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THE NEED FOR AN EQUITABLE REVOLUTION TO "APPROPRIATELY" REMEDY WRONGFULLY DENIED BENEFITS UNDER ERISA

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The inherent ambiguity in defining what constitutes a "medically necessary" or "experimental" treatment has been the center of much controversy in the realm of employer-sponsored health benefit plans.[1] These uncertain terms, which are found in almost all such plans, classify the types of medical care that the insurer will or will not cover.[2] Insurers will generally cover only "medically necessary" treatments and deny coverage for "experimental" treatments.[3] As a result, insured participants and beneficiaries, whose only interest is their own health, argue that the term "medically necessary" should be interpreted broadly enough to cover any and all treatments ordered by their physician.[4] Insurers, however, contend that the term must be construed very narrowly, so that coverage is limited and profit margins remain high.[5]

When benefits are denied based on an insurer's conclusion that a requested treatment is not "medically necessary" or is "experimental," courts must decide whether the denial was justified or wrongful. If a court concludes that covered benefits were wrongfully denied and as a result, a participant or beneficiary was harmed, then that individual is entitled to "appropriate equitable relief" under the Employee Retirement Income Security Act (ERISA).[6] The next question becomes: What constitutes relief that is both "appropriate" and "equitable"? When the United States Supreme Court has been faced with this question, it has focused almost exclusively on ERISA's use of the words "equitable relief," giving little credence to Congress's intent of providing relief that is not only equitable but also "appropriate."[7] This article considers the Court's interpretation of this issue and suggests an interpretation that reconciles precedent with Congress's underlying intent of providing "appropriate" relief to those aggrieved.

I. STRUCTURES OF HEALTH INSURANCE

Due to the complex nature of our health system, this article requires a basic understanding of how health insurance is currently structured and pro-

1. *See* Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1684 (1992).

2. *See id.*

3. *See id.*

4. LAWRENCE O. GOSTIN & PETER D. JACOBSON, LAW AND THE HEALTH SYSTEM 336 (2006).

5. *See* PHYLLIS C. BORZI, CTR. FOR HEALTH SERVS. RESEARCH & POLICY, ERISA HEALTH PLANS: KEY STRUCTURAL VARIATIONS AND THEIR EFFECT ON LIABILITY 3 (2002).

6. *See* Mertens v. Hewitt Assocs., 508 U.S. 248, 255 (1993).

7. *See id.*

vided in the United States. The two basic insurance models are private insurance and public insurance.[8] Under the private insurance model, individuals and groups pay premiums related to that individual's or group's "risk of requiring medical care and the likely expense of that care."[9] The insurer's main concern here is earning a profit for its shareholders.[10] On the other hand, public insurance is a system whereby individuals pay a predetermined fixed sum to be included in the program, regardless of the individual's actual or expected medical care needs.[11] Under this model, the insurer's main concern is assuring that all members in the community have access to health care.[12] In the United States, public insurance programs provide substantial benefits to the elderly, poor, and disabled.[13] This article, however, focuses exclusively on private insurance provided to employee-groups by their employers.

A. *The Private Insurance Model*

Under the private insurance model, individuals pay relatively small premiums, usually on a monthly basis, in return for the insurance company's promise to pay for any costs the participants or beneficiaries (the insured) of the plan incur, resulting from covered illnesses or injuries.[14] Some participants will suffer from severe illnesses which will require the insurer to cover treatments that far exceed those individuals' premiums, while other participants will remain healthy, costing the insurer very little or nothing.[15] Due to this disparity, insurers reduce their risk of suffering devastating losses by insuring large numbers of people, so that the healthy participants essentially subsidize the treatment of those participants requiring frequent or expensive care.[16] Insurers safeguard their economic viability by categorizing participants based on their "risk classification" and deciding whether they are worth

8. Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 110 (1994).

9. *Id.*

10. *See id.*

11. *Id.* at 110–11. The government's provision of police services is analogous to the public insurance model in that its citizens pay the same amount for police protections regardless of where they live or what they own. *Id.* at 111.

12. Ford, *supra* note 8, at 110.

13. GOSTIN & JACOBSON, *supra* note 4, at 336.

14. Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 665 (2003).

15. *Id.*

16. *Id.*

the risk of insuring.[17] This decision making process is commonly referred to as underwriting.[18]

In the underwriting process, insurers have broad discretion and use several tools such as applications, forms, reports from physicians, and medical examinations.[19] If an applicant is approved, the insurer will offer coverage at a specified monthly premium.[20] The premium is based on the risk or probability of the applicant requiring covered treatment.[21]

The risk analysis mentioned above is determined differently depending on whether the applicant is an individual or a group. When insurance is sold to an individual, the insurer will take into account only that individual's health risks in order to determine the premium amount.[22] When, however, a plan is offered to a group, such as employees, the insurer will assess the characteristics of the group as a whole and charge each member of that group the same premium.[23]

B. *The Structure of Employer-Sponsored Health Plans*

Employer-sponsored health plans are an important part of the United States' health system. In fact, approximately ninety percent of Americans receive their health insurance through their employer.[24] Because employers providing these benefits must tailor their plans to meet the needs of their employees, as well as their own financial incentives, employers have substantial flexibility in designing the plan that they will purchase for their employees.[25] As further discussed below, the Employee Retirement Income Security Act of 1974 (ERISA) governs the administration of employer-

17. *Id.* at 665–66.

18. *Id.* at 666.

19. Hoffman, *supra* note 14, at 666.

20. *See id.* at 665–66.

21. *Id.*

22. *Id.*

23. *Id.* at 666. The particular characteristics that insurers will look at include "gender, age, industry of the group's employer, geographic area, . . . family composition, and group size." Hoffman, *supra* note 14, at 666. "In many states, insurance providers are not required to disclose the criteria they use in making insurance decisions, and . . . state statutes provide only vague guidelines." *Id.* at 666–67; *see, e.g.*, FLA. STAT. § 627.062 (2009) (prohibiting the rates from being "excessive, inadequate, or unfairly discriminatory").

24. GOSTIN & JACOBSON, *supra* note 4, at 334 (estimating that in 1999, ninety-three percent of privately insured Americans received their insurance from their employers); Timothy S. Jost, Pegram v. Herdrich: *The Supreme Court Confronts Managed Care*, 1 YALE J. HEALTH POL'Y L. & ETHICS 187, 187 (2001) (estimating that eighty-eight percent of Americans with private health insurance have employment-based coverage).

25. *See* BORZI, *supra* note 5, at 2.

sponsored health plans by establishing uniform minimum standards and liability for those in charge of carrying out the plans.[26]

The structure of these ERISA plans often vary based on several factors.[27] For instance, while some plans are sponsored by only a single employer, other plans have multiple sponsors.[28] In all cases, however, the sponsor(s) must make certain important decisions in designing the appropriate plan. Such factors include the extent of the sponsor's insurance risk, the sponsor's level of involvement in the administration of the plan, the types of benefits offered,[29] "the methods by which benefits are delivered,"[30] "the form of the plan and the nature of the employer subsidy,"[31] and "the funding arrangement for self-insured plans."[32] Although all of these factors are important, only the sponsor's insurance risk and administrative involvement are pertinent to this discussion.

With respect to insurance risk, a plan might be "fully insured," "self-insured," or some type of combination of the two.[33] In a fully-insured plan, the employer transfers the entire risk of payment to an outside insurance company.[34] Sponsors of "self-insured" plans, however, retain the full insurance risk, except in those cases where the risk is shared through stop-loss insurance or another type of reinsurance.[35] Along with retaining the insurance risk, some self-insured plans provide that the sponsor fully administer the plan.[36] In self-administered plans, the sponsor makes all coverage decisions and retains all fiduciary obligations to participants and beneficiaries under ERISA.[37] If a sponsor is unable or unwilling to bear this burden, it

26. *Id.* at 2–3; *see* 29 U.S.C. §§ 1001–1461 (2000).

27. BORZI, *supra* note 5, at 2.

28. *Id.* The different types of plan sponsors include "single-employer plans," "multi-employer plans," and "multiple employer welfare arrangements." *Id.*

29. *See id.* at 3. A sponsor may decide to offer one package of comprehensive health benefits to its employees or put together different plans offering different benefits. *Id.* at 3–4.

30. BORZI, *supra* note 5, at 4. Different benefit delivery methods may include "fee-for-service," health maintenance organizations (HMOs), preferred provider organizations (PPOs), or a combination of any of these. *Id.* at 5. Any discussion of the details of these different methods is beyond the scope of this article.

31. *Id.* at 4. "[T]he form of the plan and the nature of the employer subsidy" determines how much of the cost or financing of the insurance will be shared by the employer. *Id.*

32. *Id.* at 5. Self-insured plans may set aside funds to pay for claims in a tax-exempt trust, usually a "voluntary employees' benefit association" (VEBA) or the employer may not set aside any funds and pay claims from the general assets of the employer. BORZI, *supra* note 5, at 5.

33. *Id.* at 3.

34. *Id.*

35. *Id.*

36. *Id.*

37. BORZI, *supra* note 5, at 3.

may outsource the plan administration and relieve itself of some obligations.[38]

Unless otherwise noted, the ERISA plans discussed in this article are presumed to be fully insured and administered by the insurer. Meaning that the sponsoring employer paid an additional premium to an insurer so that the insurer makes all coverage decisions, bears all of the risk, and the employer's liability is limited.[39]

II. EMPLOYER SPONSORED BENEFIT PLANS UNDER ERISA

In order to fully appreciate the issues analyzed herein, a basic understanding on ERISA, its history, remedial scheme, and foundation in trust law is necessary. Section A of this part gives an overview of what ERISA is and why it was enacted. Section B discusses ERISA's preemptive authority over state law. Section C identifies the remedies provided for by ERISA. Section D outlines ERISA's foundation in trust law. Finally, section E defines the roles of certain individuals subject to ERISA's provisions.

A. *ERISA Generally*

In 1974,[40] Congress enacted ERISA[41] in response to the mismanagement and failure of many employer-sponsored pension funds. This sequence of statutes was necessary to protect employees who were receiving only a small percentage of their promised benefits or none at all.[42] Although Congress's primary purpose for enacting ERISA was to protect employees through the regulation of pension funds,[43] its coverage expanded to include all employer-sponsored benefit plans.[44] In order to remedy the abuse in plan

38. *Id.* at 3–4.

39. *See id.*

40. 29 U.S.C. § 1461(a) (2000). "The provisions of this subchapter take effect on September 2, 1974." *Id.*

41. *See* 29 U.S.C. §§ 1001–1461.

42. *See, e.g.*, James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 683–84 (2001). "Some received a lump-sum payment worth a fraction of the pension they expected, and others got nothing at all." *Id.*; *see also* ERISA: THE LAW AND THE CODE §§ 2–3 (Michael G. Kushner & Karen Hsu eds., 1999).

43. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, PUB. L. NO. 93-406, §2, 88 Stat. 829, 833. "It is hereby further declared to be the policy of this Act to protect . . . the interests of participants in private pension plans. . . ." *Id.* §2(c); H.R. REP. NO. 93-533, pt. I, at 1 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4639. "The primary purpose of the bill is the protection of individual pension rights . . . ." *Id.*

44. 29 U.S.C. § 1003(a) (2000). This Act "shall apply to any employee benefit plan." *Id.*

administration, the drafters applied the "rules and remedies similar to those under traditional trust law, [which] govern[ed] the conduct of fiduciaries."[45] These rules and remedies were intended to further Congress's goals of developing a uniform federal common law,[46] ensuring the solvency of employee-benefits plans,[47] and encouraging employers to provide fringe benefits to their employees.[48] Notwithstanding these goals, ERISA does not mandate that any particular set of benefits or even that any benefits at all be provided to employees.[49]

The two sections of ERISA that embody its purposes and goals are section 514[50] and section 502.[51] Section 514 outlines ERISA's preemptive effect on state laws[52] and 502 outlines ERISA's exclusive remedial scheme.[53]

B. *ERISA Preemption*

Section 514, often referred to as the "preemption clause,"[54] provides that ERISA "shall supersede any and all [s]tate laws insofar as they may now

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45. H.R. REP. No. 93-1280, at 295 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5076; *see also* 120 CONG. REC. 29,932 (1974) (explaining that "[t]he objectives of these provisions are to make applicable the law of trusts . . . and to provide effective remedies for breaches of trust").

46. *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995); *see also* Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 11 (1987).

> It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax Packing Co., 482 U.S. at 11.

47. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at §§ 2–3.

48. *See* H.R. REP. No. 93-533, pt. I, at 1–2. The bill was designed to promote the expansion of these plans and increase the number of employees receiving them. *Id.* at 2.

49. Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 465 (2003); *see, e.g.*, 120 CONG. REC. 4440 (1974) (Statement of Bill Archer) (noting that ERISA would not change the voluntary nature of benefit plans).

50. 29 U.S.C. § 1144 (2000) [hereinafter referred to in text as § 514]. Section 514 of ERISA is also printed in the United States Code under § 1144, the two provisions are used interchangeably. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at xviii.

51. 29 U.S.C. § 1132 (2000) [hereinafter referred to in text as § 502]. Section 502 of ERISA is also printed in the United States Code under § 1132, the two provisions are used interchangeably. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at xviii.

52. 29 U.S.C. § 1144.

53. *Id.* § 1132.

54. Humana Inc. v. Forsyth, 525 U.S. 299, 310 (1999).

or hereafter *relate to* any employee benefit plan."[55] Although this "relates to clause" expresses ERISA's preemptive intent, it does not indicate how close of a relationship is required to satisfy the "relate to" language. In 1987, the United States Supreme Court applied a "broad common-sense meaning," to the phrase "relate to" and concluded that it meant having "a connection with or reference to."[56] In 1995, the Court narrowed its definition in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,[57] when it held that although Congress intended the provision to be applied broadly, it did not intend for it to preempt state laws that have only an indirect economic effect on the subject matter of an ERISA plan.[58]

Even though the Court's definition of "relates to" does not offer much guidance, the "Savings Clause" in § 514 limits the scope of ERISA from being read too broadly. This clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any [s]tate which regulates insurance, banking, or securities."[59] Moreover, section 514's "Deemer Clause" clarifies that self-insured employee benefits plans do not constitute "insurance companies" that are exempt from ERISA.[60] In other words, an employer that acts like an insurance company by providing a set of benefits to its employees—such as promising to pay medical expenses—is governed by ERISA and not state insurance regulations.[61]

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55. 29 U.S.C. § 1144 (emphasis added). ERISA further defines an "employee benefit plan" as any plan "established or maintained: (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) by both." *Id.* § 1003(a).

56. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (quoting Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985)).

57. 514 U.S. 645 (1995).

58. *See id.* at 661–62.

59. 29 U.S.C. § 1144(b)(2)(A) (2000).

60. 29 U.S.C. § 1144(b)(2)(B). Section 1144(b)(2)(B) states the following:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

61. *See* Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 234–35 (1997).

The plan described above fits into the category which ERISA defines as an "employee welfare benefits plan,[62] and in fact defines the type of plan through which ninety percent of Americans receive their health coverage.[63] Therefore, the vast majority of health plans in America are all covered by ERISA and not the different and perhaps conflicting state and local insurance regulations.[64] This furthers Congress's goal of creating a uniform federal common law. It should be noted that § 514 also has the effect of complete federal preemption, meaning that a defendant may remove any lawsuit brought against it, relating to an alleged violation of an ERISA plan, from state court to federal court, even if the plaintiff did not plead a separate federal law violation.[65]

C. *ERISA's Civil Enforcement Provision*

Section 502, commonly referred to as ERISA's "civil enforcement" [66] provision, enumerates the exclusive remedies available in ERISA actions.[67] It states as follows:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought (1) by a participant or beneficiary
>
> . . .

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62. 29 U.S.C. § 1002(1) (2000). Describing the term "employee welfare benefit plan" as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

Id.

63. *See supra* note 24 and accompanying text.

64. *See* N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

65. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1986). According to the "well-pleaded complaint rule," a defendant may not invoke federal subject matter jurisdiction if the plaintiff has not raised a federal law issue in the complaint. *See id.* The Court in *Taylor*, however, established that section 1144 of ERISA completely preempts state law claims, and according to the complete preemption doctrine, there is federal subject matter jurisdiction over these claims. *Id.* at 66. "Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." *Id.*

66. 29 U.S.C. § 1132 (2000).

67. *See id.*; *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) (stating that "ERISA's civil enforcement remedies were intended to be exclusive").

> (B) *to recover benefits due* to him under the terms of his plan, to *enforce his rights* under the terms of the plan, or to *clarify his rights* to future benefits under the terms of the plan;
>
> . . .
>
> (3) 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;
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> . . . .
>
> (g) Attorney's fees and costs; awards in actions involving delinquent contributions
>
> (1) In any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a *reasonable attorney's fee and costs* of action to either party.[68]

As a result of three separate five-to-four Supreme Court majority opinions—two of which were written by Justice Scalia—ERISA's remedial scheme has been interpreted in such a way as to prevent those who were injured as a result of wrongfully denied benefits from being "made whole."[69] The Court did so by interpreting the "*other appropriate equitable relief*" language in § 502(a)(3)(B) to exclude entitlement to consequential or punitive damages.[70] As a result, injured employees are limited to recovering from the insurer who wrongfully denied their benefits, only the monetary amount of the denied treatments—plus costs and attorney's fees—regardless of actual injuries or costs resulting from the denial.[71] In light of the purposes for enacting ERISA, ERISA's foundation in trust law, and even Justice Scalia's own words, it is apparent that the Court's interpretation of the civil enforcement provision is flawed.

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68. 29 U.S.C. § 1132 (emphasis added).

69. *See generally* Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002); Mertens v. Hewitt Assocs., 508 U.S. 248 (1993); Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985).

70. *See Mertens*, 508 U.S. at 255 (emphasis added) (noting that § 502(a)(3)'s provision for *other appropriate equitable relief* does not permit the recovery of consequential damages); *see also Russell*, 473 U.S. at 144 (asserting that the language of ERISA does not support "a private right of action for compensatory or punitive relief").

71. *See* 29 U.S.C. § 1132(g) (2000); *see, e.g.*, Hahnemann Univ. Hosp. v. All Shore, Inc., 514 F.3d 300, 314 (3d Cir. 2008) (authorizing the award of reasonable attorney's fees and costs to the prevailing party).

D. *ERISA's Relationship to Trust Law*

As Professor Langbein explained, the Supreme Court's interpretation of ERISA's remedial scheme is inconsistent with its roots in trust law.[72] After a review of ERISA's legislative history, it is beyond peradventure that its remedial scheme was drafted with the principles of trust law in mind.[73] In fact, ERISA even imposes a rule of mandatory trusteeship, requiring that "all assets of an employee benefit plan shall be held in trust by one or more trustees."[74] These trustees are subject to strict fiduciary duties, such as the duty of loyalty and prudence.[75] For instance, § 404(a)(1) of ERISA, which mandates that a fiduciary discharge his duties "solely in the interest of the participants and beneficiaries," mimics the loyalty rule in the *Second Restatement of Trusts*, requiring trustees to "administer the trust solely in the interest of the beneficiary."[76]

Most notable is the correlation between ERISA remedies and the remedies available in trust law for breach of trust. First, the *Second Restatement of Trusts* provides that in an action for breach of trust, the injured party may recover for "any loss" incurred.[77] This is analogous to § 502(a)(1), which authorizes a participant and beneficiary to recover their initial losses, which are generally the benefits that were wrongfully withheld by the fiduciary.[78]

Second, an injured trust beneficiary is entitled to "any profits" that the trustee made in breaching the trust.[79] This is analogous to § 502(a)(2), which entitles the plan to recover for any losses or profits resulting from the fiduciary's breach of the ERISA plan.[80] Although § 502(a)(2) entitles "the plan" to recover and not the participant, this distinction is illusory as recovery by

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72. For a detailed discussion on the relationship between ERISA and the trust law see 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, 1319 (2003).

73. *See id.* at 1331. "The Conference Committee explained that the drafters wanted to 'apply rules *and remedies* similar to those under traditional trust law to govern the conduct of fiduciaries.'" *Id.*

74. 29 U.S.C. § 1103(a). Note that § 1103(b) exempts a few categories of plans. *Id.* § 1103(b).

75. *See* 29 U.S.C. § 1104(a)(1) [hereinafter referred to in text as § 404]. Section 404 of ERISA is also printed in the United States Code under § 1104; the two provisions are used interchangeably. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at xviii.

76. *Compare* 29 U.S.C. § 1104(a)(1) *with* RESTATEMENT (SECOND) OF TRUSTS § 170(1) (1959).

77. RESTATEMENT (SECOND) OF TRUSTS § 205 (1959).

78. 29 U.S.C. § 1132(a)(1) (2006).

79. RESTATEMENT (SECOND) OF TRUSTS § 205 cmt. a.

80. *See* 29 U.S.C. § 1132(a).

the plan is essentially the same as recovery by plan participants and beneficiaries who receive their benefits from the plan.

Finally, the third breach of trust remedy includes any gains that would have accrued but for the breach.[81] This remedy is analogous to the § 502(a)(3) "catchall" provision which "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy."[82] Professor Langbein explains that this third remedy should be interpreted broadly enough to achieve the core principle of trust law, which is to "restore[] the victim to the position that he or she would have had 'if there had been no breach of trust.'"[83]

E. *ERISA Plan Sponsors, Fiduciaries and Providers*

In addition to preempting state law and providing an exclusive remedial scheme, ERISA mandates that every health benefits plan be established and maintained by a "plan sponsor,"[84] such as an employer providing health-benefits to its employees. The role of the ERISA plan sponsor is analogous to the role of a settlor in trust law.[85] Similar to a settlor's ability to structure the terms of the trust, a sponsor decides how it will structure the plan that it offers.

ERISA further requires that every plan be in writing and have a "named fiduciary."[86] The fiduciary may be any individual, corporation or other entity—even the plan sponsor—that has control over the management, operation, and administration of the plan and its assets.[87] This fiduciary is responsible

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81. RESTATEMENT (SECOND) OF TRUSTS § 205 cmt. a.

82. Varity Corp. v. Howe, 516 U.S. 489, 512 (1996); *see also* 29 U.S.C. § 1132(a)(3).

83. Langbein, *supra* note 72, at 1335 (quoting RESTATEMENT (SECOND) OF TRUSTS § 205(c)).

84. 29 U.S.C. § 1002(16)(B) (2006). A "plan sponsor" under ERISA includes (i) the employer in the case of a "plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) . . . [the] joint board of trustees or other similar group of representatives" in a multi-employer plan. *Id.*

85. A settlor is a person who creates a trust. GEORGE T. BOGERT, TRUSTS § 9 (6th ed. 1987).

86. 29 U.S.C. § 1102(a) (2000) [hereinafter referred to in text as § 402]. Section 402 of ERISA is also printed in the United States Code under section 1102; the two provisions are used interchangeably. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at xviii.

87. BORZI, *supra* note 5, at 18; 29 U.S.C. § 1102(c). Note that in addition to the named fiduciary, another person or entity will be considered "a fiduciary to the extent that the person: (1) exercises any discretionary authority or control over the management of the plan or deposition of its assets, (2) renders investment advice regarding plan assets for a fee for other direct or indirect compensation or has the authority or responsibility to do so, or (3) has any discre-

for ensuring that the plan is properly administered and must discharge its duties "solely in the interest of the participants and beneficiaries and for the exclusive purpose of" paying benefits and incurring "reasonable" administrative expenses.[88] Pursuant to § 402(b)(2) of ERISA, a named fiduciary may delegate fiduciary responsibilities to other fiduciaries or hire professional advisors to help carry out its duties, so long as the delegation is permitted by the health plan documents.[89] These duties are analogous to those of a trustee who protects the trust assets for the benefit of the trust beneficiaries.[90] In the event that an insured is injured by a fiduciary's breach of any of its duties, ERISA's civil enforcement provision, § 502, specifies the manner in which the insured may recover.[91]

Finally, for the purposes of this article a "provider" is the entity or individual that actually provides the medical care to the insured, such as the doctor or hospital, and who is compensated for such services by the insurer.[92] Although generally a provider owes a fiduciary duty to the insured, its patient, providers that do not participate in the administration of the plan or decide whether treatment is covered by the plan, are not subject to liability under ERISA.[93]

III. AN ERISA FIDUCIARY'S DISCRETIONARY ROLE IN PROVIDING BENEFITS

Similar to a trustee, ERISA fiduciaries generally have certain discretionary decision making powers, one such power includes the determination as to whether certain benefits are covered or denied. This determination is often guided by the specific terms defined in the ERISA policy. Section A below discusses the terms often found in policies which limit the types of benefits a fiduciary will deem covered. Section B explains how a fiduciary's

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tionary authority or control over plan administration." BORZI, *supra* note 5, at 18 (citing 29 U.S.C. § 1002(21)(A)).

88. 29 U.S.C. § 1104(a)(1) (2006). ERISA fiduciaries are held to the standards of care of a prudent person, which requires them to act "with the care, skill, prudence, and diligence under the circumstances . . . that a prudent man acting in a like capacity" would use in similar circumstances. *Id.*; *see* Donovan v. Mazzola, 716 F.2d 1226, 1232 (9th Cir. 1983) (applying the prudent person standard); BORZI, *supra* note 5, at 21.

89. *See* 29 U.S.C. § 1102(b)(2).

90. The trustee is the person who holds the title of the trust property, in trust for the beneficiary of the trust. BOGERT, *supra* note 85, at § 1.

91. 29 U.S.C. § 1132 (2000).

92. *See* 29 U.S.C. § 1002(1).

93. *See* Pegram v. Herdrich, 530 U.S. 211, 223 (2000) (distinguishing a health care provider from an ERISA fiduciary).

role may give rise to certain conflicts of interest, and the final section discusses how this conflict has been addressed by the Supreme Court.

A. *"Medically Necessary" and "Experimental" Treatments*

As noted earlier, ERISA mandates that all health insurance contracts be evidenced in writing.[94] Although the drafters intended the terms of a plan to be in black and white, inherently ambiguous terms have turned them grey. For instance, ERISA plans generally limit coverage to benefits and treatments that are "medically necessary."[95] The term "medically necessary," however, has a different meaning to physicians than it does to health plan administrators or even among administrators and physicians.[96] For instance, "medically necessary" could "mean that a procedure or test is simply not appropriate or effective for addressing a patient's condition" or it could "mean that the marginal value of a test or treatment . . . over the next best test or treatment for the same condition is . . . minimal in comparison to the marginal cost of the test or treatment over the next best test or treatment."[97]

Moreover, ERISA plans usually exclude "experimental" or "investigational" treatments.[98] The interpretation and application of these terms has caused some disagreement among different courts.[99] For example, in *Chambers v. Coventry Health Care of Louisiana, Inc.*,[100] the ERISA policy defined "'experimental or investigational procedures' as those services that do not have 'a demonstrated value based on clinical evidence reported by peer-review medical literature or by generally recognized academic experts.'"[101] In this case, the patient offered expert testimony from two doctors that a "PET fusion scan [was] widely accepted in the scientific community and in the relevant medical literature," while the administrator offered testimony

94. 29 U.S.C. § 1102(a)(1).

95. *See* Hall & Anderson, *supra* note 1, at 1640–41.

96. *See* William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 601 (2003); *see also* Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 ST. LOUIS U. L.J. 1, 13–18 (1999) [hereinafter Jost, *The American Difference in Health Care Costs*] (noting that the term "'medical necessity' could mean at least three different things").

97. Jost, *The American Difference in Health Care Costs*, *supra* note 96, at 13.

98. *See e.g.*, Hall & Anderson, *supra* note 1, at 1637–40.

99. *See e.g.*, Chambers v. Coventry Health Care of La., Inc., 318 F. Supp. 2d 382 (E.D. La. 2004); Harris v. Mut. of Omaha Cos., 992 F.2d 706 (7th Cir. 1993).

100. 318 F. Supp. 2d 382 (E.D. La. 2004).

101. *Id.* at 391.

from another doctor[102] that PET fusion scans were experimental.[103] Fortunately for the insured, the court found that the participant had provided sufficient evidence to prove that there was a substantial likelihood that the treatment was not experimental and therefore covered.[104] In *Harris v. Mutual of Omaha, Cos.*,[105] however, the court affirmed a ruling that a cancer treatment was experimental.[106] The court based its decision on an appendix of articles that had been published several years prior, notwithstanding expert testimony that the treatment was no longer in its experimental phase and was in fact "medically necessary."[107] This unpredictability is compounded by the fact that ERISA plans often grant plan administrators absolute discretion to initially determine whether requested benefits are "medically necessary," "experimental," or "investigational," regardless of the treating physician recommendation.[108]

B. *Conflict of Interest Resulting from a Fiduciary's Dual Role*

In most cases, insureds cannot afford to undergo treatment that is not covered by their ERISA plan.[109] Therefore, the insurer's determination of whether a treatment is "medically necessary" or "experimental" will generally decide whether the treatment will ultimately be provided. As such, many argue that the insured's treating physician who is most familiar with the medical needs of the insured is in the best position to determine whether a treatment is "medically necessary."[110] Others, however, argue that the administrator who analyzes a vast number of cases and is more familiar with the particular terms of the plan is best suited to make this determination.[111] There is even a third group that believes that an unaffiliated third party professional should have the final say as to whether benefits are covered.[112]

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102. *Id.* at 386. Note that the expert offered by the administrator worked as the Chief Medical Officer and Senior Vice President of the administrating company. *Id.* at 387.

103. *Id.* at 386–87.

104. *Chambers*, 318 F. Supp. 2d at 391. This was a case in which the patient sought a preliminary injunction in order to prevent the administrator from denying coverage of the PET fusion scan. *Id.*

105. 992 F.2d 706 (7th Cir. 1993).

106. *Id.* at 707.

107. *Id.* at 709.

108. *See* Hall & Anderson, *supra* note 1, at 1669–70.

109. *See id.* at 1637–39.

110. *Id.* at 1649–50.

111. *Id.* at 1665.

112. *See id.* at 1674.

Unfortunately, most plans bestow this discretionary power on the plan administrators who, in the case of fully insured and self-administered plans, are the same entities that will ultimately be required to pay for the treatments.[113] It goes without saying that such administrators have a "financial incentive to deny benefits" in order to avoid the direct expenses they would incur from approving requested treatments.[114] Therefore, an administrator "benefits directly from the denial or discontinuation of benefits."[115] This financial incentive to deny benefits appears to directly conflict with the administrator's fiduciary duty to discharge his duties "solely in the interest of the participants and beneficiaries."[116]

C. *Litigating the Denial of Benefits*

Due to the potential danger to one's health resulting from the denial of requested benefits, insureds will often appeal a denial.[117] Generally, before an insured is entitled to a judicial determination, ERISA plans require that the insured first exhaust all of the insurer's internal appellate procedures.[118] All the while, the insured may be incurring additional injuries from passage of time or the financial burden of employing legal counsel. Although § 502(g)(1) of ERISA provides for reasonable attorney's fees in litigation, courts have consistently interpreted this provision to exclude those fees incurred in pre-litigation administrative processes.[119] If the denial of benefits is affirmed and the insured still believes that the requested benefits are covered, only then may he or she file suit in a court of law.

Although Congress did not specify a particular standard for reviewing the denial of benefits, in *Firestone Tire & Rubber Co. v. Bruch*,[120] the United States Supreme Court focused on ERISA's purpose of protecting employees and its basis in trust law to establish the appropriate standard.[121] In *Fire-*

113. *See* Hall & Anderson, *supra* note 1, at 1669–70.

114. *See id.* at 1666, 1668; *see, e.g.*, Post v. Hartford Ins. Co., 501 F.3d 154, 161–64 (3d Cir. 2007); Carolina Care Plan, Inc. v. McKenzie, 467 F.3d 383, 386–87 (4th Cir. 2006); Killian v. Healthsource Provident Adm'rs, Inc., 152 F.3d 514, 521 (6th Cir. 1998); Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F.2d 1556, 1561, 1566–67 (11th Cir. 1990).

115. *Killian*, 152 F.3d at 521.

116. 29 U.S.C. § 1104(a)(1) (2006).

117. *See* Sage, *supra* note 96, at 597–98.

118. *Id.* at 624.

119. *See* Parke v. First Reliance Standard Life Ins. Co., 368 F.3d 999, 1010–11 (8th Cir. 2004); Rego v. Westvaco Corp., 319 F.3d 140, 150 (4th Cir. 2003).

120. 489 U.S. 101 (1989).

121. *Id.* at 115.

stone, it concluded "that a denial of benefits[122] . . . is to be reviewed under a *de novo*[123] standard, unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case, abuse of discretion review applies.[124] Under the abuse of discretion standard,[125] an administrator's decision "will not be disturbed if reasonable."[126] The Court noted that in cases where the fiduciary has a conflict of interest, such as a financial incentive to deny benefits, conflict should be considered as a factor in determining whether the insurer abused its discretion.[127] Unfortunately, the Court in *Firestone* did not specify exactly *how* these conflicts of interest should be weighed or how to determine whether a conflict in fact exists. As a result, disagreement among the Federal Circuits ensued.[128]

Recently, the Supreme Court reviewed the issue and stated as follows:

> Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case.[129]

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122. Note that the Court referred only to challenges under § 502(a)(1)(B) for benefits due. *Id.*

123. Reviewing these decisions *de novo* requires an analysis which is similar to construing trust provisions "without deferring to either party's interpretation." *Id.* at 112. Instead, the court would interpret the terms of the policy in light of all the circumstances and other evidence of intent. *Id.*

124. *Firestone*, 489 U.S. at 115.

125. This standard requires an assessment of whether the refusal of coverage is arbitrary and capricious, reversing the insurer's decisions only if it appears to be "without reason, unsupported by substantial evidence or erroneous as a matter of law." Fay v. Oxford Health Plan, 287 F.3d 96, 104 (2d Cir. 2002) (quoting Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995)); *see also Firestone*, 489 U.S. at 102. This standard is rooted in principles of trust law, because the insurer's discretion in determining what is medically necessary is analogous to a trustee's discretionary powers. *See id.* (noting that when a trustee is conferred with certain powers the exercise of that power is "not subject to control by the court except to prevent an abuse").

126. *Id.*

127. *Id.* at 115.

128. *See, e.g.*, Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 378–79 (3d Cir. 2000).

129. Metro. Life Ins. Co. v. Glenn, 128 S. Ct. 2343, 2346 (2008).

Justice Scalia, however, wrote a scathing dissent primarily attacking the majority's "totality of the circumstances" approach.[130] He contends that in light of ERISA's roots in trust law, courts should apply a similar standard to that of a trust fiduciary with a conflict.[131] Succinctly, he asserts that the conflict described above should not be considered "unless the conflict *actually* and *improperly motivates* the decision."[132] Justice Scalia reconciles this conclusion with the opinion in *Firestone* by disregarding, as "throwaway dictum," the language indicating that conflicts should be weighed as a "factor."[133] Regardless of whether the conflict factor is used, if a court ultimately concludes that an administrator has wrongfully denied covered benefits, the injured participant is entitled to some relief under ERISA's remedial provisions.[134]

It should be noted that some states have attempted to eliminate the conflict of interest altogether.[135] For instance, in *Standard Insurance Co. v. Morrison*,[136] Montana's Commissioner of Insurance denied an insurer's application for approval of "proposed disability insurance forms which contained discretionary clauses."[137] This denial was based on a state law that gave the Commissioner the authority to deny insurance forms that contained "inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract." [138] The insurer argued that the Commissioner was without authority to do so based on ERISA preemption.[139] The court, however, ultimately concluded that ERISA's savings clause applied to exempt the state law from preemption.[140] It noted that both factors of the savings clause were met because the law was "'specifically directed toward entities engaged in insurance'" and "'substantially affect[ed] the risk pooling arrangement between the insurer and insured.'"[141] The result of laws, such as

130. *See id.* at 2357 (Scalia, J., dissenting).
131. *Id.* at 2357–58.
132. *Id.* at 2357.
133. *Id.* at 2357–58.
134. 29 U.S.C. § 1132(a) (2000).
135. *See, e.g.*, Standard Ins. Co. v. Morrison, 584 F.3d 837, 849 (9th Cir. 2009) (affirming the denial of insurance forms containing discretionary clauses); Am. Council of Life Insurers v. Ross, 558 F.3d 600, 609 (6th Cir. 2009) (upholding a rule prohibiting insurers from marketing products containing discretionary clauses).
136. 584 F.3d 837 (9th Cir. 2009).
137. *Id.* at 841.
138. *Id.* at 840 (quoting MONT. CODE ANN. § 33–1–502 (2009)).
139. *Id.* at 841.
140. *Id.*
141. *Standard Ins. Co.*, 584 F.3d at 842 (quoting Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003)).

the one in *Morrison*, which prohibit insurers from making discretionary decisions is that in the event an insured appeals the denial of benefits, the court will have de novo review instead of the insurer-friendly abuse of discretion standard.[142]

IV. REMEDIES FOR WRONGFULLY DENIED BENEFITS

A. *Contrasting State Law and ERISA Remedies for Wrongfully Denied Benefits*

As noted in section II.B above, the vast majority of Americans receive their health insurance from their employers; and as a result, their potential remedies are governed by federal law. Those who receive benefits from sources not governed by ERISA, however, play by a different set of rules.

If an individual is injured as a result of wrongfully denied benefits under a plan that is not covered by ERISA, he or she may seek relief under the appropriate state law and potentially recover an array of monetary damages, which are typically unavailable to ERISA insureds.[143] For instance, a plaintiff might recover compensatory damages, including past and future physical and "emotional pain and suffering, as well as medical expenses, lost wages, and . . . other . . . form[s] of economic damages."[144] Such economic relief might include necessary and reasonable medical expenses to correct or mitigate an insured's injuries, future nursing care, hospital care, laboratory tests, medicines, or therapy.[145] Some plaintiffs may even recover damages for mental anguish, anxiety, or depression caused by the harmful effects of their injury.[146] Finally, under certain circumstances plaintiffs recover "attorneys' fees, costs, punitive damages, and prejudgment interest."[147] The potential awards under state laws have sometimes proven to be enormous, ranging upwards of $80 million.[148]

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142. *Id.* at 840.

143. *See* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985) (asserting that the language of ERISA does not support "a private right of action for compensatory or punitive relief").

144. Stephanie L. Schaeffer, *Cause of Action Against a Health Maintenance Organization Under State Tort Law*, *in* 17 CAUSES OF ACTION 2D 193, § 18 (2009).

145. *See id.*

146. *Id.*

147. *Id.*; *see also* Williams v. Superior Court, 36 Cal. Rptr. 2d 112, 113 (Ct. App. 1994).

148. *See, e.g.*, Humana Health Ins. Co. of Fla. v. Chipps, 802 So. 2d 492, 495 (Fla. 4th Dist. Ct. App. 2001) (awarding nearly $80 million against Humana for terminating coverage for a special therapy program for a child with cerebral palsy). Note, however, that the award was set aside for improper jury instructions and evidentiary errors. *Id.* at 496–97.

In contrast to the wide array of potential avenues of recovery under state laws, § 502 of ERISA limits the available remedies that can be recovered for wrongfully denied benefits. First, § 502(a)(1)(B) provides that a participant may "recover benefits due to him," "enforce his rights," or "clarify his rights to future benefits under the terms of the plan."[149] This provision is relatively straightforward and means that: (1) if an insured believes that covered benefits were wrongfully denied, then that individual is entitled to bring suit to recover the cost of those denied benefits; or (2) if there is a dispute over the meaning of precise terms of the plan, the court will clarify those terms.[150]

Second, § 502(a)(3)(A) provides that an insured may seek "to enjoin any act or practice which violates . . . the terms of the plan."[151] This provision is also straightforward, authorizing a participant to ask a court to prevent the plan administrator from further violating the terms of the plan.

The main controversy arises with respect to the interpretation of § 502(a)(3)(B). This subsection provides that an insured is entitled "to obtain *other appropriate equitable relief* . . . to redress such violations."[152] In analyzing this provision, the Supreme Court held that it precludes any right to consequential or punitive damages.[153] This means that if an insured was wrongfully denied benefits, such as a necessary surgery, and as a result his arm had to be amputated, that individual would be able to recover only the cost of the surgery, but no money for the loss of his arm. This would be the case even if the plan administrator knew that the surgery was covered under the plan and denied the benefits anyway.

Accordingly, the Court's interpretation appears to leave those injured as a result of wrongfully denied benefits without a sufficient remedy and may even encourage some administrators to arbitrarily deny benefits. Without a doubt, this directly contravenes Congress's intention of protecting employees and "replicat[ing] the core principles of trust remedy law, [which include] the make-whole standard of relief."[154]

149. 29 U.S.C. § 1132(a)(1)(B).

150. Aetna Health, Inc. v. Davila, 542 U.S. 200, 210 (2004).

151. 29 U.S.C. § 1132(a)(3)(A).

152. *Id.* § 1132(a)(3)(B) (emphasis added).

153. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 145, 150 (1985) (stating that the "appropriate equitable relief" section does not create an implied cause of action for remedying consequential injuries).

154. Langbein, *supra* note 72, at 1319.

V. JUDICIAL INTERPRETATION OF "OTHER APPROPRIATE EQUITABLE RELIEF" BEFORE *SEREBOFF*

ERISA's remedial scheme limits the remedies that are available to insurers as well as the insured. Although both sides have sought monetary relief under the *other appropriate equitable relief* language, for the most part, neither has been successful.[155] Section A provides a brief synopsis of the Supreme Court's initial attempts to define the subject language in breach of fiduciary duty cases brought by insureds. Section B discusses how the provision was similarly applied to an insurer's attempt to recover monetary relief. Section C points out some apparent flaws in the Court's interpretation of the language, and section D identifies the Court's most recent step in the right direction.

A. *The Law Before* Knudson

In *Massachusetts Mutual Life Insurance Co. v. Russell*,[156] the Supreme Court set the stage for its current interpretation of § 502(a)(3)'s *other appropriate equitable relief* language.[157] In *Russell*, a beneficiary of an ERISA health benefits plan brought suit to recover consequential and punitive damages for the improper processing of her claim for disability benefits under sections 409[158] and 502(a)(2) of ERISA.[159] The Court reversed the lower court's ruling that pursuant to § 409, a beneficiary is entitled to compensatory damages "'that [would] compensate [her] for all losses and injuries sustained as a direct and proximate cause of the breach of fiduciary duty,' including 'damages for mental or emotional distress.'"[160] The Court also reversed the ruling that pursuant to § 409, punitive damages were recoverable under ERISA when a fiduciary "'acted with actual malice or wanton indifference to the rights of a participant or beneficiary.'"[161] Because these types of

155. *See* Langbein, *supra* note 72, at 1318–19.

156. 473 U.S. 134 (1985). Note that this case was decided by a five to four majority opinion. *Id.* at 135.

157. *See id.* at 150.

158. 29 U.S.C. § 1109 (2000) [hereinafter referred to in text as § 409]. Section 409 of ERISA is also printed in the United States Code under § 1109; the two provisions are used interchangeably. *See* ERISA: THE LAW AND THE CODE, *supra* note 42, at xviii.

159. *Russell*, 473 U.S. at 136–138.

160. *Id.* at 138 (quoting Russell v. Mass. Mut. Life Ins. Co. (*Russell I*), 722 F.2d 482, 490 (9th Cir. 1983), *rev'd*, 473 U.S. 134 (1985)).

161. *Id.* (quoting *Russell I*, 722 F.2d at 492). The Supreme Court rejected the court of appeals' findings that a plan beneficiary could be entitled to compensatory and punitive damages based on section 409 of ERISA and the accompanying legislative history because that

damages were not expressly enumerated in § 502, the Court held that they were non-recoverable.[162] This conclusion was based on the Court's assertion that because ERISA remedy law was so carefully and comprehensively drafted, any omission of a particular remedy must have been deliberate.[163] The Court supported its conclusion with the pronouncement that in enacting ERISA the drafters "were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary."[164]

In his concurrence, Justice Brennan identified portions of the majority opinion which he believed were "both unnecessary and to some extent completely erroneous."[165] Although he agreed with the Court's decision that § 409 provides remedies only for the plan as a whole and not individual participants or beneficiaries, he noted that beneficiaries "must look elsewhere in ERISA for personal relief."[166] For instance, he explained that the Court did not decide the issue of whether a fiduciary may be held personally liable under § 502(a)(3)'s *other appropriate equitable relief* language.[167] He also noted that the main architect of ERISA, Jacob Javits, intended for § 502(a)(3) to be used by the courts to work out *appropriate* remedies in light of the purposes of ERISA.[168]

Seven years later, in *Mertens v. Hewitt Associates*,[169] the Supreme Court addressed the issue of whether § 502(a)(3) authorizes money damages for the breach of a fiduciary duty.[170] In analyzing the provision, it noted that the term *other appropriate equitable relief* could mean one of two things, either: (1) "whatever relief a court of equity is empowered to provide in the particu-

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provision was only intended to provide relief to the plan itself, not beneficiaries or participants. *Id.* at 138–140.

162. *Id.* at 146.

163. *Russell*, 473 U.S. at 146–47 (stating that "[t]he six carefully integrated civil enforcement provisions . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly") (emphasis omitted).

164. *Id.* at 142.

165. *Id.* at 155 (Brennan, J., concurring).

166. *Id.* at 150.

167. *Id.*

168. *Russell*, 473 U.S at 156 (Brennan, J., concurring) (quoting 120 CONG. REC. 29,942 (1974) (statement of Sen. Javits)); *see also* Langbein, *supra* note 72, at 1343. Justice Brennan also reiterated that ERISA's legislative history demonstrated that Congress intended courts to enforce the fundamental concept of trust law of "[awarding] beneficiaries . . . such remedies as are necessary for the protection of their interests." *Russell*, 473 U.S. at 156–57 (quoting 3 AUSTIN SCOTT, THE LAW OF TRUSTS § 199 (3d ed. 1967)).

169. 508 U.S. 248 (1993).

170. *See id.* at 249–50. In this case, the ERISA beneficiaries sought damages from non-fiduciaries who knowingly participated in the fiduciary's breach of fiduciary duty. *Id.*

lar case at issue;" or (2) "those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."[171] The majority opted for the second interpretation primarily based on Justice Scalia's assertion that the first meaning was too broad and would render the word "equitable" superfluous.[172] In the dissenting opinion, however, Justices White, Rehnquist, Stevens, and O'Connor argued that the first definition should apply.[173] The dissenting Justices insisted that the drafters of ERISA intended the term *other appropriate equitable relief* to be interpreted with respect to its roots in trust law.[174] Specifically, they focused on the remedy for breach of trust, which includes the right to compensatory damages.[175]

B. Knudson *and Where the Court Went Next*

In *Great-West Life & Annuity Insurance Co. v. Knudson*,[176] decided in 2002, the Supreme Court once again tackled the interpretation of *other appropriate equitable relief*.[177] The issues in *Knudson* differed significantly from those in *Russell* and *Mertens*. In *Knudson*, an ERISA insurance company sought reimbursement from a plan beneficiary pursuant to a reimbursement provision in the ERISA policy.[178] This provision entitled the insurer to repayment for medical expenses paid on the beneficiary's behalf out of the settlement proceeds the beneficiary received from the third-party tortfeasor responsible for her injuries.[179] In delivering the Opinion of the Court, Justice Scalia reiterated the *Mertens* rationale and applied the *typically equit-*

171. *Id.* at 256.

172. *Id.* at 257–58. Another reason why the majority chose the "typically equitable" definition is that elsewhere in ERISA and other federal statutes, Congress indicated its intention to broaden available remedies by using the terms "legal" or "remedial" in addition to "equitable." *See Mertens*, 508 U.S. at 257–60.

173. *See id.* at 263–74 (White, J., dissenting).

174. *Id.* at 265–66 (stating that "[t]he traditional 'equitable remedies' available to a trust beneficiary [for breach of trust] included compensatory damages"). The dissent further emphasized that making victims of fiduciary breaches whole by providing monetary relief avoids the "anomaly of interpreting ERISA [in such a way that] leave[s] those Congress set out to protect—[ERISA participants and beneficiaries]—with 'less protection . . . than they enjoyed before ERISA was enacted.'" *Id.* at 266–67 (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 114 (1989)).

175. *Id.*

176. 534 U.S. 204 (2002).

177. *See id.* at 209–10.

178. *Id.* at 207–09.

179. *Id.* at 207.

able interpretation of § 502(a)(3).[180] The Court concluded that the insurer could not prevail due to the fact that it was seeking to impose personal liability on a beneficiary "for a contractual obligation to pay money-relief that was not typically available in equity."[181] In support of this conclusion, Justice Scalia cited the following portion from his dissenting opinion in *Bowen v. Massachusetts*.[182]

> Almost invariably . . . suits seeking (whether by judgment, injunction, or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for "money damages," as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of [a] legal duty.[183]

Based on this rationale, Justice Scalia rejected the insurer's claim that its cause of action for reimbursement should be classified as injunctive relief, a *typically equitable* remedy.[184] The Court noted that only in rare cases, such as those that would avoid future losses, would the Court of Equity specifically enforce a contract to transfer funds.[185] The Court also rejected the insurer's argument that it was seeking the *typically equitable* remedy of restitution.[186] As dicta, the Court stated that in order to seek equitable restitution, one must ordinarily do so "in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant's possession."[187] Finally, the Court concluded that the "restitution" sought by the insurer is not equitable but a "freestanding claim for money damages."[188]

Justice Ginsburg and Justice Stevens wrote strong dissenting opinions. Justice Stevens emphasized that he agreed with Justice Ginsburg that it is unlikely that the 1974 Congress "intended to revive the obsolete distinctions

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180. *Id.* at 209–10 (stating that "'[e]quitable' relief must mean *something* less than *all* relief.' . . . [It] must refer to 'those categories of relief that were *typically* available in equity'") (quoting Mertens v. Hewitt Associates, 508 U.S. at 256, 258 n.8 (1993)).

181. *Knudson*, 534 U.S. at 210.

182. 487 U.S. 879 (1988).

183. *Id.* at 918–19 (Scalia, J., dissenting).

184. *See Knudson*, 534 U.S. at 210–11. The insurer argued that it was seeking to enjoin the beneficiaries from refusing to perform as required by the reimbursement provision in the contract. *Id.*

185. *Id.*

186. *Id.* at 212–18.

187. *Id.* at 213.

188. *Knudson*, 534 U.S. at 219 n.4.

between law and equity . . . for defining the remedies" under ERISA.[189] Further, he noted that he understood § 502(a)(3)(B) to authorize *any appropriate* order that would remedy a violation of an ERISA plan, regardless of what was available in English chancery courts.[190] Justice Ginsburg elaborated on how unreasonable it was for the majority to focus on ancient classifications and emphasized that principles of equity are flexible and were introduced to accommodate the changing needs of society.[191]

C. *Flaws in the "Typically Equitable" Definition*

As a result of *Russell*, *Mertens*, and *Knudson*, relief available under § 502(a)(3)(B) has been limited to the specific classes of remedies that Justice Scalia would consider *typically equitable*, such as mandamus, injunction, and restitution.[192] This narrow interpretation of *typically equitable* remedies excludes the possibility of recovering compensatory damages primarily because Justice Scalia believes that suits for money are essentially actions at law and therefore not equitable.[193] There are several flaws in this interpretation. First, as Professor Langbein explained, mandamus was exclusively a common law remedy and never *typically equitable*.[194] Second, although the Court asserted that restitution is *typically equitable*, the law of restitution was only created after the fusion of the courts by the American Law Institute in the *Restatement of Restitution* (1937), by integrating the equitable rule of constructive trusts and common law rule of quasi-contract.[195] Finally, and most significantly, Justice Scalia's interpretation erroneously excludes monetary damage awards because he considered them to be the "classic form of *legal* relief."[196] This interpretation ignores the fact that the payment of money is in fact a "classic form of equitable relief" for trust beneficiaries seeking equitable redress for a fiduciary's breach of trust.[197] In fact, the *Uniform Trust Code* clearly states that in order "[t]o remedy a breach of trust, . . . the court may . . . *compel the trustee to redress a breach of trust by paying money*."[198] Keeping in mind that ERISA was drafted based on trust law and the

189. *Id.* at 221–22 (Stevens, J., dissenting).
190. *Id.* at 222 (emphasis added).
191. *Id.* at 228, 233 (Ginsburg, J., dissenting).
192. *See* Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993).
193. *See id.* at 255–56.
194. *See* Langbein, *supra* note 72, at 1353–54 (noting the origins of a writ of mandamus in English common law).
195. *Id.* at 1357.
196. *See Mertens*, 508 U.S. at 255.
197. Langbein, *supra* note 72, at 1352.
198. UNIF. TRUST CODE § 1001(b)(3) (2000) (amended 2004, 2005) (emphasis added).

fact that an ERISA fiduciary's breach of its duty is analogous to a breach of trust, Congress likely intended § 502(a)(3)(B) to include monetary relief.

D. *A Step in the Right Direction*

Four years after *Knudson*, the Supreme Court decided *Sereboff v. Mid Atlantic Medical Services, Inc.*[199] In *Sereboff*, the Court once again took on ERISA's *other appropriate equitable relief* language.[200] The facts of *Sereboff* were essentially the same as those in *Knudson*.[201] Without abrogating or overruling *Knudson*, however, the Court enforced an ERISA plan's reimbursement provision based on the *typically equitable* theory of constructive trust.[202] The Court distinguished the two cases on a fact that seems arbitrary and may actually encourage fraudulent and unethical conduct.[203] In essence, the Court enabled an insurer to enforce a monetary reimbursement provision of an ERISA plan based on semantics and quick thinking.[204] Succinctly, because the *typically equitable* definition of § 502(a)(3)(B) would not permit the insurer to assert a cause of action for reimbursement under the terms of the plan, the insurer merely re-classified the remedy sought as one for a constructive trust over the specific trust in which the settlement proceeds were deposited.[205]

The result in *Sereboff* is bitter-sweet. The Court took a step in the right direction by permitting the recovery of money to be considered *other appropriate equitable relief*. The method used to achieve this result, however, will be difficult for insureds to take advantage of when seeking money for wrongfully denied benefits. This is due to the fact that when an insurer denies a request for benefits, it generally does not earmark and deposit money that would make an injured insured whole into a separate fund over which a constructive trust may be imposed.

VI. PROPERLY DEFINING "OTHER APPROPRIATE EQUITABLE RELIEF"

Without regard to the plan administrator's underlying motivation, the fact remains that courts have and will continue to conclude, from time to

199. 547 U.S. 356 (2006).
200. *See id.* at 361.
201. Robert C. Sheres, *Setting the Stage for Creative Lawyering in ERISA Reimbursement Actions*, 31 NOVA L. REV. 187, 201–02 (2006) (comparing *Sereboff* and *Knudson*).
202. *Sereboff*, 547 U.S. at 367–69.
203. *See* Sheres, *supra* note 201, at 208–10.
204. *See id.*
205. For a detailed discussion on *Sereboff*, see Sheres, *supra* note 201.

time, that covered benefits were wrongfully denied.[206] The type of benefit denied and the resulting injuries vary from case to case. For instance, an insurer might deny coverage for extended hospital stays,[207] prescription drugs,[208] or crucial surgeries.[209] As a result of the denial, the insured might incur injuries ranging from allergic reactions,[210] to the loss of a limb,[211] or even death.[212] In spite of the devastating losses and injuries that may result from a wrongful denial, insureds under an ERISA plan are limited to relief under § 502, which currently precludes consequential and punitive damages.[213] As a result, injured participants and beneficiaries are without appropriate relief to redress the damages caused by plan administrators.

This unjust result stems from the Supreme Court's unbalanced emphasis on Congress's use of the word "equitable" in § 502(a)(3)(B) and disregard for the fact that such relief must also be "appropriate." If Justice Scalia was correct, then every word used in ERISA's remedial scheme was deliberate, including the word "appropriate." Although the Court has stated that when considering the meaning of "appropriate" equitable relief, courts should "keep in mind the 'special nature and purpose of employee benefit plans,'"[214] it does not appear to have done so itself. The primary purposes of ERISA are to provide benefits to and protect employees. Therefore, the remedies available to those employees should redress the specific injury incurred by the employee.

A. *Typically Equitable and Appropriate Remedies*

The current interpretation of *other appropriate equitable relief* limits the remedies available to those *typically equitable* remedies identified by the Court which include injunction and equitable restitution.[215] Courts are given a "high degree of discretion" when awarding these remedies, enabling them to be flexible and "measure, shape or tailor relief to fit [the court's] view" of

206. *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200, 221 (2004).
207. *See, e.g.*, Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1322 (5th Cir. 1992).
208. *See, e.g.*, *Aetna Health Inc.*, 542 U.S. at 205.
209. *See, e.g.*, Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 362–63 (2002).
210. *See, e.g.*, *Aetna Health Inc.*, 542 U.S. at 205.
211. *See, e.g.*, Wickline v. State, 239 Cal. Rptr. 810, 811 (Cal. Ct. App. 1986).
212. *See, e.g.*, Gallagher v. Cigna Healthcare of Me., Inc., 538 F. Supp. 2d 286, 290 (D. Me. 2008).
213. Mertens v. Hewitt Assocs., 508 U.S. 248, 255 (1993).
214. Varity Corp. v. Howe, 516 U.S. 489, 515 (1996).
215. *See Mertens*, 508 U.S. at 256.

what is fair in a particular situation.[216] As such, courts should use the flexibility of these equitable remedies to alleviate the damage caused by the wrongfully denied benefits.

1. Injunction

An injunction is a command from the court to a defendant requiring the defendant to act or avoid acting in a certain way.[217] Due to their flexible nature, injunctions have been used in a variety of ways to prevent violations of rights, restore "rights that have already been violated," and even "establish rights" that did not otherwise already exist.[218] Because there is no general limiting principal, an "injunction is a potential remedy in any case in which it may provide significant benefits that are greater that its costs or disadvantages."[219] The following are a few examples on how injunctive relief may be fashioned to "appropriately" remedy wrongfully denied benefits in particular situations.

In *Wickline v. State*,[220] Mrs. Wickline, a plan beneficiary underwent several major surgeries on her nerves and arteries.[221] After the surgeries, the plan administrator rejected the surgeon's determination that Mrs. Wickline should remain in the hospital for eight additional days.[222] As a result, she was discharged.[223] While at home, her leg became infected and ultimately had to be amputated.[224] The surgeon concluded to a medical certainty, that had Mrs. Wickline remained in the hospital for the entire eight days, as he suggested, she would not have lost her leg.[225] Therefore, in this instance, the wrongful denial of benefits resulted in the loss of Mrs. Wickline's leg. Even though a court could not award compensatory damages to Mrs. Wickline or a similarly situated insured for their loss, perhaps it could use its injunctive powers to fashion an appropriate remedy. For instance, it might issue an injunction requiring the plan administrator to provide Mrs. Wickline with a

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216. DAN B. DOBBS, LAW OF REMEDIES: DAMAGES–EQUITY–RESTITUTION § 2.4(1), at 67 (2d ed. 1993).
217. *Id.* § 2.9(1), at 162.
218. *Id.* § 2.9(2), at 165.
219. *Id.* at 166.
220. 239 Cal. Rptr. 810 (Ct. App. 1986).
221. *Id.* at 812–13. Note that although this was not an ERISA case, the same concept would apply.
222. *Id.* at 813–15.
223. *Id.* at 815.
224. *Id.* at 816.
225. *Wickline*, 239 Cal. Rptr. at 817.

prosthetic leg and rehabilitative therapy.[226] Of course the administrator will argue that requiring the plan to pay for such relief is essentially the same as awarding consequential damages. This argument should fail in light of the Court's ruling in *Sereboff*, which permitted an insurer to recover money by fashioning a method in which the money was recovered as *equitable*.

In *Jacobs v. Kaiser Foundation Health Plan Inc.*,[227] an ERISA plan beneficiary was bulimic, however the administrator refused to pay for any out-of-plan treatment because it considered alternative treatments available from the plan provider to be reasonable.[228] The court ultimately determined that the treatment provided by the plan provider was not reasonable and therefore benefits for the requested out-of-plan treatment were wrongfully denied.[229] If a court was faced with a similar situation, its injunctive power could be used to order the plan to adopt a form of bulimia treatment that is reasonable. Because bulimia is often a lifelong struggle, this prospective remedy may be "appropriate."

In *Nolte v. BellSouth Corp.*,[230] the plaintiff brought a class action suit for breach of fiduciary duty, under ERISA §502(a)(3)(B), against the plan administrator for improperly denying benefits under a Short Term Disability Plan (STDP).[231] She alleged that the administrators failed to apply the correct definition of the term "disability."[232] As an appropriate equitable remedy, the plaintiff asked the court

> to order the removal and replacement of the alleged breaching fiduciaries, . . . further enjoin the violation of the fiduciary duties owed to Plaintiff, . . . [and] appoint an "independent neutral body to substitute for those removed fiduciar[ies],". . . which would reopen "each [STDP] claim" and determine whether the claim warranted an award of disability benefits.[233]

226. Note that the administrator will likely argue that requiring the plan to pay for these additional treatments is the same as giving the patient the money and therefore essentially the equivalent of awarding her consequential damages. The administrator might also argue that this type of remedy does not serve ERISA's purposes because the funds would be taken out of the plan's account and therefore cause all plan members to bear the cost, possibly raising premiums.

227. 265 Fed. Appx. 652 (9th Cir. 2008).

228. *Id.* at 653–54.

229. *Id.* at 654.

230. No. 1:06-cv-762-WSD, 2007 WL 120842 (N.D. Ga. Jan. 11, 2007).

231. *Id.* at *1.

232. *Id.* at *2.

233. *Id.*

The plaintiff further requested "an order establishing an administrative committee to audit and review" the administrator's compliance with the previous order and disgorging all profits realized from past violations.[234] Although the court dismissed the plaintiff's case, it did not refute that this type of injunctive relief could be "appropriate equitable relief."[235] In fact, in *Russell*, the Supreme Court specified that the phrase "other equitable or remedial relief" as used in § 409(a) of ERISA is similar to "other appropriate equitable relief" in §502(a)(3)(B) and includes the "removal of [a breaching] fiduciary."[236]

Another potential equitable remedy might be an order requiring administrators who have previously been found to have wrongfully denied benefits to refer all future benefit disputes for external review at the administrator's cost. "External review is a formal process to resolve disputes between health plans and patients by submitting those disputes to expert decision makers, independent from either the health plan or the patient."[237] It has been shown that external review uncovers that approximately fifty percent of the reviewed decisions by administrators were incorrect; therefore, this would likely be a very effective way of preventing future wrongful denials.[238]

It should be noted that courts have used their injunctive power to award monetary relief in an effort to make whole those aggrieved.[239] For example, in *Dunnigan v. Metropolitan Life Insurance Co.*,[240] the court held that prejudgment interest on late benefit payments does not constitute an award of compensatory damages.[241] In fact, the court held that if "interest is sought to make the plaintiff whole by eliminating the effect of a defendant's breach of

234. *Id.*

235. *See Nolte*, 2007 WL 120842, at *6, *7. The Court dismissed the plaintiff's case asserting that pursuant to *Varity Corp. v. Howe*, a plaintiff cannot seek remedies under § 502(a)(3) when other remedies are available through another specific provision of ERISA such as § 502(a)(1)(B). *Id.* at *6. Note, however, that other courts have interpreted *Varity Corp.* differently. *See, e.g.*, Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 89–90 (2d Cir. 2001) ("*Varity Corp.* did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available; instead, the district court's remedy is limited to such equitable relief as is considered appropriate.").

236. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 142, 150 (1985) (It is abundantly clear that ERISA's "draftsmen were primarily concerned with the possible misuse of plan assets").

237. Kathy Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer is "NO")*, 15 HEALTH MATRIX 285, 306 (2005).

238. *See id.* at 311.

239. *See id.* at 327.

240. 277 F.3d 223 (2d Cir. 2002).

241. *Id.* at 229.

a fiduciary duty, [there is] no reason why such interest should not be deemed 'appropriate equitable relief' within the scope of § 502(a)(3)(B)."[242]

2. Equitable Restitution

In addition to its injunctive power, a court may also use the remedy of restitution to assist in making an injured participant or beneficiary whole after being wrongfully denied benefits.[243] Dan Dobbs explains that although in some cases restitution may provide compensation for a plaintiff, the goal of restitution, "is to prevent unjust enrichment of the defendant by making him give up what he wrongfully obtained from the plaintiff."[244] There are several different types of equitable restitution including: "(1) the constructive trust, (2) the equitable lien, (3) subrogation, (4) . . . accounting for profits," (5) equitable rescission, and (6) reformation of instruments.[245] Due to the flexible nature of equitable remedies and the court's discretionary power, it is likely that several of these restitutionary remedies could be used in creative ways to address wrongful denials of benefits. This portion of the article will discuss the possible use of reformation and equitable rescission to achieve this goal.

Reformation is a traditionally equitable remedy which enables the court to alter a contract so that it more accurately meets the agreement of the parties.[246] This remedy, however, may also be used to reform or alter a contract to meet other legal standards such as the doctrine in insurance law which requires insurance policies to meet an insured's reasonable expectations.[247] Such expectations may have arisen from brochures or other representations by the insurer or administrator, despite contrary provisions in the written policy.[248] Therefore, if in a particular case the court finds that as a result of a plan administrator's representations, a participant or beneficiary reasonably expected certain benefits to be covered, a plan that excludes these benefits should be reformed to meet the expectations of that participant or beneficiary.

Equitable rescission is a court order that causes a contract to be "unmade," meaning that all benefits received under the contract are restored to

242. *Id.*
243. *See* DOBBS, *supra* note 216 § 1.1, at 4.
244. *Id.*
245. *Id.* § 4.3(1), at 391–92.
246. *Id.* at § 4.3(7), at 416.
247. *Id.* at § 4.3(7), at 418 (citing Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 825 (1990)).
248. DOBBS, *supra* note 216 § 4.3(7), at 418.

their original party.[249] Generally, the benefits received by the plan administrator are the premiums paid by the participant, and the benefits received by the participant would be the medical services rendered. Therefore, if the participant has paid more in premiums than he has received in benefits before being wrongfully denied, perhaps a court would award the difference to the insured. Of course, the participant would now no longer have any insurance, which may not be the most desirable result.

VII. CONCLUSION

In *Knudson,* while referring to the majority's interpretation of *other appropriate equitable relief,* Justice Ginsburg notes in her dissent that "[i]t is particularly ironic that the [Court] acts in the name of equity as it sacrifices congressional intent and statutory purpose to archaic and unyielding doctrine."[250] This emphasizes the fact that ERISA was enacted to protect employees and provide them with "appropriate remedies, sanctions, and ready access to the Federal courts."[251] The current interpretation of § 502(a)(3)(B) contravenes this goal by refusing to allow participants and beneficiaries to be made whole by way of consequential damages. What makes this fact even more troubling is that an award of consequential damages was in fact a *traditionally equitable* remedy for breach of trust, the theory upon which ERISA's remedial scheme is based. Although the decision in *Sereboff* required that the compensatory damages awarded be cloaked as equitable relief,[252] hopefully courts will view that decision as the beginning of equitable revolution relieving ERISA insureds from the Court's flawed and archaic limitations on available remedies.

For the time being, it appears as though counsel for the insured will need to be creative in fashioning the relief they seek so that it will be considered *traditionally equitable.* This author suggests, however, that a clear declaration by the Supreme Court that the proper interpretation of *other appropriate equitable relief* is the one that Justice Scalia and the majority in *Mertens* disposed of as too broad. Until this is done, courts should use their discretionary power to mold the currently permissible remedies such as injunction, restitution, and rescission to provide equitable relief that appropriately addresses the injuries caused by the wrongful denials of covered benefits.

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249. *Id.* at § 4.3(6), at 414.

250. Great-West Life Annuity Ins. Co. v. Knudson, 534 U.S. 204, 228 (2002) (Ginsburg, J., dissenting).

251. 29 U.S.C. § 1001(b) (2006).

252. *See* Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 368–69 (2006).