Court Holds that Erroneous Advice about Medical Benefits Coverage Can Expose Plans to Liability

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BY: MARK S. THOMAS

In *Kenseth v. Dean Health Plan, Inc.*, No. 11-1560 (June 13, 2013), the Seventh Circuit Court of Appeals reviewed the scope of equitable remedies available under ERISA and determined that the erroneous advice given to a plan participant could give rise to liability under ERISA?s equitable remedy. In particular, the court held that allegedly inaccurate statements made by a plan administrator to a participant over the telephone about the scope of medical benefits coverage can be actionable under ERISA. This marks a further broadening of the scope of equitable relief following the United States Supreme Court?s decision in *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (2011).

Plaintiff Deborah Kenseth underwent a vertical gastric banding, a surgical procedure designed to facilitate weight loss, in 1987. This procedure was covered by her insurer at the time. Eighteen years later, her doctor recommended a surgical operation to resolve severe acid reflux and other serious health problems resulting from complications from the first surgery. Kenseth was an employee of Highsmith, Inc., which provided employee medical benefits through Dean Health Plan, Inc. (?Dean?). In late 2005 she called Dean and asked whether the recommended surgery would be covered by the plan. A Dean service representative told her that the procedure would be covered subject to a $300 co-payment.

However, the Group Member Certificate and Benefit Summary (?Certificate?) for Dean?s medical benefits plan excludes coverage for ?surgical treatment or hospitalization for the treatment of morbid obesity,? as well as ?[s]ervices and/or supplies related to a non-covered benefit or service, denied referral or prior authorization, or denied admission.? Dean?s customer service representative did not ask Kenseth whether the surgery was related to the earlier surgery for treatment of morbid obesity, and Kenseth did not mention it.

Kenseth underwent the recommended surgery. The next day, Dean denied coverage for the surgery and associated services based on the ?morbid obesity? exclusion. Including a subsequent

hospitalization, Kenseth received a bill for $77,974, which the plan refused to pay.

Kenseth pursued plan administrative appeals but was denied coverage. She filed suit under ERISA, including a claim for equitable relief under 29 U.S.C. § 1132(a)(3), that sought, in part, a ?surcharge? payment from Dean to cover her medical bills. The district court granted summary judgment to Dean. On a first appeal, the Seventh Circuit held that the Certificate was ambiguous as to whether Kenseth?s surgery would be covered. The court also held that the Certificate was ambiguous as to how participants could obtain an *authoritative* determination on that question, as opposed to oral advice over the telephone that was, according to the Certificate, non-binding. The court concluded that the plan was ambiguous in important respects, and that Kenseth could thus bring a claim for make-whole damages against the plan fiduciary. The court remanded the case to the district court for further proceedings. When the district court again granted summary judgment for Dean, Kenseth pursued this second appeal.

Reviewing this new appeal, the Seventh Circuit applied the Supreme Court?s decision in *Cigna Corp. v. Amara*, which was decided after the Seventh Circuit?s ruling on the first appeal, and held that *Cigna Corp.* allowed Kenseth to ?seek make-whole money damages as an equitable remedy under section 1132(a)(3) if she can in fact demonstrate that Dean breached its fiduciary duty to her and that the breach caused her damages.?

An important part of Kenseth?s position was her assertion that she would not have proceeded with the 2005 surgery had she known that Dean would not cover it, and that other medical alternatives were available, including pursuit of medical treatment covered by her husband?s policy. The Seventh Circuit held that these assertions created issues of fact as to ?whether Kenseth could have avoided some or all of the costs she incurred? and whether Dean breached its fiduciary duties to disclose material information, not to mislead a plan participant, and to ?provide accurate and complete information when a beneficiary inquires about her insurance coverage.? Based on these issues of fact, the Seventh Circuit overturned the lower court?s grant of summary judgment and remanded the case for further proceedings on the merits.

In doing so, the Seventh Circuit held, however, that ?a fiduciary will not be held liable for negligent misrepresentations made by an agent of the plan to a plan participant so long as the plan documents themselves are clear and the fiduciary has taken reasonable steps to avoid such errors.?

The court analogized Kenseth?s case to the issues recently faced by the Fourth Circuit in *McCravy v. Metropolitan Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012) (for more on *McCravy*, **click here**).

Points to Remember. While the Seventh Circuit has remanded the case for further proceedings on the issues of fiduciary breach, the court?s opinion was skeptical of Dean?s arguments, particularly in light of the court?s previous conclusion that the Certificate was ambiguous on important points. The case highlights the risks that can be created by oral representations regarding benefits coverage made over the telephone by customer service representatives. The case also highlights the importance of providing clearly written statements in plan documents about which medical treatments are covered and how a plan participant can receive authoritative advice from the plan about such issues.

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