

# ERISA: REMEDIES, PREEMPTION AND THE NEED FOR MORE STATE REGULATORY OVERSIGHT

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*This article explores the current state of ERISA law and its effects concerning good faith, fiduciary breaches, and the remedies available under ERISA. Recent case law provides that the duty of good faith applies in an ERISA context; however, any breaches result in recovery to the employee benefit plan and not usually to the injured victim. According to case law, ERISA precludes state remedies, even laws specific to insurance. In part one, this paper provides an overview of ERISA and why state remedies or more state oversight are necessary to protect beneficiaries. Section two discusses the legislative background of ERISA. Section three discusses several cases that illustrate ERISA's lack of appropriate remedies for fiduciary breaches. Section four provides a case study of Unum Provident, a disability insurer that made such egregious breaches that it was required to have long-term, strict oversight by the state departments of insurance. The last section compares several theories by other authors on how to improve ERISA's remedies, along with this author's argument that the most appropriate and efficient way to remedy breaches is to require strict oversight by the state departments of insurance, which has proved to be most successful in the Unum Provident case.*

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## I. INTRODUCTION

In March 2010, Congress passed the Patient Protection and Affordable Care Act, a health care bill that expands health care to a greater portion of Americans and prohibits insurers from rejecting applicants based on, among other things, pre-existing conditions.<sup>1</sup> This law was passed in

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part because of the severe ongoing crises in healthcare. In 2009 alone, the U.S. is estimated to have spent 17.3% of the gross domestic product on healthcare.<sup>2</sup> This notable day will go down in history along with days that other great social welfare bills were passed, such as Social Security and Medicare. One glaring oversight, however, is that the bill fails to correct an erroneous interpretation by the courts that has been ongoing for decades: the remedies available under the Employee Retirement Income Security Act (ERISA).<sup>3</sup>

This paper concerns ERISA, the statutory remedies available to participants and beneficiaries, and a way to protect insureds from egregious insurer behavior. ERISA law governs the benefit plans offered by employers, such as pension and healthcare plans (called “welfare benefit plans”). The Supreme Court has held that the remedies specifically enumerated in section 502 of ERISA are the exclusive remedies available to participants and beneficiaries in any claims relating to ERISA, and has interpreted the “other appropriate equitable relief” provision to preclude make-whole relief, such as money damages, for serious fiduciary breaches. The Supreme Court interprets ERISA’s remedies section narrowly instead of following the true intent of ERISA: protecting the benefits of participants and beneficiaries of such plans balanced against the need to encourage employers to offer such plans. Most courts have decided that, in the competing interests of protecting the participants versus less regulation for employers, Congress intended for less regulation to encourage employers to offer plans. This results in less protection for breaches of fiduciary duties. In doing so, the courts reject that any state tort claims may

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else found it interesting, and for being a fantastic fiancée. I am also grateful to my family and friends for their unending support, especially my parents, Lorraine and Lawrence Redding, and my grandparents, Bill and Sandy Watson.

<sup>1</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>2</sup> NHE Fact Sheet, Centers for Medicare and Medicaid Services, NATIONAL HEALTHCARE EXPENDITURE PROJECTIONS FOR 2009-2010, [http://www.cms.gov/NationalHealthExpendData/25\\_NHE\\_Fact\\_Sheet.asp](http://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp) (last visited May 16, 2010); see also Trends in Health Care Costs and Spending, The Kaiser Family Foundation Report on Trends in Health Care Costs and Spending (March 2009), available at [http://www.kff.org/insurance/upload/7692\\_02.pdf](http://www.kff.org/insurance/upload/7692_02.pdf) (estimating that the U.S. spent 17.6% of GDP on healthcare) (last visited May 10, 2010).

<sup>3</sup> See Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. § 1001 (1988)).

apply to breaches of fiduciary duties in employee benefit health plans, such as insurance unfair trade practices, bad faith, or negligence.<sup>4</sup>

Section two of this paper discusses the history and Congressional intent in passing ERISA. Section three illustrates the problems of ERISA's lack of remedies for beneficiaries by summarizing major case law, legal articles, and investigative journalism by the popular show *Good Morning America*. Section four is a case study of a major disability insurer, Unum Group,<sup>5</sup> and the litigation and ultimate regulatory oversight due to egregious bad faith on the part of the company. Section five argues for more regulatory oversight for ERISA insurers, which has proved successful in the Unum example and arguably changed the company into a possible model of the industry.

Ultimately, this paper supports the viewpoints of several writers, namely that trust law supports consequential relief in certain instances and state insurance unfair practices statutes should be saved from preemption under the savings clause, including its remedies, as Congress expressly stated that such insurance laws must apply to employee benefit plans.<sup>6</sup> However, as Congress and the courts are unlikely to change, it is up to the regulators – the state departments of insurance – to effect this protection of

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<sup>4</sup> It is of note that penalties for violations of such claims are what keep insurance companies in check: a fear of large monetary penalties by the courts. This check is completely lacking in the ERISA context because of ERISA's conflict preemption in section 514, which requires ERISA's regulations to "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." See Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a) (2007).

<sup>5</sup> Unum Group is the parent company of Unum Life Insurance Company, the Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, and First Unum Life Insurance Company.

<sup>6</sup> See Donald Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 115 (2001); 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, 1340-41 (2007); 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, 1338, 1362 (2003); Charlotte Johnson, *Justice Ginsburg's Fiduciary Loophole: A Viable Achilles' Heel to HMOs' Impenetrable ERISA Shield*, 2006 BYU L. REV. 1589, 1591 (2006); Susan Harthill, *A Square Peg in a Round Hole: Whether Traditional Trust Law "Make-Whole" Relief is Available Under ERISA Section 502(a)(3)*, 61 OKLA. L. REV. 721, 722-24 (2008).

its citizens from bad faith practices by ERISA insurers. The purpose of this paper is to encourage the state departments of insurance to promulgate, enact, and enforce regulations for practices and procedures for ERISA insurers to follow, as they did for Unum in the Regulatory Settlement Agreements. The regulations should focus on the duties of good faith and fair dealing that insurers owe insureds, but is currently lacking in the ERISA landscape.

## II. THE HISTORY OF ERISA

ERISA was passed in 1974 with the intent to protect “millions of employees and their dependents” in their retirement benefits, as stated in the Congressional findings and declaration of policy.<sup>7</sup> This law established a regulatory and guaranty system designed to ensure that employees received the retirement benefits promised. However, some note that the health insurance provisions were hastily added last minute.<sup>8</sup>

ERISA was a reaction to the previously enacted Welfare and Pension Plans Disclosure Act (WPPDA), which sought to provide some federal oversight of retirement benefits.<sup>9</sup> WPPDA failed to provide the necessary mechanisms to adequately protect employee retirement benefits, as it lacked a method to control administration of the plans or a way to remedy abuses in plan administration, and retired workers lost anticipated benefits promised by employers.<sup>10</sup> Recognizing this failure, the Senate Committee on Labor and Public Welfare appointed a subcommittee to investigate the problem, concluded that WPPDA lacked the necessary substantive regulatory controls, and suggested a that new “comprehensive and reticulated statute” be enacted to correctly regulate the pension industry.<sup>11</sup> This new regulation was to protect against, as one writer termed

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<sup>7</sup> 29 U.S.C. § 1001; ERISA § 2.

<sup>8</sup> TOM BAKER, INSURANCE LAW AND POLICY 130 (2d ed. Aspen Publishers 2008).

<sup>9</sup> Welfare and Pension Plans Disclosure Act, Pub. L. No. 85-836, 72 Stat. 997, *repealed by* ERISA § 111(a)(1), 29 U.S.C. § 1031(a)(1) (1974).

<sup>10</sup> Bogan, *supra* note 6. Notably, the WPPDA preserved state remedies to supplement its regulation. *See* Act of Mar. 20, 1962, Pub L. No. 87-420, 76 Stat. 35 (repealed 1974); Bogan, *supra* note 6.

<sup>11</sup> Bogan, *supra* note 6, at 115-16 (citing S. REP. NO. 93-127, at 4, *reprinted in* 1974 U.S.C.C.A.N. 4841, *and* 1 SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR AND PUB. WELFARE, 94TH CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RET. INCOME SEC. ACT OF 1974 at 590 (Comm. Print 1976) [hereinafter

it, default risk and administration risk.<sup>12</sup> Default risk pertains to the danger that an employer may dishonor the promised pension, and applies mainly to defined benefit pension plans.<sup>13</sup> Administration risk is the danger that the fiduciary (person responsible for managing and investing plan assets and/or paying claims) may abuse his or her authority by performing inappropriately, misusing plan assets, or improperly refusing to pay promised benefits.<sup>14</sup> The health care and disability insurance issue concerns this latter risk because it is where the least protection is provided to claimants.

#### A. CONGRESSIONAL INTENT

In passing ERISA, Congress noted that there was a lack of transparency to employees and adequate safeguards concerning plan operation, thus “it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans.”<sup>15</sup> Congress was very specific in its intentions when passing ERISA and intended “to alleviate certain problems which tend to discourage the maintenance and growth of multiemployer pension plans”; further “provide reasonable protection for the interests of participants and beneficiaries of financially distressed multiemployer pension plans”<sup>16</sup> and “encourage the maintenance and growth of single-employer defined benefit pension plans.”<sup>17</sup> This encouragement illustrates Congress’ intent to provide a uniform framework of regulation for employee benefit plans to lessen the burden of compliance on employers and entice them to offer such plans.<sup>18</sup> Congress also sought to protect the plan participants’ interests by “providing . . . appropriate remedies, sanctions, and ready access to Federal courts.”<sup>19</sup>

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“Legislative History”]; H.R. REP. NO. 93-533, at 4 (1978), *reprinted in* 1978 U.S.C.C.A.N. 4642, *and in* 2 Legislative History at 2351)).

<sup>12</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1323.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> 29 U.S.C. § 1001(a) (1988).

<sup>16</sup> *Id.* §§ 1001a(c)(2)-(3).

<sup>17</sup> *Id.* § 1001b(c)(2).

<sup>18</sup> *See Aetna Health, Inc. v. Davila*, 542 U.S. 200, 208 (2004).

<sup>19</sup> 29 U.S.C. § 1001(b).

## B. STATUTORY LANGUAGE AND PREEMPTION

ERISA is frustrating to insureds and claimants attempting to utilize state insurance bad faith laws because of its strict preemption laws, which provide an easy out for plan fiduciaries: removal to federal court, thereby preempting all state laws. Under the Supremacy Clause, federal laws may preempt or take precedence over state laws by express provision, implication, or when there is a conflict between federal and state law.<sup>20</sup> ERISA has three main provisions that control the preemption of state laws.

The first, the “preemption clause”, in section 514(a), states: “[e]xcept as provided in subsection (b) [the “savings clause”] 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 . . . .”<sup>21</sup> The next provision, “the savings clause”, in section 514(b)(2)(A) provides: “[e]xcept as provided in subparagraph (B) [the deemer clause], 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.”<sup>22</sup> The last clause, called the “deemer clause”, in section 514(b)(2)(B), has been held only to apply to self-insured plans, and states:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.<sup>23</sup>

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<sup>20</sup> See U.S. CONST. art IV; N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995) (stating the supremacy of federal laws over state laws due to the Supremacy Clause, and its effect on ERISA).

<sup>21</sup> Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-45 (1987) (citing 29 U.S.C. § 1144(a)).

<sup>22</sup> *Id.* (citing 29 U.S.C. § 1144(b)(2)(A)).

<sup>23</sup> *Id.* (citing 29 U.S.C. § 1144(b)(2)(B)). In *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990), the Court held that the deemer clause exempts self-funded ERISA plans from state laws that “regulate insurance” within the meaning of the savings clause.

To put it more clearly, the preemption clause holds that all state insurance laws that apply an ERISA plan are preempted because they “relate” to an ERISA plan. “Relates to” has been an issue much discussed in case law, and in 1995 the U.S. Supreme Court applied a narrower reading than before in determining what exactly “relates to” means.<sup>24</sup> In essence, the Court held that if the state law references or targets an ERISA plan, or has a connection to or directly affects the ERISA plan, it is preempted.<sup>25</sup> However, the savings clause will “save” state laws that specifically pertain to insurance, banking, or securities, and those laws will still apply to ERISA plans. An example of this is when an employer purchases insurance for group coverage of its employees under a plan, thus uses an insurer, and the plan is subject to state regulation because the employer is using direct insurance and there is an insurance contract.

Under the deemer clause, self-funded plans are *not* subject to state insurance laws. A plan is self-funded when the employer completely funds the plan, or creates a trust for the employee health plans and deposits money for the claims into the trust. It is not considered insurance because there is no actual insurance contract that is transacted by the employer with regards to the plan, and the state law cannot regulate it via its power to regulate insurance contracts.<sup>26</sup> Common sense dictates that, due to numerous state insurance regulation laws which are expensive to comply with, employers are more likely to avoid the costs of complying with the insurance state regulations by creating a trust.

When presenting the bills for ERISA, the preemption provisions were described as a “reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans as ERISA’s crowning achievement” by Representative Dent.<sup>27</sup> Another politician, Senator Harrison Williams, provided that this provision “and its narrow exceptions, are intended to preempt the field for Federal regulations, thus eliminating

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<sup>24</sup> See *N.Y. State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 656-57.

<sup>25</sup> *Id.*

<sup>26</sup> See *Holliday*, 498 U.S. at 64-65 (stating that “[o]ur interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer’s insurance contracts; if the plan is uninsured, the State may not regulate it”). The Court also noted that it realized it was making a distinction between insured and uninsured plans, thus “leaving the former open to indirect regulation while the latter is not.” *Id.* at 62 (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)).

<sup>27</sup> *Pilot Life Ins. Co. v. Dedeaux*, 482 U.S. 41, 46 (1987) (citing 120 Cong. Rec. 29197 (1974)).

the threat of conflicting or inconsistent State and local regulation of employee benefit plans. “This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.”<sup>28</sup> The result: this legislation effectively deregulated employee health and disability benefits by allowing employee benefit plans to largely be exempt from state insurance regulation. While the insurance forms must still be approved by the state department of insurance and the insurer must abide by the funding requirements, the insurer is completely exempt from state unfair insurance practices statutes.

### C. REMEDIES UNDER ERISA

Section 502 provides the civil enforcement language for suits brought against plan fiduciaries. It allows participants and beneficiaries to bring suit to: (1) recover benefits due under the plan; (2) enforce his or her rights under the terms of the plan; (3) clarify his or her rights to future benefits under the terms of the plan; or (4) to enjoin fiduciaries from acts or practices that violate ERISA.<sup>29</sup> It also allows for “appropriate relief”, which includes language from section 1109, which gives the court discretion to order “such other equitable or remedial relief as the court may deem appropriate” for fiduciary breaches.<sup>30</sup> It also allows the Secretary of Health to assess and collect civil penalties for certain violations.<sup>31</sup> This section applies to both employee insurance benefit plans and trusts. Section 502, which carves out jurisdiction for federal district courts in ERISA-related claims, also allows for concurrent jurisdiction (i.e., plaintiff can bring the suit in either state or federal court) to recover plan benefits, enforce benefit rights, or clarify future benefits.<sup>32</sup> However, a cause of action will always be subject to removal to federal court.

There is a lack of state remedies and compensatory remedies afforded to plan participants and beneficiaries when an administrator violates the fiduciary duties. As noted above, section 502(a) establishes the remedies a participant or beneficiary may seek when a violation of fiduciary obligation under ERISA occurs, and the remedies are largely remedial in nature. Notably, courts have held that no remedies are available

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<sup>28</sup> *Id.* (citing 120 Cong. Rec. 29933 (1974)).

<sup>29</sup> 29 U.S.C. § 1132(a)(1)(B) (2000).

<sup>30</sup> *Id.* (referencing 29 U.S.C. § 1109(a)).

<sup>31</sup> *Id.*

<sup>32</sup> *See* 29 U.S.C. §§ 1132(a)(1)(B), (e).

to plan participants or beneficiaries *unless* it is enumerated in this section, because “Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress.”<sup>33</sup> There is no ability to bring a bad faith claim against a plan or its fiduciary or be awarded punitive damages.<sup>34</sup> This leaves plan participants and beneficiaries in the untenable condition of fighting with the plan’s administrators over benefits, with little to no recourse from the courts, especially if the plan language affords the administrator with discretionary authority to interpret the plan, raising the level of review by a court to arbitrary and capricious.<sup>35</sup>

In short, if a plaintiff brings suit because of a mishandled benefit claim and suffers health damages due to the denied treatment, all he may receive from the court is (1) an injunction to stop the insurer from wrongfully denying benefits in the future and (2) “other equitable relief.”<sup>36</sup> The courts have interpreted the “equitable remedy” to mean that the plaintiff must receive the benefit that was wrongfully denied. However, this does not allow the plaintiff to receive any damages for his suffering, the delay, or for the consequential further treatment required from the wrongful benefit refusal. As one writer states, “The courts have . . . interpreted ERISA’s ‘equitable relief’ provision to prevent an insured from obtaining ‘make-whole relief.’ Make-whole relief includes expenses that an insured may have incurred due to the wrongful denial of benefits, such as physical harm or suffering.”<sup>37</sup> The Court’s interpretation of “other equitable relief” defies insurance principles. Under traditional insurance law, plaintiffs are usually entitled to damages for insurer breaches under the notion that the insurance contract is one of adhesion, the insured is not sophisticated and is unable to negotiate in any way with the insurer, and to oppose insurer

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<sup>33</sup> See *Aetna Health Ins. v. Davila*, 542 U.S. 200, 214 (2004); *Pilot Life Ins. Co.*, 481 U.S. at 52.

<sup>34</sup> *Davila*, 542 U.S. at 214; *Pilot Life Ins. Co.*, 481 U.S. at 52-53; *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

<sup>35</sup> Discretionary authority in plan documents was highlighted and basically approved by the Supreme Court in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

<sup>36</sup> 29 U.S.C. § 1132(a).

<sup>37</sup> Elizabeth Khoury, *HMO Liability After Aetna Health, Inc. v. Davila: Are Patients’ Rights At Risk?*, 91 IOWA L. REV. 1621, 1631 (2006) (footnotes and citations omitted).

opportunism.<sup>38</sup> Courts utilize contract law, essentially the principles of reasonable expectations and unjust enrichment, to remedy plaintiffs.

#### D. ERISA, TRUST LAW, AND FIDUCIARY DUTIES

An administrator of an employee benefit plan or trust is considered a fiduciary and manages the assets within the plan or trust for the claims of the participants or beneficiaries. ERISA states the fiduciary duties owed by those who have control over the assets, management and administration of a plan in ERISA sections 404 and 405. First, fiduciaries have the duty of loyalty to the participants and beneficiaries, and must always discharge his or her duties *solely* in the interest of those participants and beneficiaries.<sup>39</sup> Next, the fiduciary must act “with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use . . . .”<sup>40</sup> Further, the fiduciary must reasonably divest the investment of assets and follow the terms of the ERISA plan, unless it violates ERISA.<sup>41</sup>

The duties of loyalty and prudence have the most teeth, as they require the fiduciary to solely act for the participants in a prudent manner – thus the fiduciary must “deal fairly and honestly with beneficiaries”.<sup>42</sup> Congress based ERISA plan administrators’ fiduciary obligations on trust law.<sup>43</sup> This “fiduciary law of plan administration governs claims administration as well as the administration of plan assets.”<sup>44</sup>

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<sup>38</sup> See *C&J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W. 2d 169 (Iowa 1975). Opportunism is described as the insurer’s ability to refuse to pay claims after the insured has faithfully paid all premiums, and it is too late for the insured to switch insurers. See *supra* note 10.

<sup>39</sup> 29 U.S.C. § 1104(a)(1)(A) (2006).

<sup>40</sup> *Id.* § 1104(a)(1)(B).

<sup>41</sup> *Id.* §§ 1104(a)(1)(C)-(D).

<sup>42</sup> *Varity v. Howe*, 516 U.S. 489, 506 (1996) (citing GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *LAW OF TRUSTS AND TRUSTEES* § 543, p. 218-19 (rev. 2d ed. 1992); 2A AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 170, at 311-12 (4th ed. 1987); RESTATEMENT (SECOND) OF TRUSTS § 170 (1959)).

<sup>43</sup> *Varity*, 516 U.S. at 506; see also Langbein, *Trust Law as Regulatory Law*, *supra* note 6, at 1316 (citing *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)); John A. Pereira, *A Fiduciary’s Right to Contribution or Indemnity Under ERISA*, 21 OKLA. CITY U. L. REV. 507, 518 (1996) (citing S. REP. NO. 93-127, at 29 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4869).

<sup>44</sup> Langbein, *Trust Law as Regulatory Law*, *supra* note 6, at 1326.

ERISA subjects the administrators of the plan to a modified and constricted version of the “core substantive rules of trust fiduciary law”.<sup>45</sup> The plan administrator or fiduciary is expected to primarily focus on ensuring that the benefit recipient's expectations are fulfilled; they should not be primarily focused on protecting the plan's assets.<sup>46</sup> ERISA allows a fiduciary to be personally liable for a breach of duties, responsibilities, or obligations.<sup>47</sup> ERISA provides that the fiduciary must “make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary” made through the use of plan assets.<sup>48</sup> Importantly, the statute gives the court discretion to order “such other equitable or remedial relief as the court may deem appropriate” for fiduciary breaches.<sup>49</sup>

Under traditional trust law, the trustee is the guardian of the trust's assets.<sup>50</sup> Trust law recognizes the need to preserve the assets in the trust to satisfy future and present claims, and requires the trustee to “take an impartial account of the interests of all beneficiaries.”<sup>51</sup> When a trustee is given discretion as to his exercise of power, the court may only intercede when there is an abuse of that discretion.<sup>52</sup> Further, one treatise suggests that a court may remove a trustee's power of discretion when there is a reason to believe that he will not act fairly, such as by showing that the trustee has already acted in bad faith.<sup>53</sup> Another source indicates that the

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<sup>45</sup> *Id.* at 1326 (citing 26 U.S.C. § 404(a)(1)(A) (2006), § 1104(a)(1)(A)(i)).

<sup>46</sup> Pereira, *supra* note 43, at 518 (citing *Pompano v. Michael Schiavone & Sons*, 680 F.2d 911, 914 (2d Cir. 1982) (noting that fiduciary's duty is to insure the honest administration of financially sound plans); H.R. REP. NO. 93-533, at 21-22 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4659-60 (noting that it is not the fiduciary's duty to primarily focus on the protection of assets)).

<sup>47</sup> 29 U.S.C. § 1109(a) (2006).

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> RESTATEMENT (SECOND) OF TRUSTS § 176 (1957).

<sup>51</sup> *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996) (citing RESTATEMENT (SECOND) OF TRUSTS §§ 183, 232 (1957)).

<sup>52</sup> RESTATEMENT (SECOND) OF TRUSTS § 187 (1957).

<sup>53</sup> *Conkright v. Frommert*, 130 S. Ct. 1640, 1647 (2010) (“If the trustee's failure to pay a reasonable amount [to the beneficiary of the trust] is due to a failure to exercise [the trustee's] discretion honestly and fairly, the court may well fix the amount [to be paid] itself. On the other hand, if the trustee's failure to provide reasonably for the beneficiary is due to a mistake as to the trustee's duties or powers, and there is no reason to believe the trustee will not fairly exercise the discretion once the court has determined the extent of the trustee's duties and powers, the court ordinarily will not fix the amount but will instead direct the

court may intercede when the trustee acts “beyond the bounds of reasonable judgment.”<sup>54</sup> Yet another treatise states that, after a trustee has abused his discretion, the court may decide “for the trustee how he should act, either by stating the exact result it desires to achieve, or by fixing some limits on the trustee's action and giving him leeway within those limits.”<sup>55</sup> Further, when there is a conflict, trust law allows a court to scrutinize conflicted discretionary acts.<sup>56</sup>

Notably, trust law allows make-whole relief, including consequential relief, for acts of “negligence or misconduct in the making or retaining of investments.”<sup>57</sup> The make-whole standard under trust law restores the victim to the position he would have been in had no breach occurred, and includes an award of monetary damages.<sup>58</sup>

Appearing to neglect the trust law precedent, the U.S. Supreme Court has interpreted “other appropriate equitable relief” to be similar to Title VII of the Civil Rights Act of 1964, and declared that ERISA

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trustee to make reasonable provision for the beneficiary's support.”) (citing 3 A. SCOTT, W. FRATCHER, & M. ASCHER, SCOTT AND ASCHER ON TRUSTS § 18.2.1, at 1348-49 (5th ed. 2007)) (footnotes omitted).

<sup>54</sup> *Id.* at 1648 (citing RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. i, at 406 (1957)).

<sup>55</sup> *Id.* at 1648 (citing GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, LAW OF TRUSTS AND TRUSTEES § 560, at 223 (2d rev. ed. 1980)).

<sup>56</sup> *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2349 (2008) (citing RESTATEMENT (SECOND) OF TRUSTS § 107, cmt. f (1957) (discretionary acts of trustee with settlor-approved conflict subject to “careful scrutiny”); RESTATEMENT (SECOND) OF TRUSTS § 107, illus. 1 (1957) (conflict is “a factor to be considered by the court in determining later whether” there has been an “abuse of discretion”); RESTATEMENT (SECOND) OF TRUSTS, § 187, cmt. d (1957); 3 A. SCOTT, W. FRATCHER & M. ASCHER, SCOTT AND ASCHER ON TRUSTS § 18.2, at 1342-43 (5th ed. 2007) (hereinafter SCOTT) (same). *See also, e.g.*, BOGERT § 543, at 264 (rev. 2d ed. 1992) (settlor approval simply permits conflicted individual to act as a trustee); BOGERT § 543(U), at 422-31 (same); SCOTT § 17.2.11, at 1136-39 (same)).

<sup>57</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1337 (quoting BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 862 at 38-39 (rev. 2d ed. 1995)).

<sup>58</sup> *Id.* at 1335 (quoting 3 AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, THE LAW OF TRUSTS § 205, at 237 (4th ed. 1988)); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) (citing RESTATEMENT OF RESTITUTION § 160, cmt. a (1936); GEORGE E. PALMER, LAW OF RESTITUTION § 1.4, at 17, § 3.7, at 262 (1978)).

precludes “awards for compensatory or punitive damages.”<sup>59</sup> The Court reasoned that such relief must be limited to the scope of appropriate relief typically available in equity.<sup>60</sup> However, in an amicus brief submitted by the Solicitor General, the argument was made that “equitable relief” included damages claims, because traditionally money damages were available in equity courts against trustees for breaches of fiduciary trust.<sup>61</sup> Interestingly, even one of the drafters of ERISA disagrees with the Court’s interpretation of “equitable relief”, stating that it is “preposterous to think that the ERISA conferees or the ERISA Congress intended to repudiate the law-equity fusion in an ERISA context, and yet would never say a word about it.”<sup>62</sup>

### III. PROBLEMS WITH ERISA AND HEALTH INSURANCE COVERAGE

The majority of courts interpret ERISA to preempt all state remedy laws, both statutory and common law. These courts are incorrect for several reasons: first, Congress’s original intent in passing ERISA; second, the equitable principles of justice in the law; and third, principles of statutory construction. All three reasons support interpreting ERISA to allow at least some state law remedies, particularly those which apply specifically to insurance companies, to apply to certain fiduciary claims in order to protect plan participants and beneficiaries, and ensure that plan fiduciaries exercise the utmost care and diligence in plan decisions, thereby always placing the participants’ needs first.<sup>63</sup>

#### A. CASE LAW

Lack of fiduciary loyalty leads to the majority of lawsuits and is a major problem in employee welfare benefit law. Plan fiduciaries must be

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<sup>59</sup> *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 255 (1993) (citing *United States v. Burke*, 504 U.S. 229, 238 (1992)).

<sup>60</sup> *Id.* at 262-63.

<sup>61</sup> *Id.* at 255-56.

<sup>62</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1333 (citing Letter from Michael S. Gordon to John Langbein (June 14, 2002)).

<sup>63</sup> It is of note that these duties are what fiduciaries are *supposed* to be held to and follow: the duty of loyalty (to discharge duties *solely* in the interest of participants and beneficiaries, *see* 26 U.S.C. § 404(a)(1)(A) (2006)) and the duty of prudence (to act with the skill and diligence of a prudent person in that position); 26 U.S.C. § 404(a)(1)(B) (2006)).

held to a higher standard, and Congress intended for the courts to hold fiduciaries to this higher standard by incorporating the fiduciaries' duties in section 404(a). Courts have, for the most part, failed to do so (and in some circumstances, specifically excused those fiduciary duties as not applying for HMOs – a real travesty of justice),<sup>64</sup> and have failed in their administration of justice, as it is highly unlikely that Congress intended to leave participants – the very people sought to be protected – without equitable redress for serious harms committed under ERISA plans.

In *Massachusetts Mutual Life Ins. Co. v. Russell*, the employee-beneficiary, Doris Russell, received her health insurance through an employee benefit plan funded by her employer, Mass. Mutual.<sup>65</sup> She became disabled due to a back ailment and received benefits for about five months, when the disability committee terminated her benefits based on an orthopedic surgeon's report. She requested an internal review and submitted a report from her psychiatrist indicating that she suffered from a psychosomatic disability, rather than an orthopedic illness. Her benefits were reinstated about five months later, after an examination by another psychiatrist.<sup>66</sup>

She claimed to have been injured from the improper refusal to pay benefits because it forced her disabled husband to cash out his retirement savings, which in turn aggravated the psychological condition that caused her back ailment. Her complaint was based on both state law and on ERISA.<sup>67</sup> The case was removed to federal court, and the court granted Mass. Mutual's motion for summary judgment, holding that the state law claims were pre-empted by ERISA and the claims for extra-contractual damages and punitive damages were barred under ERISA.<sup>68</sup> The Ninth Circuit Court of Appeals agreed that the state law claims were preempted, but held that she alleged a cause of action under ERISA, as taking 132 days to process her claim violated a fiduciary's obligation to process claims in

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<sup>64</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 231-35 (2000) (holding that HMOs are not meant to be fiduciaries and held to fiduciary duties under ERISA when making mixed eligibility decisions for participants and beneficiaries; holding the HMOs to such a standard would "in effect . . . be nothing less than elimination of the for-profit HMO" as the court must allow the HMO to make decisions influenced by financial incentives, even if it to the detriment of the participant or beneficiary).

<sup>65</sup> *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 136 (1985).

<sup>66</sup> *Id.*

<sup>67</sup> *Id.* at 137.

<sup>68</sup> *Id.*

good faith and in a diligent manner.<sup>69</sup> Thus, the appeals court reasoned, this violation gave rise to a cause of action under § 409(a) that could be asserted by a plan beneficiary pursuant to § 502(a)(2); and under § 409(a), the court has discretion to award “such other equitable or remedial relief as the court may deem appropriate.”<sup>70</sup> The appeals court believed it had “wide discretion as to the damages to be awarded”, including compensatory and punitive damages.<sup>71</sup> The Ninth Circuit held that punitive damages *are* recoverable under § 409(a) if the fiduciary “acted with actual malice or wanton indifference to the rights of a participant or beneficiary”, and the court believed this result was supported by the text of § 409(a) and the congressional purpose of providing broad remedies to prevent violations of the Act.<sup>72</sup>

The Supreme Court reversed, holding that under § 409, the remedy of “such other equitable or remedial relief as the court may deem appropriate” is only available to the plan, not to an individual.<sup>73</sup> The Court decided that, since Congress’ focus was on protecting mismanagement of pension plans, the intent was to exclude individual recovery to beneficiaries for fiduciary breaches.<sup>74</sup> The Court stated that a “fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary”, thus eliminating any hope for emotional compensatory damages to the plaintiff, based on a whim of the Court.<sup>75</sup> The Court candidly and unabashedly wrote off the need to protect the beneficiaries’ interests in a single paragraph.<sup>76</sup> Conclusively, the court held that plaintiffs may not recover extra-contractual damages, stating it was “reluctant to tamper with an enforcement scheme crafted with such evident care as the

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<sup>69</sup> *Id.* at 137-38.

<sup>70</sup> *Id.* at 138.

<sup>71</sup> *Russell*, 473 U.S. at 138.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 140.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 142.

<sup>76</sup> *Id.* at 142-43 (the Court states: “It is of course true that the fiduciary obligations of plan administrators are to serve the interest of participants and beneficiaries and, specifically, to provide them with the benefits authorized by the plan. But the principal statutory duties imposed on the trustees relate to the proper management, administration, and investment of fund assets, the maintenance of proper records, the disclosure of specified information, and the avoidance of conflicts of interest.”).

one in ERISA.”<sup>77</sup> In a subsequent case, the Court noted that this plaintiff had ultimately received all the benefits owed to her, albeit late. Her additional claim for consequential damages was for the delay in processing her claim, and ERISA, the Court concluded, “does not provide a remedy for this type of injury.”<sup>78</sup>

In *Pilot Life*, Dedeaux, the plaintiff-employee, sustained back injuries at work and brought a claim under his employer’s long-term disability plan. The insurer, Pilot Life, processed disability claims and determined who received disability benefits.<sup>79</sup> Pilot Life initially approved his benefits, and then cancelled them after two years, followed by a three-year period of several benefit reinstatements and terminations by Pilot Life.<sup>80</sup> Dedeaux brought suit in federal court, citing tortious breach of contract, breach of fiduciary duties, and fraud.<sup>81</sup> He sought damages for mental and emotional distress, along with punitive and exemplary damages, totaling \$750,000.<sup>82</sup> All of his claims were under state tort law, and not ERISA.<sup>83</sup>

The district court granted Pilot Life’s motion for summary judgment, ruling that all of the claims were preempted under ERISA.<sup>84</sup> The Fifth Circuit reversed, holding that the law was saved under the savings clause because it affected the “relationship between the insurer and the insured,” thus placing it within the ‘business of insurance’ under the McCarran-Ferguson Act, and therefore qualifying as a law which regulates insurance.<sup>85</sup>

The Supreme Court reversed. First, it noted that Dedeaux’s claims clearly ‘related to’ the ERISA plan were preempted under section 514(a).<sup>86</sup> Second, the Court rejected that the Mississippi law of bad faith is saved by the savings clause, because it is a general tort law that did not specifically

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<sup>77</sup> *Russell*, 473 U.S. at 147.

<sup>78</sup> *LaRue v. DeWolff, Boberg & Assoc.*, 552 U.S. 248, 254 (2008).

<sup>79</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 43 (1987).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 43-44.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 44.

<sup>85</sup> *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311, 1316 (5th Cir. 1985) (citing *Metro. Life Ins. Co. v. Mass.*, 105 S. Ct. 2380, 2391 (1985)).

<sup>86</sup> *Pilot Life Ins. Co.*, 481 U.S. at 47-48.

apply to insurance companies, and thus did not regulate insurance.<sup>87</sup> The Court distinguished this case from *Metropolitan Life Ins.*, stating:

Unlike the mandated-benefits law at issue in *Metropolitan Life*, the Mississippi common law of bad faith does not effect a spreading of policyholder risk. The state common law of bad faith may be said to concern “the policy relationship between the insurer and the insured.” The connection to the insurer-insured relationship is attenuated at best, however. In contrast to the mandated-benefits law in *Metropolitan Life*, the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages. The state common law of bad faith is therefore no more “integral” to the insurer-insured relationship than any State's general contract law is integral to a contract made in that State. Finally, as we have just noted, Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case.<sup>88</sup>

The Court held that in order to be saved under the savings clause the state law must specifically regulate insurance.

In *Varity Corp. v. Howe*, the employer, Varity Corporation, owned a subsidiary, Massey-Ferguson (“MF”), which employed the plaintiffs and provided a self-funded employee welfare plan.<sup>89</sup> Varity determined that

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<sup>87</sup> *Id.* at 50 (“A common-sense view of the word ‘regulates’ would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.”).

<sup>88</sup> *Id.* at 50-51.

<sup>89</sup> *Varity Corp. v. Howe*, 516 U.S. 489, 492 (1996). (Note that under the ERISA deemer clause, a self-funded plan is exempt from compliance with state insurance regulations and statutes.)

several MF divisions were losing too much money, and concocted a plan to place all of the unstable divisions and debt, and the employees, into another subsidiary, Massey Combines (MC<sup>90</sup>). The makers of the plan acknowledged the possibility that MC would fail, but saw that outcome as a victory because it would eliminate the unstable divisions and the debt transferred to MC.<sup>91</sup> If Varity did not form the separately incorporated subsidiary, then Varity itself would have to pay for the debt and the ERISA plan benefits for the unstable divisions.<sup>92</sup> Instead of terminating the plan, which would have likely resulted in the employees leaving to find new employment (and “voluntarily release[ing] Massey-Ferguson from its obligation to provide them benefits”), Varity essentially made MC the new employer and switched the employees to a new plan that was funded by MC.<sup>93</sup> However, the employees had to elect to switch employers and thus to switch plans. To persuade them, Varity held a meeting and presented the plan, passed out documents which represented that the benefits would remain the same and were safe, but noted that employment conditions in the future depended on MC’s success.<sup>94</sup> Unfortunately, all the employees agreed to Varity’s plan, and Varity also took the liberty of assigning the benefit obligations to 4,000 retired workers to MC.<sup>95</sup>

The lower court found that MC was insolvent from its very first day. It ended its first year with an \$88 million loss and its second year in receivership, thus terminating the employees’ non-pension benefits.<sup>96</sup> The Supreme Court held that Varity was a fiduciary of the plan, as it was both the employer and administrator of the plan and was acting in a fiduciary capacity during the meeting with employees.<sup>97</sup> The specific context of the events supported that Varity was exercising discretionary authority on the plan’s management or administration when it made the benefit representations to the employees.<sup>98</sup> The main message represented to the employees at the meeting, by designated fiduciaries in the plan documents, was that transferring to MC would not undermine their benefits. This constituted conveying benefit information to participants.<sup>99</sup> Such

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<sup>90</sup> *Id.* at 492-93.

<sup>91</sup> *See id.* at 493.

<sup>92</sup> *Id.*

<sup>93</sup> *See id.* at 493-94.

<sup>94</sup> *Id.* at 494, 500-01.

<sup>95</sup> *Varity Corp.*, 516 U.S. at 494.

<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 498.

<sup>98</sup> *Id.* at 498-99.

<sup>99</sup> *Id.* at 502-03.

information is specifically required under ERISA to allow participants the ability to make an informed choice about continued participation in a new benefit plan.<sup>100</sup> The district court concluded that since the fiduciaries knew that there was a high likelihood that the employees' plans were not safe and would not remain the same, their statements were materially misleading.<sup>101</sup> The Supreme Court held that knowingly deceiving plan participants and beneficiaries violates the duty of loyalty: "lying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in section 404(a)(1) of ERISA."<sup>102</sup> The Court further noted that trust law requires trustees to deal "fairly and honestly with beneficiaries."<sup>103</sup>

In determining the relief warranted under ERISA, the Court held that individual relief was appropriate under section 502(a)(3), which provides that a participant, beneficiary, or fiduciary may bring suit "(A) to enjoin any act or practice which violates any provision of this title 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 title or the terms of the plan."<sup>104</sup> The Court stated that individual relief is authorized under ERISA section 502(l) for violations of section 502(a)(5), and that section 502(a)(3) is identical to 502(a)(5), except that it allows suit to be brought by the Secretary of Labor.<sup>105</sup> Further, the legislative history supported a broad reading of section 502 to permit broad remedies for redressing or preventing violations of ERISA.<sup>106</sup> The Court further noted that it would be "hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured

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<sup>100</sup> *Id.* at 502, 505 (citing ERISA §§ 102, 104(b)(1), 105(a)). The Court rejected that these statements were made as the employer in a plan sponsor (thus in a manner similar to amending a plan, which is not a fiduciary act) because the statements were about the future of benefits, which is something that plan administrators regularly communicate to participants and beneficiaries. *Id.* at 505.

<sup>101</sup> *Varity Corp.*, 516 U.S. at 505.

<sup>102</sup> *Id.* (quoting *Peoria Union Stock Yards Co. v. Penn. Mut. Life Ins. Co.*, 698 F.2d 320, 326 (7th Cir. 1983)).

<sup>103</sup> *Id.* (citing GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *THE LAW OF TRUSTS AND TRUSTEES* § 543, at 218-19 (2d. ed. 1993); 2A AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 170, at 311-12 (4th ed. 1987)).

<sup>104</sup> 29 U.S.C. § 1132(a) (2006).

<sup>105</sup> *Varity Corp.*, 516 U.S. at 510.

<sup>106</sup> *Id.* at 512 (citing S. REP. NO. 93-127, at 35 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838).

beneficiaries a remedy.”<sup>107</sup> Therefore, individual relief is allowed under ERISA for fiduciary breaches.

In *Andrews-Clarke v. Travelers Insurance*, arguably one of the most<sup>108</sup> egregious abuses of fiduciary conduct, the plaintiff obtained health insurance through her employer, AT&T, and her children and husband were beneficiaries of the policy.<sup>109</sup> Her husband had a drinking problem and was admitted to a hospital for alcohol detoxification and medical evaluation. The hospital notified Greenspring, the review provider who, under the plan, must pre-approve treatment. Greenspring refused to approve the treatment even though the insurance policy specifically entitled the insured and beneficiaries to “at least one thirty-day inpatient rehabilitation program per year.”<sup>110</sup> Greenspring approved only a five-day stay, and he was discharged after five days, “with a diagnosis of alcohol dependence, alcohol withdrawal symptoms [and] elevated liver function.”<sup>111</sup> Twenty-five days later, he resumed drinking and admitted himself to another hospital. Despite the terms of the insurance plan, Greenspring approved only an eight-day stay.<sup>112</sup> After being discharged, he consumed a large amount of alcohol, cocaine, prescription drugs, and attempted to commit suicide. After a commitment hearing, the court clinic requested Greenspring’s approval for a thirty-day treatment at a private hospital, which it declined. Mr. Clarke was committed to Southeastern Correctional Center at Bridgewater for his detoxification and rehabilitation, where he received “little in the way of therapy or treatment” and was forcibly raped by a fellow inmate.<sup>113</sup> Upon release, he resumed drinking and committed suicide.<sup>114</sup>

Mrs. Andrews-Clarke brought suit against Travelers and Greenspring, claiming Clarke’s death was the direct and foreseeable result of the improper refusal of Travelers and its agent Greenspring to authorize appropriate medical and psychiatric treatment during Clarke’s repeated hospitalizations for alcoholism in 1994. Her claims included breach of contract, medical malpractice, wrongful death, loss of parental and spousal

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<sup>107</sup> *Id.* at 513.

<sup>108</sup> Although certainly not *the most* egregious. *See infra* Part IV.

<sup>109</sup> *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 50 (D. Mass. 1997).

<sup>110</sup> *Id.* at 50-51.

<sup>111</sup> *Id.* at 51.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.* at 52.

consortium, intentional and negligent infliction of emotional distress, and specific violations of the Massachusetts consumer protection laws.<sup>115</sup>

The district court spoke on the importance of breach of contract claims, noting that such causes of action “pre-date [the] Magna Carta” and “[are] the very bedrock of our notion of individual autonomy and property rights”, arguing that “[o]ur entire capitalist structure depends on it.”<sup>116</sup> Clearly regretting what it understood the law to be, the court granted Travelers’ motion to dismiss, effectively “slam[ming] the courthouse doors in [Andrews-Clarke’s] face and leav[ing] her without any remedy.”<sup>117</sup> The court noted that it was just another example of “the glaring need for Congress to amend ERISA to account for the changing realities of the modern health care system” because ERISA had “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.”<sup>118</sup> The judge acknowledged that the plaintiff’s claims would be cognizable if not controlled by ERISA. The federal judge concluded in a candid statement:

Employee health benefit plans lack security because of the *de facto* immunity that the law now confers upon insurers and utilization review providers associated with such plans. Unfortunately, to date, “ERISA [has proven an excellent example of the classic observation that it is a

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<sup>115</sup> *Andrews-Clark*, 984 F. Supp. at 52.

<sup>116</sup> *Id.* at 52-53 (citing E. ALLAN FARNSWORTH, CONTRACTS §§ 1.4-1.6 (2d ed. 1990)).

<sup>117</sup> *Id.* at 53.

<sup>118</sup> *Id.* (citing *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (“One consequence of ERISA preemption, therefore, is that plan beneficiaries or participants bringing certain types of state actions - such as wrongful death - may be left without a meaningful remedy.”); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (“The result ERISA compels us to reach means the [Plaintiff has] no remedy, state or federal, for what may have been a serious mistake.”); *Turner v. Fallon Cmty. Health Plan Inc.*, 953 F. Supp. 419, 424 (D. Mass. 1997) (Gorton, J.) (“An unfortunate consequence of ERISA preemption is, therefore, that plan beneficiaries or participants who bring certain kinds of state actions, e.g., wrongful death, may be left without a meaningful remedy. . . . Sadly, the case at bar compels a like result. Plaintiff’s state common law claims are preempted by the broadly sweeping arm of ERISA. Plaintiff is left without any meaningful remedy even if he were to establish that [the insurer] wrongfully refused to provide the [bone marrow transplant] his wife urgently sought.”), *aff’d*, 127 F.3d 196 (1st Cir. 1997)).

great deal more difficult for Congress to correct flawed statutes than it is to enact them in the first place . . . because interests coalesce around the advantageous aspects of the status quo. Although the alleged conduct [of wrongfully denying benefits that were clearly due to the beneficiary, resulting in his death] of Travelers and Greenspring in this case is extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Does anyone care? Do you?<sup>119</sup>

This judge brings to the forefront the serious concerns implicit in ERISA law – the lack of equitable relief allowed to injured beneficiaries in these circumstances.

In *Aetna Health, Inc. v. Davila*, there were two separate cases of egregious HMO behavior, consolidated because the preemption issues were the same for both.<sup>120</sup> Juan Davila, covered under his employer's benefit plan, was prescribed Vioxx for arthritis pain by his treating doctor.<sup>121</sup> Aetna, the plan administrator that reviews requests for coverage and pays providers, declined the prescription and advised that it would only cover Naprosyn; Davila ingested the Naprosyn and suffered a severe reaction that required hospitalization and extensive treatment.<sup>122</sup> Ruby Calad, also covered under an ERISA plan, underwent surgery and her doctor recommended an extended hospital stay to prevent post-surgery complications.<sup>123</sup> Her plan administrator's discharge nurse, a CIGNA employee, concluded that Calad did not need the extended stay and advised CIGNA to deny coverage, which it did.<sup>124</sup> Forced to return home too early, she suffered post-surgery complications and required hospitalization.<sup>125</sup>

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<sup>119</sup> *Id.* at 64-65 (first alteration in original) (footnote omitted) (quoting Catherine L. Fist, *The Last Article About the Language of ERISA Preemption?: A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 99 (1996)).

<sup>120</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 204 (2004).

<sup>121</sup> *Id.* at 205.

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

Both plaintiffs sued the plan administrators, alleging violations of a Texas bad-faith insurance statute.<sup>126</sup> The district court held that ERISA preempted the claims, and, as the plaintiffs refused to amend their complaints to allege ERISA claims, dismissed the complaints with prejudice.<sup>127</sup> On appeal, the Fifth Circuit held that plaintiffs' claims were cognizable actions under ERISA's "[section] 502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, and [section] 502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan."<sup>128</sup> But because the decisions were mixed eligibility and treatment decisions by HMOs, they were not fiduciary in nature, and no relief was available under section 502(a)(1).<sup>129</sup>

The Supreme Court noted that the plaintiffs only complained about the denials of coverage promised under the terms of the plan, and that they were fully capable of, upon denial, paying for the treatment themselves and then seeking reimbursement through a section 502(a)(1)(B) action, or through a preliminary injunction.<sup>130</sup> The Court held that essentially the claims were for the wrongful denial of benefits, which was a claim available under section 502, and that when a state law cause of action duplicates, supplements, or supplants the ERISA civil enforcement remedy, it conflicts with the clear congressional intent to make the ERISA remedy exclusive and therefore is preempted.<sup>131</sup> The Court rejected plaintiffs' argument that its claim was saved under the savings clause, which specifically regulates insurance, instead holding that because, as held in *Pilot Life Ins. Co.*, Congress set out a comprehensive remedial scheme in ERISA, and "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were

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<sup>126</sup> *Davila*, 542 U.S. at 205 (citing TEX. CIV. PRAC. & REM. § 88.001 (West 2011)).

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* at 206.

<sup>129</sup> *Id.* (citing *Pegram v. Hedrich*, 530 U.S. 211 (2000)).

<sup>130</sup> *Id.* at 211. Clearly the Court (as it was a unanimous decision) did not understand the position the plaintiffs were in and were unable to empathize or sympathize: what person can afford to pay for a hospital visit on his own, without insurance? How is this a reasonable suggestion? I cannot imagine the brazenness in even suggesting that the plaintiff take on this responsibility, when his insurance should be covering it, and failed to do so out of severe negligence. And the Court appears to support such an act, or to shield the fiduciary, when justice and Congressional intent clearly foresee a different outcome.

<sup>131</sup> *Id.* at 208-09, 213-14.

free to obtain remedies under state law that Congress rejected in ERISA.”<sup>132</sup>

Justice Ginsburg’s concurrence is enlightening; she stated that she joined the “rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.”<sup>133</sup> She noted that the Court’s interpretations of preemption and the “equitable relief” clause under section 502(a)(3) had left a “regulatory vacuum” because “virtually all state law remedies are preempted but very few federal substitutes are provided.”<sup>134</sup> She went on to give specific examples of situations in which fiduciary breaches have left the beneficiary in a deficient position due to an inability to receive ‘make-whole’ relief under ERISA.<sup>135</sup> Thus, we are left with a bad taste of ‘justice’ under ERISA: that some members of the Court recognize that it is misinterpreting or incorrectly applying ERISA, leaving plaintiffs harmed yet with little or no relief.

In *Metropolitan Life Ins. Co. v. Glenn*, the plaintiff was diagnosed with a “severe dilated cardiomyopathy, a heart condition”, and she applied for long term disability under her employer’s employee welfare benefit plan.<sup>136</sup> MetLife, the insurance provider on the plan, approved her for the initial 24 months of benefits, concluding that she could not perform the material duties of her job.<sup>137</sup> MetLife directed her to a law firm which would help her apply for Social Security disability benefits, and “an

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<sup>132</sup> *Davila*, 542 U.S. at 217 (alteration in original) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)) (internal quotation marks omitted).

<sup>133</sup> *Id.* at 222 (Ginsburg, J., concurring) (quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring)).

<sup>134</sup> *Id.* (quoting *DeFilice*, 346 F.3d at 456-57 (Becker, J., concurring)).

<sup>135</sup> *Id.* at 222-23 (citing *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (“[T]he Court stated, in dicta: [T]here is a stark absence - in [ERISA] itself and in its legislative history - of any reference to an intention to authorize the recovery of extracontractual damages for consequential injuries.”) (second and third alterations in original) (internal quotation marks omitted); *Mertens v. Hewitt Assoc.’s*, 508 U.S. 248, 255-56 (1993) (“[T]he Court held that [section] 502(a)(3)’s term ‘equitable relief’ . . . refer[s] to those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages).”) (third alteration in original) (internal quotation marks omitted); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 221 (2002) (“the Court ruled that, as [section] 502(a)(3), by its terms, only allows for equitable relief, the provision excludes “the imposition of personal liability . . . for a contractual obligation to pay money.”) (internal quotation marks omitted)).

<sup>136</sup> *Metro. Life Ins. v. Glenn*, 128 S. Ct. 2343, 2346 (2008).

<sup>137</sup> *Id.*

Administrative Law Judge found that her illness prevented her not only from performing her own job but also from performing any jobs [for which she could qualify] existing in significant numbers in the national economy,” thus meeting the standard for Social Security benefits.<sup>138</sup> She was granted permanent disability benefits, the majority of which went to MetLife and the rest of which went to the lawyers.<sup>139</sup> MetLife subsequently denied her benefits beyond the 24-month mark, determining that she was “capable of performing full time sedentary work,” applying a standard similar to the one used by the administrative judge, who had found her incapable of such work.<sup>140</sup>

She brought suit for judicial review of this denial of benefits, and the district court granted MetLife’s motion for judgment because the plan granted the plan administrator discretionary authority in deciding benefits.<sup>141</sup> The Sixth Circuit set aside the denial of benefits because of:

(1) the conflict of interest [arising from MetLife’s authority to determine whether it was obligated to pay benefits to an employee]; (2) MetLife’s failure to reconcile its own conclusion that Glenn could work in other jobs with the Social Security Administration’s conclusion that she could not; (3) MetLife’s focus upon one treating physician report suggesting that Glenn could work in other jobs at the expense of other, more detailed treating physician reports indicating that she could not; (4) MetLife’s failure to provide all of the treating physician reports to its own hired experts; and (5) MetLife’s failure to take account of evidence indicating that stress aggravated Glenn’s condition.<sup>142</sup>

The Supreme Court affirmed, holding that when a plan administrator both evaluates claims for benefits and pays benefits on claims, it creates a conflict of interest that a court may review for abuse of discretion in denying benefits, because “every dollar provided in benefits is a dollar spent by ... the employer; and every dollar saved . . . is a dollar in

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<sup>138</sup> *Id.* (internal quotation marks omitted).

<sup>139</sup> *Id.* at 2346-47.

<sup>140</sup> *Id.* at 2347.

<sup>141</sup> *Glenn v. MetLife*, 461 F.3d 660, 665 (6th Cir. 2006).

<sup>142</sup> *Metro. Life Ins.*, 128 S. Ct. at 2347.

[the employer's] pocket.”<sup>143</sup> A troubling example appears when “[t]he employer's fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary”, and “the employer has an interest . . . conflicting with that of the beneficiaries.”<sup>144</sup> Here, the Court affirmed the lower court’s review of the benefit denial, and in doing so, took a step forward in beneficiary protection.

#### B. GOOD MORNING AMERICA INVESTIGATES UNFAIR CLAIMS PRACTICES IN DISABILITY INSURANCE

In 2008, Good Morning America, a daily news program aired by ABC, broke several investigative news stories about disability insurers and unfair claims practices. In April, the story of Susan Kristoff displayed to the world the dishonest practices and lengths one insurer was willing to go to avoid paying her disability claim. She was diagnosed with Stage IV metastatic breast cancer and had several doctors’ accounts confirming that she was disabled.<sup>145</sup> The contract with Cigna, the disability insurer, provided that she be paid 60% of pre-disability income upon disability.<sup>146</sup> But Cigna denied her claims, and she spent two years attempting to furnish the “additional information” constantly requested by Cigna as “necessary” to further review her claim.<sup>147</sup> Finally, she hired a lawyer and wrote to Good Morning America about her plight. Good Morning America contacted Cigna to attempt to resolve the issue.<sup>148</sup> In response, Cigna sent a

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<sup>143</sup> *Id.* at 2348 (quoting *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987)).

<sup>144</sup> *Id.* (internal quotation marks omitted) (citing RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)); *see also* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. at 115 (1989) (citing that Restatement comment); *cf.* BLACK'S LAW DICTIONARY 319 (8th ed. 2004) (A conflict of interest is “[a] real or seeming incompatibility between one's private interests and one’s public or fiduciary duties.”)).

<sup>145</sup> *See* Chris Cuomo & Gerry Wagschal, *Denied: Fighting for Insurance Coverage*, ABC NEWS (Jun. 27, 2008), <http://abcnews.go.com/GMA/story?id=5257491&page=1>; Brent Adams, *Every Bad Faith Insurance Victim Cannot Have Good Morning America As Their Lawyer*, INJURYBOARD BLOG FAYETTEVILLE, N.C. (Feb. 1, 2009 9:20 PM), <http://fayetteville.injuryboard.com/miscellaneous/every-badfaith-insurance-victim-cannot-have.aspx?googleid=256444>.

<sup>146</sup> Adams, *supra* note 145.

<sup>147</sup> Cuomo & Wagschal, *supra* note 145; Adams, *supra* note 145.

<sup>148</sup> Cuomo & Wagschal, *supra* note 145; Adams, *supra* note 145.

canned statement to Good Morning America and promptly approved Kristoff's claim, denying that it was because of the show's involvement.<sup>149</sup>

Another story published online in 2009 described Charles Tucker's fight with Standard Insurance over disability benefits. Tucker, a 48 year-old accountant, suffered from a severe and debilitating form of multiple sclerosis.<sup>150</sup> He had been paying for long-term disability insurance coverage, but when he became too sick to work, he stopped working and filed a claim. He received constant notices requesting more information and for months could not receive a final determination from the insurer.<sup>151</sup> Eleven doctors examined Tucker, and all concluded that he had MS. However, the insurer's doctor, without examining Tucker or contacting him about the inquiry, determined that there was insufficient evidence for such a conclusion. Tucker hired an attorney and contacted Good Morning America. The show's anchor contacted the insurer and spoke with a spokeswoman for the company, Susan Pisano, also a lobbyist for America's Health Insurance Plans. The next day, Standard Insurance approved Tucker's claim, but denied that it was because of Good Morning America's investigation.<sup>152</sup>

One personal injury attorney blogged about this seeming epidemic of disability claims denials, arguing that disability claimants are in the worst position to fight denials.<sup>153</sup> He stated what should be obvious: "The disabled person is the least likely to be able to afford an attorney [because] a major source of income has been taken away."<sup>154</sup> Perhaps his assertion is correct, that most insurers are betting on the fact that denials will *not* be appealed due to lack of money, or fear that the insurer will insist that a fraud is being committed, or lack of understanding of the denial-appeal system.<sup>155</sup> If this is true, then the argument for strict regulatory oversight becomes absolutely necessary, as this will ensure that such claimants will

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<sup>149</sup> Cuomo & Wagschal, *supra* note 145; Adams, *supra* note 145.

<sup>150</sup> See Chris Cuomo & Gerry Wagschal, 'GMA' Gets Answers: Man with MS Fights for Long-Term Disability Insurance, ABC NEWS (Feb. 26, 2009), <http://abcnews.go.com/GMA/TheLaw/gma-answers-man-ms-fights-long-term-disability/story?id=6689847>.

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> See Frank J. Dito Jr, *Good Morning America Airs Report about Disability Insurance*, NEW YORK INJURY LAW BLOG (Nov. 19, 2009), <http://nyinjurylawupdateblog.com/good-morning-america-air-report-about-disability-insurance>.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

not only have fair reviews of their claims but have recourse and knowledge of the appropriate recourse.

### C. VIEWS AND RECOMMENDATIONS TO RESOLVE ERISA'S REMEDIES PROBLEM

Several authors write of different approaches for allowing extra-contractual relief under ERISA. Three authors argue that compensatory (i.e., money) damages are appropriate under ERISA's "other appropriate equitable relief" clause in section 502, because such relief is allowed in trust law.<sup>156</sup> Another argues that plaintiffs use RICO claims to receive appropriate relief.<sup>157</sup> Yet another approach argues that state insurance unfair practices statutes must be saved from preemption, as section 514(b)(2)(B) expressly enforces state insurance laws, while section 502 only generally provides remedies and does not expressly preempt insurance laws.<sup>158</sup>

#### 1. Trust Law As A Basis For Additional Remedies To Beneficiaries

In a poignant review of the U.S. Supreme Court's decision in *Aetna v. Davila*, Charlotte Johnson advocates that the Court has not enforced ERISA as it was intended by Congress, and has effectively, but inadvertently, "painted itself into a corner by restrictively interpreting ERISA to preclude compensatory relief to victims of HMO patient treatment decisions."<sup>159</sup> She argues that, as ERISA was enacted before the surge of HMOs, Congress could not have anticipated ERISA's effect and regulation of HMO liability.<sup>160</sup> The Court has time and again decided that, under ERISA, injured participants and beneficiaries may only receive traditional equitable relief, i.e., injunction or restitution, and not compensatory relief, e.g., money damages; thus, the Court has provided a shield for HMOs against plan participant claims.<sup>161</sup>

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<sup>156</sup> Johnson, *supra* note 6, at 1589; Harthill, *supra* note 6, at 722; Langbein, *Trust Law As Regulatory Law*, *supra* note 6, at 1340-41; Langbein, *What ERISA Means by "Equitable"*, *supra* note 6, 1338, 1362.

<sup>157</sup> Lalena J. Turchi, *Health Insurance: Paying the Premium or Paying the Price? – ERISA Preemption and RICO's Recourse*, 5 RUTGERS J. L. & PUB. POL'Y 526, 551-59 (2008).

<sup>158</sup> Bogan, *supra* note 6, at 113-14.

<sup>159</sup> Johnson, *supra* note 6, at 1589-90.

<sup>160</sup> *Id.* at 1590.

<sup>161</sup> *Id.*

The only way of effectively getting around this shield was pointed out by Justice Ginsburg in her *Davila* dissent: allow make-whole compensatory relief under section 502(a)(3).<sup>162</sup> The Court's interpretation of "appropriate equitable relief" is strange, in that it refuses to impose personal liability on the defendant, as that would transfer the equitable restitution to one of legal restitution.<sup>163</sup> However, section 409 allows a fiduciary to be personally liable for breaches, thus such personal liability is, in fact, permitted and authorized under ERISA.<sup>164</sup> Johnson also advocates Justice Stevens' position, that Congress intended ERISA to provide a broad framework under which the courts may apply make-whole compensatory relief, due to ERISA's skeletal framework incorporating some facets of trust law combined with Congressional intent to "protect the interests of participants in employee benefit plans."<sup>165</sup> Further, monetary (compensatory) damages are authorized under ERISA because, as shown in *Varity*, section 502(a)(5) permits payment of civil penalties for fiduciary breaches to participants and beneficiaries, and sections 502(a)(5) and 502(a)(3) are nearly identical.<sup>166</sup> Further, Johnson argues that trust law permits monetary equitable relief to individuals, yet the Court's decision to overlook this principle of trust law has resulted in fiduciary breaches, in the HMO context, to not be a breach at all.<sup>167</sup>

Johnson concedes that the remedial scheme in ERISA is properly fixed by Congress, not "creativity in the courts."<sup>168</sup> This article is encouraging in its analysis of trust law, however, the concession that only Congress can fix the problem is frustrating. Courts interpret laws, and if they misinterpret the laws, Congress may react and amend the law. Unfortunately, this does not always happen, and the health insurance industry likely has a stronghold on many politicians that prevented such an amendment from being passed.

Professor John Langbein argues that Congress only referenced trust law as a regulatory structure, by using the tenets of loyalty and prudence, but left ERISA skeletal in form to be refined by the judiciary.<sup>169</sup> The Court itself acknowledged that Congress intended the judiciary to look to settled

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<sup>162</sup> *Id.* at 1591.

<sup>163</sup> *Knudson*, 534 U.S. 204, 214 (2002).

<sup>164</sup> *See* 29 U.S.C. § 1109 (2006).

<sup>165</sup> Johnson, *supra* note 6, at 1612 (citing 29 U.S.C. § 1001(b) (2006); *Varity Corp. v. Howe*, 516 U.S. 489, 496-97, 502-03 (2006)).

<sup>166</sup> *Id.* at 1613 (citing *Varity*, 516 U.S. at 510).

<sup>167</sup> *Id.* at 1622-23.

<sup>168</sup> *Id.* at 1617.

<sup>169</sup> Langbein, *What ERISA Means by "Equitable"*, *supra* note 6, at 1326.

common law in shaping ERISA, thus creating a “federal common law of rights and obligations under ERISA-regulated plans.”<sup>170</sup> Langbein illustrates several instances where the Court failed to correctly apply trust law principles, such as in *Russell* by rejecting the plaintiff’s claim for delay damages.<sup>171</sup> Delay in making a distribution from a trust fund “has long been understood to be a breach of trust.”<sup>172</sup> In the Uniform Trust Code of 2000, money damages for breaches of trust are included in the available remedies.<sup>173</sup> In Bogert’s treatise on trust law, breaching trustees “may be directed by the court to pay damages to the beneficiary” and in cases of negligence or misconduct, the beneficiary may have a claim “to recover money damages from the trustee.”<sup>174</sup> Thus, it seems clear that trust law, in fact, does allow beneficiaries to recover compensatory and consequential damages.

In drafting ERISA, Congress surpassed trust law verbiage and further subjected the fiduciary to “such other equitable or remedial relief as the court may deem appropriate,” on top of making the fiduciary liable to the plaintiff for recovery of the loss incurred, profits made by the fiduciary in the breach, and any gains made from the breach.<sup>175</sup> This phrase is also found in section 502(a)(3), and is more expansive than the trust law standard, and it is the belief of several scholars that this language is meant to provide compensatory and consequential relief, as Congress was simply wording it in a way to address fairness.<sup>176</sup> If the Court refuses to utilize trust law principles, then perhaps the statutory construction should persuade it that, because this phrase surpasses trust law verbiage, Congress intended for fairness to govern, thus allowing additional recovery for egregious breaches.

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<sup>170</sup> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989).

<sup>171</sup> *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985).

<sup>172</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1328.

<sup>173</sup> *Id.* at 1336 (citing UNIF. TRUST CODE §§ 106, 1002 (amended 2001)).

<sup>174</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1337 (citing GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *THE LAW OF TRUSTS AND TRUSTEES* § 862, at 34, 38-39 (rev. 2d ed. 1982)).

<sup>175</sup> See ERISA § 409(a), 29 U.S.C. § 1109 (1988); Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1335.

<sup>176</sup> Langbein, *What ERISA Means by “Equitable”*, *supra* note 6, at 1335-36.

2. Applying the Savings Clause with Force: State Unfair Insurance Practices Statutes Should be Saved from Preemption under the Pilot Life Rationale

In an article written before *Davila*, Professor Donald Bogan argues that state unfair insurance practices laws should be saved from preemption under the savings clause.<sup>177</sup> These laws are specifically aimed at the regulation of the insurance industry, fulfill the requirements in the savings clause, and are saved from preemption under section 502 because of the express language in section 514(b)(2)(B), authorizing and enforcing state insurance laws to ERISA plans.<sup>178</sup> In analyzing *Pilot Life*, he argues that the Court only preempted the law at issue because it was a general bad faith law that did not specifically regulate insurance, and as such was preempted by the remedies in section 502.<sup>179</sup> In this case the Court made a landmark decision: that section 502 was intended by Congress as “the exclusive vehicle for actions by ERISA-plan participants . . . asserting improper processing of a claim for benefits.”<sup>180</sup>

Bogan points out that state unfair insurance practices statutes do more than simply provide punitive damages remedies, they “establish and define a standard of care owed by the insurer to the insured that attaches to every insurance policy.”<sup>181</sup> The Supreme Court has, in the past, declared that state insurance laws affect an integral part of the policy relationship between the insurer and insured, and are saved from preemption.<sup>182</sup> Bogan

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<sup>177</sup> Bogan, *supra* note 6, at 113-14.

<sup>178</sup> *Id.* at 114.

<sup>179</sup> *Id.* at 124-25 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)).

<sup>180</sup> *Id.* at 126 (citing *Pilot Life*, 481 U.S. at 52; *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)). In a subsequent decision by the Eleventh Circuit Court of Appeals, a claim under the Florida unfair insurance practices statute for disability benefits was denied. It was denied for two reasons: while it directly regulated insurance, it failed to meet all three prongs under the McCarran Ferguson test, thus precluding it from regulating the “business of insurance.” The court concluded that this plus the *Pilot Life* analysis forced preemption due to section 502. *Id.* at 131-32 (citing *Anschultz v. Conn. Gen. Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988)).

<sup>181</sup> *Id.* at 133.

<sup>182</sup> *See, e.g.*, *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 743-44 (1985); Bogan, *supra* note 6, at 134 (citing *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 374 (1999) (holding that a California notice-prejudice law, requiring the insurer to establish prejudice before denying a claim filed late, was saved from preemption because it served as an integral part of the policy relationship)).

asks: why are state insurance unfair practice statutes not also saved, when they clearly affect every insurance contract and “effectively create mandatory contract terms that require insurers to timely investigate and settle claims, to notify insured employees of the benefits and coverage contained in the insurance policies that are pertinent to a claim, and to refrain from attempts to obtain fraudulent releases of claims from their insureds?”<sup>183</sup> He notes several lower courts, which have held that state insurance bad faith remedies laws *do* regulate insurance and are thus saved from preemption.<sup>184</sup> Most of these cases, however, have subsequently been overruled since his article was published.

Bogan further argues that, taking Supreme Court precedent of saving insurance laws from preemption, those laws should be preempted because of the express language in section 514(b)(2)(B), even when the state remedies laws conflict with section 502, as the former expressly exempted state laws that regulate insurance.<sup>185</sup> The issue really boils down to two competing sections of the same federal statute: one provision expressly exempting certain state statutes from preemption, and one provision providing general remedies.<sup>186</sup> He asserts that statutory construction principles mandate that the courts give effect to legislative intent in such circumstances.<sup>187</sup>

The savings clause is unambiguous in its exemption of state insurance laws. There is no support in the legislative history that the court may pick and choose which insurance laws to apply, especially with regards to state insurance remedies laws.<sup>188</sup> However, looking at the statement of Senator Williams on page 7 *infra*, it would appear that the remedies in section 502 eliminate all other laws, except for the provided “narrow exceptions” in ERISA. Bogan argues that the “narrow exceptions” *are* the state insurance bad faith laws, and thus are saved from preemption and section 502.<sup>189</sup> Therefore, as the Court has saved other insurance laws from preemption under the savings clause, it should also save state

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<sup>183</sup> Bogan, *supra* note 6, at 134.

<sup>184</sup> *Id.* at 144-45. An example of the cases cited: *Colligan v. UNUM Life Ins. Co. of Am.*, No. 00-K-2512, 2001 U.S. Dist. LEXIS 8103 (D. Colo. Apr. 23, 2001), *overruled by* *Kidneigh v. UNUM Life Ins. Co.*, 345 F.2d 1182 (10th Cir. 2003).

<sup>185</sup> Bogan, *supra* note 6, at 152.

<sup>186</sup> *Id.* at 153.

<sup>187</sup> *Id.* at 153-54.

<sup>188</sup> *Id.* at 154 (citing *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 745-46 (1985)).

<sup>189</sup> *Id.* at 154.

insurance unfair practices statutes, as they were intended to be saved by Congress because they integrally affect the insurer-insured insurance policy relationship.

This is a different view on ERISA and does not entail rejecting any statutory language. I support this reading of ERISA; however, the Court has, as aptly described by Johnson, “painted itself into a corner” and likely will not adopt this reading. The Court is unlikely to undertake a sweeping change of heart and overrule twenty-plus years of precedent.<sup>190</sup>

### 3. Alternative Pleading: One Argument to Use RICO for Fraudulent Claims Practices

In an article written by an employee benefits consultant, Lalena Turchi empathizes with the strife many beneficiaries face with benefits claims against fiduciaries.<sup>191</sup> She is able to give a first-hand account of the administrative inefficiencies inherent in the insurer-provider billing system which leads to erroneous rejections, and the disheartening rejection due to a decision that the treatment is not “medically necessary.”<sup>192</sup> She argues that, since the Court has rejected application of state insurance bad faith laws, the Racketeer Influenced and Corrupt Organizations Act (RICO), found in 18 U.S.C. § 1961, should be used.<sup>193</sup> It is of note that RICO claims allow for treble damages against defendants.<sup>194</sup>

The Court allowed the plaintiffs-beneficiaries to assert a RICO claim in *Humana v. Forsyth*, and permitted the treble damage provision to

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<sup>190</sup> Perhaps the Court only takes such drastic action once a millennium, such as was necessary in *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954), and such action is not deemed as important for the health insurance industry and protection of plan participants.

<sup>191</sup> Turchi, *supra* note 157, at 526.

<sup>192</sup> *Id.* at 527.

<sup>193</sup> *Id.* at 551.

<sup>194</sup> See 18 U.S.C. § 1964(c): “Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee, except that no person may rely upon any conduct that would have been actionable as fraud in the purchase or sale of securities to establish a violation of section 1962. The exception contained in the preceding sentence does not apply to an action against any person that is criminally convicted in connection with the fraud, in which case the statute of limitations shall start to run on the date on which the conviction becomes final.”

apply in a suit against an insurer involved in a scheme where it received discounts for hospital services but failed to pass those discounts on to the plan beneficiaries. The plan agreement, which provided that the insurer would pay 80% and the insured is responsible for the remaining 20%, was not followed, as the insurer paid at a discount and forced the insured to pay more than the agreed-upon 20%.<sup>195</sup> The Court held that RICO complemented the state statutory and common law claims for relief, and therefore did not supersede, preclude or conflict with the state laws under McCarran-Ferguson.<sup>196</sup> The claims alleged violations of RICO through a pattern of racketeering activity consisting of mail, wire, radio and television fraud.<sup>197</sup> The Court noted that RICO advances the state's interest in protecting against insurance fraud and does not frustrate state policy, and insurers have relied on RICO when bringing fraud claims.<sup>198</sup> However, this insurer was not governed under ERISA.

*Turchi* finds support for RICO claims in ERISA plans in several cases, such as *Maio v. Aetna*, where plan participants in an HMO brought suit against the insurer for overpayment of insurance.<sup>199</sup> While the court dismissed for lack of standing, it stated that the plaintiffs would have had standing if they had alleged that the health care received under the plan "actually was compromised or diminished as a result of insurer's management decisions challenged in the complaint."<sup>200</sup> Accordingly, had the proper allegations been made, a RICO claim apparently would have been permissible. In another case, a plaintiff sued for a fraudulent insurance telemarketing scheme when an insurer sold her a death and dismemberment policy with limited value, and led her to believe it was a term life plan.<sup>201</sup> The district court, granting a motion to dismiss in part, however, stated that her loss of funds through premiums paid to the insurer was a cognizable injury to property as required under RICO.<sup>202</sup>

In *Klay v. Humana, Inc.*, a suit brought by physicians against HMOs, the doctors alleged that the HMOs were engaged in a scheme to underpay the physicians via a computer program that reimbursed the

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<sup>195</sup> *Id.* at 552 (citing *Humana, Inc. v. Forsyth*, 525 U.S. 299, 299-301 (1999)).

<sup>196</sup> *See* 525 U.S. at 311.

<sup>197</sup> *Id.* at 299 (citing RICO, 18 U.S.C. § 1961).

<sup>198</sup> *Humana*, 525 U.S. at 299, 302.

<sup>199</sup> *Turchi*, *supra* note 157, at 554 (citing *Maio v. Aetna, Inc.*, 221 F.3d 472 (3d Cir. 2000)).

<sup>200</sup> *Id.* (citing *Maio*, 221 F.3d at 472).

<sup>201</sup> *See McClain v. Coverdell & Co.*, 272 F. Supp. 2d 631, 634 (E.D. Mich. 2003).

<sup>202</sup> *Turchi*, *supra* note 157, at 555 (citing *McClain*, 272 F. Supp. 2d at 637).

physicians based on “financially expedient cost and actuarial data rather than medical necessity.”<sup>203</sup> The RICO claims included racketeering activities through mail fraud, wire fraud, and extortion, as the HMOs threatened that the physicians, if they refused to cooperate, would lose patients, be blacklisted, and not be paid in full if they were not under contract with the HMO.<sup>204</sup> The Eleventh Circuit held that “it would be unjust to allow corporation to engage in rampant and systemic wrongdoing, and then allow them to avoid class actions because the consequences of being held accountable for the misdeeds would be financially ruinous” in response to the insurers’ argument that such a suit would devastate the health care industry.<sup>205</sup>

Turchi argues that health plan participants suffer the same harm and experience the same calculated wrongdoing when denied benefits as the plaintiffs in the above mentioned cases, and RICO claims are the best method to obtain adequate remedies.<sup>206</sup> Her analysis states that, in allowing a RICO claim, the Court will provide the much needed relief for ERISA preemption when an insurer denies benefits and insured suffers injuries, as it will force insurance companies to be more conservative in their benefit denials when there is a possibility for treble damages for bad faith.<sup>207</sup>

This approach is optimistic and inventive. Unfortunately, it is likely to be rejected by the Supreme Court, under the view that the remedies provided in section 502 are the sole remedies available. It is not an issue of federal versus state laws that can apply; the issue is that the language in section 502 is narrowly construed by the Court, and such a narrow interpretation will likely not allow a plaintiff to invoke RICO as the “other appropriate equitable relief” allowed under section 502(a)(3). An alternative to this is stricter regulatory oversight of insurers, specifically ERISA insurers, which should have the same result – compliance with insurance regulations and protection of beneficiaries.

#### IV. CASE STUDY: UNUM PROVIDENT

The Unum scandal has been immortalized as probably the most egregious known scheme to defraud participants and commit fiduciary

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<sup>203</sup> *Id.* at 557 (citing *Klay v. Humana, Inc.*, 382 F.3d 1241, 1246 (11th Cir. 2004), *cert. denied*, 543 U.S. 1081 (2005)).

<sup>204</sup> *Id.*

<sup>205</sup> *Id.* at 559 (citing *Klay*, 382 F.3d at 1274).

<sup>206</sup> *Id.* at 560.

<sup>207</sup> *Id.*

breaches. Unum is a disability insurer. It is made up of the parent company, Unum Group, and several subsidiaries, including Unum Life Insurance Company of America, the Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, and First Unum Life Insurance Company. In 1997, the parent company acquired the Paul Revere Company, a Massachusetts corporation providing individual long-term disability insurance.<sup>208</sup> In 1999, the parent company became Unum as a result of a merger between Unum Corporation and Provident Companies, Inc. When the companies were merged, an oversight resulted in no streamlining of policies, practices or procedures among the newly acquired groups.<sup>209</sup> Thus, claims adjusters were localized and followed whatever procedures had been in place before the merger and had little oversight by the parent company.

#### A. THE LAWSUITS AND SCANDAL

An attorney at Unum realized that the company could gain discretionary review of its plan decisions, i.e., its claim denials, by incorporating *Firestone* language, which limits judicial review of benefit denials to only abuse of discretion situations.<sup>210</sup> An internal Unum executive memorandum advocated the “enormous advantages that ERISA, as interpreted by the courts, bestowed upon Unum” because of state law

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<sup>208</sup> MULTISTATE MARKET CONDUCT EXAMINATION REPORT, Rackeman, Sawyer & Brewster, P.C., submitted to state departments of insurance at 2 (Apr. 14, 2008).

<sup>209</sup> Telephone interview with senior management employee, Unum (July 1, 2010). The interviewee requested to remain anonymous.

<sup>210</sup> *Id.* at 1321; *see Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 111, 115 (1989) (Stating: “Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. *See* Restatement (Second) of Trusts § 187 (1959) ([w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion’). *See also* G. Bogert & G. Bogert, *Law of Trusts and Trustees* § 560, pp. 193-208 (2d rev. ed. 1980). A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee’s interpretation will not be disturbed if reasonable. *Id.*, § 559, at 169-71. Whether ‘the exercise of a power is permissive or mandatory depends upon the terms of the trust.’ 3 W. Fratcher, *Scott on Trusts* § 187, p. 14 (4th ed. 1988).”)

preemption.<sup>211</sup> Further, it advocated that such protection precludes jury trials, compensatory or punitive damages, and provides relief only for the amount of the benefit in question, which Unum would have had to pay anyway, but not before the claimant pays a lot of money and time to force such payment.<sup>212</sup> The memorandum went on to state that twelve claims situations were identified “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.”<sup>213</sup> This memo illustrates ERISA’s weaknesses and insurers’ ability to exploit those weaknesses (loopholes which shield insurers from liability and penalties), to the detriment of beneficiaries with claims.

J. Harold Chandler, the CEO of Unum until 2003, instituted cost-containment measures, whereby claims processors were pressured to deny valid claims, especially during the last month of the quarter to meet “projections” and “budget goals.”<sup>214</sup> Several investigative reporting television programs demonstrated these mechanisms through internal Unum emails, which advised claims employees to deny claims in order to meet desired goals.<sup>215</sup> One Unum employee, a staff physician, admitted that Unum instructed him to use language to support denials of disability claims and denied him the ability to request additional medical testing to fully determine a claimant’s disability.<sup>216</sup>

In *Weiss v. First Unum Life Insurance Co.*, the beneficiary, Weiss, sued First Unum under RICO, claiming that First Unum discontinued payment of his disability benefits as part of its racketeering scheme involving an intentional and illegal policy of rejecting expensive payouts to disabled insureds.<sup>217</sup> Weiss, an investment banker, had insurance through his employer, which included long-term disability (“LTD”) insurance by First Unum. He had a heart attack in 2001, which left him suffering permanently with ventricular tachycardia and unable to work due to lightheadedness, weakness, and shortness of breath.<sup>218</sup> His claim for was

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<sup>211</sup> *Id.* at 1321 (citing Memorandum from Jeff McCall to IDC Management Group & Glenn Felton, Provident Internal Memorandum, Re: ERISA (Oct. 2, 1995)).

<sup>212</sup> *See id.*

<sup>213</sup> *Id.* (citing Memorandum, *supra* note 211).

<sup>214</sup> Langbein, *Trust Law as Regulatory Law*, *supra* note 6, at 1318.

<sup>215</sup> *Id.* at 1319.

<sup>216</sup> *Id.* (citing *McSharry v. Unum/Provident Corp.*, 237 F. Supp. 2d 875, 877 (E.D. Tenn. 2002)).

<sup>217</sup> *Weiss v. First Unum Life Ins. Co.*, 482 F.3d 254, 255-56 (3d Cir. 2007).

<sup>218</sup> *Id.* at 256.

approved for short-term disability benefits, which resulted in seven months of benefit payments.<sup>219</sup> At the end of the maximum allowable short-term disability benefits, Unum paid Weiss LTD benefits for another three months, and then discontinued paying benefits.<sup>220</sup> Weiss brought suit in state court, and Unum removed to federal court and filed a motion to dismiss, arguing that the state claims were preempted under ERISA.<sup>221</sup> While the case was pending, Unum resumed payment of his LTD benefits, retroactive to the prior termination date.<sup>222</sup>

Weiss added both federal and state RICO claims, arguing that his claim was terminated because it exceeded \$11,000 per month.<sup>223</sup> In support of this argument, he alleged that on October 3, 2001, defendants David Gilbert, Paul Keenan, George DiDonna, Lucy-Baird Stoddard, Unum employees, and others conspired at a roundtable meeting to terminate Weiss's benefits and devise a rationalization for doing so.<sup>224</sup> Weiss claimed that DiDonna, the insurer physician, did not receive or examine his hospital records until the termination decision was reached, and tests that would make clear the severity of his injury were purposely never ordered.<sup>225</sup> Weiss sidestepped a simple state bad faith claim by arguing that his denial is one instance in a pattern of fraudulent activity by First Unum aimed at depriving its insureds with large disability payouts of their contractual benefits.<sup>226</sup>

The District Court dismissed his RICO claims, believing that the allowance of such a RICO claim would interfere with New Jersey's statutory regulation of insurers, and thus run afoul of the McCarran-Ferguson Act.<sup>227</sup> The Third Circuit Court of Appeals reversed, using the *Humana* analysis for ability to assert RICO claims.<sup>228</sup> The court noted that

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<sup>219</sup> *See id.*

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> *Weiss*, 482 F.3d at 257.

<sup>224</sup> *Id.*

<sup>225</sup> *Id.*

<sup>226</sup> *Id.*

<sup>227</sup> *Id.* at 255.

<sup>228</sup> *Id.* at 256. The court expansively noted *Humana v. Forsyth* in its analysis, stating: "In sum, the *Humana* analysis explored the specific interplay between RICO and the state insurance scheme. As described above, the non-exclusive list of factors the Court examined in *Humana* included the following: (1) the availability of a private right of action under state statute; (2) the availability of a common law right of action; (3) the possibility that other state laws provided

the state insurance trade practices act (“ITPA”) allowed the insurance commissioner to determine whether an insurer had engaged in an unfair or deceptive practice, which includes unfair claims settlement practices.<sup>229</sup> If a violation was found, the commissioner may assess a \$1,000 penalty for each negligent act or violation, unless the insurer knew or should have known the act was a violation - then the penalty is \$5,000 per act or violation.<sup>230</sup> The commissioner was required to investigate upon receipt of a consumer complaint of a violation of this act, and upon a finding of violations, may order the insurer to pay restitution to the aggrieved party or other equitable relief.<sup>231</sup> The court also found there was a state common law private right of action against insurers for wrongly withheld benefits, other state laws allow claims, and the New Jersey Consumer Fraud Act, which provided treble damages available to redress such violations.<sup>232</sup>

The appeals court found that the claim alleged that First Unum embarked on a fraudulent scheme to deny insureds their rightful benefits, “clearly an unconscionable commercial practice in connection with the performance of its obligations subsequent to the sale of merchandise, i.e. payment of benefits.”<sup>233</sup> Ultimately, the court held that Weiss could appropriately bring a RICO claim against First Unum, and remanded the case.<sup>234</sup>

In *McCauley v. First Unum*, the plaintiff’s disability insurance was through his employer plan and First Unum was both the administrator and payor of benefits.<sup>235</sup> McCauley was diagnosed with advanced colon cancer in April 1991 and underwent severe chemotherapy treatments to save his life.<sup>236</sup> Due to these treatments, he took several short-term disability leaves

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grounds for suit; (4) the availability of punitive damages; (5) the fact that the damages available (in the case of Nevada, punitive damages) could exceed the amount recoverable under RICO, even taking into account RICO’s treble damages provision; (6) the absence of a position by the State as to any interest in any state policy or their administrative regime; and (7) the fact that insurers have relied on RICO to eradicate insurance fraud.” *Id.* at 261 (citing *Humana*, 525 U.S. at 311-14).

<sup>229</sup> *Weiss*, 462 F.3d. at 263 (citing N.J. STAT. § 17:29B-5 (2003)).

<sup>230</sup> *Id.* (citing N.J. STAT. § 17:29B-7(a) (2003)).

<sup>231</sup> *Id.* at 264 (citing N.J. STAT. § 17:29B-18 (2003)).

<sup>232</sup> *Id.* at 264-67.

<sup>233</sup> *Id.* at 266.

<sup>234</sup> *Id.* at 269. Note here that the court completely failed to mention ERISA’s preemption clauses and section 502, which limits the remedies available.

<sup>235</sup> *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126, 129 (2d Cir. 2008).

<sup>236</sup> *Id.* at 128-29.

in 1991 under the group disability plan.<sup>237</sup> Over the next three years, he experienced health problems in connection with his cancer and took several short-term disability leaves.<sup>238</sup> In 1994, he notified his employer that his health conditions were too traumatic and he could not continue to work.<sup>239</sup>

In May 1995, First Unum denied his claim.<sup>240</sup> Upon McCauley's appeal and submission of additional information, First Unum again rejected his claim in September 1995.<sup>241</sup> McCauley attempted to rejoin the workforce and accepted a General Counsel position, but his health problems persisted.<sup>242</sup> Because he found work, his former employer ceased paying the disability plan premiums and advised him to convert the policy and make future payments, which he did.<sup>243</sup> On January 16, 1996, he applied for long-term disability benefits under his conversion policy, as he accepted that he simply could not work due to his severe health problems.<sup>244</sup> First Unum again denied his claim on the basis that the employment with the former employer had terminated in 1994, and, therefore, that he had exercised his conversion after the allowable period.<sup>245</sup>

McCauley brought suit for wrongful denial of benefits. He alleged that certain procedural irregularities, such as missing documents from his file and the incorrect assertion to McCauley that a medical doctor reviewed his file (only a nurse reviewed it) which occurred in the handling of his claim demonstrated that First Unum's conflict of interest had affected its decision to deny him benefits.<sup>246</sup> While both courts held that the insurer's first denial of benefits was proper, as McCauley's physician's letter did not indicate total disability,<sup>247</sup> the additional information submitted should have resulted in coverage.<sup>247</sup> This additional information was a memorandum

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<sup>237</sup> *Id.* at 129.

<sup>238</sup> *Id.*, noting, for instance, he had part of his liver removed because cancer was found, and subsequently suffered a severe liver infection. He also underwent surgery to repair a hernia. *Id.*

<sup>239</sup> *Id.* The court noted his physical traumas, stating that, while the cancer treatment was successful, it caused "chronic diarrhea, chronic and acute renal impairment, incontinence, progressive vascular sclerosis, high cholesterol, insomnia, depression, and incisional scarring and pain." *Id.*

<sup>240</sup> *Id.*

<sup>241</sup> *McCauley*, 551 F.3d at 129.

<sup>242</sup> *Id.*

<sup>243</sup> *Id.*

<sup>244</sup> *Id.*

<sup>245</sup> *Id.*

<sup>246</sup> *Id.* at 131.

<sup>247</sup> *McCauley*, 551 F.3d at 134.

written by McCauley, with the advice and knowledge of his physician, listing his medical issues as (1) chronic diarrhea, (2) chronic and acute renal impairment, (3) progressive vascular sclerosis, (4) high cholesterol, (5) insomnia, and (6) incisional scarring and pain, and stated:

[He] is only able to control bowel movements by carefully timing his food ingestion and lists a number of ways in which this limits his daily activities. Respecting his renal impairment, the memorandum explains that McCauley has chronic blood in the urine and pain in the kidney area and that he forms a kidney stone every two weeks. As a result, his physician recommends that he not sit for long periods of time. Moreover, the memorandum states that during the acute phase of his renal impairment, “it is impossible for the patient to perform at any level.” As to his vascular sclerosis, the memorandum explains that McCauley’s vascular system was permanently damaged by the chemotherapy treatments and that he suffers “severe chronic headaches at the base of the skull, resulting in an inability to focus eyesight and a lack of concentration.” His insomnia is described as “chronic and recurring,” resulting in a “general feeling of lethargy and malaise” and leaving him with a “need to take naps during the day.” The memorandum also states that McCauley “is in pain on an almost constant basis” and takes Percocet, an opiate, to manage that pain.<sup>248</sup>

A nurse, not a doctor, reviewed this additional evidence and rejected his claim, because it was “not an official document from [an] attending physician.”<sup>249</sup> However, the rejection letter stated that it had rejected the claim because “these conditions were acknowledged by your physician on the initial application and in his narrative letter of March 1995.”<sup>250</sup>

The court granted First Unum’s motion for summary judgment, stating that a *de novo* standard of review of the benefit denial was not applicable because the plan had *Firestone* language (which granted the insurer discretionary authority in benefit determinations, and a court may

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<sup>248</sup> *Id.* at 134-35.

<sup>249</sup> *Id.* at 135.

<sup>250</sup> *Id.* “First Unum never told McCauley that the absence of a physician’s signature was a reason for rejecting his information.” *Id.*

only review where there has been an arbitrary or capricious action).<sup>251</sup> On appeal, the Second Circuit Court of Appeals reversed, under the *Metropolitan Life v. Glenn* standard, and found that the plan administrator abused its discretion in denying the plaintiff's second claim for long-term disability benefits, because its reason for doing so was deceptive and unreasonable.<sup>252</sup>

Several bad faith suits were brought against Unum, and in one case (a non-ERISA case), a five million dollar punitive judgment was awarded by the jury due to the egregious bad faith acts by Unum.<sup>253</sup> A district court in Massachusetts wrote that “an examination of cases involving First Unum . . . reveals a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.”<sup>254</sup> That court listed more than thirty cases in which First Unum's denials were found to be unlawful, including one decision in which the behavior was “culpably abusive.”<sup>255</sup> A state insurance commissioner noted that Unum looked “for every technical legal way to avoid paying a claim.”<sup>256</sup> Several insurance state commissioners enforced fines, to the tune of millions of dollars, for the unfair and egregious claims practices of Unum employees.<sup>257</sup>

#### B. THE REGULATORY AUTHORITIES STEP IN

On January 7, 2003, the Massachusetts Division of Insurance conducted a market conduct examination of the Paul Revere Company's handling practices of individual disability insurance claims (“IDI”

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<sup>251</sup> *Id.* at 130-31.

<sup>252</sup> *Id.* at 128, 133, 135 (“Following *Glenn*, a plan under which an administrator both evaluates and pays benefits claims creates the kind of conflict of interest that courts must take into account and weigh as a factor in determining whether there was an abuse of discretion, but does not make *de novo* review appropriate.” (citing *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2348, 2348 (2008))).

<sup>253</sup> Langbein, *Trust Law as Regulatory Law*, *supra* note 6, at 1319 (citing *Hangarter v. Paul Revere Life Ins. Co.*, 236 F. Supp. 2d 1069, 1082 (N.D. Cal. 2002), *aff'd*, 373 F.3d 998 (9th Cir. 2004)).

<sup>254</sup> *Radford Trust v. First Unum Life Ins. Co of Am.*, 321 F. Supp. 2d 226, 247 (D. Mass. 2004), *rev'd on other grounds*, 491 F.3d 21, 25 (1st Cir. 2007).

<sup>255</sup> *Id.* at 247 n.20.

<sup>256</sup> Langbein, *Trust Law as Regulatory Law*, *supra* note 6, at 1320 (citing Mike Pare, *\$1 Million Fine Hits Unum*, CHATTANOOGA TIMES FREE PRESS, Mar. 19, 2003, at C1).

<sup>257</sup> *See id.*

claims).<sup>258</sup> In September 2003, a multistate targeted market conduct examination was commenced by the Maine Bureau of Insurance, the Massachusetts Division of Insurance, and the Tennessee Department of Commerce and Insurance, concerning the claims practices of Unum, Revere and Provident in both IDI and group LTC policies.<sup>259</sup> Additionally, the remaining forty-seven states plus the District of Columbia acted as “participating states” in this 2003 exam.<sup>260</sup> Contemporaneously with the Multistate Examination, the Department of Labor conducted an investigation of the companies (the “DOL Investigation”) pursuant to Section 504 of ERISA.<sup>261</sup>

According to the exam report, the examination team requested the companies to provide a comprehensive database including all claims closed during 2002.<sup>262</sup> Initially, 300 claim files randomly selected from IDI and LTD claims closed during 2002, or for which benefit determinations were appealed or litigated during 2002, or claims open as of year-end 2002 were evaluated for the initial review.<sup>263</sup> The initial review comprised 300 claims (100 claims each for Unum, Revere and Provident).<sup>264</sup> “The proportion of selected IDI and LTD claims was based on the relative reported reserves for each company as of December 31, 2002.”<sup>265</sup> The team also commenced a second, follow-up review in 2004, as the companies advised that they had made several changes in claim administration implemented in 2003.<sup>266</sup>

The initial review actually consisted of 299 files instead of 300, because the companies were unable to locate one of the claims files

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<sup>258</sup> 2008 MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 208, at 3.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.* at 3-4.

<sup>261</sup> *Unum Provident Regulatory Settlement Agreement*, § A.3, MAINE.GOV (Nov. 2004), [http://www.maine.gov/pfr/insurance/unum/UNUM\\_Regulatory\\_Settlement\\_Agreement.htm](http://www.maine.gov/pfr/insurance/unum/UNUM_Regulatory_Settlement_Agreement.htm).

<sup>262</sup> TARGETED MULTISTATE MARKET CONDUCT EXAMINATION REPORT, MAINE.GOV (Nov. 18, 2004), [http://www.maine.gov/pfr/insurance/unum/Unum\\_Multistate\\_ExamReport.htm](http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm).

<sup>263</sup> *Id.*

<sup>264</sup> *Id.*

<sup>265</sup> *Id.*

<sup>266</sup> *Id.* In 2004, the team reviewed 75 claim files (25 each for Unum, Revere and Provident) which were randomly selected from the Companies’ IDI and LTD claims for which benefit determinations were first appealed during the period of December 2003 through February 2004. *Id.*

selected for review.<sup>267</sup> This initial review concluded with four “general areas of concern” for both the IDI and LTD claims handling. The four areas were: (1) excessive reliance on in-house medical professionals; (2) an unfair bias and inappropriate interpretation of medical reports to the detriment of claimants based on the excessive reliance upon the in-house medical professionals; (3) failure to evaluate the totality of the claimants’ medical conditions (benefits were denied due to the failure to “properly evaluate cumulative effects” of multiple claimant conditions); and (4) the inappropriate burden placed on claimants to justify eligibility for benefits.<sup>268</sup>

After the follow up review in 2004, the team concluded that further regulatory action was necessary, resulting in the Regulatory Settlement Agreements (“RSA”), which provided a “Plan of Corrective Action” that the companies implement in their claims handling procedures.<sup>269</sup> The RSA stated that a further review would be completed in 24 months to assess implementation of the practice and procedures set forth in the RSA.<sup>270</sup> The RSA also provided for a \$15 million penalty to be paid by the companies.<sup>271</sup>

The RSA required the following changes in claims practices and procedures to reduce any potential bias and promote claims handling accuracy:

- The engagement of experienced claim personnel at the earliest possible stage of claim reviews;
- Increased emphasis upon claim staff accountability for compliance with the terms of insurance policies and applicable law;
- Increased involvement of higher levels of claim management staff in each claim denial or claim termination decision;
- Creation of a separate compliance/accountability function at the claim denial and claim termination level;

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<sup>267</sup> *Id.*

<sup>268</sup> TARGETED MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 262.

<sup>269</sup> *Id.*

<sup>270</sup> *Id.*

<sup>271</sup> *Id.*

- Assurance that co-morbid conditions are properly evaluated at every level of claim review;
- Increased utilization of Independent Medical Examinations;
- Additional compliance training for all claim staff, with emphasis upon the results of the multistate examination, the Plan, and the NAIC Unfair Claim Settlement Practices Act; and
- Additional training for group policyholder human resources personnel so as to better facilitate the process for LTD claims.<sup>272</sup>

With regards to the corporate governance, the companies were required to address corporate control issues by implementing the following changes:

- The Board of Directors of the Parent Company will be expanded by three members, each of which will have significant insurance industry or insurance regulatory experience (two will have regulatory experience); each candidate will be approved by the Lead States and by the DOL;
- The Audit Committee of the Board of Directors will be expanded by one member; at least one of the new members of the Board of Directors will be appointed to the Audit Committee;
- The Board of Directors will establish a new Regulatory Compliance Committee, comprised of two of the new members of the Board, and three existing independent directors; the Regulatory Compliance Committee will have responsibility for monitoring compliance with the Plan and other compliance-related oversight functions; and
- The companies will create a Regulatory Compliance Unit, which will report directly to the Regulatory Compliance Committee; the Regulatory Compliance Unit will monitor compliance with the Plan (including the functions of the Claim Reassessment Unit) through the performance of periodic audits, provide assistance

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<sup>272</sup> *Id.* See also Unum Provident Regulatory Settlement Agreement, *supra* note 261, at § B.3.h.

to claimants to ease and facilitate the claim submission process, and gather data for the Lead States' ongoing monitoring of compliance with the Plan.<sup>273</sup>

Further, the RSA and Plan required the Regulatory Compliance Committee, the companies' senior management, the lead regulators and the DOL to meet on a quarterly basis to evaluate compliance with the Plan and RSA.<sup>274</sup> In 2005, the RSA was amended to allow LTD and IDI claimants the opportunity to have denied claims reassessed.<sup>275</sup>

The reassessment of claims was performed by the Claim Reassessment Unit ("CRU"), a newly formed claims unit within the companies.<sup>276</sup> Its results were evaluated in another multistate market conduct examination, conducted in 2007, to evaluate compliance by the companies. More than 79,000 claimants elected to have their claims reassessed, however, only 23,190 claimants correctly submitted the required Reassessment Information Forms.<sup>277</sup> Therefore, only 23,190 claims were actually reassessed by the companies, which is approximately 29% of the total requested reassessments.<sup>278</sup>

The examining team concluded that 41.7% of the claims (including both IDI and LTD) reassessed were reversed in whole or part, resulting in approximately \$676.2 million in benefits paid to claimants, either immediately or reserved for future payments.<sup>279</sup> Forty-five percent of the LTD reassessed claims were reversed in whole or part, resulting in approximately \$558.6 million of benefits paid or reserved for future payment.<sup>280</sup> Twenty-two percent of IDI reassessed claims were reversed in whole or part, resulting in approximately \$117.6 million in benefits paid or

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<sup>273</sup> TARGETED MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 262.

<sup>274</sup> *Id.*

<sup>275</sup> *Amendment to Unum Provident Regulatory Settlement Agreement*, MAINE.GOV (Oct. 3, 2005), [http://www.maine.gov/pfr/insurance/unum/UNUM\\_RSA\\_Amendment.htm](http://www.maine.gov/pfr/insurance/unum/UNUM_RSA_Amendment.htm).

<sup>276</sup> 2008 MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 208, at 6.

<sup>277</sup> *Id.*

<sup>278</sup> *Id.* It is unclear why only 29% of the claimants correctly filed the Reassessment Forms. The Report indicates that Unum correctly mailed the forms to the claimants, as required under the RSA.

<sup>279</sup> *Id.*

<sup>280</sup> *Id.*

reserved for future payment.<sup>281</sup> In total, it appears the companies paid more than a billion dollars in benefits due to the reassessed claims.

The 2007 exam also evaluated the companies' compliance with the claims procedures required under the RSA. The team evaluated claims reassessed by the CRU, both IDI and LTD, along with a sample of claims assessed by other claims personnel.<sup>282</sup> The team assessed 50 CRU IDI claims, 100 CRU LTD claims, 50 Operations IDI claims, and 100 Operations LTD claims.<sup>283</sup> According to the RSA, the error rate in claims could not exceed 7% for each area assessed.<sup>284</sup> The team concluded that the companies were well below this error rate, and in some instances there were zero errors.<sup>285</sup> Therefore, according to the 2008 multistate market conduct examination report, the companies are in complete compliance with the RSA.

In 2007, California's Department of Insurance ("CDI") also conducted an independent market conduct exam, releasing the report in 2008.<sup>286</sup> The examiners evaluated the reassessed claims subject to the separate California Settlement Agreement between Unum and CDI. One hundred and ninety-one reassessed claims were reviewed, along with 30 post-CSA claims (closed between December 2005 and May 2006) and 60 post-CSA claims (closed between August 2006 and July 2007).<sup>287</sup>

The examiners found seven violations in evaluating the 191 reassessed claims (approximately 3% error).<sup>288</sup> The violations included: (1) five instances of failure to comply with the CSA's definition of "total disability" in denying claims and (2) two instances of failure to effectuate

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<sup>281</sup> *Id.* at 7.

<sup>282</sup> 2008 MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 208, at 8-9.

<sup>283</sup> *Id.* at 9.

<sup>284</sup> *Id.* at 10; *see also* Unum Provident Regulatory Settlement Agreement, *supra* note 261, at § B.3.j.

<sup>285</sup> 2008 MULTISTATE MARKET CONDUCT EXAMINATION REPORT, *supra* note 208, at 10.

<sup>286</sup> CALIFORNIA DEPARTMENT OF INSURANCE, REPORT OF THE MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF UNUM LIFE INSURANCE COMPANY, PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, AND PAUL REVERE LIFE INSURANCE COMPANY 2 (2008), *available at* [http://www20.insurance.ca.gov/e\\_pubacc/REPORT/109890.htm](http://www20.insurance.ca.gov/e_pubacc/REPORT/109890.htm) [hereinafter CALIFORNIA INSURANCE MARKET CONDUCT REPORT].

<sup>287</sup> *Id.* at 3. The breakdown of claims reviewed: 137 group LTD claims and 54 IDI claims. *Id.* at 7.

<sup>288</sup> *Id.* at 4.

prompt, fair and equitable settlements of claims where liability was reasonably clear.<sup>289</sup> In response, Unum voluntarily imposed a written refresher training course for the CRU employees, emphasizing compliance, and reassessed the noted claims.<sup>290</sup>

There were no violations found in the 90 post-CSA claims.<sup>291</sup> The report noted a 54% drop in consumer complaints against Unum after it adopted the measures required in the regulatory settlement agreements.<sup>292</sup>

#### C. THE REST OF THE STORY: UNUM IS NOW A MODEL DISABILITY INSURER AND TRIES TO AMELIORATE ITS BAD REPUTATION

I had the opportunity to speak with a senior management employee at Unum. He acknowledged the egregious behavior which occurred and resulted in the lawsuits and RSA, but was very clear about Unum's complete turnaround. He advised that it is a completely different company under these new claims practices and procedures, as evidenced by the most recent market conduct reports. The procedures implemented to ensure compliance and fairness include an ethics hotline, where employees are encouraged to report any wrongdoing in business practice and remain anonymous, a notice to beneficiaries upon a denied claim of their right to request an independent medical exam, a requirements for claims personnel to contact attending physicians if there are questions or when clarification is necessary, and a policy to give significant weight to social security disability decisions and attending physician decisions.<sup>293</sup>

The departments of insurance view this outcome as a success. In a 2009 letter from the Maine, Massachusetts, Tennessee and New York departments of Insurance to the editor of the Insurance Forum, the commissioners and superintendents advocated that the "systemic misconduct" that led to the multistate examinations was no longer present at Unum, according to the latest exam reports.<sup>294</sup> Mila Kaufman, superintendent of the Maine Department Insurance declared that "this case . . . is an example of effective state-based insurance regulation for insurance

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<sup>289</sup> *Id.* at 10-11.

<sup>290</sup> *Id.* at 6.

<sup>291</sup> *Id.* at 4.

<sup>292</sup> CALIFORNIA INSURANCE MARKET CONDUCT REPORT, *supra* note 286, at 7.

<sup>293</sup> *Id.* at 6.

<sup>294</sup> Letter from Me. Bureau of Ins., Mass. Div. of Ins., Tenn. Dep't of Commerce and Ins., and N.Y. Dep't of Ins. to Joseph Belth, Editor, The Ins. Forum (Jan. 6, 2009) (on file with author), *available at* [http://www.maine.gov/pfr/insurance/unum/unum\\_exam\\_settlement.htm](http://www.maine.gov/pfr/insurance/unum/unum_exam_settlement.htm).

consumers. Regulators identified a problem and worked together to effectively address it.”<sup>295</sup> She went on to support Unum’s change, stating “it is also an example of an insurer reforming its practices and becoming a model for other insurers. The strong new processes and the resulting change in corporate culture – measure by the very low rate and in some cases a 0% error in claim determinations is remarkable.”<sup>296</sup> This view was also advocated by the Massachusetts Insurance Commissioner, stating she “is pleased” with Unum Group’s compliance and using the procedures to “ensure its claimants are treated fairly going forward.”<sup>297</sup>

In my interview, the company seems to be frustrated with the lack of knowledge of the RSA and changes in procedure. In my insurance classes, when studying bad faith and ERISA law, we read about the Unum cases but never read about the regulatory involvement; perhaps due to time constraints. Unum is a great case study to show regulators working together to reform an insurer into a fully compliant and better market actor. During the RSA negotiations, Unum was advised that the standards provided in the RSA would eventually be enforced nationally. Unfortunately, this is not true, as is seen from the Good Morning America cases.<sup>298</sup>

#### V. MORE REGULATORY OVERSIGHT WILL ALLEVIATE EGREGIOUS INSURER ACTIONS AND ENSURE COMPLIANCE

The kind of regulatory cooperation between states that occurred in the Unum case is exactly what is needed at present to ensure beneficiaries are protected from unscrupulous insurers. As discussed, ERISA fails to provide the remedies to claimants when benefits are wrongly denied. As the Supreme Court is unlikely to change its position on interpreting ERISA and Congress is unlikely to amend ERISA, it is left to the state regulators to

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<sup>295</sup> Press Release, Mila Kaufman, Superintendent, Me. Bureau of Ins., Unum Landmark Multi-State Settlement Agreement and Examinations Concluded (Apr. 15, 2008) (on file with author), *available at* <http://www.maine.gov/tools/whatsnew/index.php?topic=INS-PressReleases&id=54160&v=Default>.

<sup>296</sup> *Id.*

<sup>297</sup> Press Release, Mass. Office of Consumer Affairs & Bus. Regulation, Div. of Ins. Completes Review of Unum Group Disability Claims Payments (Apr. 15, 2008) (on file with author), *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=2008+DOI+Press+Releases&sid=Eoca&b=terminalcontent&f=doi\\_Media\\_media\\_press\\_73&csid=Eoca](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=2008+DOI+Press+Releases&sid=Eoca&b=terminalcontent&f=doi_Media_media_press_73&csid=Eoca).

<sup>298</sup> *See supra* Part III.B, pp. 29-30.

effect change and compliance. Per the savings clause, ERISA insurers are still subject to compliance with state insurance laws. Thus, regulators must strictly enforce the types of procedures required of Unum as to all ERISA insurers, which will alleviate the need for money damages; as such procedures and examinations will ensure compliance and result in protection of beneficiaries. To this end, the National Association of Insurance Commissioners (NAIC) should assist in implementing this change.

#### A. PURPOSE OF STATE DEPARTMENTS OF INSURANCE

Each state has a regulatory authority which oversees the insurance industry transacting business in its state. They generally regulate insurer activity and compliance with all state insurance laws and regulations, such as licensing, policy form approval, rate approval, ensure adequate financial conditions, receive consumer complaints and conduct market conduct examinations to ensure compliance and fairness to consumers.<sup>299</sup> These departments exist primarily to ensure compliance with state laws and to protect consumers. ERISA-insured plans are governed by these laws and oversight by the state departments of insurance.

#### B. REGULATORY COOPERATION WILL LEAD TO INCREASED BENEFICIARY PROTECTION

As demonstrated above, the Supreme Court has held that ERISA does not allow compensatory or consequential money damages beyond that of the denied benefit. In *Mass. Mutual v. Russell*, the U.S. Supreme Court held that an unreasonable delay in receipt of benefits does not warrant consequential damages, or money damages, being paid to the beneficiary in an individual capacity, as ERISA only envisioned the plan to receive such damages.<sup>300</sup> In *Varity Corp.*, the Court held that an individual may recover

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<sup>299</sup> See, e.g., Conn. Dep't of Ins., *Purpose and Duties of the Connecticut Insurance Department*, CT.GOV, <http://www.ct.gov/cid/cwp/view.asp?q=254384> (last visited July 4, 2010); *State Insurance Regulation: History, Purpose and Structure*, NAIC, available at [http://www.naic.org/documents/consumer\\_state\\_reg\\_brief.pdf](http://www.naic.org/documents/consumer_state_reg_brief.pdf) (last visited July 4, 2010); Ind. Dep't of Ins., *Indiana Department of Insurance*, IN.GOV, <http://www.in.gov/idoi/> (last visited July 4, 2010).

<sup>300</sup> *Russell*, 473 U.S. at 144, 148.

individually.<sup>301</sup> In *Pilot Life* and *Andrews-Clarke*, the Court refused to apply state bad faith statutes because they were not specific to the insurance industry, no matter how egregious the misconduct by the insurer.<sup>302</sup> In *Aetna Health, Inc. v. Davila*, the Court refused to apply a state insurance bad faith statute to the HMO, noting that although it was specific to the insurance industry, an HMO's mixed decision on treatment and eligibility was not a fiduciary function, thus it could not be held liable for any damage that occurred as a result.<sup>303</sup> The Court instead suggested that beneficiaries who were wrongly denied benefits pay for the services out of their own pocket and then bring suit for enforcement.<sup>304</sup> This statement by the Court is completely out of touch with America and current economic conditions. With unemployment at 10% and economic crisis abroad, what average person, who relies on an employer-provided health plan, has the wherewithal to single-handedly pay for medical services, which are extremely expensive, out of their own pocket? As shown in the Good Morning America cases, several of the beneficiaries who were denied benefits were left with no income and often choose between paying the mortgage, the utilities, or food for their family, never mind paying an attorney to fight with the insurer over the denied benefits.<sup>305</sup>

As a result, there is only one authority left with the ability to adequately regulate this industry and protect consumers: the state departments of insurance. Not only is it their stated purpose as state agencies, but it is sorely needed due to the lack of oversight elsewhere. The Unum example demonstrates that regulators are able to cooperate and work together to implement fair practices and procedures and oversee compliance. The state departments of insurance simply need to enact the same practices and procedures from the RSA in each state, and even on a national level, to ensure beneficiaries everywhere are protected from insurer opportunism.

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<sup>301</sup> See 29 U.S.C. § 1132(a) (2011); *Varity Corp. v. Howe*, 516 U.S. 489, 510 (1996).

<sup>302</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 55-56 (D. Mass. 1997).

<sup>303</sup> *Aetna Health Inc. v. Davila*, 542 U.S. 200, 212 (2004).

<sup>304</sup> *Id.* at 211.

<sup>305</sup> *Cuomo & Wagschal*, *supra* note 145.

## VI. CONCLUSION

The current regime of insurer regulation in the ERISA context is in danger of harming beneficiaries due to the lack of motivation by insurers to be fair and to strictly comply with state claims practices laws. To combat this inequity, I propose that the state departments of insurance intercede and enforce strict regulatory oversight of such insurers, as was done in the Unum situation. There, the state departments of insurance collaborated and implemented practices and procedures for Unum to adopt and use in its claims handling. As a result, Unum has drastically changed in its claims practices and is arguable a model for the industry in terms of its customer service of claimants. These practices and procedures are not nationally enforced. If such practices and procedures were enforced, it would admittedly serve as an added expense on insurers. However, these practices and procedures would more effectively regulate this area, thereby leading to fairness in claims handling, and ultimately protecting beneficiaries the entire goal behind ERISA. If strict regulation is in force, then beneficiaries would not need to resort to additional remedies, as the insurers would fear large penalties from state department of insurance for noncompliance. This fear, along with reputation damage, would keep ERISA insurers in line.