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DELAYED & DENIED: RECALIBRATING THE ERISA ATTORNEY'S
FEE FACTORS FOR HEALTHCARE CLAIMS

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ABSTRACT

Millions of Americans count on employer-sponsored health insurance. Recent lawsuits and investigations show, however, that valid claims are often denied. The governing law, the Employee Retirement Income Security Act of 1974 (ERISA), shields plan administrators from their mistakes; if a claim is denied without a valid reason, a consumer may sue for the benefit that should have been paid, but not consequential or punitive damages.

One aspect of ERISA potentially incentivizes plan administrators to process claims correctly the first time: an attorney's fee provision gives judges discretion to award fees to either side; courts have developed a five-factor test to guide their discretion. But individual healthcare claimants can rarely satisfy two of the test's five factors, thus eroding their chances of recovering fees and blunting any incentive for administrators to decide claims correctly the first time. The attorney's fee test arose in the 1970s in common fund and pension malfeasance claims; it is an awkward fit for today's healthcare claims. The Supreme Court observed in 2010 that the factors bear "no obvious relation" to ERISA or existing fee-shifting jurisprudence, holding that courts need not use them at all. Yet courts still do.

This Article proposes that courts recalibrate the attorney's fee factors for individual healthcare claims. The current factors impose duties and considerations found nowhere in ERISA, and many prevailing ERISA plaintiffs cannot recover their attorney's fees under this standard. A revised five-factor test would help ensure that the fee provision functions as intended and serves ERISA's dual goals of protecting benefits and providing ready access to the federal courts.

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INTRODUCTION

A boy, Nate, has mental health and substance use disorders; he is suicidal, and his long-time therapist concludes that outpatient therapy is no longer sufficient.¹ Nate is a beneficiary on his mother's employer-sponsored health benefit plan, which covers mental health treatments, including residential treatment.² When Nate is admitted to residential treatment in 2016, however, his plan covers some care but then denies most of it.³ His mother appeals the denial through multiple levels of review, collecting supporting documents and notes from physicians setting out the need for care.⁴ The insurer responds with flat denials, ignoring the medical evidence Nate's mother provided.⁵

Four years after the first denial, a federal court finds that the insurer failed to follow the claims regulations, denied the claims without any basis, and made no factual findings to support the denials.⁶ The denials contained only conclusory statements, "lack[ing] any analysis, let alone a reasoned analysis."⁷ The court orders the administrator to go back and review the evidence as the law requires and state reasons for its decisions.⁸ For her four years of claim appeals and litigation, the mother receives no compensation or attorney's fee.⁹ For its repeated denials devoid of facts or reasoning, the administrator suffers no consequence, except the court's order to take the steps it should have taken in the first place.¹⁰ Thus, apart from reputational concerns, the insurer has little reason to follow the law.

Over 150 million other Americans, like Nate and his mother, rely on employer-sponsored healthcare benefits.¹¹ Of the approximately 1.4 billion claims filed per year, 100 million—or one out of every fourteen—is initially denied.¹² Some denials are appropriate, such as when the plan does not cover the person or when the benefit is expressly excluded. In

1. *Kerry W. v. Anthem Blue Cross & Blue Shield*, 444 F. Supp. 3d 1305, 1309 (D. Utah 2020) (explaining the factual scenario before the plan denied Nate's benefits).

2. *Id.* at 1307–08.

3. *Id.* at 1309.

4. *Id.* at 1309–10.

5. *Id.* at 1313.

6. *Id.*

7. *Id.* (internal quotation marks omitted) (quoting *McMillan v. AT&T Umbrella Benefit Plan No. 1*, 746 F. App'x 697, 706 (10th Cir. 2018)).

8. *Id.*

9. *See id.*

10. *See id.*

11. *See* Kaiser Family Found., *Health Insurance Coverage of the Total Population*, KFF, <http://www.kff.org/state-indicator/total-population> [https://perma.cc/T3DN-724T] (last visited Apr. 2, 2021).

12. Karen Pollitz & Daniel McDermott, *Claims Denials and Appeals in ACA Marketplace Plans*, KFF (Jan. 20, 2021), <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>.

other cases, however, promised benefits are improperly denied, sometimes by mistake but other times on a systematic basis.¹³ Consumers appeal only about one in every 10,000 claims,¹⁴ so improper denials result in gains for the payor most of the time.

Administrators have little to lose by denying a covered claim. Consumers can sue for their benefits under the governing Employee Retirement Income Security Act of 1974 (ERISA),¹⁵ but the remedies are sparse—no consequential or punitive damages are allowed, no matter how long consumers pursue covered care and no matter what they suffer from its absence.¹⁶ Failure to follow claims regulations generally results in no remedy at all.¹⁷ Courts use a deferential standard to review claims decisions, so denials stand if they have any support in the record.¹⁸

In one bright spot for consumers, an attorney's fees provision gives judges discretion to award fees to either side, in keeping with ERISA's goal of providing "ready access to the Federal courts."¹⁹ To guide this discretion, courts in the 1970s crafted a test calling for the analysis of five factors.²⁰ Courts continue to apply the five factors test today. Courts ask whether the fee defendant acted in bad faith or culpably, whether the fee

13. *See infra* Part I.

14. *See id.*

15. "[T]he continued well-being and security of millions of employees and their dependents are directly affected by" employer-sponsored benefits. 29 U.S.C. § 1001(a) (2022). ERISA is intended to "protect . . . participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." *Id.* § 1001(b).

16. *See* 29 U.S.C. § 1132(a)(3) (allowing a participant or beneficiary to bring a civil action "(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"); *see also* *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (allowing no remedy for delay in claims processing); *id.* (allowing no consequential damages); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (noting ERISA's lack of remedies for even serious claims processing mistakes).

17. *See, e.g., Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 157 (5th Cir. 2009) (quoting *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 537 (5th Cir. 2007)) ("[F]ailure to fulfill procedural requirements generally does not give rise to a substantive damage remedy."); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 971 (9th Cir. 2006) (noting that failure to follow claims regulations leads to no substantive remedy); *Duncan v. Assisted Living Concepts, Inc.*, No. 03-1931, 2005 U.S. Dist. LEXIS 1975, at *10 (N.D. Tex. Feb. 10, 2005) (noting that there is no substantive remedy for procedural violations). *But see Bard v. Bos. Shipping Ass'n*, 471 F.3d 229, 244–46 (1st Cir. 2006) (striking defendant's evidence and awarding benefits where procedural violations were "serious, had a connection to the substantive decision reached, and call[ed] into question the integrity of the benefits-denial decision itself").

18. *See infra* Part IV.

19. 29 U.S.C. § 1001(b).

20. *See Eaves v. Penn*, 587 F.2d 453, 464–65 (10th Cir. 1978).

defendant can satisfy a fee award, what the deterrent effect would be on other similar actors, whether the fee claimant sought to or did benefit all plan members or resolved a complex legal issue, and what the merits are of the parties' positions.²¹

The early ERISA fee cases involved financial malfeasance and recoveries that accrued to all plan members—these features are reflected in the attorney's fee test that grew out of those cases. The test accordingly inquires as to the defendant's bad faith or culpability; another factor rewards claimants who seek to benefit all plan members or who resolve a complex legal issue.²² These two factors worked well for that original context but have become a barrier to attorney's fee awards in healthcare claim cases.

The bad faith or culpability factor is applied inconsistently in healthcare cases, with some courts requiring actual dishonesty before the factor can be satisfied. Plaintiffs struggle to show a defendant's dishonest mental state because discovery is generally prohibited in ERISA cases, particularly into the defendant's motivations.²³ Besides, defendants who improperly deny claims often are not dishonest *per se*—they just don't pay covered claims. Their tactics may include ignoring evidence that supports the claim, using internal guidelines that are stricter than those in the plan documents, denying valid claims, forcing the plaintiff to litigate, and using overly aggressive utilization review.²⁴

As to the factor asking whether the plaintiff intended to or actually benefitted other plan members or resolved a complex legal issue, this factor made sense in the common fund cases in which it originated.²⁵ In those cases, courts applied equitable fee-shifting principles and found that where litigation created a common fund or benefit that accrued to all plan members, the non-litigating members would be unjustly enriched without also sharing in the attorney's fee. There is no common fund and no such equitable issue, however, when individual plaintiffs simply seek their rightful benefits under ERISA. In these cases, the wrong-doing defendant, not the plan, generally pays the fees. And, to satisfy this factor as it is commonly interpreted, plaintiffs would have to enlarge their claims (to include other plaintiffs) and theories (to include more complex legal issues), which cuts against ERISA's goal of speedy and inexpensive claims resolution. Thus, in healthcare cases particularly, this factor burdens plaintiffs' efforts to recover their benefits and attorney's fees, thus thwarting ERISA's goal of safeguarding benefits and providing ready access to the federal courts.

21. *See* *Hardt v. Reliance Standard Ins. Co.*, 560 U.S. 242, 249 n.1 (2010).

22. *See id.*

23. *See infra* Section IV.A.2.

24. *See infra* Part III.

25. *See* *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1304 (6th Cir. 1991) (“This appears to be a codification of the common fund doctrine of the common law.”).

The five-factor test is no longer required; the Supreme Court in 2010 said the factors bear “no obvious relation” to ERISA or fee-shifting jurisprudence and that courts need not use them.²⁶ Yet courts still apply the five factors to almost every ERISA attorney’s fee decision, including individual healthcare claims, where plaintiffs can almost never satisfy two of the factors.²⁷

This Article proposes that the five-factor test be recalibrated for today’s healthcare claims, starting with the bad faith or culpability factor and the factor calling for plaintiffs to benefit other plan members. Courts should discount or disregard these two factors in healthcare cases or consider them satisfied differently. For the bad faith or culpability factor, courts should focus on the culpability aspect of this disjunctive test and consider this factor satisfied when a fee defendant fails to follow its ERISA-imposed fiduciary duty of care, ignores evidence supporting the consumer, or refuses to pay a proper claim. The factor asking that individual plaintiffs also benefit all plan members while seeking their own contracted benefits should be discounted in the individual healthcare benefits context or fulfilled when a plaintiff holds a plan administrator to account by navigating the multi-step, uncompensated administrative appeal process and bringing suit.

The case for recalibrating the attorney’s fee factors is urgent, as today’s healthcare landscape is hostile to consumers. In the 1970s and 80s, when the five factors took hold, companies paid claims according to physicians’ diagnostic judgment.²⁸ But before long, payors put aggressive cost-saving utilization review measures in place.²⁹ ERISA encouraged the rise of these measures because it shields payors from the consequences of their mistakes.³⁰ Moreover, since the Supreme Court’s *Firestone Tire & Rubber Co. v. Bruch*³¹ case in 1989, claim denials are reversed only if the administrator’s decision is arbitrary or capricious; unless the denial is completely without evidence or guiding principle, it stays in place.³² For consumers

26. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 254–55 (2010).

27. *See infra* Part III.

28. *See infra* Section III.A.

29. *See id.*

30. JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 283 (2005) (“ERISA played an important role in the development of utilization review . . . because the preemption and remedial provisions shield[] utilization reviewers from liability for mistakes.”).

31. 489 U.S. 101 (1989).

32. *Id.* at 115. The *Firestone* case stated that the standard of review in ERISA cases should be de novo unless the plan administrator and participants agree on a narrower standard. *Id.* Following this decision, discretion-granting provisions became ubiquitous in ERISA plans, so that standard is now usually the arbitrary and capricious standard. *Id.* This standard “afford[s] less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.” *Id.* at 114.

with complex cases, particularly mental health claims, this standard has been devastating.³³

Courts, therefore, should accept the Supreme Court's invitation to ignore irrelevant attorney's fee factors and recraft the five-factor ERISA fees test for healthcare claims. To fulfill ERISA's promise of protecting benefits and providing access to the federal courts, plaintiffs need access to attorney's fees as ERISA intended, so they can pursue benefit claims.

Part I explains consumers' lack of remedies when healthcare claims are improperly delayed or denied. Part II shows how a financial malfeasance case produced today's five-factor ERISA fees test and explains how that test applies. Part III shows how today's climate of cost controls, utilization review, and discretion for plan administrators has tilted the balance, favoring plan administrators over consumers. Part IV explains why the fees test needs an update: two of the five factors—bad faith or culpability and a claimant's intent to aid all plan members—miss the point when a company just refuses to pay an individual's valid healthcare claim. Part V shows why ERISA's fees provision must function unburdened by tangential considerations, so ERISA can protect benefits as intended.

I. ERISA AIMS TO PROTECT BENEFITS BUT VIOLATIONS GO UNPUNISHED

ERISA aims to protect employee benefits, but it lacks incentives for administrators to process claims correctly the first time—even if an administrator wrongfully withholds benefits for years and forces the consumer to sue, the administrator usually just ends up being ordered to follow the rules it should have followed initially.

The consequences of improper claims processing are so slight that some plan administrators do not even feign concern. Courts have noted—and criticized—payors' "cavalier attitude" in the face of ERISA laws and regulations.³⁴ When one payor was accused of backdating documents so the payor appeared to comply with the regulations, the payor responded that the payor would not have done so because there was no incentive for that—lack of compliance has no consequence.³⁵

33. See generally Katherine T. Vukadin, *On Opioids & ERISA: The Urgent Case for a Federal Ban on Discretionary Clauses*, 53 U. RICH. L. REV. 687 (2019).

34. See, e.g., *Finks v. Life Ins. Co. of N. Am.*, No. 08-1272, 2009 WL 2230899, at *4 (D.D.C. July 24, 2009).

35. *Id.* The payor stated:

There was no incentive to backdate. ERISA caselaw is clear that, at most, a plan administrator's failure to meet any regulatory requirement, including appeals deadlines, enables a claimant to proceed directly to court without waiting for the denial to be issued, and *might* trigger a *de novo* review even when the plan provides deference to the administrator.

Id. The court in that instance took the plan administrator's attitude as evidence of bad faith toward the plaintiff in the attorney's fee analysis. *Id.*

Congress enacted ERISA to protect consumers' employer-sponsored benefits.³⁶ ERISA focused at first on pension benefits, addressing the problem of workers unexpectedly losing an anticipated pension due to an employer's underfunding or mismanagement.³⁷ In resolving these concerns, ERISA is considered effective.³⁸

ERISA covers welfare benefits such as healthcare plans too,³⁹ but ERISA is less protective of these benefits than the state laws and remedies that it displaces. That is, ERISA preempts most state laws and claims, including their punitive damages and other remedies, leaving consumers with little in their place.⁴⁰ Insured plans (i.e., those whose claims are paid by an insurance company rather than by the plan itself) are still subject to state laws governing insurance.⁴¹ But plans that self-fund, or pay their own claims, are not subject to state insurance laws.⁴² When ERISA was enacted, most plans did not self-insure—only larger plans tended to do so.⁴³ More plans sought self-funding, however, as state governments passed laws requiring certain benefits or regulating other aspects of health insurance plans.⁴⁴ In addition, stop-loss insurance to guard against unusually large claims made self-funding more feasible even for smaller plans.⁴⁵ Now, most plans are self-funded.⁴⁶ Because of preemption and the rise of self-

36. ERISA is intended to “protect . . . participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.” 29 U.S.C. § 1001(b) (2022).

37. See WOOTEN, *supra* note 30, at 51–52 (explaining that the movement that led to the passage of ERISA “began in December 1963, when the Studebaker Corporation shut down its auto production plant . . . [and] the pension plan for hourly workers did not have enough funds to meet its obligations”).

38. See, e.g., John H. Langbein, *What ERISA Means by “Equitable”: The Supreme Court’s Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1322 (2003) (noting that ERISA has largely eliminated the default risk to pension benefits).

39. ERISA applies “to any employee benefit plan if it is established or maintained” by any employer or employee organization. 29 U.S.C. § 1003(a). “[E]mployee benefit plan” or “plan” means an employee welfare benefit plan or an employee pension benefit plan.” *Id.* § 1002(3).

40. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (holding that ERISA provides “no remedy, state or federal, for what may have been a serious mistake”); see also WOOTEN, *supra* note 30, at 283–84 (noting the limited remedies available to plan participants).

41. See 29 U.S.C. § 1144(b)(2) (saving from ERISA preemption “any law of any [s]tate which regulates insurance, banking, or securities”).

42. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (“We read the deemer clause [of ERISA] to exempt self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within the meaning of the saving clause.”).

43. See WOOTEN, *supra* note 30, at 281.

44. See *id.*

45. See *id.* at 281–82.

46. See *id.* at 282.

insurance, most employer-sponsored plans are regulated only by ERISA's sparse regime.⁴⁷

Consumers can sue under ERISA for their benefits in federal court.⁴⁸ But they must first exhaust the levels of appeal available within the plan.⁴⁹ Most consumers never appeal once, much less the two times that ERISA plans can require.⁵⁰ Fewer than one percent of denied claims are appealed at all.⁵¹ Possible reasons are the confusing nature of the appeal process, consumers' multiple bills and claims, and the overwhelming nature of coping with underlying illness at the same time.⁵² Moreover, even if a consumer goes on to sue and win, the consumer cannot receive an award of attorney's fees for this administrative phase of the process.⁵³

When consumers reach federal court and sue for their benefits, the available remedies are thin.⁵⁴ ERISA generally permits only recovery of the benefit's value or the actual procedure, but not both.⁵⁵ That is, if a consumer is improperly denied a lung transplant and then successfully sues in federal court to obtain it, the consumer still only receives the lung transplant.⁵⁶ The same is true even where the consumer has suffered damages beyond the claim's value.⁵⁷ And, when administrators fail to fol-

47. *See id.*

48. ERISA allows plaintiffs to bring a case to "recover benefits due to [them] under the terms of [the] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B) (2022).

49. *See D'Amico v. CBS Corp.*, 297 F.3d 287, 291 (3d Cir. 2002).

50. 29 C.F.R. § 2560.503-1(c)(2) ("The claims procedures of a group health plan will be deemed to be reasonable only if . . . [they] do not contain any provision . . . that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act.").

51. Pollitz & McDermott, *supra* note 12 (explaining that the percentage of claims denied varies widely across plans and consumers appealed less than one percent of their denied claims).

52. *See, e.g.*, KAREN POLLITZ, CYNTHIA COX, KEVIN LUCIA & KATIE KEITH, MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE 29–30 (Henry J. Kaiser Family Found. 2014) (explaining some of the reasons that consumers with denied claims do not appeal, such as the overwhelming nature of illness and the confusing process).

53. *See, e.g.*, *Parke v. First Reliance Standard Life Ins. Co.* 368 F.3d 999, 1011 (8th Cir. 2004) ("We join the Second, Fourth, Sixth, and Ninth Circuits in holding that term 'any action' . . . does not extend to pre-litigation administrative proceedings." (quoting 29 U.S.C. § 1132(g)(1))).

54. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1986)); *see also DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003) (Becker, J., concurring) (noting that "virtually all state law remedies are preempted but very few federal substitutes are provided").

55. *See, e.g.*, *Martin v. Ark. Blue Cross Blue Shield*, 299 F.3d 966, 972–73 (8th Cir. 2002) (affirming judgment that awarded a lung transplant); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (allowing no consequential damages for claims processing delays).

56. *See, e.g., Martin*, 299 F.3d at 972.

57. *See, e.g., Mertens v. Hewitt Assocs.*, 508 U.S. 248, 250, 255 (1993).

low regulations governing claims processing, they are at worst told to go back and try again.⁵⁸ The consumer receives no compensation for the protracted—often years-long—effort required to secure payment.

II. COURTS DEVELOP AN ERISA ATTORNEY'S FEE TEST

Without the risk of consequential or punitive damages, administrators who improperly delay or deny ERISA claims have one remaining concern: attorney's fees. The default in American litigation is that each party pays its own attorney's fees, unless a statutory exception applies.⁵⁹ ERISA contains such an exception, granting judges discretion to award fees to either side.⁶⁰ The provision itself contains no guidance for the discretion, and ERISA's legislative history is also unhelpful in this regard.⁶¹ Soon after ERISA's enactment, however, courts fashioned their own guidance, requiring a fee claimant to achieve "some degree of success on the merits" and satisfy a five-factor test.⁶² The attorney's fee decision is reviewed for abuse of discretion.⁶³

A. "Some Degree of Success on the Merits"⁶⁴

To receive an attorney's fees award, a party must first achieve "some success on the merits."⁶⁵ The exact degree of success is not completely

58. Most often, the administrator must only reprocess the claim using the proper guidelines. *See, e.g.,* *Boyd v. Sysco Corp.*, No. 13599, 2015 WL 7737966, at *14, *18 (D.S.C. Dec. 1, 2015) (noting that defendant United Behavioral Health "failed to comply with the procedural requirements of ERISA [in regard to document disclosure]" but denying request for attorney's fees and simply remanding case to the administrator for another review); *Lukas v. United Behav. Health*, 504 F. App'x 628, 629–30 (9th Cir. 2013) (noting that defendant failed to provide a reason for the denial and did not disclose, upon request, file notes in its possession that contained a more complete explanation of its decision).

59. *See* *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, 421 U.S. 240, 247 (1975).

60. 29 U.S.C. § 1132(g)(1) (2022) ("In any action under this subchapter [other than actions on behalf of the plan for employer contributions under 29 U.S.C. § 1145], the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.").

61. *See* Da-Wai Hu, *Running the Caucus-Race: Prevailing Parties and Fee Shifting Under ERISA*, 67 U. CHI. L. REV. 217, 220 (2000) (noting that "[l]egislative history is . . . unhelpful in suggesting proper applications of fee shifting under ERISA"); *see also* *Eddy v. Colonial Life Ins. Co. of Am.*, 59 F.3d 201, 203 (D.C. Cir. 1995) ("Neither the statute nor the legislative history indicates whether or how that discretion should be guided."); *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1303 (6th Cir. 1991) (stating that "no history exists to provide guidance to the courts").

62. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 254 (2010) (quoting *Ruckelshaus v. Sierra Club*, 463 U.S. 680, 694 (1983)).

63. *See* 29 U.S.C. § 1132(g)(1); *see, e.g.,* *Mullins v. Kaiser Steel Corp.*, 642 F.2d 1302, 1320 (D.C. Cir. 1980).

64. *Hardt*, 560 U.S. at 256.

65. *Id.* Compare 29 U.S.C. § 1132(g)(1) (showing no prevailing party requirement), *with id.* § 1132(g)(2) (imposing a prevailing party requirement). The degree of success can include varying results. *See* *Taaffe v. Life Ins. Co. of N. Am.*,

clear, but the Supreme Court, in establishing this standard, characterized the circumstances in that case—remand, a favorable view of the merits, and an eventual award of benefits—as “far more” than those required for a fee award. This implies that circumstances less favorable can also merit such an award.⁶⁶

Remand for reprocessing is a common outcome in ERISA claims cases, and most courts now consider this sufficient success on the merits to satisfy the first prong of the attorney’s fee analysis.⁶⁷ A minority of courts still hold that a remand, without more, is insufficient.⁶⁸ Even when courts conclude that a remand is enough of a success, a remand still will not result in a fee award if the claimant cannot satisfy the five-factor test.⁶⁹

B. *The Five-Factor Test*

The second prong of the attorney’s fee analysis is a five-factor test, developed in the 1970s when courts addressed the first claims under the recently enacted ERISA statute.⁷⁰ These early cases concerned financial

769 F. Supp. 2d 530, 542 (S.D.N.Y. 2011) (finding success where a plan’s insurer gave the plaintiff all she sought in her complaint); *Rangel v. Aetna Life Ins. Co.*, No. 15-303, 2016 WL 1449539, at *1 (C.D. Cal. Apr. 12, 2016) (noting a voluntary settlement shows some success); *Carlson v. HSBC-N. Am. (US) Ret. Income Plan*, 542 F. App’x 2, 7–8 (2d Cir. 2013) (finding some success where a defendant’s change in how it credited a break in service led to the plaintiff obtaining most of the relief she sought).

66. *See* *Gross v. Sun Life Assurance Co. of Canada*, 763 F.3d 73, 76 (1st Cir. 2014).

67. *See id.* at 80 (holding that a remand for further consideration was sufficient success on the merits where the court had stated that the more deferential standard of review should not apply); *McKay v. Reliance Standard Life Ins. Co.*, 428 F. App’x 537, 54647 (6th Cir. 2011) (affirming lower court’s decision that remand was sufficient success on the merits because the plaintiff received “another shot” at his claimed benefits through the remand for further consideration); *Barnes v. AT&T Pension Benefit Plan—Nonbargained Program*, 963 F. Supp. 2d 950, 961–62 (N.D. Cal. 2013) (holding that a remand is sufficient success on the merits to satisfy that prong of the attorney’s fee analysis because remand is neither a purely procedural victory nor a trivial success).

68. *See, e.g.,* *Vivas v. Hartford Life & Accident Ins. Co.*, No. 10-22992, 2013 WL 5226720, at *3 (S.D. Fla. June 17, 2013) (denying attorney’s fees request and deeming outcome a “purely procedural victory” where plaintiff secured a review on remand due to the defendant’s breach of a fiduciary duty); *Dickens v. Aetna Life Ins. Co.*, No. 10-88, 2011 WL 1258854, at *6 (S.D.W. Va. Mar. 28, 2011) (denying fee request after remand for further consideration).

69. For example, where a defendant did not comply with the ERISA claims procedures and “failed to provide plaintiff a reasonable opportunity for a full and fair review,” a court still did not award fees. *Saint Joseph’s Hosp. v. Carl Klemm, Inc.*, 459 F. Supp. 2d 824, 833–34 (W.D. Wis. 2006). The court explained that there was no indication that the defendant was “simply out to harass” the plaintiff. *Id.* at 834; *see also* *Geiger v. Pfizer, Inc.*, 549 F. App’x 335, 338–39 (6th Cir. 2013) (affirming a district court’s decision not to award attorney’s fees because although the plaintiff had achieved “some degree of success on the merits” the defendant was insufficiently culpable and its position had some merit).

70. *See* *Eaves v. Penn.*, 587 F.2d 453, 464–65 (10th Cir. 1978) (setting out five factors). The five factors are:

malfeasance under ERISA—the test accordingly considers moral culpability and benefit to members of the plan.⁷¹ But the test is nonetheless grounded in ERISA’s over-arching goals: to maintain plan participants’ benefits and to provide “ready access” to the federal courts.⁷² The five factors remain virtually unchanged today.⁷³

The case that first stated the five-factor test addressed the standards of conduct of ERISA fiduciaries, specifically, a breach of fiduciary duties by the trustee of an employee profit-sharing plan.⁷⁴ The trustee carried out financial transactions that enriched himself at plan participants’ expense, thus breaching his fiduciary duties by failing to act in the sole interest of plan participants.⁷⁵

The court announced without explanation the five factors still used today: (1) “the degree of the “offending [opposing] parties’ culpability or bad faith,” (2) the opposing party’s ability to pay attorney’s fees, (3) whether an award would have a future deterrent effect in similar circumstances, (4) whether the parties seeking an award benefitted all participants and beneficiaries of a plan or resolved a significant ERISA legal question, and (5) the relative merits of the parties’ positions.⁷⁶ “No single factor is determinative,” and courts usually “consider each factor in exercising their discretion.”⁷⁷

The factors are generally applied as follows, with some variation across the circuits:

- (1) The degree of the opposing party’s culpability or bad faith. This factor usually requires more than simply denying a claim

(1) the degree of the offending parties’ culpability or bad faith; (2) the degree of the ability of the offending parties to personally satisfy an award of attorney’s fees; (3) whether or not an award of attorney’s fees against the offending parties would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the pension plan as a whole; and (5) the relative merits of the parties’ position.

Id.

71. *See id.*

72. S. REP. NO. 93–127, at 4865 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4865.; *see also* *Smith v. CMTA-IAM Pension Tr.*, 746 F.2d 587, 589 (9th Cir. 1984) (noting that a court applying its discretion should do so consistently with ERISA’s purpose of protecting employee benefits and giving access to the federal courts); *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 872 (2d Cir. 1987) (“ERISA’s attorney’s fees provisions must be liberally construed to protect the statutory purpose of vindicating retirement rights, even when small amounts are involved.”).

73. *See, e.g., Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 249 (2010).

74. *Eaves*, 587 F.2d at 464–65.

75. *Id.* at 456.

76. *Id.*; *see, e.g., Lawrence v. Westerhaus*, 749 F.2d 494, 495–96 (8th Cir. 1984).

77. *Moon v. Unum Provident Corp.*, 461 F.3d 639, 642–43 (6th Cir. 2006).

incorrectly.⁷⁸ Even if the claim denial is so incorrect as to be deemed arbitrary and capricious, those actions may not satisfy this factor.⁷⁹ “Bad faith” can mean “arbitrary, reckless, indifferent, or intentional disregard of the interests of the person owed a duty.”⁸⁰ Defendants who litigate a novel theory in good faith will not have this factor charged against them.⁸¹ While some courts require actual ill will, others note the disjunctive nature of the factor and consider the concepts of bad faith and culpability separately, finding that either one may satisfy this factor.⁸²

(2) The opposing party’s ability to pay attorney’s fees. As to this factor, interpretations vary. Some courts take notice of a defendant’s status as a household name or member of the Fortune 100 and infer that the defendant can satisfy an attorney’s fee award, while others require evidence of ability to pay.⁸³ Early ERISA cases set out the rule that any fee award should be paid by the offending party personally and that non-culpable, non-party plan participants should not pay the fee.⁸⁴

(3) Whether an award would have a future deterrent effect in similar circumstances. Interpretation of this factor varies, with some courts finding this factor satisfied if a plaintiff simply holds a plan administrator to account by bringing a lawsuit, but with

78. *Rangel v. Aetna Life Ins. Co.*, No. 5:15-cv-00303-ODW, 2016 WL 1449539, at *2 (C.D. Cal. April 12, 2016) (declining to assume bad faith simply due to a claim denial).

79. *See, e.g., Heffernan v. UNUM Life Ins. Co. of Am.*, 101 F. App’x 99, 109 (6th Cir. 2004) (“An arbitrary and capricious denial of benefits does not necessarily indicate culpability or bad faith.”).

80. *Sun Life Assurance Co. of Can. v. Jackson*, No. 3:14-cv-41, 2018 WL 4489289, at *3 (S.D. Ohio Sept. 19, 2018) (quoting *Benkert v. Med. Protective Co.*, 842 F.2d 144, 149 (6th Cir. 1988)).

81. *See Alexandra H. v. Oxford Health Ins., Inc.*, 778 F. App’x 797, 800 (11th Cir. 2019).

82. *Tedesco v. I.B.E.W. Local 1249 Ins. Fund*, 729 F. App’x 136, 139 (2d Cir. 2018).

83. *Compare Priority Sols., Inc. v. Cigna & Price Waterhouse Health Plan*, No. 98 CIV. 4336 MBM., 1999 WL 1057202, at *4 (Dec. 20, 1999) (holding that CIGNA, as a major insurance company, was capable of paying attorney’s fees), *with Mendez v. Teachers Ins. & Annuity Ass’n*, 789 F. Supp. 139, 141 (S.D.N.Y. 1992) (holding that “TIAA–CREF clearly has the resources to pay Plaintiff’s attorney’s fees.”).

84. *See, e.g., Eaves v. Penn.*, 587 F.2d 453, 464 (10th Cir. 1978) (“By enacting a statutory authorization for award of attorney’s fees, we believe Congress intended that the offending party bear the costs of the award, rather than non-culpable, non-party plan participants.”); *Freund v. Marshall & Ilsley Bank*, 485 F. Supp. 629, 643–44 (W.D. Wis. 1979) (assessing fees against the individual defendants and noting that “[w]hile the private plaintiffs’ attorneys have gained a benefit for the Plan as a whole, there is no reason why that benefit should be diminished by a deduction for fees and costs”).

others requiring more.⁸⁵ Some courts consider the deterrent effect on other plan administrators, not just on the defendant.⁸⁶ The deterrent effect is usually regarded as strongest where the defendant engages in deliberate misconduct, such as denying a claim without any basis, rather than when the defendant is merely mistaken.⁸⁷ Deterrent effects have also included fostering appropriate behavior in defending and settling lawsuits.⁸⁸

(4) Whether the parties seeking an award sought to benefit all participants and beneficiaries of a plan or to resolve a significant ERISA legal question. This factor generally requires that the plaintiff do more than ask that the plaintiff's own rightful benefits be paid.⁸⁹ What more is required, however, is not always clear. Some courts look to whether the victory had an actual effect that would benefit other plan participants, such as an increase in benefits.⁹⁰ Others examine whether the plaintiff *sought* rather than actually conferred such a benefit.⁹¹ Other considerations may include whether a plaintiff sought to resolve a key or particularly complex legal issue.⁹²

85. *See, e.g., Eddy v. Colonial Life Ins. Co. of America*, 59 F.3d 201, 208–09 (D.C. Cir. 1995) (holding that it was incorrect to hold that there was no deterrent effect from a lawsuit that could create incentives for ERISA administrators to keep better records of contacts with participants); *Rodriguez v. MEBA Pension Tr.*, 956 F.2d 468, 472 (4th Cir. 1992) (finding a deterrent where a fiduciary made a mistake and then breached fiduciary duties); *Nat'l Cos. Health Benefit Plan v. Saint Joseph's Hosp.*, 929 F.2d 1558, 1575 (11th Cir. 1991) (noting that a deterrent effect can include encouraging appropriate behavior in litigating and settling cases).

86. *See, e.g., Gaeth v. Hartford Life Ins. Co.*, 538 F.3d 524, 531 (6th Cir. 2008) (“This court has consistently interpreted the deterrence factor as requiring consideration of a fee award’s deterrent effect on *other plan administrators*.”).

87. *See, e.g., Foltice v. Guardsman Prods., Inc.*, 98 F.3d 933, 937 (6th Cir. 1996) (“[F]ee awards are likely to have the greatest deterrent effect where deliberate misconduct is in the offing.”).

88. *See Eddy*, 59 F.3d at 208 (noting that ERISA is designed to protect benefits for plan participants, and also to “deter[] unnecessary prolongation or unjust resolution of ERISA claims”).

89. *See Rangel v. Aetna Life Ins. Co.*, No. 5:15-cv-00303-ODW, 2016 WL 1449539, at *3 (C.D. Cal. April 12, 2016) (finding the factor unsatisfied where a plaintiff simply wanted his benefits to be paid).

90. *See, e.g., Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 872 (2d Cir. 1987) (“Those opinions looked not to plaintiff’s motive in bringing suit, but to the effect of plaintiff’s victory. It is the latter that is controlling . . . since the district court found that [plaintiff’s] suit had the effect of conferring a common benefit, the fifth factor of the test was satisfied.”).

91. *Rangel*, 2016 WL 1449539, at *3 (noting that the inquiry should be into whether the plaintiff sought to benefit all plan participants or not); *Oster v. Barco of Cal. Emps.’ Ret. Plan*, 869 F.2d 1215, 1222 (9th Cir. 1988) (deciding that this factor was not satisfied where plaintiff sought “benefit for himself, regardless of the impact such a payment might have on the future beneficiaries of the Plan”).

92. *See, e.g., Eddy*, 59 F.3d at 206.

Generally, if plaintiffs simply want their own benefits to be paid, this factor will count against plaintiffs.⁹³

(5) The relative merits of the parties' positions.⁹⁴ For this factor, courts look to whether each party's position had a basis, or whether the position was unjustified or frivolous.⁹⁵ This factor weighs against a plaintiff's fee award if the defendant took a well-reasoned position with some factual support or if the law was uncertain and the defendant's position was justified on that basis.

The Seventh Circuit adds a "substantial justification" test to the five factors—if a party's position is "substantially justified," then attorney's fees should not be assessed against it.⁹⁶ The court applying this test asks whether the losing party took its position in good faith and was substantially justified or whether it was simply trying to harass its opponent.⁹⁷

The application of these five factors often results in no fee award, even where a plaintiff pursues a claim through multiple levels of internal appeal and secures a reassessment of the denial.⁹⁸

III. AN INCREASINGLY HARSH CLAIMS ENVIRONMENT

Recalibration of the attorney's fee factors is particularly urgent, as consumers face cost containment measures and plan terms that make benefits more difficult to obtain. And, due to changes in the standard of review, plan administrators' risk of facing consequences for their mistakes is lower than ever.

A. *The Rise of Cost Containment Measures*

When ERISA was enacted in 1974, the focus was on risks to participants' pensions from poor planning or mismanagement. Health plans were not the source of concern, as they typically followed an indemnity

93. See *Eddy v. Colonial Life Ins. Co. of America*, 844 F. Supp. 790, 794 (D.D.C. 1994) ("This factor does not weigh in favor of an award. The plaintiff did not seek to benefit others in his claim.").

94. See, e.g., *Lawrence v. Westerhaus*, 749 F.2d 494, 495–96 (8th Cir. 1984).

95. *Id.*

96. *Kolbe & Kolbe Health & Welfare Benefit Plan v. Med. Coll. of Wis., Inc.*, 657 F.3d 496, 506 (7th Cir. 2011).

97. See *Raybourne v. Cigna Life Ins. Co. of N.Y.*, 700 F.3d 1076, 1090 (7th Cir. 2012).

98. See, e.g., *Graham v. Hartford Life & Accident Ins. Co.*, 501 F.3d 1153, 1162 (10th Cir. 2007) (holding that while the administrator acted arbitrarily and capriciously, the attorney's fee issue was not ripe until after remand); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 479 (7th Cir. 1998) (affirming a finding that the benefits denial was arbitrary and capricious, but reversing the attorney's fee award because the denial was not "totally lacking in justification"); *Saint Joseph's Hosp. v. Carl Klemm, Inc.*, 459 F. Supp. 2d 824, 834 (W.D. Wis. 2006).

model, paying claims with little controversy and without questioning physician's judgment.⁹⁹

Yet as medical technologies advanced and complex therapies emerged, healthcare spending grew rapidly.¹⁰⁰ The plans' approach of retrospective payment, or simply paying for services provided, came to be inconsistent with the growth in services and new technologies.¹⁰¹ And, ERISA's liability shield for claims administration mistakes opened the door to cost-cutting tactics that blurred the lines between medical and insurance judgment.¹⁰² This growth in spending led to aggressive cost-cutting measures, including the use of narrower provider networks, gatekeeping through primary care providers, and utilization review.¹⁰³ By 2000, however, consumer and provider dissatisfaction led to less restrictive cost containment measures.¹⁰⁴

Then, after costs grew once again, health plans reintroduced utilization review methods that they had previously loosened.¹⁰⁵ Plans also used policies including requests for authorization after a consumer reaches a certain threshold of use, such as a third MRI or a certain number of chiro-

99. WOOTEN, *supra* note 30, at 283 ("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, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 862 (1991); see Van Vactor v. Blue Cross Ass'n, 365 N.E.2d 638, 645 (Ill. App. Ct. 1977) (holding that an insured was justified in relying on his physician's judgment that treatment was medically necessary and that the insurance company could not deny the claim based on simple disagreement with that judgment); Mount Sinai Hosp. v. Zorek, 271 N.Y.S.2d 1012, 1016 (N.Y. Civ. Ct. 1966) ("Only the treating physician can determine what the appropriate treatment should be [a]ny other standard would involve intolerable second guessing").

100. In the 1970s and 1980s, the cost of healthcare rose considerably in the United States. See E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1720 (1987). "Per capita healthcare costs . . . trebled" from 1950 to the 1980s, "rising from 5% to nearly 11% of the GNP between 1960 and 1983. By the end of 1987, health care spending was [approaching] half a trillion dollars [or] 11.4% of the GNP." *Id.* (footnotes omitted).

101. See *id.* at n.7 (citing Aaron & Schwartz, *Hospital Cost Control: A Bitter Pill to Swallow*, HARV. BUS. REV., Mar.-Apr. 1985, at 160-61 (1985)) ("[D]escribing development of health care 'payment system designed to shield patients and providers from the cost of hospital care'").

102. See WOOTEN, *supra* note 30, at 283 ("[B]ecause 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.").

103. See Glen P. Mays, Gary Claxton & Justin White, *Managed Care Rebound? Recent Changes in Health Plans' Cost Containment Strategies*, 23 HEALTH AFFS. W4-427, W4-427 (2004), <https://www.healthaffairs.org/doi/10.1377/hlthaff.W4.427> [<https://perma.cc/PS6F-V4UP>].

104. See *id.* at W4-427, n.4.

105. *Id.* at W4-429 ("Health plans in six of the twelve study communities reintroduced prior authorization requirements for selected services after having eliminated these requirements." (citation omitted)).

practor visits.¹⁰⁶ Other techniques included concurrent review, by which a person's hospital stay or other ongoing use is reviewed as it occurs.¹⁰⁷ While these techniques had previously been used in Health Maintenance Organizations (HMOs) rather than Preferred Provider Organizations (PPOs), in the early 2000s, PPOs also started to monitor care this way.¹⁰⁸ In addition, the early 2000s saw health plans increase their investments in information systems that would make retrospective review and application profiling more feasible.¹⁰⁹ Today, utilization review serves as a significant gatekeeper in accessing care.¹¹⁰

"Medical necessity" terms are a key part of cost containment; today, practically all health plans contain such a term. In principle, the idea of providing care based on medical necessity makes sense—care should not be given or covered under a health plan unless there is some reason for it.¹¹¹ But the use of this term has gone beyond the idea of having a physician's approval for a course of treatment. Instead, health plans are able to define this term and interpret it themselves in order to restrict care, often according to opaque standards and reasons.

The terms themselves contain multiple parts and are complex,¹¹²

106. *Id.* at W4-429–30.

107. *Id.* at W4-430.

108. *Id.*

109. *Id.* at W4-431.

110. See, e.g., Christopher Smith, *It's a Mistake: Insurer Cost Cutting, Insurer Liability, and the Lack of ERISA Preemption Within the Individual Exchanges*, 62 CLEV. ST. L. REV. 75, 98–99 (2014).

111. Janet L. Dolgin, *Unhealthy Determinations: Controlling "Medical Necessity"*, 22 VA. J. SOC. POL'Y & L. 435, 436 (2015).

112. As an example, here is the definition of "medically necessary" from a Blue Cross Blue Shield of Texas employer-sponsored plan in 2018:

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.

inviting non-objective considerations to play a role.¹¹³ Even clinically indicated care may be denied under a standard such as this.¹¹⁴ And, each individual plan (if governed by federal law) or each state (for plans governed by state law) can adopt its own definition of “medical necessity,” leading to even more confusion about what will and will not be covered.¹¹⁵ As a result, coverage determinations under this standard may turn as much on the decision-maker’s motives as on the reasons for the proposed care.¹¹⁶ Under the lenient arbitrary-and-capricious standard of review, denials based on interpretation of the medical necessity term tend to be affirmed.

All of these developments in claims processing occurred after the circuits adopted the five-factor fee test. Assessment of ERISA’s attorney’s fee factors should take into account the far different claims landscape that exists now as compared to the one that plaintiffs faced in the 1970s when the factors first arose.

B. *A Standard of Review that Favors Defendants*

Another significant change since the five factors’ development is that ERISA claims are now reviewed on a deferential arbitrary and capricious standard of review. In 1989, the Supreme Court held that ERISA claims should be decided on a de novo standard of review, to avoid giving ERISA

BLUECROSS BLUESHIELD OF TEX., YOUR HEALTH CARE BENEFITS PROGRAM 63–64 (2016), <https://www.bcbstx.com/static/tx/pdf/policy-forms/mmh3.pdf> [<https://perma.cc/43NP-8PAD>].

113. See Dolgin, *supra* note 111, at 443 (“[M]edical necessity determinations depend on the knowledge, politics, motives, and inclinations of those who render them far more than they depend on objective truths.”).

114. *Id.* at 438–39 (“[V]arious stakeholders assume different interpretations of the phrase . . . ‘To many health plans, [the term] means “not covered even though not expressly excluded from coverage,” which gives them a degree of comfort issuing denials based on established insurance practice even though such decisions outrage physicians.’”) (quoting William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 601 (2003)).

115. See United States Psychiatric Rehabilitation Association, Comment Letter to the Center for Medicare & Medicaid Services regarding the Mental Health Parity & Addiction Equality Act of 2008 (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/J97V-R8TJ>].

116. See Dolgin, *supra* note 111, at 443.

[A]t the level of medical necessity determination, whether coverage is extended or denied in particular cases continues to depend on a slew 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).

Id.; see also Sage, *supra* note 114, at 601 (“[D]ecisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust and, if disputes arise, relatively unprincipled, results-oriented judicial resolution.”).

claimants fewer rights than they had before ERISA was enacted.¹¹⁷ The Court noted that plans and participants were free to decide on a narrower standard—and administrators promptly inserted a discretion-granting clause into practically every ERISA plan.¹¹⁸ Discretionary clauses are banned as unfair to consumers in twenty-five states,¹¹⁹ yet they are permitted in ERISA plans. States that ban discretionary clauses are from across the political spectrum, including Texas,¹²⁰ Utah,¹²¹ and California.¹²²

Today, when an ERISA plan administrator's claim denial is challenged in federal court, the discretionary clause triggers the lenient "arbitrary or capricious" standard of review.¹²³ Under this standard, the plan administrator's decision is undisturbed if there is some evidence to support it. For healthcare consumers, this standard of review is difficult to overcome, as it is the "least demanding form of judicial review . . ."¹²⁴ The standard is so deferential that a decision is said to remain in place unless it was without basis or simply "whimsical."¹²⁵ One court stated that it would be an overstatement—but not much of one—to say that a decision stays in place under this standard unless one cannot state it "without a

117. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

118. *Id.*

119. 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 16, *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009) (No. 08-35246). Due to ERISA's preemption of state laws, these bans do not reach ERISA plans.

120. 28 TEX. ADMIN. CODE § 3.1203 (2010).

121. UTAH CODE ANN. § 31A-21-201(3) (West 2021).

122. CAL. INS. CODE §10110.6 (West 2012).

123. *See, e.g., Cory v. Liberty Life Assurance Co.*, 499 F.3d 389, 398 (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." (internal quotation marks omitted) (quoting *Vega v. Nat'l Life Ins. Serv., Inc.*, 188 F.3d 287, 297 (5th Cir. 1999))).

124. *Collins v. Unum Life Ins. Co. of America*, 682 F. App'x 381, 385 (6th Cir. 2017) (internal quotation marks omitted) (quoting *Schwalm v. Guardian Life Ins. Co. of America*, 626 F.3d 299, 308 (6th Cir. 2010)).

125. The Seventh Circuit Court of Appeals equated the arbitrary or capricious standard to "totally unreasonable" in *Allen v. United Mine Workers of America 1979 Benefit Plan & Trust*, 726 F.2d 352, 354 (7th Cir. 1984), and to "whimsical, random, or unreasoned" in *Teskey v. M.P. Metal Prods., Inc.*, 795 F.2d 30, 32 (7th Cir. 1986). *See also Graham v. L & B Realty Advisors, Inc.*, No. Civ. A. 3:02CV0293-N, 2003 WL 22388392, at *2 (N.D. Tex. Sept. 30, 2003) ("Although there is clear evidence to the contrary, the Court, with some reluctance, acknowledges some concrete evidence supporting Unum's decision.").

loud guffaw[.]”¹²⁶ This discretion thus amounts to free rein to assess claims and often to deny them.¹²⁷

Particularly in complex medical cases or claims for mental health treatment, the lenient arbitrary and capricious standard can be outcome-determinative in favor of the ERISA defendant. Under this standard, a plan administrator can take a complex factual record and tie something in the record to the decision, which is often all that is required to have the denial affirmed.¹²⁸

Thus, developments in the claims processing environment make denials easier to justify and mistakes less likely to be corrected. ERISA’s purpose remains, however, to protect plan participants’ right to benefits and to provide ready access to the federal courts. If ERISA is to accomplish its purpose, attorney’s fees must be available, as they are the only consequence for improper denials in an environment that increasingly disfavors individual claimants.

IV. RECALIBRATING TWO OF THE FIVE FACTORS

The Supreme Court made clear that the factors are not required and bear no obvious relation to ERISA;¹²⁹ other courts have long stated that the factors are just guidelines, and courts are not bound to use them.¹³⁰ Thus, a redesign and update of the factors is realistic and possible.

Two of the five attorney’s fee factors should be disregarded or applied differently in the healthcare claim context if the factors are to serve ERISA’s mission of helping claimants secure their benefits and access the

126. *Pokratz v. Jones Dairy Farm*, 771 F.2d 206, 209 (7th Cir. 1985) (“Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review . . .”).

127. *See, e.g., Johnson v. Allsteel, Inc.*, 259 F.3d 885, 890 (7th Cir. 2001) (“[A]dministrators empowered . . . with discretionary authority to construe the plan enjoy ‘a broad, unchanneled discretion to deny claims.’” (quoting *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 333 (7th Cir. 2000)); *see also Foster McGaw Hosp. of Loyola Univ. v. Bldg. Material Chauffeurs, Teamsters & Helpers Welfare Fund, Local 786*, 925 F.2d 1023, 1026 (7th Cir.1991) (“[W]ith the [administrator’s] decision entitled to deference, the outcome is foredoomed.”).

128. *Foster v. Principal Life Ins. Co.*, 920 F.2d 298, 304 (5th Cir. 2019) (describing an arbitrary decision as one that is “made without a rational connection between the known facts and the decision or between the found facts and the evidence.”); *Holland v. Int’l Paper Co. Ret. Plan*, 576 F.3d 240, 246 (5th Cir. 2009) (noting that a plan’s decision is an abuse of discretion if it is not based on some evidence, even if disputed, that supports the denial).

129. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010).

130. *See, e.g., Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1266 (5th Cir. 1980) (setting out the five factors and noting that “some [factors] may not be apropos in a given case”); *Williams v. Metro. Life Ins. Co.*, 609 F.3d 622, 635 (4th Cir. 2010) (describing the factors as “general guidelines” to be applied).

federal courts.¹³¹ Individual healthcare claimants can rarely satisfy these two factors, namely the bad faith or culpability factor and the intended or actual common benefit factor. As explained below, including these factors as part of the test for individual healthcare claimants undercuts ERISA's goals. Moreover, the healthcare claims climate today features challenges that did not exist when the five factors arose more than forty years ago; the factors should change accordingly.

A. *The Bad Faith or Culpability Factor*

The bad faith or culpability factor is often understood as requiring proof of a dishonest mental state. With limited discovery, individual healthcare plaintiffs can rarely establish a dishonest mental state, especially when payors simply deny claims without a valid reason. The factor is applied inconsistently, with some courts reciting the factor as “bad faith or culpability” and then focusing exclusively on the “bad faith” prong of this disjunctive test.¹³² “Bad faith” in this context tends to be interpreted as “dishonesty of belief or purpose.”¹³³ Some require evidence of the defendant's ill intent, such as a defendant being “simply out to harass” the plaintiff.¹³⁴ Courts tend not to find bad faith for an unjustified claim denial, even when the denial is arbitrary and capricious, meaning the denial has little or no foundation in the factual record.¹³⁵ While this factor often seems to take on an outsized importance in the five-factor test, denial of

131. “It is well established that ‘Congress intended the fee provisions of ERISA to encourage beneficiaries to enforce their statutory rights.’” *Donachie v. Liberty Life Assurance Co.*, 745 F.3d 41, 46 (2d Cir. 2014) (quoting *Slupinski v. First Unum Life Ins. Co.*, 554 F.3d 38, 47 (2d Cir. 2009)); see *Locher v. Unum Life Ins. Co. of Am.*, 389 F.3d 288, 298 (2d Cir. 2004) (“ERISA’s attorney’s fee provisions must be liberally construed to protect the statutory purpose of vindicating retirement rights” (quoting *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 872 (2d Cir. 1987))).

132. See, e.g., *Lampert v. Metro. Life Ins. Co.*, No. 03 Civ. 5655 (GEL), 2004 WL 1395040, at *1–*2 (S.D.N.Y. June 21, 2004) (listing the factor as “culpability or bad faith” but then referring to the factor as “bad faith” in the analysis).

133. *Denver Health & Hosp. Auth. v. Beverage Distribs. Co.*, No. 11-cv-01407-LTB-KLM, 2012 WL 5354700, at *4 (D. Colo. Oct. 30, 2012) (quoting *United States v. Lain*, 640 F.3d 1134, 1137 (10th Cir. 2011)).

134. *Pactiv Corp. v. Sanchez*, No. 13-cv-8182, 2015 WL 4508667, at *8 (N.D. Ill. July 23, 2015) (holding that the bad faith or culpability factor was not satisfied where “there [was] no indication that [the defendant] took the position that it did in this litigation in bad faith or to harass [the plaintiff]”); *Saint Joseph’s Hosp. v. Carl Klemm, Inc.*, 459 F. Supp. 2d 824, 834 (W.D. Wis. 2006) (denying motion for attorney’s fees because the defendant was not “simply out to harass” plan participant).

135. See, e.g., *Voltz v. Chrysler Group LLC—UAW Pension Plan*, 63 F. Supp. 3d 770, 785 (N.D. Ohio 2014) (noting that an arbitrary or capricious denial does not necessarily indicate bad faith).

attorney's fee based on the absence of bad faith alone may be considered error.¹³⁶

Other courts, however, find the factor satisfied with less, often by focusing on the factor's culpability prong. Courts have found this factor satisfied where a defendant took an unjustified position and then persisted in that position until litigation¹³⁷ or where the defendant violated the plain meaning of a plan.¹³⁸ Others find culpability based on the summary rejection of medical evaluations that supported the opposing view.¹³⁹ Courts differ on whether this factor is satisfied when a defendant acts arbitrarily and capriciously.¹⁴⁰

This factor would be better tailored to individual healthcare claims if courts would take to heart its disjunctive nature—bad faith *or* culpability—and consider it satisfied when defendants act culpably by failing to follow claims regulations, ignoring evidence that supports the plaintiff's claim, or otherwise breaching their fiduciary duties to plan participants. This is because, as explained more fully below: (1) ERISA plaintiffs generally cannot pursue discovery to root out bad faith, which may occur at higher corporate levels than the claims level, (2) the test is disjunctive, such that culpability equally satisfies the factor, and (3) non-payment, not motivation, is the point of individual healthcare claims. In individual healthcare claims, then, this factor should be disregarded or should be satisfied when a defendant acts culpably by denying a valid claim or ignoring evidence that supports paying the claim.

1. *No Discovery into the Administrator's Motivations*

Plaintiffs in ERISA cases are usually denied discovery into the defendant's motivations and mental processes—the very evidence needed to satisfy this factor—unless they can make a prima facie showing of misconduct

136. See, e.g., *Donachie*, 745 F.3d at 47 (reversing denial of attorney's fees that was based on the absence of bad faith and noting that “a party need not prove that the offending party acted in bad faith” in order to receive a fee award).

137. See, e.g., *Lampert*, 2004 WL 1395040, at *2 (finding this factor satisfied where defendant took an unjustified position, was unresponsive to pre-litigation settlement, but then “capitulated immediately” upon initiation of litigation).

138. See *Priority Sols., Inc. v. Cigna & Price Waterhouse Health Plan*, No. 98 CIV. 4336 MBM, 1999 WL 1057202, at *4 (S.D.N.Y. Dec. 20, 1999) (holding that the factor was satisfied when CIGNA violated the plain meaning of a plan's terms).

139. See, e.g., *Slupinski v. First Unum Life Ins. Co.*, 554 F.3d 38, 53 (2d Cir. 2009); *Voltz*, 63 F. Supp. 2d at 785 (finding culpability but not bad faith where a plan administrator ignored a company doctor's claim that a person had a mental health condition).

140. Compare *Heffernan v. UNUM Life Ins. Co. of Am.*, 101 F. App'x 99, 109 (6th Cir. 2004) (“An arbitrary and capricious denial of benefits does not necessarily indicate culpability or bad faith.”), with *Moon v. Unum Provident Corp.*, 461 F.3d 639, 644 (6th Cir. 2006) (holding that defendant's arbitrary and capricious actions satisfied the bad faith or culpability factor).

or bias.¹⁴¹ Plaintiffs can seek some limited information as to whether the defendant complied with ERISA's procedural requirements and whether the defendant has provided coverage in similar situations.¹⁴² The plaintiff generally cannot, however, pursue discovery much beyond the plaintiff's own file.¹⁴³ This limited review of benefit decisions is due to concerns of cost and expediency, as well as the broad discretion granted to administrators.¹⁴⁴ In some instances, plaintiffs are granted discovery on issues going beyond the claims decision.¹⁴⁵ These may include the completeness of the administrative record, whether the plan administrator has a conflict of interest and the extent of any such conflict, which arises from the administrator's dual role of simultaneously making benefits determinations and funding the plan.¹⁴⁶

Bad faith may be difficult to root out when it occurs at higher corporate levels than would be found in the claims file, as the recent class action case *Wit v. United Behavioral Health*¹⁴⁷ shows. In that case, United Behavioral Health used its own, stricter internal guidelines to decide claims rather than the standards advertised in the plans and even those required by law.¹⁴⁸ Through extensive discovery, the court found that the administrators put profits ahead of their fiduciary duties, "prioritizing cost savings

141. See, e.g., *Crosby v. La. Health Serv. & Indem. Co.*, 647 F.3d 258, 262 (5th Cir. 2011). Where the claim is one for benefits, evidence is not generally admissible unless it: (1) is in the administrative record, (2) is connected to the administrator's past interpretations of the plan, or (3) would help the court understand medical terms and procedures. *Id.*; see also *Semien v. Life Ins. Co. of North Am.*, 436 F.3d 805, 814–15 (7th Cir. 2006) (denying discovery because "the plan administrator's motivations should not be questioned absent a prima facie showing of some misconduct or conflict of interest" and referring to instances in which additional discovery is allowed as "exceptional cases").

142. See *Crosby*, 647 F.3d at 263–64.

143. Under ERISA, claims for plan benefits under section 1132(a)(1)(B) are often limited to the review of the administrative record; courts are concerned that additional discovery "would frustrate 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. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005)).

144. See *Mulligan v. Provident Life & Accident Ins. Co.*, 271 F.R.D. 584, 587 (E.D. Tenn. 2011) ("This general prohibition [on discovery] is founded on two separate principles: First, the reviewing court's role, ordinarily, is . . . merely to determine whether the administrator's decision was defensible . . . [and to] effectuate[] ERISA's 'primary' goal—the 'inexpensive[] and expeditious[]' resolution of disputes." (quoting *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990))); *Semien*, 436 F.3d at 814.

145. *Crosby*, 647 F.3d at 263.

146. *Id.*

147. No. 14-cv-02346-JCS, 2020 WL 6479273, at *1 (N.D. Cal. Nov. 3, 2020), *rev'd*, No. 20-17363, 2022 WL 850647 (9th Cir. Mar. 22, 2022).

148. The *Wit* case included claims based on multiple plans against an administrator of those plans; some of the plans were fully insured, and others were funded by employers. *Wit*, No. 14-cv-02346-JCS, 2019 WL 1033730, at *14.

over members' [recovery of benefits]."¹⁴⁹ Even when state standards required the use of particular definitions of medical necessity, the claims administrator ignored that definition and substituted its own more restrictive definition.¹⁵⁰ In this way, the claims administrator violated the laws of Illinois, Connecticut, Rhode Island, and Texas.¹⁵¹ Even beyond its claims practices, United Behavioral Health then lied to regulators and tried to mislead the court at trial.¹⁵² These actions would probably not be found in individual claim files—usually ERISA plaintiffs' only source of evidence—as the decisions to create stringent internal standards were made at much higher corporate levels. To expect individual plaintiffs to demonstrate this sort of bad faith without access to discovery is to set plaintiffs up for failure on this factor.

2. *Culpability Should Satisfy This Disjunctive Test*

For individual healthcare claims, courts should focus on the second part of this disjunctive fee factor—the “culpability” part. “Culpable” conduct is generally less blameworthy than bad faith and does not include malice, implying rather that the “act or conduct spoken of is reprehensible or wrong, but not that it involves malice or a guilty purpose.”¹⁵³ If conduct breaches a legal duty or commits a fault, it is culpable conduct.¹⁵⁴

Application of this concept of “culpability” to ERISA defendants should take into account that ERISA defendants are held to a high standard of behavior because any ERISA decision-maker is a fiduciary.¹⁵⁵ The fiduciary duty includes a duty of care and a duty of loyalty.¹⁵⁶ Indeed, ERISA's duty of loyalty “‘is the highest known to the law.’ ERISA fiduciaries must ‘discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries.’”¹⁵⁷ ERISA decision-makers are

149. *Id.* at *5.

150. *Id.* at *42–45.

151. *Id.* at *42.

152. *Supra* note 148.

153. *McPherson v. Emps.' Pension Plan of Am. Re-Insurance Co.*, 33 F.3d 253, 256–57 (3d Cir. 1994) (quoting BLACK'S LAW DICTIONARY (6th ed. 1990)).

154. *See id.*

155. 29 U.S.C. § 1002(21)(A) (2022) (defining a fiduciary as one who exercises discretionary authority or control over the plan and its management, administration, or disposition of assets).

156. ERISA charges fiduciaries with: (1) a duty of care to discharge duties prudently and in accordance with the Plan, and (2) a duty of loyalty to act “solely in the interest of the” beneficiaries. *See* 29 U.S.C. § 1104(a)(1). The duty of care requires fiduciaries to act “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.” *Id.* § 1104(a)(1)(B). The duty of loyalty requires a fiduciary to discharge its duties “for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan.” *Id.* § 1104(a)(1)(A).

157. *Singh v. RadioShack Corp.*, 882 F.3d 137, 149 (5th Cir. 2018). These duties help ensure that consumers receive their benefits. *See Brundle v. Wilming-*

under a fiduciary duty to provide benefits to those who are entitled to them.¹⁵⁸

Because ERISA decision-makers are subject to these duties, the “culpability” factor should be considered satisfied whenever a defendant breaches its standard of care (imposed by ERISA’s fiduciary duties) by ignoring evidence supporting a claim, by failing to follow claims regulations, or by improperly delaying payment.¹⁵⁹ Some courts do exactly this.¹⁶⁰ For these courts, culpability is established when a defendant makes a benefit determination “unsupported by competent medical evidence.”¹⁶¹ This factor may also be met when a denial is arbitrary and capricious.¹⁶²

Furthermore, to require actual dishonesty for this factor is to hold ERISA fiduciaries to a less stringent standard of behavior than the standard for commercial insurers who are under no fiduciary duty. That is,

ton Tr., N.A., 919 F.3d 763, 770 (4th Cir. 2019) (“These duties ‘ensure that employees will not be left empty-handed once employers have guaranteed them certain benefits.’” (quoting *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996))).

158. 29 U.S.C. § 1104(a). “ERISA imposes higher-than-marketplace quality standards” on plan administrators, requiring them to “‘discharge [their] duties . . . solely in the interests of the participants and beneficiaries’ of the plan.” *Metro. Life Ins. Co. v. Glen*, 554 U.S.105, 115 (2008) (citing 29 U.S.C. § 1104(a)(1)). A fiduciary “must consider the interests of deserving beneficiaries as it would its own.” *Joseph F. v. Sinclair Servs. Co.*, 158 F. Supp. 3d 1239, 1253 (D. Utah 2016) (quoting *Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807–08 (10th Cir. 2004)).

159. *See, e.g., Donachie v. Liberty Life Assurance Co.*, 745 F.3d 41, 47 (2d Cir. 2014) (noting that the “concepts of ‘bad faith’ and ‘culpability’ are distinct, and either one may satisfy the first [] factor”). The *Donachie* court noted that the defendant had acted culpably by ignoring evidence that favored the claimant. *Id.*

160. *See Moon v. Unum Provident Corp.*, 461 F.3d 639, 643–44 (6th Cir. 2006) (per curiam) (finding the bad faith or culpability factor met when defendant repeatedly ignored substantial evidence supporting the plaintiff’s claim); *Hoover v. Provident Life & Accident Ins. Co.*, 290 F.3d 801, 809–10 (6th Cir. 2002) (finding culpability where defendant relied only on a physician it employed and disregarded evidence supporting the plaintiff’s claim); *Tedesco v. I.B.E.W. Local 1249 Ins. Fund*, 729 F. App’x 136, 139 (2d Cir. 2018) (holding that a defendant’s reliance on two psychiatrists who did not consult with the treating psychiatrist could satisfy the culpability factor); *Perrin v. Hartford Life Ins. Co.*, No. 06-182-JBC, 2008 WL 2705451, *3 (E.D. Ky. July 7, 2008) (“Based on the defendant’s disregard for objective medical evidence, the court finds that the defendant was highly culpable, and thus, this factor weighs in favor of an award of attorney’s fees.”); *Brooking v. Hartford Life & Accident Ins. Co.*, No. 04-95KSF, 2007 WL 781333, *7 (E.D. Ky. Mar. 12, 2007) (noting that a defendant ignoring substantial evidence in the record should be found culpable); *Plummer v. Hartford Life Ins. Co.*, No. C-3-06-094, 2007 WL 838926, *2 (S.D. Ohio Mar. 15, 2007) (finding defendant highly culpable, in part because the defendant terminated benefits based on flawed medical opinions).

161. *See, e.g., Gaeth v. Hartford Life Ins. Co.*, 538 F.3d 524, 530–531 (6th Cir. 2008) (finding the bad faith or culpability factor satisfied where the defendant acts culpably by denying a claim without competent medical evidence to support the denial).

162. *See Priority Sols., Inc. v. Cigna & Price Waterhouse Health Plan*, No. 98 CIV. 4336 MBM, 1999 WL 1057202, at *4 (S.D.N.Y. Dec. 20, 1999) (holding that a party who is arbitrary and capricious is culpable for purposes of this factor).

commercial non-ERISA insurers have long been held to act in bad faith or otherwise subject to penalties when they denied claims without investigation,¹⁶³ when they delayed or denied payment after receiving sufficient proof of loss,¹⁶⁴ or when they refused to pay an insured's covered claim without "proper cause."¹⁶⁵ Thus, to search in every ERISA case for a defendant who is "out to get" or to "harass" a plaintiff is to set individual ERISA plaintiffs up to fail on this factor.

3. *To Require Bad Faith Is to Miss the Claim's Point*

When an administrator does not pay a covered claim, the consumer suffers from a lack of healthcare or from financial harm due to paying for care that should have been covered. The issue here is one of the payor retaining money that should go to the consumer, not financial malfeasance per se, as was the case with the early attorney's fee cases in which this factor originated.¹⁶⁶ ERISA's goal is to protect consumers' right to benefits, and its attorney's fee provision should be interpreted the same way—to require bad faith before the attorney's fee provision can function is to burden the provision with concerns not expressed in ERISA.

If courts ignore the culpability prong of this factor and look for bad faith alone, as bad faith is traditionally understood, then individual plaintiffs with denied claims are unlikely to satisfy this factor.¹⁶⁷ For the most part, these are sophisticated corporate defendants who are unlikely to memorialize a desire to "harass" a healthcare claimant, as some courts have required.¹⁶⁸

Thus, due to lack of discovery, the operation of bad faith at higher levels, and questionable relevance of bad faith to this kind of claim, to require bad faith to satisfy this factor is to set the bar unreasonably high for individual plaintiffs to meet in an ordinary ERISA health claims case. A focus on culpable conduct instead—taking into account the high stan-

163. See, e.g., *Kilmer v. Conn. Indem. Co.*, 189 F. Supp. 2d 237, 248–49 (M.D. Pa. 2002) (holding that a jury could find the defendant acted in bad faith where it delayed a claim and investigated in an unreasonable manner).

164. See, e.g., *State Farm Mut. Auto. Ins. Co. v. Brown*, 892 S.W.2d 519, 523 (Ark. Ct. App. 1995).

165. *Pemberton v. Farmers Ins. Exch.*, 858 P.2d 380, 382 (Nev. 1993) (noting that an insurance company acts in bad faith when it fails to pay an insured's covered claim and that this is a breach of the covenant of good faith and fair dealing).

166. See, e.g., *supra* note 71.

167. See, e.g., *Eddy v. Colonial Life Ins. Co. of Am.*, 59 F.3d 201, 210 (D.C. Cir. 1995) (analyzing the first factor as "bad faith" only and finding that a court could reasonably conclude that even a defendant's "inexplicable omission" was not evidence of bad faith); *Clark v. Feder, Semo & Bard, P.C.*, 59 F. Supp. 3d 114, 118 (D.D.C. 2014) (citing the "bad faith or culpability" factor but then focusing exclusively on bad faith).

168. See, e.g., *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 478 (7th Cir. 1998) (stating that the question is whether the administrator's decision is justified and taken in good faith or whether the administrator was out to "harass" the claimant).

dards that ERISA imposes on decision-makers' behavior—is more appropriate for this factor.

B. *The Common Benefit Factor*

Courts have taken different approaches to analyzing the common benefit factor—some have considered how it originated,¹⁶⁹ and others have recited it and then ignored it.¹⁷⁰ This reaction is understandable, as the factor is a poor fit for individual benefit claims: (1) this factor has no basis in ERISA itself or in attorney's fee principles, so it creates a burden on plaintiffs' access to federal courts that conflicts with ERISA, (2) the equitable concerns in common fund cases are absent here, (3) application of this factor encourages plaintiffs to pursue broader and more complex claims than they otherwise would, which is antithetical to ERISA's goal of prompt claims resolution.

1. *No Basis in ERISA*

This fee factor implies that in seeking their own benefits due, ERISA plaintiffs should also litigate on behalf of other plan participants; but ERISA does not impose or even mention such a duty. And, this factor originated in equitable concerns surrounding common fund cases, where fees were paid from a pool of money obtained in the lawsuit, concerns absent from individual healthcare claims. Because this factor unfairly burdens plaintiffs' claims for benefits, it should be recalibrated as described further below.

ERISA protects individuals' right to benefits—it does not impose a duty toward other plan participants. ERISA aims to secure benefits, to provide ready access to the federal courts, and to provide a uniform set of laws and regulations for the administration of employee benefits.¹⁷¹ To accomplish this, ERISA provides for “appropriate remedies, sanctions, and ready access to the Federal courts.”¹⁷²

ERISA imposes strict fiduciary duties on plan administrators and other decision-makers, not on beneficiaries.¹⁷³ ERISA fiduciaries are

169. See, e.g., *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1304 (6th Cir. 1991) (“This appears to be a codification of the common fund doctrine of the common law . . . we might give the fourth *King-Eaves* factor a broader meaning.”).

170. See, e.g., *Raymond M. v. Beacon Health Options, Inc.*, 463 F. Supp. 3d 1250, 1287 (D. Utah 2020) (setting out all five factors but analyzing only four, leaving out the common benefit factor).

171. Congress meant to “protect . . . the interests of participants in employee benefit plans and their beneficiaries . . .” 29 U.S.C. § 1001(b) (2022). The congressional findings and declaration of policy explain the importance of ensuring that pensions are sufficiently funded and that “disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans . . .” *Id.* § 1001(a).

172. *Id.* § 1001(b).

173. ERISA imposes a fiduciary duty on anyone who “exercises any discretionary authority or discretionary control respecting management of [the] plan or dis-

under a duty of loyalty, which requires that the fiduciary “shall discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries”¹⁷⁴ Nowhere in ERISA does the law impose a duty by a plan participant or claim plaintiff toward other plan participants. ERISA fiduciaries are prohibited from acting in a self-serving manner, while ERISA’s provisions protect participants’ rights and create a path to federal court for the participants to secure their own benefits. Why, then, should a duty from one beneficiary to the others appear nowhere else, but as a factor in an attorney’s fee award? The answer may lie in the kind of case in which this factor first appeared, discussed below.¹⁷⁵

2. *No Basis in Fee-Shifting Principles*

This factor originated in common fund cases, where equitable concerns prompted courts to spread the attorney’s fee burden across the group of people who benefitted from the case; that concern is absent from individual healthcare claims. The factor first appeared as part of the ERISA fees test in *Eaves v. Penn.*,¹⁷⁶ an early ERISA case involving a pension fund, a breach of fiduciary duties resulting in personal enrichment, and the subsequent return of money to the fund.¹⁷⁷ The judgment in that case resulted in a fund that benefitted all plan participants, and the lower court used the common fund approach instead of an ERISA-specific approach to award fees from the fund.¹⁷⁸ The court of appeals questioned whether the common fund approach was correct and announced instead the factors the lower court should have considered in applying ERISA’s attorney’s fee provision—those were the same factors applied today.¹⁷⁹ The court of appeals held that the ERISA attorney’s fee provision is not simply a codification of the common fund principle, but is a new doctrine permitting a fee award from the defendant personally.¹⁸⁰ The court reaffirmed that any award of fees should come from the wrongdoer, rather

cretionary control respecting management of [the] plan or exercises any authority or control respecting management or disposition of its assets.” 29 U.S.C. §§ 1002(21)(A)(i), (iii).

174. 29 U.S.C. § 1104(a)(1)(A).

175. See, e.g., Jessica Michelle Westbrook, *Resolving the Dispute Over When Attorney’s Fees Should Be Awarded Under ERISA in Two Words: Plaintiff Prevails*, 53 ALA. L. REV. 1311, 1318 (2002) (noting that this factor resembles the common fund principle by which courts can award fees from a common fund that benefits non-litigating parties).

176. 587 F.2d 453 (10th Cir. 1978).

177. *Id.* at 464–65.

178. See *id.* at 464 (noting that the plaintiffs recovered assets on behalf of the Plan and analyzing whether attorney’s fees in that case should be paid by the common fund or from the defendants personally).

179. *Id.* at 465.

180. See *id.* at 464–65 (“[Section 1132(g) is] a specific statutory authorization of attorney’s fees [that] will, in most cases, eliminate the necessity which gave rise to the common fund exception to the American rule.”).

than from non-party, non-culpable plan participants.¹⁸¹ Other appellate courts followed suit in cases addressing similar financial issues that set out to benefit all plan members.¹⁸²

In those early common fund and pension benefit ERISA cases, equitable principles militated in favor of fees being paid from the common fund award—otherwise, plan participants who had not litigated yet who benefited from the litigation's result would be unjustly enriched if they did not also share in its cost.¹⁸³ A fee award from the recovery avoided a windfall to those who had risked nothing in the litigation.¹⁸⁴ Thus, courts shifted a share of the fees onto the non-litigating beneficiaries' recovery.¹⁸⁵ The doctrine of common fund fee recovery is different from that of fee-shifting statutes such as ERISA's; under common fund fee recovery, the beneficiaries of the litigation pay the fees.¹⁸⁶ A fee-shifting statute, on the other hand, has the losing party pay the prevailing party's fees.¹⁸⁷ This is true of ERISA's fee-shifting provision too.¹⁸⁸ If the fees are to be paid by the plan and the plan would not be able to pay other claims, then that concern would be addressed in another attorney's fee factor—the second factor

181. See *id.* at 464 (“Congress intended that the offending party bear the costs of the award, rather than non-culpable, non-party plan participants.”).

182. Without analysis, the Ninth Circuit adopted the five factors in a case involving a forfeiture clause in a profit-sharing plan. *Hummel v. S.E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980). The same happened in the Second Circuit, when the court decided a pension case in which a plaintiff sued for the removal of a plan amendment that disfavored the workers and was held to violate ERISA. *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 870–71, 873 (2d Cir. 1987).

183. See, e.g., Tiana S. Mykkeltvedt, *Common Benefit & Class Actions: Eliminating Artificial Barriers to Attorney Fee Awards*, 36 GA. L. REV. 1149, 1150–51 (2002) (noting that attorney's fee awards in common fund cases were meant to spread the cost of litigation across the benefitting group).

184. “[P]ersons who obtain the benefit of a lawsuit without contributing to its cost are unjustly enriched at the successful litigants' expense.” *Boeing Co. v. Van Gemert*, 444 U.S. 472, 472, 478 (1980); see *Gay v. Davis*, 12 S.E. 194, 194–95 (N.C. 1890) (“In the absence of statutory provision, the courts, in the exercise of chancery powers, [can] make allowances [of] . . . reasonable compensation to counsel . . .”).

185. See, e.g., *Brundle v. Wilmington Tr.*, 919 F.3d 763, 785 (4th Cir. 2019).

186. See *id.*

187. See *id.* at 786 (citing *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, 421 U.S. 240, 247 (1975); *James C. v. Aetna Health & Life Ins. Co.*, 499 F. Supp. 3d 1105, 1124–25 (D. Utah 2020) (noting that any attorney's fee award would be paid by defendant Aetna, whose ability to pay “is not seriously in question”); *James F. ex rel. C.F. v. Cigna Behav. Health Inc.*, No. 1:09CV70DAK, 2011 WL 2441900, at *2 (D. Utah June 15, 2011) (noting that fees would be paid by Cigna, who is “certainly in a position to pay any award of attorney fees”).

188. While the provision's text permits recovery to either party, case law requires that to recover attorney's fees, an ERISA litigant must achieve “some degree of success on the merits.” *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010) (quoting *Ruckelshaus v. Sierra Club*, 463 U.S. 680, 694 (1983)).

explicitly addresses the “offending party’s ability to satisfy personally an award of attorney’s fees.”¹⁸⁹

The equitable principle of unjust enrichment underlying the common fund fee analysis is absent from the ERISA individual health claim context. ERISA plaintiffs already receive bare-bones recoveries, if any, as consequential and punitive damages are unavailable.¹⁹⁰ As the Eighth Circuit Court of Appeals pointed out, the concerns are different when the plaintiff does not receive a “pool of money” from which fees can be paid.¹⁹¹ Furthermore, ERISA is meant to provide ready access to the federal courts—nowhere is that aim tempered by a requirement that ERISA claimants also seek to benefit all other plan members.

Moreover, unlike the common fund and pension cases that gave rise to this factor, in an ERISA healthcare claim, the lawsuit’s express goal is simply to obtain the benefit for the plaintiff. This factor penalizes plaintiffs for bringing claims expressly provided in ERISA and would reduce the plaintiff’s recovery (by forcing plaintiffs to pay their own attorney’s fees) for arbitrary circumstances generally beyond plaintiffs’ control. That is, to the extent the factor asks whether the case resolves a particularly important or complex legal issue, that is not generally the plaintiffs’ focus in trying to obtain their rightful benefits, nor does the ERISA statute condition a plaintiff’s right to benefits on the difficulty of the legal issues. And, if there are insufficient plan participants situated similarly to the plaintiff who would also benefit from the litigation, it would be wrong to penalize the plaintiff just because the defendant has not harmed enough other people for the litigation to be of broader benefit.¹⁹²

As most courts interpret this factor, an individual healthcare claimant could almost *never* satisfy it. That is, when a factor requires that a plaintiff “[sought] to obtain a common benefit for all of the participants in [the] plan and . . . that other participants in the plan were similarly situated[.]”¹⁹³ individual plaintiffs will not succeed. An individual healthcare claimant seeking that a benefit be properly paid cannot satisfy this factor because that is not what the claim entails, and even if an individual wanted to seek out similarly situated plan members, ERISA’s limits on discovery¹⁹⁴ generally will not permit individual plaintiffs to find them.

189. *Davidson v. Canteen Corp.*, 957 F.2d 1404, 1409 (7th Cir. 1992).

190. *See infra* Part II.

191. *Martin v. Ark. Blue Cross Blue Shield*, 299 F.3d 966, 972 (8th Cir. 2002).

192. *Lampert v. Metro. Life Ins. Co.*, No. 03-Civ. 5655, 2004 WL 1395040, at *3 (S.D.N.Y. June 21, 2004) (“[A]s plaintiff correctly points out, he should not be penalized simply because the defendant’s actions did not harm enough individuals for the suit to benefit anyone but himself.”).

193. *Bustetter v. CEVA Logistics U.S., Inc.*, No. 18-58-DLB-EBA, 2019 WL 6719485, at *7 (E.D. Ky. Dec. 10, 2019) (first alteration in original).

194. *See supra* Section III.A.1.

3. *Rewarding a Multiplicity of Claims and Theories*

In individual claims cases, this factor undercuts the expediency goals of ERISA because it rewards plaintiffs who expand their claims and theories.¹⁹⁵ That is, some courts analyzing this factor look for indications that the plaintiff sought to include other plan participants in the litigation or to resolve unsettled legal issues. A factor that incentivizes the expansion of claims litigation is a poor fit for individual ERISA claim litigation and should not be used in individual claims cases.

Courts are of course free to recite the common benefit factor and discount or ignore it in their discretion, and some have done just that.¹⁹⁶ An alternative approach is to find this factor satisfied when the plaintiff brings suit, thereby holding the defendant accountable for following plan terms and proper procedures. As explained above,¹⁹⁷ plan administrators for the most part act without consequence.¹⁹⁸ By navigating through the complex appeal process and suing in federal court, individual plaintiffs hold ERISA administrators accountable in a manner that rarely happens and that occurs only with great personal effort.¹⁹⁹ Courts subscribing to this point of view note that the fee factors used in health benefit cases originated in pension cases, where a prevailing party's fees "may be awarded at the direct expense of other plan beneficiaries."²⁰⁰ In health claim cases, on the other hand, there is a benefit to other plan members in simply bringing suit and ensuring the administrators answer for their actions, particularly given that the plaintiff's remedies are so limited.

V. ATTORNEY'S FEES MUST BE AVAILABLE FOR ERISA TO FUNCTION AS INTENDED

The attorney's fee provision is part of a carefully designed set of ERISA duties and incentives that function together to protect benefits and

195. See *Sec'y of Dep't of Labor v. King*, 775 F.2d 666, 669 (6th Cir. 1985) (stating that the resolution of a significant legal issue under ERISA would satisfy this factor).

196. See, e.g., *Raymond M. v. Beacon Health Options, Inc.*, 463 F. Supp. 3d 1250, 1287 (D. Utah 2020) (setting out the traditional five factors but not explicitly analyzing the common benefit factor in granting plaintiff's fee request).

197. See *supra* Part I.

198. See, e.g., *Schoedinger v. United Healthcare of the Midwest, Inc.*, No. 4:04-cv-664 SNL, 2006 WL 3803935, at *8 (E.D. Mo. Nov. 6, 2006) ("United continuously processed claims improperly, long after it was made aware of its mistakes. Despite countless requests by Plaintiffs, Defendant refused to remedy its errors, at times owing up to \$600,000 in past due fees.").

199. Plaintiffs must navigate the two levels of appeal without any chance of recovering attorney's fees for that phase of the litigation.

200. *Pitcher v. Principal Mut. Life Ins. Co.*, 870 F. Supp. 2d 903, 916 (S.D. Ind. 1994). The *Pitcher* court noted that the factor analyzing the benefit to other plan participants is "focused on pension plans" and found it satisfied when the plaintiff brought suit to enforce the plan. *Id.* at 917 ("While her suit could conceivably result in higher premiums in the long run (or perhaps in a modification of the policy), adherence to the policy should benefit other insureds.").

provide ready access to the federal courts.²⁰¹ The factors are not required, and courts should take a more flexible approach to the factors so the provision can accomplish its goal.

A. *The Five Factors Tamper with the Attorney's Fee Provision*

By imposing a burden on individual health claimants that they can rarely meet, the five factors alter ERISA's fee provision by making fees unavailable to many individual plaintiffs. ERISA's enforcement scheme was drafted carefully, and courts are discouraged from adding to or subtracting from it.²⁰² The Supreme Court has expressed reluctance to tamper with ERISA's provisions—declining, for example, to find remedies where they are not included in the text.²⁰³ As currently applied, however, the five attorney's fee factors similarly meddle with ERISA's provisions by burdening the protective attorney's fee provision with considerations that are nowhere in ERISA's text and that ill suit individual claims. Because individual ERISA plaintiffs can rarely access the federal courts without money to pay an attorney, ERISA's fee-shifting provision must be functional if the statute is to be effective.

The absence of other remedies makes the fee provision the only disincentive (other than reputational concerns) for defendants to deny claims without basis, so that provision is particularly crucial.²⁰⁴ The current system of cost-free do-overs for non-compliance and deferential review gives little incentive for administrators to comply with the claims regulations.²⁰⁵

201. *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (noting that “ERISA is a ‘comprehensive and reticulated statute,’ the product of a decade of congressional study of the Nation’s private employee benefit system.” (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993))).

202. *See, e.g., Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (stating that ERISA’s “carefully crafted and detailed enforcement scheme provides ‘strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly’” (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146–47 (1985))).

203. *Id.*

204. *Schoedinger v. United Healthcare*, No. 4:04-cv-664 SNL, 2006 WL 3803935, at *8 (E.D. Mo. Nov. 6, 2006) (awarding attorney’s fees). The *Schoedinger* court noted:

[W]hether it be purposeful or negligent, insurance companies regularly reduce and deny claims without cause, thereby increasing the cost of healthcare to providers and patients alike. If it became cost prohibitive for insurance companies to engage in this behavior, it would incentivize more accurate claims administration and processing in the future.

Id.

205. *See, e.g., Gatlin v. Nat’l Healthcare Corp.*, 16 F. App’x 283, 290 (6th Cir. 2001) (“[A] stiffer penalty encourages plan administrators to alter their behavior with respect to employee appeals”); *Perrin v. Hartford Life Ins. Co.*, No. 06-182-JBC, 2008 WL 2705451, at *4 (E.D. Ky. July 7, 2008) (“[T]he defendant will take a closer look at the administrative record and its denial decisions if it is faced with more than the prospect of merely reinstating benefits.”); *Elliott v. Metro. Life Ins. Co.*, No. 04-174-DLB, 2007 WL 1558519, at *3 (E.D. Ky. May 29, 2007) (“Companies would likely take a much closer look at denial decisions, and the presenta-

ERISA aims to provide “ready access” to the federal courts.²⁰⁶ Without some chance of recovering attorney’s fees, however, individual plaintiffs are unlikely to recover their benefits as ERISA intends, as the high cost of litigation is one of the major obstacles to individuals’ access to the courts.²⁰⁷ ERISA plaintiffs face particular challenges, as they must administratively appeal their denial at least once and often twice before bringing suit—they generally cannot recover for attorney’s fees for this required exhaustion of administrative appeals.²⁰⁸

While the specter of an avalanche of lawsuits is frequently offered to rebut any change in favor of ERISA claimants, the actual proportion of claimants who take even the first steps toward suing is small. Only a slight percentage of plan participants with a denied claim appeal the denial.²⁰⁹ Even if attorney’s fees were made more available to plaintiffs, claims administrators still have multiple opportunities to correct innocent errors or oversights—generally two administrative appeals and, since the Affordable Care Act’s passage, external review of denials by an independent entity. Thus, defendants have many opportunities to avoid the risk of paying attorney’s fees. And, as some courts have observed, a plan or insurance company will be more inclined to take care when denying or terminating

tion of that decision, if forced to take into account the possibility that fees will be awarded”); *Powell v. Premier Mfg. Support Servs., Inc.*, No. Civ. A. 1-05-0012, 2006 WL 1529470, at *10 (M.D. Tenn. June 1, 2006) (“A fee award serves as a deterrent to conclusory statements that are devoid of specific and fact-supported reasons for denial of benefits.”).

206. 29 U.S.C.A. § 1001(b).

207. Westbrook, *supra* note 176, at 1311 (noting that litigation expenses are one of the major obstacles to access to courts for those of limited means).

208. *Cann v. Carpenters’ Pension Tr. Fund for N. Cal.*, 989 F.2d 313, 316 (9th Cir. 1993) (examining ERISA’s “in any action” language and concluding that it refers to an action in court and not to pre-litigation administrative proceedings); *Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999, 1011 (8th Cir. 2004) (joining “the Second, Fourth, Sixth, and Ninth Circuits in holding that the term ‘any action’ . . . does not extend to pre-litigation administrative proceedings.” (quoting 29 U.S.C. § 1132(g)(1)). Some pre-litigation work may be included within the “any action” umbrella, however. *See, e.g., Dishman v. Unum Life Ins. Co. of Am.*, 269 F.3d 974, 987–88 (9th Cir. 2001) (awarding fees for investigative work prior to filing); *Trs. of E. States Health & Welfare Fund v. Crystal Art Corp.*, No. 00 Civ. 0887 (NRB), 2004 WL 1118245, at *5 (S.D.N.Y. May 18, 2004); *Pennsylvania v. Del. Valley Citizens’ Council for Clean Air*, 478 U.S. 546, 561 (1986).

209. *Between You and Your Doctor: The Private Health Insurance Bureaucracy: Hearing Before the Subcomm. on Domestic Policy*, 111th Cong. 46 (2009) (statement of Patricia Farrell, Senior Vice President, Aetna Inc.) (“[I]n 2008 only a small percentage of claims generated an appeal or a complaint.”); *see, e.g., Caroline E. Mayer, The Claim Game: Here’s How to Fight Back When Your Insurance Company Denies a Claim*, AARP MAG. (Nov. 2009), https://www.aarp.org/health/medicare-insurance/info-09-2009/health_claim_game.html [<https://perma.cc/9XHJ-FC4K>] (citing Connecticut’s healthcare advocate Kevin Lembo as stating that ninety-six percent of denials are not appealed).

benefits if an improper denial or termination is likely to result in more than a perfunctory request to reprocess the claim.²¹⁰

B. *The Factors Should Be Updated Post-Hardt*

Overall, the five factors have resulted in erratic and inconsistent fee awards that fail to advance ERISA's goals.²¹¹ Courts are free to tailor the factors to the particular cases before them, as the five factors are not required.²¹² Even when circuit caselaw extends maximum flexibility, district courts are reluctant to question whether a particular factor makes sense in any particular case. For the fees provision to be available to individual plaintiffs, however, courts should do so.

The *Hardt v. Reliance Standard Life Ins. Co.*²¹³ Court requires claimants to show "some degree of success on the merits," but noted that the five factors "bear no obvious relation" to ERISA's text or the Court's fee-shifting jurisprudence and "are not required for channeling a court's discretion when awarding fees under this section."²¹⁴ Courts may award fees to a party obtaining some success on the merits without any additional inquiry, the Court explained, or a court may use the factors to make its decision.²¹⁵ Several courts of appeals have further emphasized that the factors are considerations rather than a checklist and that there is flexibility in their application.²¹⁶

Despite the Court's holding on the five factors, no circuit court of appeals has yet abandoned the test. Various post-*Hardt* approaches, however, have emerged in the courts of appeals. Some hold that courts must still use the five factors to guide their discretion to award fees in ERISA cases.²¹⁷ Other courts of appeals and district courts have held that the

210. See, e.g., *Gatlin*, 16 F. App'x at 290 ("[A] stiffer penalty encourages plan administrators to alter their behavior with respect to employee appeals . . ."); *Powell*, 2006 WL 1529470, at *10 ("A fee award serves as a deterrent to conclusory statements that are devoid of specific and fact-supported reasons for denial of benefits."); *Eddy v. Colonial Life Ins. Co.*, 59 F.3d 206, 211–13 (D.C. Cir. 1995); *Becker v. Weinberg Group, Inc.*, 554 F. Supp. 2d 9, 18 (predicting that if defendants knew culpable conduct would result in attorney's fee awards, they would be deterred from such actions).

211. See *Westbrook*, *supra* note 176, at 1316 (noting the "erratic and conflicting fee award[s]" that have resulted from the five factors and the factors' failure to advance ERISA's goals).

212. See *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 254–55 (1983).

213. *Id.*

214. *Id.* at 244, 254.

215. *Id.*; see also *Donachie v. Liberty Life Assurance Co.*, 745 F.3d 41, 46 (2d Cir. 2014) (noting that success on the merits is the only required component of the attorney's fee test and that courts need not apply the five factors).

216. See, e.g., *Martin v. Ark. Blue Cross Blue Shield*, 299 F.3d 966, 972 (8th Cir. 2002) (noting that the five factors are non-exclusive and are not to be mechanically applied and that to do so could undermine ERISA's purpose).

217. See *Temme v. Bemis Co.*, 762 F.3d 544, 550 (7th Cir. 2014) (noting that no circuit court of appeals has rejected the five-factor test post-*Hardt*); *Raybourne*

threshold “some degree of success on the merits” test is the only part of the ERISA fees test that the court *must* apply and that the five factors are optional or flexible.²¹⁸ Post-*Hardt*, the five factors are not mandatory in the Second Circuit,²¹⁹ and a denial of fees based on the five factors alone is error.²²⁰ But while courts in the Second Circuit have discretion not to apply the factors at all, they cannot cherry pick factors; they must at least consider all of them, if they consider any.²²¹

Even in circuits that expressly provide for maximum flexibility in applying or ignoring the factors, the five factors’ pull remains strong. In the Fourth Circuit, the factors are considered guidelines, yet courts still tend to apply all five without questioning whether a particular factor makes

v. Cigna Life Ins. Co. of N.Y., 700 F.3d 1076, 1090 (7th Cir. 2012); Nat’l Sec. Sys., Inc. v. Iola, 700 F.3d 65, 103–04 (3d Cir. 2012) (“[T]he court must consider the [five] policy factors in determining whether to award fees and costs”); Treasurer, Trs. of Drury Indust., Inc., v. Goding, 692 F.3d 888, 898–99 (8th Cir. 2012); Cross v. Quality Mgmt. Grp., LLC, 491 F. App’x 53, 55 (11th Cir. 2012); Williams v. Metro. Life Ins. Co., 609 F.3d 622, 635 (4th Cir. 2010) (“[C]ourt[s] should continue to apply the general guidelines that we identified”); *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118, 1121 (9th Cir. 2010) (“[D]istrict courts must still consider the [five] factors before exercising their discretion to award fees”); *Thies v. Life Ins. Co. of N. Am.*, 839 F. Supp. 2d 886, 891 (W.D. Ky. 2012) (requiring the factors); *Ortiz v. A.N.P., Inc.*, 768 F. Supp. 2d 896, 906 (S.D. Tex. 2011) (noting that several courts of appeal and district courts have held that courts should continue to apply the five factors post-*Hardt*); *Toussaint v. J.J. Weiser, Inc.*, 648 F.3d 108, 110 (2d Cir. 2011); *O’Callaghan v. SPX Corp.*, 442 F. App’x 180, 186 (6th Cir. 2011) (deciding that *Hardt* did not change the five-factor test); *Lincoln Fin. Co. v. Metro. Life Ins. Co.*, 428 F. App’x 394, 396 (5th Cir. 2011). The five factors are still applied as originally written in the Sixth Circuit, despite the Supreme Court’s signal of flexibility in *Hardt*. *Voltz v. Chrysler Group LLC*, 63 F. Supp. 3d 770, 785 (N.D. Ohio 2014) (noting that “a five-factor test [is used] in assessing whether the district court properly exercised its discretion in awarding fees” and citing to a pre-*Hardt* case); *Bustetter v. CEVA Logistics U.S., Inc.*, No. 18-58-DLB-EBA, 2019 WL 6719485, at *7–8 (E.D. Ky. Dec. 10, 2019) (noting that the five factors are mandatory and declining to award fees where a defendant acted negligently in not providing plan documents as required).

218. See *Williams*, 609 F.3d at 635 (noting that the factors are “guidelines” for courts to apply).

219. See *Toussaint*, 648 F.3d at 110–11 (noting that courts “may [still] apply . . . the [five] factors in ‘channeling [their] discretion when awarding fees’ under § 1132(g)(1)” (quoting *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (1983))); *Donachie*, 745 F.3d at 46 (holding that “whether a plaintiff has obtained some degree of success on the merits is the sole factor that a court *must* consider in exercising its discretion.”); *Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan*, 5:14-CV-1403 (BKS/TWD), 2017 WL 3267922, at *1 (N.D.N.Y. July 31, 2017) (finding no need to consider the five factors in the case before the court).

220. *Levitian v. Sun Life & Health Ins. Co.*, 486 F. App’x 136, 141 (2d Cir. 2012) (holding that “a denial of attorney’s fees after ‘[c]onsidering [solely] . . . the [five] factors’ constitutes an error of law” (quoting *Levitian v. Sun Life & Health Ins. Co.*, No. 09 CIV. 2965 GBD, 2011 WL 565330, at *6, n. 6 (S.D.N.Y. Feb. 9, 2011))).

221. *Donachie*, 745 F.3d at 47 (noting that courts “cannot selectively consider some factors while ignoring others”).

sense in that context.²²² Individual plaintiffs in this circuit are often taken as not satisfying the common benefit factor, simply because their claims are individual in nature,²²³ even though circuit caselaw points out that certain factors “may not be apropos in a given case.”²²⁴ To include the common benefit factor and find it lacking in individual cases, though, is to penalize the kind of cases that ERISA intended plan members to bring. Similarly, courts in the Second Circuit may opt not to use the factors and focus just on the plaintiff’s success on the merits, but several courts have chosen to apply the factors nonetheless.²²⁵ In awarding fees in individual cases despite the lack of any “common benefit” as that is traditionally understood, several courts have recited this factor among the five and just stated that it is not essential.²²⁶

The appellate courts are divided on whether ERISA’s attorney’s provision results a slight presumption in favor of prevailing plaintiffs receiving a fee award²²⁷ or not.²²⁸ Either way, though, no court holds that the presumption should be *against* a fee award, which is the effect when the test involves a five-factor test and two of the factors are so hard for individual plaintiffs to satisfy.

CONCLUSION

To give ERISA’s attorney’s fee provision its proper effect, courts should be more willing to question particular factors’ utility and effect in the cases before them. It is undisputed that Congress intended ERISA to

222. *See, e.g.*, *Feldman’s Med. Ctr. Pharmacy, Inc., v. CareFirst, Inc.*, 898 F. Supp. 2d 883, 910 (D.C. Md. 2012) (applying the traditional five factors in a case between a pharmacy and a payor and finding that the common benefit factor was not satisfied and no fees should be awarded).

223. *See, e.g.*, *Vincent v. Lucent Techs., Inc.*, No. 3:07-cv-00240, 2011 WL 5075650, at *3 (W.D.N.C. Oct. 25, 2011) (“[T]he Court finds this to be a case largely of a personal nature rather than one in which Plaintiff ‘sought to benefit all participants or beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself.’” (quoting *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017, 1029 (4th Cir. 1993))).

224. *Quesinberry*, 987 F.2d at 1029.

225. In the Second Circuit, courts applying the factors have awarded fees by finding the bad faith or culpability factor satisfied in the case of an arbitrary or capricious denial. *Valentine v. Aetna Life Ins. Co.*, No. 14-CV-1752, 2016 WL 4544036, at *5 (E.D.N.Y. Aug. 31, 2016). And the common factor either unnecessary or satisfied when a case’s outcome might encourage other administrators to follow correct procedures. *Id.* at *6; *Dwinnell v. Fed. Express Long Term Disability Plan*, No. 3:14-cv-01439, 2017 WL 1371254, at *2 (D. Conn. Apr. 14, 2017).

226. *See, e.g.*, *Valentine*, 2016 WL 4544036 at *5–6.

227. *See, e.g.*, *Reinking v. Phila. Am. Life Ins.*, 910 F.2d 1210, 1218 (4th Cir. 1990) (noting that “a prevailing individual beneficiary ‘should ordinarily recover attorney’s fees unless special circumstances would render such an award unjust’” (quoting *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1984))).

228. *See, e.g.*, *Williams v. Metro. Life Ins. Co.*, 609 F.2d 622, 635 (4th Cir. 2010) (“We note at the outset that even a successful party . . . does not enjoy a presumption in favor of an attorneys’ fee award.”).

“encourage beneficiaries to enforce their statutory rights” and that the provision should be “liberally construed” to protect beneficiaries’ rights.²²⁹ Courts should thus be willing to reject or recast fees factors that do not fit the circumstances before them.

Hardt has made clear that the five factors are not required and are not even related to ERISA—courts should accept this invitation to tailor the five factors to cases before them so this sole incentive for plan administrators to process claims correctly the first time can function as intended.

229. *See, e.g.*, *Slupinski v. First Unum Life Ins. Co.*, 554 F.3d 38, 47 (2d Cir. 2009) (“Congress intended the fee provisions of ERISA to encourage beneficiaries to enforce their statutory rights.”); *Locher v. Unum Life Ins. Co. of Am.*, 389 F.2d 288, 298 (2d Cir. 2004) (“ERISA’s attorney’s fee provisions must be liberally construed to protect the statutory purpose of vindicating retirement rights . . .” (quoting *Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F.2d 869, 872 (2d Cir. 1987))).

