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ERISA's Fiduciary Fantasy and the Problem of Mass Health Claim Denials

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ERISA'S FIDUCIARY FANTASY AND THE PROBLEM OF MASS HEALTH CLAIM DENIALS

Katherine T. Vukadin *

ABSTRACT

Over 100 million Americans face healthcare debt. Most of those in debt have health insurance, with the debt often springing from services people thought were covered. Before and even after receiving care, those seeking coverage must run a gauntlet of obstacles such as excessive pre-authorization requests, burdensome concurrent review of care, and retrospective review, which claws back payment after a treatment is pre-authorized and payment made. Increasingly, this procedural tangle leaves people with unwarranted and unexpected medical bills, quickly spiraling them into debt.

Who polices health insurers' claims practices? What keeps insurance companies from designing overly burdensome pre-authorization requirements or guidelines that deny legitimate claims on a broad scale? The answers depend on the insurance's source. Employer-sponsored health benefits—the predominant form of health insurance in the United States—is governed by the Employee Retirement Income Security Act, known as ERISA. ERISA regulates health benefits only lightly, but it supplants all state law claims and remedies, giving in exchange only the barest of federal remedies. Over the decades since ERISA's enactment, health benefit administrators have exploited this permissive environment, moving from an indemnity model, in which claims are paid nearly without question, to one of active involvement in treatment decisions and cost controls. ERISA's regulation of health plans has not kept pace.

But employer-sponsored health plans have a feature that other health insurance does not: the plans' decision-makers are deemed fiduciaries under ERISA, legally bound to place plan participants'

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interests above their own. Fiduciaries within health plans wield far-reaching powers. They not only decide individual claims, but they also develop guidelines that affect thousands of others, such as the contours of pre-authorization requirements or the applicable standard of care. These broader fiduciary decisions can result in mass claim denials, and it is these powers—and the lack of consequences for abusing them—that this Article addresses.

Part I lays out the drafters' goals in imposing fiduciary duties and the crucial role of fiduciary status in ERISA's overall scheme. Part II describes the problems in claims processing that plan participants face, caused in part by a lack of consequences for large-scale fiduciary breaches. Part III examines emerging legal theories and remedies for fiduciary breach, designed to ameliorate the problem of mass claim denials and resulting medical debt.

TABLE OF CONTENTS

INTRODUCTION	1328
I. FIDUCIARY DUTIES AS AN ESSENTIAL TENET OF ERISA	1332
A. <i>The Push to Stamp Out Pension Plan Abuses</i>	1332
B. <i>Fiduciary Duties as an Answer</i>	1334
C. <i>Overview of Liability for Breach of Fiduciary Duties</i>	1337
D. <i>Fiduciary Breaches Are Compensable in the Retirement Plan Context</i>	1338
II. HEALTH PLANS' FIDUCIARY FANTASY	1341
A. <i>An Early—and Prescient—Warning of “Fiduciary Immunity”</i>	1341
B. <i>The Rise of Aggressive Utilization Review</i>	1342
C. <i>Are Plan Guidelines and Algorithms Created with an “Eye Single” to Plan Participants?</i>	1345
D. <i>The Reality of Fiduciary Immunity</i>	1349
III. ERISA'S FIDUCIARY BREACH REMEDIES MUST ADAPT TO MODERN HEALTH BENEFIT PLANS.....	1352
A. <i>Non-Fiduciary Protections Are Meager or Non-Existent</i>	1352
B. <i>New or Expanded Solutions to the Fiduciary Immunity Problem</i>	1356
C. <i>Harm to the Entire Plan Under ERISA's Section 1109</i>	1358
D. <i>The Surcharge Remedy</i>	1362
E. <i>A Roadmap to Legislative Solutions</i>	1364
CONCLUSION	1367

*“[A]ll decisions regarding an ERISA plan must be made with an eye single to the interests of the participants and beneficiaries.”*¹

INTRODUCTION

When Allyson Ward, a nurse practitioner in a neonatal intensive care unit (“NICU”), looks at her patients’ parents, she worries.² She worries about the financial troubles that are sure to follow the NICU stay: “[t]hey have no idea,” she said.³ But Ward knows. When her own twins were born prematurely, the family fell \$80,000 into debt, despite their health insurance.⁴ Thousands of dollars in claims were denied as medically unnecessary.⁵ Ward feared the family would become homeless; the twins are now ten years old, and the family still owes \$10,000.⁶

Over 100 million Americans face medical debt.⁷ Most of those in debt have health insurance; their debt often springs from services that they believed were covered.⁸ Indeed, a broad study revealed this as the main insurance issue leading to debt.⁹ Increasingly, Americans using health insurance must navigate a plethora of obstacles that insurers use to limit and deny coverage. Pre-authorization requests, burdensome review of care as it is received, improper denials, and retrospective review—by which payment can be clawed back, even after a treatment is pre-authorized and

1. *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 448 (6th Cir. 2002) (quoting *Krohn v. Huron Mem’l Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999)).

2. Noam N. Levey, *Double Shifts, Credit Card Debt, and Family Loans when Twins Were Born Early*, in *Upended: How Medical Debt Changed Their Lives*, KAISER HEALTH NEWS, <https://khn.org/news/article/diagnosis-debt-investigation-faces-of-medical-debt/> [https://perma.cc/9WJ8-GEJR] (Jan. 10, 2023).

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *E.g.*, Noam N. Levey, *100 Million People in America Are Saddled with Health Care Debt*, KAISER HEALTH NEWS (June 16, 2022), <https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/> [https://perma.cc/5ME5-7L KZ].

8. *See* Levey, *supra* note 2 (noting that most Americans with healthcare debt in the study had health insurance and believed the services they owe for would be covered: “Such insurance issues are the most common form of billing problem cited by Americans with debt.”).

9. *See id.*; *see also* Lunna Lopes, Audrey Kearney, Alex Montero, Liz Hamel & Mollyann Brodie, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, KAISER FAM. FOUND. (June 16, 2022), <https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/> [https://perma.cc/U3XV-ZBYZ] (noting the pertinent results of the study at Figure 8 in “Main Findings”).

payment made—all heavily burden the insured.¹⁰ The necessity for care may be judged not by the standards of care that physicians and hospitals follow, but by insurers' undisclosed—and narrower—standards. Recent settlements reveal the use of algorithms to flag and deny all claims within arbitrary categories, algorithms that are not mentioned in plan documents.¹¹

These practices discourage people from seeking care, may result in improper denials, and can force people into debt.¹² In response, legislators are developing solutions.¹³ Philanthropists are paying off people's debt randomly.¹⁴ A search for GoFundMe fundraisers involving insurance denials produces over five hundred results.¹⁵ But one solution to the problem of medical debt is more glaring and direct: make health insurance cover what it should, without undue burdens.

Who polices insurers' internal guidelines, utilization review, and claims processing practices? What keeps insurance companies from designing overly burdensome pre-authorization requirements, algorithms that deny legitimate claims, or internal standards that set the standard of care too strictly? The answers depend on the insurance's source. Employer-sponsored group health plans are governed by the Federal Employee Retirement Income Security

10. See, e.g., Lauren Weber, *Patients Stuck with Bills After Insurers Don't Pay as Promised*, KAISER HEALTH NEWS (Feb. 7, 2020), <https://khn.org/news/prior-authorization-revoke-d-patients-stuck-with-bills-after-insurers-dont-pay-as-promised/> [<https://perma.cc/D4MZ-HD2B>] (citing several examples of families who received approval for a person's treatment but were left owing money—and in one case filing bankruptcy—after insurers retracted that approval after the care was given).

11. E.g., Press Release, Off. of the N.Y. Att'y Gen. Leticia James, Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage (May 20, 2022), <https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental> [<https://perma.cc/ZJ43-ALYU>] (noting that UnitedHealthcare's ALERT algorithm improperly flagged claims for denial).

12. See Weber, *supra* note 10.

13. E.g., Jack Pitsor, *Medical Debt: How States Are Supporting Consumers*, NAT'L CONF. OF STATE LEGISLATURES (Jan. 26, 2022), <https://www.ncsl.org/news/details/medical-debt-how-states-are-supporting-consumers> [<https://perma.cc/RCC7-GPLR>] (describing strategies for helping consumers avoid medical debt).

14. Yuki Noguchi, *This Group's Wiped Out \$6.7 Billion in Medical Debt, and It's Just Getting Started*, NPR (Aug. 15, 2022, 5:00 AM), <https://www.npr.org/sections/health-shots/2022/08/15/1093769295/this-groups-wiped-out-6-7-billion-in-medical-debt-and-its-just-getting-started> [<https://perma.cc/SUC6-LDE2>] (describing the organization RIP Debt and its work in buying up and then paying off hospital bills).

15. GOFUNDME, <https://www.gofundme.com/s?q=medical+insurance+denial> [<https://perma.cc/C79C-6AYW>] (using a search of medical insurance denial).

Act of 1974 (“ERISA”),¹⁶ but ERISA preempts state laws, including state claims and remedies.¹⁷ So, state legislatures’ responses to consumer complaints do not touch these plans.¹⁸ In return for giving up these rights, ERISA provides a federal cause of action for benefits but without consequential or punitive damages.¹⁹ So when claims are improperly denied and a person sues, the defendant’s worst-case scenario is to have to pay the claim it should have paid in the first place. Given that most denials are never even internally appealed,²⁰ there is little incentive to avoid improper delays and denials. Attorney’s fees are available only if a stringent five-factor test is met.²¹ Employer-sponsored health plans thus occupy a zone of few regulations and even fewer remedies, leaving them effectively unpoliced.

16. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461).

17. See, e.g., *Aetna Health Inc. v. Davila*, 542 U.S. 200, 216 (2004) (explaining that ERISA remedies are the exclusive remedies for plan-related claims).

18. For example, the State of New York passed Timothy’s Law after a boy died by suicide when his family could not access the mental health care he needed. N.Y. Ins. Law § 3221 (Consol. 2006); Brian Hufford, *Diluting Timothy’s Law*, TIMES UNION (May 12, 2018), <https://www.timesunion.com/opinion/article/Commentary-Diluting-Timothy-s-Law-12909739.php> [<https://perma.cc/BC76-G458>] (“[Timothy’s parents’] multiyear effort resulted in landmark legislation to abolish insurance coverage that discriminates against mental illness. Timothy’s Law affirmatively requires insurance plans to cover mental health—going beyond the Federal Mental Health Parity Act passed two years after New York acted—and to do so at the same level as physical health coverage.”).

Timothy’s Law mandates that New York group health plans [p]rovide broad-based coverage for the diagnosis and treatment of mental disorders at least equal to the coverage provided for other health conditions[,] [c]over at least 30 days of inpatient care and 20 visits of outpatient care per year[,] [and] [c]onduct utilization review and calculate co-payments and co-insurance in a manner consistent with medical/surgical benefits.

HEALTH CARE BUREAU, N.Y. STATE OFF. OF THE ATT’Y GEN., MENTAL HEALTH PARITY LAWS: ENSURING EQUAL ACCESS TO TREATMENT COVERAGE, https://ag.ny.gov/sites/default/files/mental_health_parity_brochure.pdf [<https://perma.cc/UH87-RCRX>]. It fines those who do not comply. *Id.*

19. *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533–34 (11th Cir. 1994). “When employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange.” *Id.* (describing the “ERISA bargain”).

20. Karen Pollitz, Matthew Rae & Salem Mengistu, *Claims Denials and Appeals in ACA Marketplace Plans in 2020*, KAISER FAM. FOUND. (July 5, 2022), <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/> [<https://perma.cc/FG9F-QE5H>] (noting that large group data is not yet available but that “[a]s in [the authors’] previous analysis of claims denials, we find that consumers rarely appeal denied claims and when they do, insurers usually uphold their original decision. In 2020, HealthCare.gov consumers appealed just over one-tenth of 1% of denied in-network claims, and insurers upheld most (63%) of denials on appeal”).

21. Katherine T. Vukadin, *Delayed & Denied: Recalibrating the ERISA Attorney’s Fee Factors for Healthcare Claims*, 67 VILL. L. REV. 339, 370–71 (2022).

But employer-sponsored health plans have a feature that other health insurance does not: the plans' decision-makers are deemed fiduciaries, legally bound to place plan participants' interests above their own.²² Fiduciary duties of care, prudence, and loyalty—the highest duties in the law—bind ERISA plan decision-makers to put plan participants' interests above their own.²³ When ERISA's drafters wrote the law, they aimed to raise the standard of decision-makers' behavior so that the poor oversight and broken promises that had plagued benefit plans in the past would not do so again.²⁴

Now, nearly fifty years later, investigations, studies, and lawsuits suggest that, in many cases, those who design and implement utilization review standards are not living up to their fiduciary obligation to make decisions with the plan participants' sole interests in mind. In fact, the standards in many cases diverge from established standards of care, burden consumers' access to care, and may leave them either without care or burdened by bills they should not be paying.

This Article explains how and why these fiduciary duties and remedies are not working for health plans and how this malfunction is allowing payors to push more costs—and debt—onto plan participants. This Article then proposes solutions to this fiduciary fantasy. Part I lays out the drafters' goals in imposing fiduciary duties and the crucial role they play in ERISA's overall scheme. Part II describes the problems in utilization review and claims processing that plan participants face. It goes on to discuss the lack of incentives for health plan fiduciaries to abide by their duties to plan participants rather than bow to countervailing pressures from higher-ups and shareholders. Part III sets out proposed solutions to the problem of fiduciary immunity, including recognition of plans' decrease in value when they fail to provide covered care, the emerging surcharge remedy, and potential legislative changes.

22. See 29 U.S.C. § 1101(c)(3)(A)–(D).

23. See *id.*

24. Memorandum from the Off. of Mgmt. & Budget, Exec. Off. of the President to President Gerald R. Ford, Enrolled Bill H.R. 2—Employee Retirement Income Security Act of 1974 (Aug. 27, 1974), <https://www.fordlibrarymuseum.gov/library/document/0055/1668670.pdf> [<https://perma.cc/U5N8-VFFX>].

I. FIDUCIARY DUTIES AS AN ESSENTIAL TENET OF ERISA

In the 1970s, a wave of pension defaults and broken retirement promises in American companies prompted lawmakers to craft a legislative response.²⁵ To secure workers' promised employee pensions and other benefits, Congress enacted the Employee Retirement Income Security Act of 1974,²⁶ a comprehensive statute setting out funding and reporting requirements and establishing schedules for funding and vesting.²⁷ The law preempts state laws, removing access to all state claims and remedies.²⁸ ERISA offers in their place a set of federal duties and claims, including fiduciary duties and claims for breach of those duties.²⁹ These fiduciary duty provisions and claims are part of the "ERISA bargain" and are central to ERISA's proper functioning. As explained below, fiduciary duties and claims are functioning well for retirement plans but not for health plans.

A. *The Push to Stamp Out Pension Plan Abuses*

As pension plans grew in popularity in the 1940s and 1950s, abuses mounted too, as some pension plan officials used employee monies for their own purposes or otherwise mismanaged funds.³⁰ In the largest and most visible pension default, that of the Studebaker-Packard pension plan, deteriorating business conditions and insufficient funds resulted in retirees receiving lower payments than promised; in some cases, they received nothing at all.³¹

25. *History of EBSA and ERISA*, U.S. DEP'T OF LAB.: EMP. BENEFITS SEC. ADMIN., <https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/history-of-ebsa-and-erisa> [https://perma.cc/2JHA-DP8Q].

26. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461).

27. *Massachusetts v. Morash*, 490 U.S. 107, 112–13 (1989).

28. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 208–09 (2004) (explaining that Congress intended ERISA's remedies to be the exclusive remedies for ERISA claims, even when the ERISA cause of action is not exactly the same as the preempted state claim).

29. *Id.* at 208, 210.

30. JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 45 (2004) (noting that the new plans "created a fertile environment for mismanagement and corruption").

31. *Id.* at 51–52. The President's Committee on Corporate Pension Funds studied the pension funding problem and set out their findings in a pre-ERISA report. *Id.* at 77.

The resulting public outcry fueled the drive to regulate private pension plans.³² As one early government report explained, fairness and public funding (in the form of tax subsidies) required government action to ensure that pensions delivered as promised.³³ So, legislators worked for years to draft ERISA, which contains minimum vesting rules, funding standards, termination insurance, and other provisions.³⁴ To ensure integrity in plan administration, the drafters imposed fiduciary duties not only on named fiduciaries but on all those who exercise discretionary authority or discretionary control.³⁵ These duties require high standards of conduct and bind decision-makers to follow ERISA's other provis-

32. 1 LEE T. POLK, ERISA PRACTICE AND LITIGATION § 3:25, Westlaw (database updated Sept. 2022) (“There is no doubt that a high standard in the management of plan assets was a cornerstone of Congressional policy in enacting ERISA. Congress was motivated by horror stories of insolvent pension funds that resulted in failed pension promises for thousands of workers, and by other similar failures in the availability of funded benefits.”).

33. WOOTEN, *supra* note 30, at 80.

34. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461); *see also* 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, 1322–23 (2003) (explaining that the movement that led to the passage of ERISA “effectively commenced in 1963, when the financially troubled automaker, Studebaker, defaulted on its pension plan, frustrating the support expectations of several thousand workers and retirees”); 29 U.S.C. § 1001 (“The Congress finds . . . that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; . . . [therefore] it is desirable in the interests of employees and their beneficiaries . . . that minimum standards be provided assuring the equitable character of such plans and their financial soundness. . . . It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries . . .”); *Aetna Health*, 542 U.S. at 208; *Donovan v. Dillingham*, 688 F.2d 1367, 1370 (11th Cir. 1982) (“Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans.”).

35. 29 U.S.C. § 1002(21)(A). An ERISA fiduciary is one who “exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets” or who “has any discretionary authority or discretionary responsibility in the administration of such plan.” *Id.*

ions.³⁶ Lawmakers incorporated fiduciary duties into ERISA with little controversy.³⁷

At the time, pensions—not health benefit plans—were the problem at hand, although health plans too are included under ERISA’s umbrella.³⁸ The discussion and negotiation leading up to ERISA’s passage included little about employer-sponsored health plans.³⁹ At that time, health claims were generally paid if based on a physician’s recommendation; utilization review—the process of questioning whether a prescribed therapy is medically necessary and covered under a plan’s terms—had not yet taken hold.⁴⁰ Thus, lawmakers had little reason to focus on health benefit plans in particular, and the resulting law barely regulated health plans at all, except for fiduciary duties, disclosure, and reporting rules.⁴¹ This lack of regulation leaves participants in health benefit plans vulnerable to improper claim procedures and denials.

B. *Fiduciary Duties as an Answer*

Fiduciary status plays a powerful role in ERISA’s scheme because it triggers a high standard of conduct, one of the highest in the law. Fiduciaries are under a duty of loyalty and must act “solely

36. 29 U.S.C. § 1104(a)(1).

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and
(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

Id.

37. Peter J. Wiedenbeck, *Untrustworthy: ERISA’s Eroded Fiduciary Law*, 59 WM. & MARY L. REV. 1007, 1036–37 (2018).

38. 29 U.S.C. § 1002(1) (stating that the term “employee welfare benefit plan” includes medical, accident, disability, death, unemployment, childcare, training, scholarship, pre-paid legal, and vacation benefit plans).

39. WOOTEN, *supra* note 30, at 281.

40. *Id.* at 283.

41. *Id.* at 283–84.

in the interest of the participants and beneficiaries . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries.”⁴² They must be prudent, exercising duties with “the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent [person] acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.”⁴³

People who exercise discretion regarding health plans and benefits are fiduciaries.⁴⁴ Indeed, any plan decision-making authority triggers fiduciary status, as does any discretionary authority or control over the administration or management of the plan, or any control (whether discretionary or not) over the plan’s assets.⁴⁵ ERISA’s test for fiduciary status is functional—fiduciary status turns on what a person does, rather than on any particular title.⁴⁶ ERISA’s fiduciary duties extend to all those who exercise discretion over the administration of, or who handle assets for, benefit plans.⁴⁷ An entity that performs only ministerial duties, on the other hand, is not a fiduciary.⁴⁸ In health benefit plans, an entity

42. 28 U.S.C. § 1104(a)(1).

43. *Id.* § 1104(a)(1)(B).

44. Under ERISA section 3(21)(A), a person is considered a fiduciary with respect to the plan based on certain conduct, whether that person is a designated fiduciary or not. *See* H.R. REP. NO. 93-1280, at 301 (1974) (discussing the imposition of fiduciary duties with regard to “allocation or delegation of duties with respect to payment of benefits”); 120 CONG. REC. 29929 (1974) (remarks of Sen. Williams) (stating that ERISA imposes “strict fiduciary obligations upon those who exercise management or control over the assets or administration of an employee pension or welfare plan.”).

45. Colleen E. Medill, *Regulating ERISA Fiduciary Outsourcing*, 102 IOWA L. REV. 505, 516 (2017).

46. *See* *Mason Tenders Dist. Council Pension Fund v. Messera*, 958 F. Supp. 869, 881 (S.D.N.Y. 1997). “Unlike the common law definition under which fiduciary status is determined by virtue of the position a person holds, ERISA’s definition is functional.” *Id.*

47. *See* 29 U.S.C. § 1002(21)(A). “Congress intended ERISA’s definition of fiduciary ‘to be broadly construed.’” *LoPresti v. Terwilliger*, 126 F.3d 34, 40 (2d Cir. 1997) (quoting *Blatt v. Marshall & Lassman*, 812 F.2d 810, 812 (2d Cir. 1987)).

48. *See* *CSA 401(k) Plan v. Pension Pros., Inc.*, 195 F.3d 1135, 1138–39 (9th Cir. 1999) (stating that “third-party administrators are not fiduciaries if they merely perform ministerial functions” unless they “in fact exercise discretionary authority or control over the [p]lan”). Functions that do not involve the exercise of discretion do not give rise to fiduciary responsibility. *See id.* Entities do not act in a fiduciary capacity when they perform “administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons” such as the “[a]pplication of rules determining eligibility for participation or benefits,” “[p]rocessing of claims,” and “[c]alculation of benefits.” *See* 29 C.F.R. § 2509.75-8 (2022); *Gelardi v. Pertec Comput. Corp.*, 761 F.2d 1323, 1325 (9th Cir. 1985) (finding no fiduciary duty where an entity “perform[ed] only administrative functions, processing claims within a framework of policies, rules, and procedures established by” an employer), *overruled on other grounds by* *Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202, 1207 (9th Cir. 2011).

is a fiduciary if it makes decisions about claims, rather than just applying a mathematical formula or following guidelines set by others.⁴⁹ Thus, third-party administrators that decide claims, particularly those that interpret plan term definitions and policies, are fiduciaries, and ERISA's duties apply to them.

Individual claim decisions are crucial and can be financially significant, life changing, or even fatal.⁵⁰ But health plan fiduciaries also operate in a further-reaching and less apparent way when they interpret plan terms and create guidelines that apply to an entire plan.⁵¹ This latter type of broad plan interpretation and decision-making may touch and determine every claim within a plan, or even every plan for which it processes claims, rather than just one.⁵² And, while individual claim denials can be at least partially remedied at the individual level, this broader type of fiduciary breach can result in mass claims denials and is thus extremely damaging. Although these decisions are subject to ERISA's fiduciary provisions, their breach has no obvious, accessible remedy at present, leaving little disincentive to breach fiduciary duties. This kind of broad fiduciary decision-making within health plans is this Article's central concern.

49. See, e.g., *IT Corp. v. Gen. Am. Life Ins. Co.*, 107 F.3d 1415, 1420 (9th Cir. 1997) ("So far as we can tell from the record, General American's decisions about claims would have to have involved plan interpretation and judgment, not just typing a treatment code number and treatment provider identification onto a computer screen for generation of a payment check.").

50. See, e.g., Cynthia Koons & John Tozzi, *As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage*, BLOOMBERG (May 16, 2019, 6:00 AM), <https://www.bloomberg.com/news/features/2019-05-16/insurance-covers-mental-health-but-good-luck-using-it> [<https://perma.cc/97VF-AKHQ>] (discussing the overdose death of a man shortly after his health plan denied further coverage for treatment of substance use disorder).

51. See *Peterson v. UnitedHealth Grp., Inc.*, 913 F.3d 769, 775–76 (8th Cir. 2019) (holding that defendant breached its fiduciary duties by interpreting plan terms in a way that was not supported by the plan documents or ERISA).

52. See, e.g., *id.* (explaining cross-plan offsetting, the practice of reducing payments to one plan by the amount of an alleged overpayment to an unrelated plan); *Wit v. United Behav. Health*, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at *41–42, *51–53, *204–05, *210–11, *215–16 (N.D. Cal. Mar. 5, 2019) (finding that the guidelines promulgated by a claims administrator and applied to the processing of all plans' claims were "more restrictive than generally accepted standards of care"), *rev'd on other grounds*, Nos. 20-17363, 21-15193, Nos. 20-17364, 21-15194, 2023 U.S. App. LEXIS 2039 (9th Cir. Jan. 26, 2023).

C. Overview of Liability for Breach of Fiduciary Duties

In general, ERISA enforces its fiduciary duties through two causes of action: the provisions directly addressing fiduciary duties and their breach⁵³ and ERISA's overall enforcement mechanism, the "catchall" provision, which allows "other appropriate equitable relief" for any violation of ERISA.⁵⁴

Under the more specific provision, breaching plan fiduciaries are subject to personal liability, which can include returning profits gained from using plan assets, curing any losses to the plan, removal from the fiduciary position, and any other equitable or remedial relief that the court finds appropriate.⁵⁵ The claim must be brought for the plan's benefit; an individual's fiduciary breach claim for benefits cannot exceed the plan's benefits.⁵⁶

These principles are based on the reasoning by the Supreme Court of the United States that ERISA's fiduciary provision is concerned with plan integrity as a whole rather than individual wrongs.⁵⁷ The same reasoning has been applied to the catchall provision of section 1132(a)(3), which allows "other equitable relief" for any breach of ERISA, including breaches of fiduciary duty.⁵⁸ Nevertheless, a claim lies where a fiduciary breaches its duties,

53. 29 U.S.C. § 1109(a).

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to 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 which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

Id.

54. 29 U.S.C. § 1132(a)(3) (stating that a claim may be brought "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan").

55. 29 U.S.C. § 1109.

56. *Mass. Mut. Life Ins. v. Russell*, 473 U.S. 134, 144 (1985) (quoting *Horan v. Kaiser Steel Ret. Plan*, 947 F.2d 1412, 1418 (9th Cir. 1991)).

57. See *Horan*, 947 F.2d at 1417–18.

58. 29 U.S.C. § 1132(a)(3); see U.S.C. § 1109(a). "The Supreme Court reasoned the fiduciary duty provisions in ERISA are primarily concerned with protecting the integrity of the plan, which in turn protects all the beneficiaries, rather than remedying each wrong suffered by individual beneficiaries." *Horan*, 947 F.2d at 1418.

resulting in harm to the plan.⁵⁹ Those duties specifically include the proper administration of the plan.⁶⁰

D. *Fiduciary Breaches Are Compensable in the Retirement Plan Context*

ERISA sets out claims and remedies for breaches of fiduciary duties; these are readily enforced in the retirement plan context. Courts analyzing these duties have adapted to retirement plans' evolution from defined benefit (traditional pensions) to defined contribution (401(k)-type plans).⁶¹ If retirement plan fiduciaries embezzle or mismanage funds, causing loss to the plan (or improper profits), they face personal exposure.⁶² Soon after ERISA's enactment, claims of fiduciary breach in connection with retirement plans started to appear in the courts.⁶³

Today, liability for fiduciary breaches is a major concern for people holding that position.⁶⁴ Fiduciary litigation over pension plans, their fees, their communications, and other acts and decisions has been on the rise in recent years, with settlements and judgments in the hundreds of millions of dollars annually.⁶⁵ Following, are some examples of mismanagement and dishonesty alleged against retirement plan fiduciaries and the claims that resulted:

59. See *Russell*, 473 U.S. at 142–43 (“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.”).

60. *Id.*

61. Samuel Estreicher & Laurence Gold, *The Shift from Defined Benefit Plans to Defined Contribution Plans*, 11 LEWIS & CLARK L. REV. 331, 331 (2007).

62. 29 U.S.C. § 1109(a).

63. See, e.g., *Marshall v. Craft*, 463 F. Supp. 493, 494 (N.D. Ga. 1978) (alleging breach of ERISA's fiduciary duties in connection with a pension fund's purchase of land); *Morgan v. Laborers Pension Tr. Fund for N. Cal.*, 433 F. Supp. 518, 522 (N.D. Cal. 1977) (alleging breach of ERISA's fiduciary duties based on denial of pension benefits); *Whitaker v. Texaco, Inc.*, 566 F. Supp. 745, 747 (N.D. Ga. 1983) (alleging fiduciary breaches based on false and misleading representations to plaintiffs concerning the pension plan).

64. See, e.g., PENSION PLAN FIX-IT HANDBOOK § 920 (Jane Meacham ed. 2019) (2004), Westlaw 5045895 (noting that those who serve as ERISA fiduciaries often wish to reduce their liability).

65. Richard Binder, *The 10 Biggest ERISA Class Action Settlements of 2021*, ALM BENEFITS PRO (Jan. 25, 2022, 8:37 AM), <https://www.benefitspro.com/2022/01/25/the-10-biggest-erisa-class-action-settlements-of-2021/> [https://perma.cc/SX7H-HTM7] (noting that “[t]he top 10 ERISA settlements totaled \$837.3 million last year, a massive increase over 2020's total of \$380.1 million”).

- Failure to monitor investment fees: Participants in a 401(k) plan prevailed in a class action alleging that the employer breached its fiduciary duties by paying a management company excessive fees and misdirecting \$1.7 million in “float.”⁶⁶
- Intentional misrepresentations about safety of pension benefits: Employees recovered for breach of fiduciary duty when their employer purposely deceived them into withdrawing money from a plan and forfeiting their benefits.⁶⁷ The Supreme Court held that “[t]o participate knowingly and significantly in deceiving a plan’s beneficiaries in order to save the employer money at the beneficiaries’ expense is not to act ‘solely in the interest of the participants and beneficiaries.’”⁶⁸ The Court reinstated the employees to the plan they had left; the relief was available as “other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.”⁶⁹
- Failure to remove imprudent investment choices from available investment choices in employee retirement plan: Employees stated a claim for breach of fiduciary duty when plan fiduciaries included more expensive investment options alongside similar less expensive options.⁷⁰ The Supreme Court rejected the reasoning of the United States Court of Appeals for the Seventh Circuit that, because the investors could choose their preferred options, they could not complain about other options.⁷¹

Fiduciary breach litigation over pensions is effective not only due to ERISA’s provisions themselves, but also because courts’ interpretation of these provisions has evolved as retirement plans have changed since ERISA’s enactment. That is, from the mid-seventies to the mid-nineties, retirement plans underwent a sea change from traditional pensions to 401(k)-type plans; the former consist of a promise to pay an annuity at some future date, while the latter consist of an individual account, funded by each employee and often by employer contributions as well.⁷² Courts initially insisted that remedies for violations of ERISA’s fiduciary provisions must be on behalf of the plan as a whole, rather than

66. *Tussey v. ABB, Inc.*, 746 F.3d 327, 333 (8th Cir. 2014), *vacated*, *Tussey v. ABB, Inc.*, No. 06-CV-04305-NKL, 2012 U.S. Dist. LEXIS 157428 (W.D. Mo. Nov. 2, 2012).

67. *Varity Corp. v. Howe*, 516 U.S. 489, 492 (1996).

68. *Id.* at 506.

69. *Id.* at 492, 494–95, 508–09 (quoting 29 U.S.C. § 1109(a)).

70. *See Hughes v. Nw. Univ.*, 142 S. Ct. 737, 742 (2022).

71. *See id.*

72. *See, e.g.*, Estreicher & Gold, *supra* note 61 (“From the 1930s through the mid-1970s, defined benefit (DB) pension plans were the predominant form of private pension arrangement and defined contribution (DC) plans played a distinctly secondary, supplementary role. By the 1990s the situation was reversed; in a little over 20 years, DC plans—and in particular 401(k) plans—had become predominant and that predominance has continued apace.”).

inuring to individual beneficiaries.⁷³ This was based on the fiduciary duty provisions' focus on the plan as a whole and its integrity—concerns that involve all the beneficiaries, not harms suffered by individuals.⁷⁴ But faced with harms to 401(k) plan benefits—which exist in individual accounts rather than shared funds, as is the case with traditional pensions—courts adapted in light of ERISA's overarching goals.⁷⁵ While courts had previously insisted that claims concern the “entire plan,” the Court held that these references were “beside the point in the defined contribution context.”⁷⁶ Today, litigation involving a variety of breaches of fiduciary duty in retirement plans is on the rise.⁷⁷

Thus, participants in workplace retirement plans, whether the plans are traditional pensions or 401(k) plans, are well protected against their administrators' potential breaches of fiduciary duties. Although health benefit plans have been within ERISA's purview since 1974, ERISA's fiduciary duties are not functioning properly to preserve participants' rights to their benefits. Part II explains why, and Part III sets out proposals for reform.

73. When a claimant sued for life insurance benefits following a breach of fiduciary duty, for example, the Sixth Circuit insisted that individual benefits could not be awarded on this theory. *Walker v. Fed. Express Corp.*, 492 F. App'x 559, 562–63 (6th Cir. 2012) (citing *Bryant v. Int'l Fruit Prod. Co.*, 886 F.2d 132, 135 (6th Cir. 1989) (per curiam) (“the language regarding fiduciary duty suits in section 1109 makes clear [that] ERISA contemplates that breaches of fiduciary duties injure the plan, not individual beneficiaries, and any recovery thus goes to the plan”)); *Kuper v. Iovenko*, 66 F.3d 1447, 1452–53 (6th Cir. 1995) (“ERISA does not permit recovery by an individual who claims a breach of fiduciary duty. Instead, § 1109 contemplates that breaches of fiduciary duty injure the plan, and, therefore any recovery under such a theory must go to the plan.”); *Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 608 (6th Cir. 2007) (“Plaintiffs cannot bring suit under § 1132(a)(2) to recover personal damages for misconduct, but rather must seek recovery on behalf of the plan.”).

74. *Bryant*, 886 F.2d at 135.

75. *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 255–56 (2008) (“The ‘entire plan’ language in Russell speaks to the impact of § 409 on plans that pay defined benefits. Misconduct by the administrators of a defined benefit plan will not affect an individual's entitlement to a defined benefit unless it creates or enhances the risk of default by the entire plan. . . . For defined contribution plans, however, fiduciary misconduct need not threaten the solvency of the entire plan to reduce benefits below the amount that participants would otherwise receive.”).

76. *Id.* at 256.

77. Jacklyn Wille, *Spike in 401(k) Lawsuits Scrambles Fiduciary Insurance Market*, BLOOMBERG LAW: BENEFITS & EXEC. COMP. (Oct. 18, 2021, 6:00 AM), <https://news.bloomberglaw.com/employee-benefits/spike-in-401k-lawsuits-scrambles-fiduciary-insurance-market> [https://perma.cc/8ZDD-P9XA]. Nearly 100 class action lawsuits alleging breach of fiduciary duty in retirement plans were filed in 2020, up from twenty in 2019. *Id.* The lawsuits often focus on excessive fees in the retirement plan investment options. *Id.*

II. HEALTH PLANS' FIDUCIARY FANTASY

Lawmakers focused on pension plans when they designed ERISA,⁷⁸ as that was the immediate crisis. Nevertheless, welfare plans such as health benefit plans are unequivocally included within ERISA's regulatory umbrella and within its fiduciary obligations, too. Yet as health plans have shifted from an indemnity arrangement to a gatekeeping role in the decades since ERISA's enactment, judicial interpretation of ERISA has not kept pace, largely leaving broad-scale fiduciary breaches compensable in the retirement context but not in the health plan context. Despite their fiduciary obligations, health plan administrators are increasingly creating a web of guidelines that erect barriers between plan participants and their benefits, favoring the payors. These guidelines—which evade the transparency requirements of a permissible plan amendment⁷⁹—affect participants' right to benefits. They must be brought out of the shadows and made properly subject to ERISA's fiduciary claims and remedies.

A. *An Early—and Prescient—Warning of “Fiduciary Immunity”*

Lawmakers enacted ERISA in 1974,⁸⁰ when health plans operated quite differently from the way they operate today. Plans generally paid claims according to the treating physician's judgment.⁸¹ If a physician prescribed a treatment, the treatment's medical necessity was established without question.⁸² The diagnostic and treatment phase of a person's care was thus distinct from the

78. Langbein, *supra* note 34, at 1322.

79. See, e.g., Coffin v. Bowater Inc., 501 F.3d 80, 91–92 (1st Cir. 2007)

[A]n ERISA plan amendment must be in writing; it must be executed by a party authorized to amend the plan; the language of the amendment must clearly alert the parties that the plan is being amended; and the amendment must meet any other requirements laid out for such amendments in the plan's governing documents. This insistence on specificity ensures that disputes between employees and their employers may be resolved by reference to the documents that govern the plan.

Id.

80. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001–1461).

81. WOOTEN, *supra* note 30 at 282–83 (“When Congress passed ERISA, health plans generally operated on a traditional fee-for-service or indemnity-insurance model. . . . The insurer would decide whether the claim was covered by the plan and then reimburse or not reimburse accordingly.”); David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 861–62 (1991).

82. WOOTEN, *supra* note 30, at 283.

payment phase—health plans dealt only in the latter.⁸³ Today's plans in part reflect the need to control the high costs of sophisticated therapies, but they also reflect the permissive legal landscape regarding fiduciary duties that developed in the courts.

Little more than a decade after ERISA's enactment, the Supreme Court closed the door on consequential damages for a fiduciary breach alleged alongside a claim for benefits.⁸⁴ The Court reversed the Ninth Circuit, which had warned of the consequences of limited liability for breach of fiduciary duty in welfare plan administration and the risk of "fiduciary immunity" that would result.⁸⁵ If there are no separate consequences for a fiduciary breach in a benefit plan, the Ninth Circuit had observed, a plan administrator's worst case scenario would be to pay the claim originally owed.⁸⁶

Before long, the Ninth Circuit's prediction of fiduciary immunity was proven correct, as without the risk of consequential damages for breaches of fiduciary duty associated with improper claims processing, claims administrators were free to delve further and more aggressively into medical decision-making and gatekeeping, as described below.

B. *The Rise of Aggressive Utilization Review*

Today's health plan claims administrators actively engage in patient care decisions, serving as gatekeepers and arbiters of the therapies a patient should receive.⁸⁷ This role emerged in response

83. *Id.* ("In the traditional indemnity model, it was relatively easy to distinguish diagnostic decisions from payment decisions.")

84. *See* *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

85. *Russell v. Mass. Mut. Life Ins. Co.*, 722 F.2d 482, 490 (9th Cir. 1983) ("More important, a fiduciary could ignore or unreasonably perform its duties and responsibilities with respect to the disposition of claims with virtual impunity and at the sole cost of the participant who has suffered harm as a result of such misconduct. We believe that Congress did not intend to afford such fiduciary immunity."), *rev'd*, 473 U.S. 134 (1985), *vacated*, 778 F.2d 482 (9th Cir. 1985).

86. *Id.* ("A contrary reading would conflict with the language of the statute and provide little encouragement to fiduciaries to abide by the Act, since the most that could be forfeited in the event of misconduct would be benefits already owed by the plan."); *see also id.* at 488 ("Protection from fiduciary conduct that violates these duties is necessary to implement Congress' express policy of imposing 'strict fiduciary obligations upon those who exercise management or control over the assets or administration of an employee pension or welfare plan.'")

87. Jennifer Belk, *Undefined Experimental Treatment Exclusions in Health Insurance Contracts: A Proposal for Judicial Response*, 66 WASH. L. REV. 809, 811 (1991) (noting that

to rising healthcare costs, but also in response to ERISA itself.⁸⁸ As advances in medical technologies and therapies drove broad cost increases, the previous approach (passive indemnity) became untenable.⁸⁹ But ERISA too made this new, more active role possible. That is, a cost-cutting provision or interpretation can result in a person not receiving care and perhaps suffering resulting harm or even death,⁹⁰ but ERISA protects against liability for treatment-related decisions.⁹¹ And, the lack of consequences for fiduciary breaches set out in *Russell* paved the way for aggressive guidelines and algorithms that can lead to mass claim denials.⁹²

Given the cost increases and protection from liability, insurance companies developed techniques for controlling the use of insurance, such as pre-authorizations, narrow networks, complex plan definitions, and so forth.⁹³ The indemnity model (payment for service almost without question) may not have been tenable long term, but today's tight controls over healthcare access have opened the door to high profits: UnitedHealth Group's profits exceeded \$5,000,000,000 for one quarter in 2022.⁹⁴

"[i]nsurers serve as 'gatekeepers,' encouraging the use of safe and effective treatments by paying for them and deterring unsafe and ineffective treatments through non-coverage.").

88. WOOTEN, *supra* note 30, at 283 ("ERISA played an important role in the development of utilization review and other managed-care arrangements because the preemption and remedial provisions shielded utilization reviews from liability for mistakes.").

89. H.J. Aaron & W.B. Schwartz, *Hospital Cost Control: A Bitter Pill to Swallow*, HARV. BUS. REV., Mar.–Apr. 1985, at 160, 160–61 (describing development of health care "payment system expressly designed to shield patients and providers from the cost of hospital care"); *see also* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1720 (1987) (asserting that the cost of healthcare rose considerably in the 1970s and 80s).

90. WOOTEN, *supra* note 30, at 283 (noting that "because adverse decisions under utilization review often occur before treatment and may result in a patient not receiving care, disputes about coverage take on a much more threatening cast.").

91. *Id.* ("ERISA . . . shield[s] utilization reviewers from liability for mistakes.").

92. *See* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 136–38, 148 (1985).

93. *See, e.g.*, STEVEN PLITT, DANIEL MALDONADO, JOSHUA D. ROGERS & JORDAN R. PLITT, COUCH ON INSURANCE § 144:8 (3d ed. rev. 2006) ("Such [utilization review] techniques include preadmission certification of hospital admissions, concurrent review of health care services, as well as various 'gate keeper' arrangements, such as funneling access to specialists through the insured's primary care provider."). Utilization review, or utilization management, is "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision." INST. OF MED. DIV. OF HEALTH CARE SERVS., CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 1 (Bradford H. Gray & Marilyn J. Field eds., 1989).

94. Bruce Japsen, *UnitedHealth Group's Profits Top \$5 Billion as Optum and Health Plans Grow*, FORBES (July 15, 2022, 7:03 AM), <https://www.forbes.com/sites/brucejapsen/20>

Plans started to create barriers to treatment, insisting, for example, that participants visit primary care providers before visiting specialists or take other preliminary steps before accessing care.⁹⁵ Plan definitions, too, have taken on an important role in cost containment.⁹⁶ These are not straightforward definitions but complex, multi-part terms on which a claim can easily founder.⁹⁷ Where the definitions are so complex, subjective judgment and individual motivations can enter into the decision-making.⁹⁸ Medical necessity decisions in particular are criticized for their subjective nature.⁹⁹

22/07/15/unitedhealth-groups-profits-top-5-billion-as-optum-and-health-plans-grow/?sh=32ac954b6afc [https://perma.cc/93RS-N9H3].

95. See Glen P. Mays, Gary Claxton & Justin White, *Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies*, 23 HEALTH AFFAIRS: WEB EXCLUSIVES, Aug. 11, 2004, at W4-427, -429.

96. The most significant term is the "medical necessity" definition that practically all plans contain. Janet L. Dolgin, *Unhealthy Determinations: Controlling "Medical Necessity"*, 22 VA. J. SOC. POL'Y & L. 435, 436 (2015).

97. As an example, here is the definition of "medically necessary" from a BlueCross BlueShield of Texas employer-sponsored plan in 2019:

Medically Necessary or Medical Necessity means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claim Administrator . . . shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

BLUECROSS BLUESHIELD OF TEX., YOUR HEALTH CARE BENEFITS PROGRAM: CITY OF RICHARDSON 52 (2019), <https://www.cor.net/home/showdocument?id=20972> [https://perma.cc/7RQQ-U5KR].

98. Dolgin, *supra* note 96, at 438 (citing William M. Sage, *Managed Care's Crime: Medically Necessary, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003)) ("[V]arious stakeholders assume different interpretations of the phrase.").

99. See, e.g., *id.* at 442–43 (discussing medical necessity determinations and noting that "whether coverage is extended or denied in particular cases continues to depend on a slew

Utilization review, while necessary in some cases to reduce fraud, can turn abusive when designed to discourage consumers from using their rightful benefits. Consumers have been saddled with unexpected medical bills due to techniques such as retrospective denial and cross-plan offsetting.¹⁰⁰ Using retrospective denial, an insurer reviews care and may deny a claim after the fact, even after care has been pre-authorized and paid for.¹⁰¹ This practice can blindside consumers—who relied on pre-authorization and proceeded with treatment—forcing them to pay for treatment that they did not agree to receive.¹⁰²

In recent years, gatekeeping and utilization review methods have not only led to improper cost containment but also to improper claim denials.¹⁰³

C. Are Plan Guidelines and Algorithms Created with an “Eye Single” to Plan Participants?

In crafting and interpreting plan definitions, judging evidence in patient files, and making claim decisions, plan decision-makers are exercising judgment and are thus subject to fiduciary duties. The employer-based benefit system is a voluntary one. Employers' decisions on whether to have a plan, and what the terms of the plan should be, are not subject to fiduciary duties.¹⁰⁴ These decisions are

of factors including, most importantly, the name, position, and motives (both express and implicit) of the decision-makers, as well as the shifting economic and political choices of payers (by whom the decision-makers are usually employed, either directly or indirectly)"); U.S. Psychiatric Rehabilitation Ass'n, Comment Letter on Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 (Public Law 110-343) (May 26, 2009), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/1210-AB30/00250.pdf> [<https://perma.cc/DRK5-HLBW>]; Sage, *supra* note 98, at 601 (noting the results-orientated nature of medical necessity decision-making).

100. Weber, *supra* note 10.

101. *Id.*

102. *Id.* (citing examples of people who received pre-approval for treatment but who were left in debt when the claims were denied after treatment).

103. See, e.g., Wayne Drash, *\$91 Million Case Against Nation's Largest Insurer Is a 'Clear Win' for Patients*, CNN, <https://www.cnn.com/2019/01/28/health/california-supreme-court-insurance-commissioner-decision/index.html> [<https://perma.cc/8ARQ-BX4F>] (Jan. 28, 2019, 9:47 AM) (“PacifiCare’s sloppy internal practices resulted in patients who were in desperate need of health care services being denied coverage and access to medical care”); Rick Karlin, *Timothy’s Law Fines Total \$2.7M*, TIMES UNION (May 8, 2012), <https://www.timesunion.com/local/article/Timothy-s-Law-fines-total-2-7M-3544091.php#ixzz1uMy pxigU> [<https://perma.cc/UP7V-DL6Y>].

104. See Dana Muir & Norman Stein, *Two Hats, One Head, No Heart: The Anatomy of the ERISA Settlor/Fiduciary Distinction*, 93 N.C. L. REV. 459, 479 (2015).

distinct from the creation of internal guidelines for plan administration, which are management and interpretation functions and are thus subject to fiduciary duties.¹⁰⁵ Thus, health plan administration decisions should be made with the utmost loyalty to plan participants and with an “eye single” toward plan participants’ interests.¹⁰⁶

Yet multiple plan guidelines—and the resulting large profits—appear to favor only the payor, not the plan participants. Examples include the following:

- Cross-plan off-setting, a practice by which claims administrators reduce a payment rightfully due to a provider for a patient’s care by the amount of a disputed unrelated payment (involving a separate patient under a separate benefit plan) to the same provider.¹⁰⁷ This practice can leave consumers charged with payments they had no reason to anticipate.
- Routine denial of medically necessary care. A recent American Hospital Association report¹⁰⁸ describes medical necessity as the

[I]n light of the voluntary nature of the private pension system governed by ERISA, the Department [of Labor] has concluded that there is a class of discretionary activities which relate to the formation, rather than the management, of plans. These so-called “settlor” functions include decisions relating to the establishment, termination and design of plans and are not fiduciary activities subject to Title I of ERISA.

Id.

105. The Department of Labor letter cited above went on to note that “the Department [of Labor] has emphasized that activities undertaken to implement the termination decision are generally fiduciary in nature.” Letter from Dennis M. Kass, Ass’t Sec’y, Dep’t of Labor, to John N. Erlenborn, Chairman, Advisory Council on Emp. Welfare & Pension Benefit Plans (Mar. 13, 1986) (on file with U.S. Dep’t of Labor) [hereinafter Letter from Kass to Erlenborn].

106. See *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 448–49 (6th Cir. 2002) (quoting *Krohn v. Huron Mem. Hosp.*, 173 F.3d 542, 547 (6th Cir. 1999)).

ERISA’s fiduciary duty involves three components: (1) a duty of loyalty, requiring that “all decisions regarding an ERISA plan ‘must be made with an eye single to the interests of the participants and beneficiaries;’” (2) a “prudent person fiduciary obligation,” requiring that a plan fiduciary exercise his or her duties “with the care, skill, prudence, and diligence” of a prudent person acting under similar circumstances; and (3) a duty to act for the exclusive purpose of providing [sic] benefits to plan participants.

Id.

107. Dennis Fiszer, *Employers Take Note: The Collapsing Legal Basis for Cross-Plan Off-setting*, BENEFITS PRO (Aug. 11, 2021, 9:41 AM), <https://www.benefitspro.com/2021/08/11/employers-take-note-the-collapsing-legal-basis-for-cross-plan-offsetting/> [https://perma.cc/G E4F-K7PP].

108. AM. HOSP. ASS’N, ADDRESSING COMMERCIAL HEALTH PLAN ABUSES TO ENSURE FAIR COVERAGE FOR PATIENTS AND PROVIDERS 1 (2020), <https://www.aha.org/system/files/media/file/2020/12/addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf> [https://perma.cc/XP3T-FRZ7] (finding, based on an extensive American Hospital Association survey, that “[c]overage through [private] plans is eroding as some health

most common basis given for inappropriate denials.¹⁰⁹ According to the report, even clearly necessary care is often denied; one hospital gave the example of care for a first psychotic episode being denied on the basis that there was no history of psychosis.¹¹⁰

- Expansion of prior authorization requirements, without any indication of necessity for doing so. Hospitals report the increasing misuse of utilization review practices—particularly prior authorization—to create unjustified barriers to care.¹¹¹
- Opaque and varying clinical guidelines, differing from one plan to another and often not shared with providers.¹¹²
- Use of employees without the necessary expertise to resolve disputes and to assess the proposed treatment.¹¹³
- Specific changes that are to the detriment of plan participants, such as a more restrictive definition of sepsis, such that sepsis care would not be covered until it is more advanced.¹¹⁴
- Denial of coverage for inpatient hospital stays that are clinically justified. Administrators may “downcode” these claims or reduce the coding for the intensity of the claims’ care to an “observation” level, rather than inpatient status.¹¹⁵ This difference is significant, as observation status can lead to denials, either because the patient was given the wrong status¹¹⁶ or because the patient did

insurers restrict access to health care services by abusing utilization management programs and changing health plan rules in the middle of a contract year”).

109. *Id.* at 4 (noting that “hospitals and health systems frequently experience situations where a service was clearly medically necessary, but the plan denies it anyway, resulting in additional staff time to resolve the dispute”).

110. *Id.*

111. *Id.* at 1 (noting that “some plans are now applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of abuse”). The report also notes that eighty-nine percent of respondents said denials had increased over the past three years; fifty-one percent said denials had increased to a “significant” degree. *Id.* at 5.

112. *Id.* at 4.

113. *Id.* (citing the example of a urologist being assigned to assess whether a particular cancer treatment was appropriately prescribed by an oncologist).

114. *Id.* at 5 (noting that some health plans have adopted the Sepsis-3 criteria rather than Sepsis-2 for sepsis coverage, meaning that only more advanced sepsis is covered). This is particularly troubling, as “[e]arly treatment is critical to prevent the progression of sepsis and any reduction in early intervention could result in increased mortality.” *Id.*

115. *Id.*

116. Elizabeth Davis, *Why You May Pay More if You Are Hospitalized for Observation*, VERY WELL HEALTH, <https://www.verywellhealth.com/an-explanation-of-inpatient-v-observation-status-1738455> [https://perma.cc/JCQ6-JP4X] (July 31, 2022) (“For example, if you’re an inpatient but your health insurance company determines that you should have been assigned observation status, it can deny the claim. In some cases, you might not discover this until you receive a letter stating that the claim has been denied.”). The guidelines for each status are often subjective and unclear. *Id.* (“The guidelines [for observational versus inpatient status] are complex and change every year. While many parts of the guidelines are de-tailed and clearly spelled out, others are vague and open to interpretation.”).

not obtain prior authorization for the “downcoded” observational status.¹¹⁷

- Use of algorithms that increase denials of mental health claims.¹¹⁸ For example, in *Wit v. United Behavioral Health*, United Behavioral Health’s (“UBH”) algorithm imposed guidelines more stringent than those represented in the patients’ plans and more stringent than required by state law, when UBH was required to use state law definitions and guidelines.¹¹⁹ This resulted in mental health care being discontinued and these claims being improperly denied.¹²⁰ A federal judge found that UBH “breached its fiduciary duty to Plan members over a period of years to protect its bottom line.”¹²¹ It “denied mental health and substance use disorder treatment coverage to tens of thousands of class members using internal guidelines that were inconsistent with the terms of the class members’ health insurance plans.”¹²²

To be sure, not all claims should be paid. A benefit plan’s fiduciary duty with regard to claims runs in two directions—the fiduciary is to “provid[e] benefits to participants and their beneficiaries” but also to “defray[] reasonable expenses.”¹²³ Just as the improper non-payment of a claim may amount to a breach of a fiduciary duty, so may an improper payment. But certain plan decisions—such as the choice to assign peer reviewers without the necessary clinical expertise to review treatment—seem to be a clear violation of the fiduciary duty of prudence and loyalty.¹²⁴ Such a decision is as

117. AM. HOSP. ASS’N, *supra* note 108, at 5.

118. *Wit v. United Behav. Health*, 578 F. Supp. 3d 1060 (N.D. Cal. 2022).

119. *Id.*

120. *Id.* (“In addition to plan terms requiring UBH to use generally accepted standards of care, UBH was specifically required, pursuant to the laws of Illinois, Connecticut, Rhode Island, and Texas, to administer requests for benefits pursuant to Plans governed by those states’ laws in accordance with those laws. For the reasons stated above, the Court finds that UBH did not adhere to these state law requirements.”).

121. *Wit*, 578 F. Supp. 3d at 1073.

122. *Id.* The Ninth Circuit later reversed this decision, finding that this departure from the standard of care was within the administrators’ discretion. *Wit v. United Behav. Health*, No. 20-17363, 2022 U.S. App. LEXIS 7514, at *10 (9th Cir. Mar. 22, 2022). Yet the facts of this case were the basis of the Department of Labor’s and the New York Attorney General’s lawsuit and eventual settlement against UBH and UnitedHealthcare Insurance Company. Complaint at 1–2, *Walsh v. United Behav. Health*, No. 21-cv-4519 (E.D.N.Y. 2021); Press Release, U.S. Dep’t of Labor, *United Behav. Health, United Healthcare Insurance Co. Plans to Pay \$15.6M, Take Corrective Actions After Federal, State Investigations* (Aug. 12, 2021), <https://www.dol.gov/newsroom/releases/ebsa/ebsa20210812> [<https://perma.cc/P3ZG-MUT3>].

123. 29 U.S.C. § 1104(a)(1)(A).

124. A question in a recent American Medical Association survey asked physicians: “When completing a peer-to-peer review during the prior authorization process, how often does the health plan’s ‘peer’ have the appropriate qualifications to assess and make a determination regarding the prior authorization request?” Only fifteen percent of the respondents said that the “peer” always or usually has the necessary qualifications. AM.

important to the delivery of benefits as the decision to charge unnecessary fees in the retirement context; the latter decision is considered a compensable breach of fiduciary duty, and the former should be as well.

It could be argued that these outcomes are due to simple mistakes or irregularities in claims processing. But the widespread nature of the complaints suggests that the problems are not idiosyncratic or isolated.¹²⁵ Rather, the problems appear to be based on guidelines or algorithms that were put in place intentionally.

D. *The Reality of Fiduciary Immunity*

What happens to health plan decision-makers who breach their fiduciary duties? Not much, as it turns out. Fiduciary breaches can be lucrative—and essentially cost-free. Just as the Ninth Circuit predicted decades ago, without fear of far-reaching consequences, fiduciaries are free to act with impunity,¹²⁶ pushing the boundaries of what ERISA permits and correcting course only when practices are eventually challenged and a court draws the line.

As the following examples show, fiduciary breaches in health plans at present are corrected piecemeal, failing to capture the large-scale profits that can result from the application of improper guidelines to claims for years.¹²⁷

One example of this run-until-tackled approach to fiduciary duties is cross-plan offsetting. Multiple courts now prohibit cross-plan offsetting as a breach of fiduciary duty,¹²⁸ but the practice has

MED. ASS'N, REPORT OF THE COUNCIL ON MEDICAL SERVICE (2021), <https://www.ama-assn.org/system/files/2021-06/j21-cms-report-4.pdf> [<https://perma.cc/PMTK-2XL7>].

125. The hospital survey, for example, surveyed hundreds of hospitals and hundreds more executives. AM. HOSP. ASS'N, *supra* note 108, at 1–2.

126. *Russell v. Mass. Mut. Life Ins. Co.*, 722 F.2d 482, 490 (9th Cir. 1983).

127. Empirical research has revealed a correlation between the profitability of a plan administrator and its willingness to deny or downgrade claims. Jeffrey D. Greenberg et al., *Reimbursement Denial and Reversal by Health Plans at a University Hospital*, 117 AM. J. OF MED. 629, 633 (2004) (finding a “strong positive correlation” between net profit margin and the adjusted odds that a plan would discount the cost of a day’s stay in the hospital).

128. *See, e.g.*, *Peterson ex rel. E v. UnitedHealth Grp. Inc.*, 913 F.3d 769, 776–77 (8th Cir. 2019); *Lutz Surgical Partners PLLC v. Aetna, Inc.*, No. 3:15-CV-02595, 2021 U.S. Dist. LEXIS 115523, at *49 (D.N.J. June 21, 2021) (“By ‘failing to pay a benefit owed to a beneficiary under one plan in order to recover money for the benefit of another plan,’ the practice of cross-plan offsetting ‘may constitute a transfer of money from one plan to another.’” (quoting *Peterson*, 913 F.3d at 777)).

existed since at least 2007.¹²⁹ Cross-plan offsetting is the practice of using one plan's alleged overpayment to a provider as an offset against another payment—from a separate and unrelated plan—to the same provider.¹³⁰ This practice is now recognized as a violation of ERISA's prohibition on acting adversely to the plan's interests.¹³¹ In addition, the practice may result in unwitting plan participants' claims going unpaid, when the money that should have paid for their care is spent on a separate and unrelated claim.¹³²

For more than a decade, companies including UnitedHealth Group engaged in this practice as to thousands of plans, all to the detriment of providers and participants.¹³³ Thus, even when plaintiffs challenge a long-standing practice and the claims wind their way through the federal courts, the practice may be stopped and remedied as to the particular plaintiffs, but years or even decades of damage have been done. When a breach of ERISA's fiduciary duty provisions results in no damages or other disincentive beyond the narrow damages for plaintiffs before the court, payors are free to "push the boundaries of what ERISA permits."¹³⁴

Where is the limit to fiduciary impunity? How far can fiduciary breaches go? What would be the legal result, for example, if plan decision-makers inserted an algorithm that denied all claims within a certain category, such as lab fees, but then paid those claims upon appeal? As an initial matter, this would be a profitable strategy, as the vast majority of denials are not appealed.¹³⁵ For those claims that are appealed and eventually pursued in federal court, the remedy would be to pay the claim itself, with no additional payment for the breach of fiduciary duty.¹³⁶ Of course,

129. *Peterson*, 913 F.3d at 772.

130. *Id.*

131. ERISA prohibits a plan fiduciary from "act[ing] in any transaction involving the plan on behalf of a party (or represent[ing] a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries." 29 U.S.C. § 1106(b)(2).

132. *Fiszer*, *supra* note 107 ("The practice often also causes a ripple effect that may unfairly saddle a participant with additional costs.")

133. *Peterson*, 913 F.3d at 776–77.

134. *Id.* at 777 (regarding the practice of cross-plan offsetting "with some skepticism" and describing it as "pushing the boundaries of [] ERISA").

135. *Pollitz et al.*, *supra* note 20 (noting that large group data is not yet available but that "[a]s in our previous analysis of claims denials, we find that consumers rarely appeal denied claims and when they do, insurers usually uphold their original decision. In 2020, HealthCare.gov consumers appealed just over one-tenth of 1% of denied in-network claims, and insurers upheld most (63%) of denials on appeal").

136. *See, e.g.*, *Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 959, 961 (9th Cir. 2016).

plaintiffs could organize into a class and bring a class action. This strategy, however, would first require knowledge that a certain guide-line was being broadly applied, which is difficult to discern given ERISA's limited discovery.¹³⁷ In addition, class certification could founder on the issue of whether the claims must be considered individually.¹³⁸

The scenario imagining a guideline denying all claims in a certain category is not far-fetched: UBH did in fact flag all claims within a certain category for years, resulting in many being denied—they ended the practice (and paid millions in fines) only when the U.S. Department of Labor and the New York Attorney General's Office sued.¹³⁹ Here too, the practice had been widespread for nearly a decade, so while a fine in the millions may seem to be a deterrent, that amount pales in comparison to a decade's worth of mental health claims for millions of plan participants.¹⁴⁰ ERISA's fiduciary duty provisions were meant to impose high standards and to hold fiduciaries accountable. When payors can do as they please until challenged years or decades later and then suffer only minimal consequences, ERISA's fiduciary standards and

137. Claims for ERISA benefits plan benefits are generally limited to the review of the administrative record due to concerns that additional discovery would thwart ERISA's goal of "provid[ing] a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously." *Colaco v. ASIC Advantage Simplified Pension Plan, Inc.*, 301 F.R.D. 431, 434 (N.D. Cal. 2014) (quoting *Boyd v. Bell*, 410 F.3d 1173, 1178 (9th Cir. 2005)).

138. *See, e.g., Wit v. United Behav. Health*, Nos. 20-17363, 21-15193, Nos. 20-17364, 21-15194, 2023 U.S. App. LEXIS 2039, at *25–28 (9th Cir. Jan. 26, 2023) (highlighting the individualized nature of denial of benefits claims brought under section 1132(a)(1)(B) and reversing the district court's class certification).

139. UnitedHealth Group agreed to pay \$15.7 million, including \$13.6 million in restitution and a \$2.1 million fine to settle the Department of Labor and the New York Attorney General's allegations that it improperly denied claims and used algorithms to flag certain permitted therapies. Press Release, Emp. Benefits Sec. Admin., *supra* note 122.

An investigation by the department's Employee Benefits Security Administration found that—going back to at least 2013—United reduced reimbursement rates for out-of-network mental health services, thereby overcharging participants for those services, and flagged participants undergoing mental health treatments for a utilization review, resulting in many denials of payment for those services.

Id.

"[U]nder its Algorithms for Effective Reporting and Treatment (ALERT) program, United had set arbitrary thresholds to trigger reviews of psychotherapy, which often led to denials of coverage." Press Release, Off. of N.Y. Att'y Gen. Leticia James, *supra* note 11.

140. *See* Complaint for ERISA Violations at 4–9, *Walsh v. United Behav. Health*, No. 21-cv-4519 (E.D.N.Y. Aug. 11, 2021).

remedies are not serving their intended function of protecting plan participants' right to benefits.

III. ERISA'S FIDUCIARY BREACH REMEDIES MUST ADAPT TO MODERN HEALTH BENEFIT PLANS

ERISA's fiduciary duties and their enforcement mechanisms—that work well in the retirement plan context—are currently ineffective in preventing health plan decision makers from crafting broad and aggressive guidelines, policies, and algorithms that directly oppose participants' interests, in violation of fiduciary duties. The hoped-for guardrails—such as reputational concerns—have not materialized. Claims administrators are therefore increasingly emboldened, tipping the balance in their own favor and against Americans struggling to pay for healthcare. This result is antithetical to the goals of ERISA.

Potential solutions to this problem, set out below, include a fiduciary breach claim for the decrease in a plan's value caused by undisclosed restrictions on coverage, an expanded view of the surcharge remedy, and legislative solutions.

A. Non-Fiduciary Protections Are Meager or Non-Existent

Fiduciary duties are particularly important in health plans, as state claims and remedies are preempted, benefits are unvested, and hoped-for reputational protections have not materialized.¹⁴¹

ERISA's broad preemption provision preempts all state claims and remedies.¹⁴² In their place, ERISA offers only slight remedies—a claim for benefits can at most result in an award of the value of the benefit itself, interest, and, under narrow circumstances, attorney's fees.¹⁴³ More often, however, a claims administrator is simply ordered to reprocess the claim as it should have in

141. See Wiedenbeck, *supra* note 37, at 1036 (“Rather than broadly safeguarding workers' reasonable expectations, ERISA has evolved to admit only a narrow and diluted set of rights in pension and welfare benefits.”).

142. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (“[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.”).

143. Vukadin, *supra* note 21, at 371.

the first place.¹⁴⁴ At worst, a claims administrator who improperly denies a claim can be required to pay the claim as it should have initially.¹⁴⁵ Given the low proportion of denied claims that are appealed even once, let alone the multiple times often required before suing in federal court,¹⁴⁶ claims administrators can safely assume that a number of improperly denied claims will remain undisturbed.

Another feature of welfare benefit plans such as healthcare plans is that the benefits are not vested, and employers are free to amend the plans at will.¹⁴⁷ Employers who modify plans are not acting as fiduciaries¹⁴⁸ and are free to amend plans as they wish.¹⁴⁹ Thus, employers have been permitted by federal courts to amend a plan to increase benefits in exchange for employees' release of claims against the employer¹⁵⁰ and to lower the lifetime cap on health benefits for AIDS from \$1 million to \$5,000, a change made after an employee contracted the illness.¹⁵¹ Given employers' wide latitude to craft health plans, the fiduciary duties that bind decision-makers in the plans' implementation are particularly important and should be given their proper effect.

And, although ERISA's protections are based on trust law, ERISA allows conflicts that traditional trust law does not. First, private trust fiduciaries cannot put themselves in positions that conflict with their fiduciary responsibilities.¹⁵² This is based on the

144. See, e.g., *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 157 (5th Cir. 2009) (noting that remand is generally appropriate when an administrator does not complete a proper initial review).

145. See, e.g., *WOOTEN*, *supra* note 30, at 283.

146. See, e.g., Karen Pollitz, Justin Lo, Rayna Wallace & Salem Mengistu, *Claims Denials and Appeals in ACA Marketplace Plans in 2021*, Kaiser Fam. Found. (Feb. 9, 2023), <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/> [<https://perma.cc/EK7Y-TX9U>].

147. "Welfare benefit plan administrators are required to comport with the fiduciary responsibility requirements and the reporting and disclosure requirements. They are explicitly exempted, however, from the obligations of the participation and vesting sections and the funding sections of the Act." *Adams v. Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir. 1990).

148. *Wiedenbeck*, *supra* note 37, at 1024–1029 (discussing the force of the settlor function and the "startling—perhaps shocking" results it can yield); *U.S. Airways, Inc. v. McCutchen*, 569 U.S. 88, 101–02 (2013).

149. *Wiedenbeck*, *supra* note 37, at 1027 (noting that settlor decision-making is "unconstrained by the expectations, needs, and interests of participants and beneficiaries").

150. *Lockheed Corp. v. Spink*, 517 U.S. 882, 885 (1996).

151. *McGann v. H & H Music Co.*, 946 F.2d 401, 405–06 (5th Cir. 1991).

152. See RESTATEMENT (THIRD) OF TRUSTS § 78(2) & cmts. a–b (AM. L. INST. 2007); WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 57.6 (4th ed. 1987); *Pegram v.*

belief that even if a person struggles against personal interests, a person's own interest is likely to taint the judgment.¹⁵³ Based on this thinking, even if a private trustee's decision is fair to the beneficiary, the decision is tainted by conflict and the trustee is in breach of the trust—this is known as the “no-further-inquiry rule.”¹⁵⁴ ERISA, however, permits conflicted fiduciaries, perhaps due to existing practice in benefit plans before ERISA's enactment.¹⁵⁵ In the case of health claims, practically every claims decision is made under a conflict.¹⁵⁶ When a plan is fully insured, the conflict between fiduciary duties and financial interests are obvious—every claim paid results in fewer dollars in the payor's pockets.¹⁵⁷ Even when plans are not fully insured, payors still seek to keep costs down so their plans are competitive in the marketplace.

In addition, ubiquitous discretionary clauses in plans tip the balance in favor of decision-makers.¹⁵⁸ These discretionary clauses—implicitly permitted by a 1989 Supreme Court case¹⁵⁹—are banned as unfair to consumers in twenty-five states, but are allowed in some ERISA plans.¹⁶⁰ Because of these clauses, fiduciaries' plan

Herdrich, 530 U.S. 211, 224 (2000) (quoting IIA WILLIAM F. FRATCHER, SCOTT ON TRUSTS § 170 (4th ed. 1998)).

153. “If permitted to represent antagonistic interests the trustee is placed under temptation and is apt in many cases to yield to the natural prompting to give himself the benefit of all doubts, or to make decisions which favor the third person who is competing with the beneficiary.” BOGERT, TRUSTS AND TRUSTEE § 543, at 475–76 (2d ed. 1960); *see also* 2 AUSTIN W. SCOTT, TRUSTS § 170 (2d ed. 1956); *id.* § 502, at 3235–36; 76 AM. JUR. 2D *Trusts* § 311-315 (1945).

154. Wiedenbeck, *supra* note 37, at 1071 (noting that “[t]his ‘no-further-inquiry’ rule establishes a prophylactic standard designed to bar deals involving a high risk of abuse.”).

155. *Id.* at 1072.

156. *See, e.g.*, Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 120 (2008) (Roberts, J., concurring) (noting that the conflict-of-interest concern applies to most ERISA benefit denial cases).

157. *Id.* at 112 (a fiduciary's duties “may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary.”). Thus, the payor has an interest “conflicting with that of the beneficiaries.” *Id.* “[E]very dollar provided in benefits is a dollar spent by . . . the employer; and every dollar saved . . . is a dollar in [the employer's] pocket.” *Id.* (quoting *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d. Cir. 1987)).

158. The Supreme Court's *Firestone v. Bruch* decision allowed plans to insert self-serving plan terms that give discretion to the plan decision-maker to interpret the plan. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111, 113–15 (1989).

159. *See id.* at 115.

160. *See Owens v. Liberty Life Assurance Co.*, 184 F. Supp. 3d 580, 584 (W.D. Ky. 2016). The National Association of Insurance Commissioners deems these clauses “inequitable, deceptive, and misleading to consumers.” Brief for Nat'l Ass'n of Ins. Comm'rs as Amici Curiae Supporting Appellee at 8, *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (No. 08-35246).

interpretations are reviewed under the lenient “arbitrary and capricious” standard.¹⁶¹ A plan administrator’s judgment is generally left in place unless the outcome lacks evidence or is unreasonable.¹⁶²

Nor do reputational concerns appear to provide any protection. An early theory supposed that health benefit plans and the employers sponsoring them would reject sharp claims processing practices that might risk a reputational backlash.¹⁶³ Many of today’s plans, however, are packaged, sold, and administered by multi-billion-dollar publicly traded corporations—as a result, people who set guidelines and lead claims processing departments are under multiple, competing pressures, including the pressure to deliver results to shareholders and the pressure to keep costs down, so the plans are competitive in the marketplace.

As one example, the Department of Labor sued United Healthcare for improper claims practices, settling for millions of dollars in 2022; that same year, UnitedHealth Group’s profits only increased.¹⁶⁴ Occasionally, bad publicity for improper denials or mystifying pre-authorization requirements erupts on social media. Physicians or patients may post on Twitter, for example, calling out specific health insurance companies in frank terms for their practices in particular instances and appealing directly for relief.¹⁶⁵ The company in question generally responds directly, swiftly

161. See, e.g., *Corry v. Liberty Life Assurance Co.*, 499 F.3d 389, 397–98 (5th Cir. 2007) (“[R]eview of the administrator’s decision need not be particularly complex or technical; it need only assure that the administrator’s decision fall somewhere on a continuum of reasonableness—even if on the low end.”).

162. *Collins v. Unum Life Ins. Co. of Am.*, 682 F. App’x 381, 385–86 (6th Cir. 2017).

163. See, e.g., *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999) (“Large businesses . . . want to maintain a reputation for fair dealing with their employees. They offer fringe benefits such as disability plans to attract good workers, which they will be unable to do if promised benefits are not paid. We have no reason to think that UNUM’s benefits staff is any more ‘partial’ against applicants than are federal judges when deciding income-tax cases.”).

164. *Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage*, *supra* note 11; Bruce Japsen, *UnitedHealth Group’s Profits Top \$5 Billion As Optum and Health Plans Grow*, FORBES (July 15, 2022, 7:03 AM), <https://www.forbes.com/sites/brucejapsen/2022/07/15/unitedhealth-groups-profits-top-5-billion-as-optum-and-health-plans-grow/?sh=5bcb8f556afc> [<https://perma.cc/XAR8-6R3F>].

165. For example Physician Lauren Wilson, M.D. tweeted on July 29, 2022: “Hey @anthemBCBS. Have readmitted a teenager with Crohn’s to the hospital, extremely ill. Her BMI is 12. Her gastroenterologist prescribed Humira—denied. Would you like to talk to this family for me, since you’re making the . . . medical decisions here?” Lauren Wilson MD (@DrLaurenWilson), TWITTER (July 29, 2022, 11:43 AM), <https://twitter.com/DrLaurenWilson/status/1553043576598118401?s=20> [<https://perma.cc/8VD9-P3S6>].

resolving the problem and tamping down any outrage.¹⁶⁶ Plan participants should not have to rely on their social media expertise and number of followers to secure their proper benefits.

B. New or Expanded Solutions to the Fiduciary Immunity Problem

As explained above, courts' interpretation of fiduciary duties in the retirement plan context has adapted over time, as the retirement plans changed from traditional pensions to 401(k)-type plans, so ERISA could have meaning in this new retirement environment.¹⁶⁷ One court noted: "That landscape has changed."¹⁶⁸ In the retirement plan context, then, remedies are clearly available through ERISA's text and harms are relatively easily quantified.¹⁶⁹

So too has the landscape changed in the health plan context, with the shift from simple indemnity to byzantine gatekeeper, and legal approaches should likewise adapt. To be sure, ERISA's history already leaves no doubt that fiduciary duties were to be taken seriously and that breaches should be remedied; the fact that Congress was more focused on pension plans than welfare plans at the time of ERISA's enactment does not detract from the explicit inclusion of welfare plans such as health benefit plans within ERISA's protective fiduciary umbrella and the expansive nature of the remedies.

The problem is that remedies for fiduciary breach in the health plan context are either (1) available but serve as insufficient deterrents due to their narrow nature or (2) sufficiently broad but not clearly available without a strained reading of the fiduciary breach provision. Furthermore, the problem of tracing any remedy to the fiduciary breach is an ongoing and vexing challenge.

166. Lauren Wilson MD (@DrLaurenWilson), TWITTER (July 29, 2022, 4:50 PM), <https://twitter.com/DrLaurenWilson/status/1553120909585571840?s=20> [<https://perma.cc/4X9M-RB8G>].

167. See *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 255 (2008) (declining, in the 401(k) context, to apply Court precedent from the pension plan context: "The 'entire plan' language in *Russell* speaks to the impact of § 409 on plans that pay defined benefits.").

168. *Id.* at 254.

169. See, e.g., *Tussey v. ABB, Inc.*, No. 06-CV-04305-NKL, 2019 U.S. Dist. LEXIS 138880, at *5 (W.D. Mo. Aug. 16, 2019) ("ABB breached its fiduciary duties of prudence and loyalty to the Plans by: (1) failing to monitor and ensure the reasonableness of the Plans' recordkeeping fees (\$13.4 million in losses) and (2) removing the Vanguard Wellington fund and replacing it with the Fidelity Freedom funds (\$21.8 million in losses).").

The statute includes an individual claim for too-narrow guidelines and other fiduciary breaches:

When plan fiduciaries impose guidelines that are too narrow or that improperly burden participants' right to benefits, this can amount to a breach of fiduciary duty. Under these circumstances, a claim for breach of fiduciary duty will lie, even in the absence of specific harm to a plaintiff.¹⁷⁰ A health plan fiduciary is bound to act "solely in the interest of the participants and beneficiaries,"¹⁷¹ "with . . . care, skill, prudence, and diligence,"¹⁷² and "in accordance with the documents and instruments governing the plan."¹⁷³

For example, even as the Ninth Circuit in *Wit v. United Behavioral Health* reversed the lower court's judgment in favor of a plaintiff class alleging broad fiduciary breaches, the court agreed that plaintiffs had alleged a sufficiently concrete individual harm by claiming that fiduciaries improperly narrowed plaintiffs' benefits.¹⁷⁴ The alleged harm was the risk of administration under too-narrow guidelines and plaintiffs' lack of information about the scope of their coverage.¹⁷⁵ To state such a claim, plaintiffs need not show that their claims were actually denied.¹⁷⁶ There is also a cognizable harm under ERISA where a participant or beneficiary suffers "the loss of a right protected by ERISA or its trust-law antecedents."¹⁷⁷

These circumstances amount to an individual harm, but an improper guideline or unreasonable pre-authorization requirements cannot be fully remedied on an individual basis. This is because of

170. *Wit v. United Behav. Health*, Nos. 20-17363, 21-15193, Nos. 20-17364, 21-15194, 2022 U.S. App. LEXIS 7514, at *7–9 (9th Cir. Mar. 22, 2022); see *Ziegler v. Connecticut Gen. Life Ins. Co.*, 916 F.2d 548, 551 (9th Cir. 1990) ("Congress intended to make fiduciaries culpable for certain ERISA violations even in the absence of actual injury to a plan or participant.").

171. 29 U.S.C. § 1104(a)(l).

172. *Id.* § 1104(a)(l)(B).

173. *Id.* § 1104(a)(l)(D).

174. No. 20-17363, 2022 U.S. App. LEXIS 7514, at *5 (9th Cir. Mar. 22, 2022).

175. *Id.* at *7 ("Plaintiffs' alleged harm includes the risk that their claims will be administered under a set of Guidelines that narrows the scope of their benefits, and also includes the present harm of not knowing the scope of the coverage their Plans provide. The latter implicates plaintiffs' ability to make informed decisions about the need to purchase alternative coverage and the ability to know whether they are paying for unnecessary coverage.").

176. *Id.* at *9 ("[P]laintiffs need not have demonstrated that they were, or will be, actually denied benefits to allege a concrete injury.").

177. *Cigna Corp. v. Amara*, 563 U.S. 421, 444 (2011) (noting that where a company gave improper notice to a plan participant class, the plaintiffs need not have themselves acted in reliance on the summary documents: "We doubt that Congress would have wanted to bar those employees from relief.").

the nature of health benefit plans and the reality of claims processing—for every person who even appeals a claim once, let alone sues in federal court, there are ninety-nine or so more who never appeal and never sue. The claimed harms in the *Wit* case had gone on for more than a decade, and the lawsuit itself took years (and was ultimately unsuccessful for plaintiffs).¹⁷⁸ Thus, the reprocessing claim that plaintiffs sought could not match the years of denied mental health claims and hence the large sums of money not spent.

When these claims are brought as class actions, class certification encounters headwinds due to the arguably individual nature of medical claim determinations.¹⁷⁹ If such a claim could be brought as a harm to the entire plan, however, then damages could be considered on a much broader basis.

C. Harm to the Entire Plan Under ERISA's Section 1109

When a plan fiduciary sets an improper standard or algorithm that results in an individual claim's denial, an individual claimant's harm is considered remedied when a court awards the claim's value, even if a fiduciary breach accompanied that claim denial.¹⁸⁰ Yet that improper standard or algorithm does more than result in denials—it impairs the value of the entire plan, resulting in denied claims and discouraged participants who stop seeking care. When people pay to participate in an employee health benefit plan, they are paying for coverage included within the plan documents. Thus, to disincentivize this type of fiduciary breach, a claim to recover that impairment of plan value is necessary.

ERISA's specific fiduciary breach provision (section 1109) targets losses to the plan and restoration of profits from fiduciary breaches,¹⁸¹ in keeping with the pension-related concerns of the

178. *Varity Corp. v. Howe*, 516 U.S. 489, 492 (1996) (reversing lower court's judgment that had found in favor of plaintiffs).

179. *See, e.g., Wit*, 2022 LEXIS 7514, at *9 (assuming without deciding that "plaintiffs avoided the individualized nature of the benefits remedy available under § 1132(a)(1)(B) by seeking 'reprocessing'" as a remedy).

180. *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 375 (6th Cir. 2015) (Plaintiff's "injury was remedied when he was awarded the wrongfully denied benefits and attorney's fees—as potentially supplemented by award of prejudgment interest, still to be determined. Despite Rochow's attempts to obtain equitable relief by repackaging the wrongful denial of benefits claim as a breach-of-fiduciary-duty claim, there is but one remediable injury and it is properly and adequately remedied under § 502(a)(1)(B).").

181. 29 U.S.C. § 1109. Section 1109(a) establishes liability for breach of fiduciary duty:

day.¹⁸² Yet, as explained below, this provision may also provide an avenue for broad fiduciary breaches that affect the core function of a health plan—to provide contracted benefits.

Health plans are of course structurally different from retirement plans in that, rather than consisting of a fund, a health plan consists of a set of promises to pay benefits.¹⁸³ This is the sole function of a health plan, yet this type of plan too is protected by ERISA's specific fiduciary provision—Congress took care to include welfare plans within the fiduciary duties section of ERISA, even as it explicitly excluded certain other types of plans.¹⁸⁴ The fiduciary provision is far from a perfect fit for broad fiduciary harms to health plans, likely because health plans were quite different, and less problematic, at the time.

Some read section 1109 as concerning only plan assets and financial integrity, which was Congress's paramount concern when drafting ERISA.¹⁸⁵ In addition, there are separate sections of

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to 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 which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this Title.

Id. at § 1109(a).

182. *Pegram v. Herdrich*, 530 U.S. 211, 232 (2000) (“[W]hen Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries’ financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits.”).

183. Eric D. Chason, *Redressing All ERISA Fiduciary Breaches Under Section 409(a)*, 83 TEMP. L. REV. 147, 152–53 (2010) (arguing that the duty of loyalty is “virtually incoherent when applied to unfunded ERISA plans”).

184. See 29 U.S.C. §§ 1003, 1101. Section 1101 states that all plans listed in section 1003(a) (which includes “any employee benefit plan”) are included within the fiduciary section, § 1101(a); § 1003(a); section 1101 goes on to exclude plans that are unfunded and maintained primarily for deferred compensation to a particular “group of management or highly compensated employees” as well as certain agreements paying a retired or deceased partner. § 1101(a).

185. See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142–43 (1985).

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. Those duties are described in Part 4 of Title 1 of the Act, which is entitled “FIDUCIARY RESPONSIBILITY,” whereas the statutory provisions relating to claim procedures are found in Part 5, dealing with “ADMINISTRATION AND ENFORCEMENT.”

ERISA for fiduciary duties (Part 4: “Fiduciary Responsibility”) and for claims and administration (Part 5: “Administration and Enforcement”).¹⁸⁶ This view has been sufficient for some courts to dismiss such a claim on the basis that section 1109 is concerned with managing plan assets and financial viability, and that this kind of breach therefore does not damage the plan in a way that would merit section 1109 relief.¹⁸⁷ Indeed, some view the refusal to pay claims correctly as a boon to the plan, as the plan would have more money.¹⁸⁸ Yet this reading is the opposite of ERISA’s goal—to preserve participants’ benefits rather than to enhance a fund by *not* paying benefits.¹⁸⁹

To be sure, the specific fiduciary breach section does refer to recovering “losses” to the plan,¹⁹⁰ but nowhere is there a requirement that the losses be a loss of plan assets per se. A loss in value of the plan itself may equally be a “loss.” As further support, ERISA’s foundation in traditional trust law provides the alternative remedy of restoring plan participants to the position in which they would

Id. (citing Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, §§ 401–414, 502(a), 503, 88 Stat. 874–890, 891, 893 (codified as amended at 29 U.S.C. 1101–1114, 1132(a), 1133)).

186. *Id.*

187. *See, e.g.,* *Cromwell v. Kaiser Found. Health Plan*, No. 18-cv-06187-EMC, 2019 U.S. Dist. LEXIS 58617, at *13–15, *17 (N.D. Cal. Apr. 4, 2019) (citing *Amalgamated Clothing & Textile Workers Union v. Murdock*, 861 F.2d 1406, 1414 (9th Cir. 1988)) (dismissing section 1109 claims on the basis that the alleged breach saved money by not paying claims and stating that section 1109 is not concerned with individual injuries). But under certain narrow circumstances, a breach of fiduciary claim has been found to lie under this provision and call for damages after prohibited actions involving a claims administrator. *See Guyan Int’l, Inc. v. Pro. Benefits Adm’rs, Inc.*, 689 F.3d 793, 800 (6th Cir. 2012). Where, for example, a claims administrator kept plan money for itself instead of sending it to providers to pay legitimate claims, a court awarded damages that made the plan whole. *See id.* at 796–97, 800, 802 (stating that the claims administrator had to make the plan whole “for losses resulting from [that] breach”). The court found that the claims administrator’s check-writing authority made it a fiduciary with control over assets, and that it breached its duty by keeping funds instead of paying them to providers. *Id.* at 798–99.

188. *See* *Cromwell*, 2019 U.S. Dist. LEXIS 58617, at *12–15.

189. *Physicians HealthChoice, Inc. v. Trs. of Auto. Emp. Benefit Tr.*, 988 F.2d 53, 55 (8th Cir. 1993) (stating that a plan that did not pay claims did not cause “losses” but noting that it was not dispositive that a harm was not obviously contemplated by section 1109).

190. 29 U.S.C. § 1109(a)

Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to 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 which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

Id.

have occupied but for the breach of trust.¹⁹¹ In other words, plan participants and beneficiaries purchase a certain set of health benefits, based on their understanding of the plan. If claims are administered in such a way as to make the expected coverage unavailable as a practical matter, then the participant has experienced the loss of that benefit.

As to the use of the term “assets” in the provision, the set of promises that comprise a health plan is not generally considered an “asset” of the plan, although there is no requirement that plan assets be tangible or monetary, as retirement plan assets generally are.¹⁹² Indeed, the premiums that employees pay are considered assets, and the employer contributions may be as well.¹⁹³ Besides, the provision on liability for breaches of fiduciary duty only mentions the word “assets” in terms of a breaching fiduciary’s need to restore profits to the plan if they are made by using plan assets.¹⁹⁴ This is just one of the available claims under that section and does not exclude others.

Like retirement plans, health plans, too, pay money in the interest of beneficiaries, so ERISA’s fiduciary duties are fully implicated. As the Court noted in *Pegram*, the management of money is the hallmark of a fiduciary decision: “[T]he common law trustee’s most defining concern historically has been the payment of money in the interest of the beneficiary.”¹⁹⁵

191. See *Eaves v. Penn*, 587 F.2d 453, 462 (10th Cir. 1978); RESTATEMENT (SECOND) OF TRUSTS § 205, cmt. a (1959).

192. U.S. Dep’t of Labor, Advisory Op. No. 92-24A, 1992 WL 337539, *2 (Nov. 6, 1992) (AO 92-24A).

Apart from participant contributions, applying ordinary notions of property rights, the assets of a welfare plan generally include any property, tangible or intangible, in which the plan has a beneficial ownership interest. The identification of plan assets therefore requires consideration of any contract or other legal instrument involving the plan, as well as the actions and representations of the parties involved.

Id.

193. The Sixth Circuit held, for example, that a party was a plan fiduciary because it controlled assets, namely the premiums paid. *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740, 746 (6th Cir. 2014) (“Collectively, these ‘actions and representations’ establish that BCBSM, [the employer] and the company’s employees all understood that BCBSM would be holding ERISA-regulated funds to pay the health expenses and administrative costs of enrollees in the [] Health Plan. As a result, [the] Plan beneficiaries had a reasonable expectation of a ‘beneficial ownership interest’ in the funds held by BCBSM.”).

194. 29 U.S.C. § 1109(a).

195. *Pegram v. Herdrich*, 530 U.S. 211, 231 (2000) (“[W]hen Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries’ financial decisions,

Thus, while pension malfeasance and the protection of pension assets were certainly the main concerns of the day, as described above, this was far from the drafters' only concern—the drafters left an avenue for other types of plans too. If the plan that participants have paid for is reduced in value by a breaching fiduciary's improper guidelines, then the plan should arguably be put back in the position that it was in before, by crediting plan participants with the missing value.¹⁹⁶ This approach is in keeping with traditional trust law, which provides for broad and flexible equitable remedies in cases involving breaches of fiduciary duty.¹⁹⁷

D. *The Surcharge Remedy*

The surcharge remedy is already available, but it could be expanded to remedy fiduciary harms more fully. That is, a plaintiff suing for breach of fiduciary duty relating to the terms of a plan can sue for surcharge, which is “monetary ‘compensation’ for a loss resulting from a [fiduciary’s] breach of duty, or to prevent the [fiduciary’s] unjust enrichment.”¹⁹⁸ This remedy is found in both avenues to a fiduciary recovery, in the specific fiduciary provision as well as for a catchall claim.

While ERISA does not at present permit consequential damages, a surcharge remedy could still be effective, particularly if aimed at undue profits. The Supreme Court noted that, “[e]quity courts possessed the power to provide relief in the form of monetary ‘compensation’ for a loss resulting from a trustee’s breach of duty, or to prevent the trustee’s unjust enrichment.”¹⁹⁹ Thus, a claims

focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits.”).

196. See *Eaves v. Penn*, 587 F.2d 453, 462 (10th Cir. 1978); RESTATEMENT (SECOND) OF TRUSTS, § 205, cmt. a (AM. L. INST. 1959).

197. See RESTATEMENT (SECOND) OF TRUSTS, § 205, cmt. a (AM. L. INST. 1959).

198. *CIGNA Corp. v. Amara*, 563 U.S. 421, 422 (2011) (citing *N.Y. State Psychiatric Ass’n, Inc. v. UnitedHealth Grp.*, 798 F.3d 125, 134-35 (2d Cir. 2015); *A.F. v. Providence Health Plan*, 157 F. Supp. 3d 899, 920 (D. Or. 2016)); RESTATEMENT (THIRD) OF TRUSTS § 100 (AM. L. INST. 2012) (“If [a] suit for breach of trust is successfully brought against the trustee, recovery may take the form of a money judgment or (if feasible) specific restitution.”).

199. *CIGNA*, 563 U.S. at 441–42 (citing RESTATEMENT (THIRD) OF TRUSTS § 95 cmts. a–c (AM. L. INST., Tentative Draft No. 5, 2009) (noting that disgorgement, accounting, and surcharge remedies can all be considered appropriate equitable relief.)); see also *Harris Tr. & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250 (2000) (“The trustee or beneficiaries may then maintain an action for restitution of the property (if not already disposed of) or disgorgement of proceeds (if already disposed of), and disgorgement of

administrator that profits due to improper utilization review standards or improper peer-to-peer reviews could be required to disgorge all of the profit derived from that breach of fiduciary duty.

With the disgorgement remedy, one challenge is measuring the amount of harm and tracing it to the breach.²⁰⁰ The plaintiffs in the *Wit* class action sought this remedy, and the court entertained awarding it.²⁰¹ The court observed that any remedy could well capture proper processing as well as improper processing.²⁰² While any such remedy would have been reversed under the Ninth Circuit Court of Appeals' subsequent merits decision, the court discussed the proof potentially necessary, which was lacking in that case.²⁰³ The difficulty of capturing the profit from fiduciary breaches, the inadequacy of individual claims, and courts' refusal to consider consequential or punitive damages in ERISA cases suggest that broader solutions are necessary to disincentivize fiduciary breaches.

the third person's profits derived therefrom." (citing RESTATEMENT (SECOND) OF TRUSTS §§ 284, 291, 294, 295, 297 (AM. L. INST., 1959)).

200. "The object of the disgorgement remedy—to eliminate the possibility of profit from conscious wrongdoing—is one of the cornerstones of the law of restitution and unjust enrichment." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 51 cmt. e (AM. L. INST., 2011). Because this equitable remedy is aimed at preventing unjust enrichment on the part of the wrongdoer rather than compensating the plaintiff for an actual loss, the claimant's recovery "may potentially exceed any loss to the claimant." *Id.* cmt. a. The difficulty courts often face, however, is determining "the net increase in the assets of the wrongdoer . . . that . . . is attributable to the underlying wrong." *Id.* at cmt. e.

201. The plaintiffs sued for the amount the defendant was paid to process the denied claims. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, U.S. Dist. LEXIS 205429, at *13, *50–51 (N.D. Cal. Nov. 3, 2020) ("Because Plaintiffs seek a surcharge as a restitutionary remedy based on disgorgement, the Court looks to the principles of restitution in evaluating whether UBH is entitled to summary judgment as to Plaintiffs' surcharge remedy.").

202. *Id.*

Plaintiffs did not point to any evidence that would allow the Court to reasonably determine the amount of UBH's profits that is attributable to the alleged wrongdoing, namely, applying flawed Guidelines to Plaintiffs' claims. Instead, Plaintiffs assert that they can establish the amount of the surcharge by presenting evidence showing the amount UBH was paid to administer *all* of the class members' claims, including claims that may have been approved and claims that were denied but did not rely on the Guidelines as the basis for the denial. The measure proposed by Plaintiffs would capture profit that is not attributable to UBH's creation of the challenged Guidelines and application of those Guidelines to the class members' claims for coverage.

Id. at *51–53.

203. *Id.* (noting that plaintiffs did not have any evidence or expert testimony that would precisely establish the profit attributable to the improper guidelines).

E. A Roadmap to Legislative Solutions

If a claim for breach of fiduciary duty in the health claims context remains ineffective, then legislative solutions may be the only viable avenue to hold health plans accountable for their fiduciary acts. Healthcare-related legislation, particularly legislation involving ERISA, faces strong legislative headwinds, as corporations and their industry lobbying groups spend millions of dollars to preserve ERISA preemption and to avoid additional regulation.²⁰⁴ Legislation could take one of several approaches, such as a micro-level approach that smooths out particular aspects of the pre-authorization and utilization review processes or an approach that takes aim at ERISA's fiduciary provisions directly, authorizing specific claims for breaches of welfare plan fiduciary duties.

First, as to the micro-level approach, legislative solutions have been proposed for other health benefit-related problems, such as unreasonable pre-authorization demands and delays in the context of Medicare Advantage plans²⁰⁵ as well as in the context of "surprise billing."²⁰⁶ The example of Medicare Advantage plans shows

204. The lobbying group America's Health Insurance Plans spent \$13.2 million on lobbying in 2022. *America's Health Insurance Plans: Summary*, OPEN SECRETS, <https://www.opensecrets.org/Lobby/clientsum.php?id=D000021819&year=2022> [https://perma.cc/X7XU-8JJP] (Feb. 16, 2023).

205. The Improving Seniors' Timely Access to Care Act of 2022 helps reduce barriers to care caused by improper and uneven prior authorization requirements and undisclosed clinical requirements. This legislation, although not enacted, secured broad bipartisan support. See Improving Seniors' Timely Access to Care Act of 2022, H.R. 3173, 117th Cong. § 2(a)(1)–(2).

206. "Surprise billing" occurs when a person seeks care, generally choosing facilities and providers within the patient's network, but then the patient receives a bill for treatment that was unexpectedly given outside the patient's network. Following popular outcry over this practice, Congress passed the No Surprises Act in 2021, which "protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers." See *No Surprises: Understand Your Rights Against Surprise Medical Bills*, CRTS. FOR MEDICARE & MEDICAID SERVS. (Jan. 3, 2022), <https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills> [https://perma.cc/YD6Y-AN4B]. This law

- Ban[s] surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand
- Bans out-of-network cost-sharing . . . for most emergency and some non-emergency services
- Ban[s] out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility

a possible solution applicable to ERISA plans: after an Office of the Inspector General (“OIG”) report detected problems in accessing care, legislators responded with a bill to address the problems.²⁰⁷ The OIG investigation uncovered the routine denial of medically necessary care.²⁰⁸ The report resulted in calls for: (1) new guidance on clinical criteria; (2) updated audit protocols; and (3) identification of reasons for errors.²⁰⁹ Currently, the Improving Seniors’ Timely Access to Care Act was introduced in the 117th Congress and garnered significant bipartisan support.²¹⁰ The new law would have streamlined the authorization process with a view to easing

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- Require[s] that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections

Id.

207. Press Release, Rep. Suzan DelBene, DelBene, Kelly, Bera, Bucshon Introduce Bipartisan Legislation to Make Care More Efficient for Seniors by Reforming Prior Authorization (May 13, 2021), <https://delbene.house.gov/news/documentsingle.aspx?DocumentID=2809> [<https://perma.cc/HS7Q-8LKY>].

208. OFF. OF INSPECTOR GEN., U.S. DEP’T OF HEALTH & HUM. SERVS., OEI-09-18-00260, SOME MEDICARE ADVANTAGE ORGANIZATION DENIALS OF PRIOR AUTHORIZATION REQUESTS RAISE CONCERNS ABOUT BENEFICIARY ACCESS TO MEDICALLY NECESSARY CARE (2022). The OIG undertook this study due to annual Centers for Medicare and Medicaid Services audits of Medicare Advantage plans that revealed “widespread and persistent problems related to inappropriate denials of services and payment.” *Id.* Based on a random sample of prior authorization and payments requests, the OIG estimated that thirteen percent of prior authorization denials should have been granted. *Id.* Eighteen percent of denied payment requests should also have been granted. *Id.* The insurers did reverse some denials, either upon appeal or upon discovering their own errors. *Id.* The denials were based on the “us[e] of [] clinical criteria that [were] not contained in Medicare coverage rules; requesting unnecessary documentation; and making manual review errors and system errors.” *Id.* The American Medical Association reported that this experience “mirror[ed] physician experiences” with Medicare Advantage plans. Press Release, Gerald E. Harmon, President, Am. Med. Ass’n, AMA Agrees With Recommendations from Investigation of Medicare Advantage Plans (Apr. 28, 2022), <https://www.ama-assn.org/press-center/press-releases/ama-agrees-recommendations-investigation-medicare-advantage-plans> [<https://perma.cc/4EZN-LSWW>].

209. OFF. OF INSPECTOR GEN., *supra* note 208. According to a summary of the legislation, “This bill establishes several requirements and standards relating to prior authorization processes under Medicare Advantage (MA) plans. Specifically, MA plans must (1) establish an electronic prior authorization program that meets specified standards, including the ability to provide real-time decisions in response to requests for items and services that are routinely approved; (2) annually publish specified prior authorization information, including the percentage of requests approved and the average response time; and (3) meet other standards, as set by the Centers for Medicare & Medicaid Services, relating to the quality and timeliness of prior authorization determinations.” *Improving Seniors’ Timely Access to Care Act of 2021: Summary*, CONGRESS.GOV, <https://www.congress.gov/bill/117th-congress/house-bill/3173> [<https://perma.cc/VTJ4-K4WV>].

210. The bill currently had 326 cosponsors. *Improving Seniors’ Timely Access to Care Act of 2021: Cosponsors*, CONGRESS.GOV, <https://www.congress.gov/bill/117th-congress/house-bill/3173> [<https://perma.cc/VTJ4-K4WV>] (last visited Feb. 27, 2023).

access to care.²¹¹ This kind of legislation is an example of incremental change that would remedy some of the most vexing guidelines in ERISA health plans too.

Similarly, another legislative advancement addressed the problem of surprise billing; the legislation was born out of public outcry and a Kaiser Health investigation.²¹² The No Surprises Act does affect ERISA plans as well as non-ERISA plans—yet deeper changes to ERISA’s regime face a unified and effective lobbying effort, spearheaded by an organization of 100 of the largest corporations in the United States.²¹³ With sufficient outcry and sustained energy, legislative change is possible for health plans.

Second, and least likely to be politically viable, the fiduciary breach provisions of ERISA in section 1109 could be revised to more explicitly include fiduciary breaches of the kind that tend to occur in health plans. At present, section 1109 focuses on “losses” and “assets of the plan,” which reflect the focus on pension funds at the time ERISA was drafted.²¹⁴ These provisions are not helpful where the problem is a failure to pay claims or the crafting of guidelines in a manner that breaches fiduciary duties. Nothing in ERISA’s legislative history suggests, however, that fiduciary

211. The new law would have created an electronic system to streamline authorizations; create national clinical standards for clinical documents; established national standards for clinical documents that would reduce administrative burdens; created a process for real-time decisions for certain items and services that are routinely approved; and increased transparency to improve communication channels and utilization between plans, health care providers, and patients. Improving Seniors’ Timely Access to Care Act of 2022, H.R. 3137, 117th Cong (the bill died at the end of 117th Congress when it failed to be passed by the Senate).

212. *No More Surprises: Protecting Patients from Surprise Medical Bills: Hearing Before the Sub comm. on Health of the H. Comm. on Energy & Com.*, 116th Cong. 1–2 (2019) (statement of Rep. Anna G. Eshoo; see also Karen Pollitz, Matthew Rae, Gary Claxton, Cynthia Cox & Larry Levitt, *An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them*, PETERSON-KFF: HEALTH SYSTEM TRACKER (Feb. 10, 2020), <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/> [<https://perma.cc/AD8D-79FL>] (reporting that “[f]or people in large employer plans, 18% of all emergency visits and 16% of in-network hospital stays had at least one out-of-network charge associated with the care in 2017.”).

213. This lobbying group, known as the Erisa Industry Committee (“ERIC”), works at all levels of government and in the courts to protect ERISA preemption and to support employer-friendly policies. ERIC states that it “works to shape benefit policies before they shape you.” *How ERIC is Different from Other Groups*, ERISA INDUS. COMM., <https://www.eric.org/about-eric/how-is-eric-different/> [<https://perma.cc/X6NW-G3AE>]. In addition, “ERIC Lobbies: 1.) Exclusively for large employers in their capacity as benefit plan sponsors[;] 2.) On public policies impacting health, retirement, and compensation plans[;] 3.) At all three levels of government—federal, state, and local.” *Id.*

214. 29 U.S.C. § 1109; see also *supra* Part I.

breaches were intended to be excused in certain plans—rather, the provision simply does not easily address the types of fiduciary breaches that can occur today, in today's plans.

Thus, to address these fiduciary breaches, the provisions could be revised to expressly include equitable remedies such as surcharge where plan fiduciaries benefit from fiduciary breaches, whether or not they do so by using plan “assets.”²¹⁵

CONCLUSION

The passage of ERISA was met with high hopes for broad protections, but it now provides only a frustrating lack of remedies, particularly in the health plan context. ERISA was intended to protect benefits and to provide remedies when necessary. The law was enacted “to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation[s] for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the [f]ederal courts.”²¹⁶ ERISA's core function is thus to “protect contractually defined benefits.”²¹⁷

ERISA's fiduciary duties play a leading role in supporting that overall mission. ERISA is based on trust law, but the drafters went further than that—to underscore their commitment to fiduciary protections they diverged from trust law to strengthen ERISA's fiduciary duties.²¹⁸ While trust law allows fiduciaries to benefit from exculpatory provisions,²¹⁹ ERISA prohibits any such provision.²²⁰ ERISA's legislative history—and the explicit inclusion of welfare

215. 29 U.S.C. § 1109 (stating that a breaching fiduciary shall be “personally liable to 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 which have been made through use of assets of the plan by the fiduciary”).

216. 29 U.S.C. § 1001(b).

217. *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100 (2013) (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)).

218. “One key statutory modification that promotes ERISA's protective policy is section 1110(a).” Colleen E. Medill, *Regulating ERISA Fiduciary Outsourcing*, 102 IOWA L. REV. 505, 520 (2017).

219. “Except as stated in Subsections (2) and (3), the trustee, by provisions in the terms of the trust, can be relieved of liability for breach of trust.” RESTATEMENT (SECOND) OF TRUSTS § 222 (AM. L. INST. 1959).

220. “[A]ny provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part [4 of Title I of ERISA] shall be void as against public policy.” 29 U.S.C. § 1110; *see also* Medill, *supra* note 218, at 520.

plans within its most specific fiduciary provision—further suggests that plan participants should receive a remedy for fiduciary breaches.²²¹ Additionally, fiduciaries under trust law owe strict duties directly to beneficiaries in trust administration.²²²

Today, though, fiduciary breaches such as unfair guidelines, too-narrow standards, and byzantine utilization review stand between people and their benefits. The fiduciary provisions of nearly fifty years ago are an awkward fit for today's claims landscape. And this is no accident—today's claims landscape exists because ERISA's fiduciary provisions lack teeth in the health plan context.

The statutory language provides either a claim that is too narrow to remedy the broad fiduciary breaches that can go on for years or a claim that does not make obvious sense, given the statute's language. Whether the approach is an expansion of remedies based on existing language or an incremental or broader legislative approach, change is needed to give ERISA's fiduciary provisions their full, intended meaning.

221. *See, e.g.*, 120 CONG. REC. 29933 (1974) (statement of Sen. Williams) (remarking that beneficiaries are entitled to recover benefits “as well as to obtain redress of fiduciary violations”); 1974 U.S.C.C.A.N. 5038, 5076 (describing “remedies similar to those under traditional trust law to govern the conduct of fiduciaries”).

222. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 152–53 (1985); RESTATEMENT (SECOND) OF TRUSTS § 182 (AM. L. INST. 1959); G. BOGERT & G. BOGERT, LAW OF TRUSTS § 109 (1973).