interest based, nominally, on the court's interpretation of section 502(a)(3) but noting that "[e]very one who contracts to pay money on a certain day knows that, if he fails to fulfill his contract, he must pay the established rate of interest as damages for his nonperformance. Hence it may correctly be said that such is the implied contract of the parties." (quoting *Spalding v. Mason*, 161 U.S. 375, 396 (1896))).