14-20

United States Court of Appeals
For the Second Circuit

NEW YORK STATE PSYCHIATRIC ASSOCIATION, INC., in a representational capacity on behalf of its members and their patients, MICHAEL A. KAMINS, on his own behalf and behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, JONATHAN DENBO, on his own behalf and on behalf of all other similarly situated health insurance subscribers,

(caption continued on inside cover)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF OF PLAINTIFFS–APPELLANTS

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Plaintiffs–Appellants,

JORDAN OLIN, on his own behalf and on behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, BRAD SMITH, on his own behalf and on behalf of his beneficiary son, and on behalf of all other similarly situated health insurance subscribers, Ed.D. JULIE ANN ALLENDER,

Plaintiffs

v.

UNITEDHEALTH GROUP, UHC INSURANCE COMPANY, UNITED HEALTH-CARE INSURANCE COMPANY OF NEW YORK, UNITED BEHAVIORAL HEALTH,

Defendants–Appellees.

CORPORATE DISCLOSURE STATEMENT

In conformance with Rule 26.1 of the Federal Rules of Appellate Procedure, Plaintiff–Appellant New York State Psychiatric Association, Inc. states that it has no parent corporation and that no publicly held corporation owns any of its stock.

TABLE OF CONTENTS

PAGE

TABLE OF CITATIONS

PAGE

CASES

RULES

TREATISES

REGULATIONS

STATUTES

OTHER

STATEMENT OF JURISDICTION

This is an appeal from a final judgment of the United States District Court for the Southern District of New York (McMahon, *J.*), dismissing claims under the Employee Retirement Income Security Act of 1974 ("ERISA") and state law. The district court had subject matter jurisdiction over the ERISA claims pursuant to 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331, and supplemental jurisdiction over the state law claims pursuant to 28 U.S.C. § 1367. The district court issued its decision on October 31, 2013, JA 207, and the clerk entered final judgment on December 4, 2013, JA 250. Appellants filed a timely notice of appeal on December 31, 2013. JA 252. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

ISSUES PRESENTED

1. Whether a claims administrator that is a fiduciary of an employee benefits plan may be subject to a civil action for injunctive or other appropriate equitable relief to redress violations of ERISA pursuant to § 502(a)(3), 29 U.S.C. § 1132(a)(3).

2. Whether a claims administrator that is a fiduciary of an employee benefits plan may be subject to a civil action to redress violations of the terms of the plan pursuant to § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

3. Whether the New York State Psychiatric Association, a professional association of psychiatrists, has associational standing to pursue claims for injunctive relief under ERISA and related state laws concerning the review of benefits claims for mental health treatment: (a) on behalf of its members who sustain injury-in-fact as assignees of benefits and as treating professionals who are denied the ability to provide appropriate mental health treatment to their patients; or (b) on behalf of its members' patients, who are denied appropriate mental health treatment.

STATEMENT OF THE CASE

A. The Complaint

In the First Amended Complaint ("FAC" or "Complaint") filed on April 26, 2013, JA 25–169, Plaintiffs, the New York State Psychiatric Association ("NYSPA"); Dr. Shelly Menolascino, a member of NYSPA;

Dr. Julie Ann Allender, a psychologist; and four individuals who submitted health insurance claims for mental health treatment either for themselves or for a dependent, allege, among other things, that United[1] discriminated against their mental health insurance benefit claims in violation of the Mental Health Parity Act (the "Parity Act"), 29 U.S.C. § 1185a, by systematically imposing more restrictive limitations on those claims than it does on non-mental health claims. These restrictions include: (a) applying special, more restrictive guidelines for determining whether mental health services are medically necessary than United applies to medical services; (b) imposing higher evidentiary burdens on mental health claims; (c) imposing more stringent utilization review practices; (d) refusing to pay for treatment pending reviews, which are often delayed; and (e) applying less favorable reimbursement standards for mental health treatment than for equivalent medical services. JA 31–32, ¶ 5. The Complaint alleges that United applies these policies across-the-board in its role as a claims

[1] UnitedHealth Group is the corporate parent of UHS Ins. Co., United–NY, and UBH; each of which are subsidiaries that administer claims for particular health insurance plans. JA 43–44, ¶¶ 34–37. To keep things simple, Defendants–Appellees are referred to in this brief collectively as "United."

administrator for health insurance plans that have delegated to United the responsibility for making mental health benefit determinations.

The Complaint alleges five federal claims for relief. Counts I through III, brought under the Parity Act and ERISA, seek an order enjoining United from applying internal policies and procedures that violate the anti-discrimination mandate of the Parity Act and directing United to reprocess claims through an ERISA-compliant process. Further, these Counts seek to compel United to pay benefits which were denied improperly in violation of plan terms. Count IV seeks benefits that were "recouped" from Dr. Menolascino by United when it determined retroactively that it had overpaid claims for services rendered to one of her patients by withholding payments due for services rendered to *other* patients on behalf of *other* plans. Count IV also requested injunctive relief to require future compliance with ERISA's procedural protections. Count V seeks to enjoin United from violating the provision of the Affordable Care Act codified at ERISA, 29 U.S.C. § 1185d, imposing requirements of appellate review of health care benefits claims. In addition to seeking relief for NYSPA on behalf of its members and their

patients, the Complaint seeks certification of the individual plaintiffs as representatives of appropriate classes.[2]

The Complaint describes United's across-the-board discriminatory policies and their application to particular patients, including the effects of such applications on their treatment and health. For example, United uses internal guidelines concerning "Level of Care" or "Determination of Coverage" that deviate from professional treatment standards. *See, e.g.*, JA 57–108, ¶¶ 78, 111, 155, 160, 161, 186, 201, 228 (allegations including quotations from United correspondence relying on its internal guidelines to deny or limit coverage); JA 67–68, ¶ 199 (provider correspondence noting the discrepancy between United's standards and actual standards of care in the profession).

The Complaint further alleges that United discriminates against mental health treatment through the standards it uses to determine medical necessity, JA 59–62, ¶¶ 82–85, 92; its utilization review standards, JA 60, ¶ 86; and its assessment of treatment by means other

[2] Counts VI–X of the Complaint allege state law claims. JA 162–65. In light of its dismissal of the federal claims, JA 242, the district court declined to exercise supplemental jurisdiction over these claims, and deemed Counts IX and X withdrawn by Plaintiff Kamins, who elected not to pursue them, JA 240.

than medication, JA 62, ¶ 91. The Complaint also describes the grievances that NYSPA has received from its members and conveyed to United concerning: across-the-board requirements for concurrent reviews imposing prospective limitations on treatment, JA 102, ¶ 210; deviation from national standards of care, JA 102–03, ¶ 212; curtailment of psychotherapy, JA 103, ¶ 213; and denials of intermediate care, JA 103, ¶ 214. In addition, the Complaint alleges that, when United seeks to recover previous benefits paid to providers, it treats itself as the source of funds by withholding payments owed to a provider (Dr. Menolascino) for treating a patient covered by one plan to "offset" alleged overpayments with respect to other patients insured by other plans. JA 118–20, ¶¶ 256–61.

The Complaint supports its general allegations about United's discriminatory policies with specific instances drawn from the experience of providers (Drs. Menolascino and Allender) and subscribers (Messrs. Kamins, Denbo, Smith, and Olin). These specific allegations show the harmful impact of United's policies on the treatment of mental illness. For example, the Complaint describes the harm United's treatment denials imposed on a patient of Dr. Allender

who elected not to be identified in the Complaint because of the stigma associated with mental illness. JA 109, ¶ 234.

Likewise, the Complaint describes how United limited psychotherapy for Dr. Kamins' severely mentally-ill son, JA 37, ¶ 18; JA 49–51, ¶¶ 53–63, leading him to be re-hospitalized because of lack of treatment, JA 49, 58 ¶¶ 55, 80. Despite severe symptoms and serious risks, United imposed preauthorization requirements that restricted his care. JA 37, ¶¶ 16, 17; JA 45, 49–50 ¶¶ 41, 56–57. Similarly, United imposed prospective review of Mr. Denbo's psychotherapy. JA 38, ¶ 20; JA 64, ¶ 101; JA 73, ¶ 124. For Mr. Smith's severely-ill son, United applied "fail first"/"step therapy" policies to deny coverage for needed residential treatment. JA 39–40, ¶¶ 23, 24; JA 76–78, ¶¶ 137, 139, 143. United also refused to authorize residential treatment for Mr. Olin's severely mentally-ill son, despite the serious harm he sustained outside a residential setting—forcing the family to pay out-of-pocket. JA 41–42, ¶¶ 28, 29, 31; JA 87–88, ¶¶ 171, 174–76.

B. The Applicable Statutory and Regulatory Framework

The allegations of the Complaint, taken as true, show that United has systematically violated two substantive requirements of ERISA: the

Parity Act, which forbids discrimination in the administration of mental health benefits, as compared to medical/surgical benefits; and the Affordable Care Act, which confers certain appeal rights before benefits for an ongoing course of treatment can be denied.

1. The Parity Act

Congress enacted the Parity Act in 2008 to prevent those responsible for administering employer health insurance plans from discriminating against patients in need of mental health services. H.R. Rep. 110-374, Pt. 3, at 12 (2008) (purpose "is to have fairness and equity in coverage of mental health and substance-related disorders vis-à-vis coverage for medical and surgical disorders"). The Parity Act passed with broad bipartisan support and built upon the protections of parity laws enacted by 49 States, including New York. *Id.* at 4.

Congressional efforts to curb such discrimination began in 1996 with the enactment of the Mental Health Parity Act of 1996. That act prohibited health insurance plans from imposing annual and lifetime limits on mental health benefits which exceeded those applicable to medical/surgical benefits. In response, many health insurers began imposing other discriminatory restrictions on mental health benefits.

GAO, Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited, at 12 (2000). *See also* Mental Health: A report of the Surgeon General (1999); S. Rep. 110-53, at 4 (2007); H.R. Rep. 110-374, Pt. 3, at 13. As a result, additional legislation became necessary.

Congress viewed achieving "parity in mental health coverage" as "an urgent matter because of the fact that mental disorders are a leading cause of disability." H.R. Rep. 110-374, Pt. 3, at 2. Although Congress recognized that improving access to mental health services through private insurance would impose certain costs, "[i]nvesting in mental health parity is beneficial for the Nation because the costs associated with lost worker productivity and the costs of providing extra physical health services outweigh the costs of implementing parity for mental health treatment." *Id.* Among other things, the Parity Act prohibits treatment limitations applicable to mental health benefits that are more restrictive than "the predominant treatment limitations applied to substantially all medical and surgical benefits" and "separate treatment limitations" applicable only to mental health benefits. 29 U.S.C. § 1185a(a)(3)–(4).

The Departments of Treasury, Labor, and Health and Human Services have issued Interim and Final Rules implementing the Parity Act within their respective administrative jurisdictions. 78 Fed. Reg. 68240-96 (Nov. 18, 2013) (Final Rule); 75 Fed. Reg. 5410-51 (Feb. 2, 2010) (Interim Rule). The Parity Act regulations identify specific practices forbidden by the Act, which are of particular relevance to this case. These include "nonquantitative treatment limitations" on mental health services such as "Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness" and "Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)." 29 C.F.R. § 2590.712(c)(4)(ii)(F) (included in both Interim and Final Rules). The "processes, strategies, evidentiary standards, or other factors used in applying" non-quantitative treatment limitations—factors not typically included in plan terms but developed by claims administrators to determine whether a given treatment is covered—are subject to the statute's parity requirements. 29 C.F.R. § 2590.712(c)(4)(i).

2. The Affordable Care Act

The Affordable Care Act ("ACA"), Pub. L. 111-148, 124 Stat. 270 (Mar. 23, 2010), includes a provision making certain health insurance protections applicable to employer plans regulated by ERISA. 29 U.S.C. § 1185d. Those protections include rights to appeal denials of coverage and to continuation of coverage pending appeal. 42 U.S.C. § 300gg-19.

3. Private Civil Enforcement of ERISA, Including the Parity Act and the Affordable Care Act

Congress provided for the private civil enforcement of the substantive requirements of ERISA, including the Parity Act and the ACA, through section 502 of ERISA. Section 502(a)(1) "empower[s] . . . a participant or beneficiary" to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights [to benefits] under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Section 502(a)(3) "empower[s] . . . a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

C. The District Court's Dismissal Order

On June 10, 2013, United filed a motion to dismiss the Complaint. Although the Complaint seeks to enjoin United from applying its global policies that Plaintiffs allege discriminate against claims for mental health services, the district court began by describing the Complaint as "essentially a denial of benefits case" under § 502(a)(1)(B), JA 208, and "really seven different lawsuits amalgamated (inappropriately) in a single caption," JA 211. Consistent with that view, the district court's opinion is organized by plaintiff, beginning with the claims (Counts I–V) of three individual plaintiffs—Messrs. Denbo, Smith, and Olin, JA 211–36—followed by the claims of Dr. Allender (Counts I & V), JA 231–34, and Dr. Menolascino (I, II, IV, & V), JA 234–38. From there, the court addressed its supplemental jurisdiction over Mr. Kamins's state law claims (VI–X), JA 239–42, and then concluded by considering NYSPA's associational standing, JA 242–48.

The district court's resolution of the five federal law claims rested on four central legal conclusions. *First*, the district court concluded that United was not a proper defendant in an action under § 502(a)(1)(B). The district court found that Plaintiffs had pleaded valid Parity Act

violations, but concluded that regardless of United's exclusive role in developing and implementing the disputed policies and United's status as a fiduciary, "Plaintiffs are suing the wrong party." JA 218. The district court imposed what it called a "bright-line rule that only entities that have been designated formally as 'plan administrators' under 29 U.S.C. § 1002(16)(A) are proper 'administrator' defendants in § 502(a)(1)(B) actions," which the court asserted had been followed by "the larger number" of district judges in this Circuit. JA 219.

Second, the district court concluded that United was not a proper defendant in an action to enforce the Parity Act or the ACA under § 502(a)(3). The district court acknowledged United's obligations under ERISA as a plan fiduciary, and agreed that an action under § 502(a)(3) could be based on United's alleged violations of the Parity Act. But the court relied on its reading of *Varity Corp.* v. *Howe*, 516 U.S. 489 (1996) and subsequent decisions from this Court, to hold that relief under § 502(a)(3) was unavailable against United because Plaintiffs could obtain adequate relief by suing *other parties* for the recovery of plan benefits under § 502(a)(1)(B). JA 222–23.

Third, the district court ruled that "United is not a party to which the Parity Act [and the ACA] applies," JA 226, because United was not itself a "group health plan" or an insurer of a group health plan, and therefore could not be sued under § 502(a)(3) for violating either the Parity Act or the ACA provisions of ERISA.

Fourth, the district court ruled that NYSPA could not satisfy the test for associational standing set out in *Hunt* v. *Washington State Apple Adver. Comm'n*, 432 U.S. 333 (1977), notwithstanding allegations in the Complaint that one named member of NYSPA (Dr. Menolascino) and other unnamed members have been harmed by United's practices and policies both financially (because they are assignees of claims for benefits) and professionally (because United's policies interfere with treatment). The district court deemed the assignment of benefits to NYSPA members to be insufficient to give those members "their own right" to sue. Although this Court and other Circuits have recognized that assignees have statutory and constitutional standing, and while ERISA defines an assignee as a "beneficiary," the district court viewed the relevant inquiry as whether NYSPA members could invoke the legal rights of their patients—a question of third-party standing. To answer

that question, the district court relied on the Seventh Circuit's opinion in *MainStreet Org. of Realtors* v. *Calumet City, Ill.*, 505 F.3d 742 (7th Cir. 2007), a case involving real estate agents invoking legal rights of prospective clients, to hold that NYSPA physicians did not have standing to represent the interests of their current patients.

D. Developments Since the Dismissal Order

Since the Dismissal Order, Plaintiffs Olin, Smith, and Allender have dismissed their appeals after entering into confidential settlements with United. This appeal proceeds on behalf of NYSPA, Mr. Denbo, Mr. Kamins, and Dr. Menolascino.

SUMMARY OF THE ARGUMENT

Deeming the Complaint to allege "essentially a denial of benefits case," the district court treated all of Plaintiffs' claims as plan term violations under § 502(a)(1)(B), rather than statutory violations under § 502(a)(3). JA 207–08. Yet, the heart of Plaintiffs' allegations is not that United violated plan terms, but that, in processing claims, United uniformly applied policies and procedures that violate the Parity Act's anti-discrimination mandate and the ACA's procedural protections.

Plaintiffs' claims therefore fall primarily under § 502(a)(3), not § 502(a)(1)(B).

United is a proper defendant under either subsection of § 502. United is a claims administrator for the employer health insurance plans at issue in this case and a fiduciary to the beneficiaries of the plans, who include employees, their dependents, and mental health care providers who have accepted assignments of benefits. United—not the plans, the plan administrators, or anyone else—has been delegated the duty and sole discretion to process and determine claims for benefits under the plans. In exercising that delegated discretion, United applies its own internal policies and guidelines, and discriminates systematically against Plaintiffs and other plan beneficiaries who have submitted claims for mental health services.

Here, as even the district court acknowledged, JA 228, Plaintiffs have alleged acts or practices by United that violate the Parity Act's anti-discrimination mandate in ERISA. Under the plain language of ERISA § 502(a)(3)(A), beneficiaries like Plaintiffs are authorized to bring "[a] civil action" to enjoin "any act or practice"—like United's acts and practices—"which violate[]" ERISA's substantive provisions.

The Supreme Court has held that liability under § 502(a)(3) is not limited to certain kinds of defendants, nor does liability "depend on whether ERISA's substantive provisions impose a specific duty on the party being sued." *Harris Trust & Sav. Bank* v. *Salomon Smith Barney, Inc.*, 530 U.S. 238, 245 (2000). Rather, what matters in determining whether a particular defendant is the proper target of a § 502(a)(3) claim is whether that defendant is engaged in an act or practice that violates a substantive provision of ERISA. *Id.*

Accordingly, the district court erred as a matter of law in concluding that ERISA limits liability to the plan or officially-designated plan administrator for violations of the Parity Act or other ERISA requirements. United is a fiduciary that wields delegated authority to decide benefits claims. United itself violated the Parity Act in exercising that power, and so United is subject to an injunction for violating provisions of the ERISA subchapter containing the Parity Act. 29 U.S.C. § 1132(a)(3).

The district court also erred in concluding that United could not be held liable for injunctive relief under § 502(a)(3) because Plaintiffs could have sued other parties—the plans or plan administrators—under a

different subsection of ERISA, § 502(a)(1)(B). That subsection provides for the recovery of benefits when a benefits denial violates the *terms of a plan*. It does not provide a remedy for statutory violations such as those presented in the Complaint. Furthermore, the plans and plan administrators could be liable for United's ERISA violations only to the extent they were knowing participants in those violations. And any individual relief that Plaintiffs could obtain by means of a § 502(a)(1)(B) action against any party (including United) would be inadequate to remedy United's systematic wrongdoing.

In addition to holding that United could not be sued for injunctive or other appropriate equitable relief under § 502(a)(3), the district court ruled that United could not be sued under § 502(a)(1)(B) because "only ERISA plans, ERISA plan trustees, and ERISA plan administrators may be sued under ERISA § 502(a)(1)(B)." JA 219. But § 502(a)(1)(B) does not limit the kinds of defendants who can be sued under that provision. Nor has this Court ever established the "bright line rule" that the district court purported to apply.

The district court was also wrong as a matter of law to conclude that NYSPA lacks standing as an association to pursue its claims against

United. The allegations in the Complaint satisfy easily the Supreme Court's test for associational standing—that is: (a) NYSPA's members, as assignees of their patients' claims against United, have standing to sue United for its ERISA violations in their own right; (b) there is no dispute that the interests that NYSPA seeks to protect in this case are germane to its purpose; and (c) the participation of individual members of NYSPA is not required for its claims or the relief it asserts because *United's* testimony and documents will be the main evidence for NYSPA's claims, and the injunctive and equitable relief that NYSPA is seeking will not require any evidence from its members on damages. *See Hunt*, 432 U.S. at 343 (elements for associational standing). Rather than applying these three straightforward elements of associational standing, the district court resorted to concepts that do not belong—such as prudential third-party standing and class certification standards under Federal Rule of Civil Procedure 23. As a result, the district court concluded incorrectly that NYSPA cannot pursue its claims against United.

ARGUMENT

The district court accepted the allegations of the Complaint as true for purposes of its decision and ordered dismissal as a matter of law. This Court's review is *de novo*. *Capital Mgmt. Select Fund Ltd.* v. *Bennett*, 680 F.3d 214, 219 (2d Cir. 2012) (Rule 12(b)(6) dismissal); *Donoghue* v. *Bulldog Investors Gen. P'ship*, 696 F.3d 170, 173 (2d Cir. 2012) (standing under Rule 12(b)(1)).

I. United Can Be Sued Under ERISA § 502(a)(3) to Enjoin Its Unlawful Practices

The district court agreed that "Plaintiffs have pleaded facts that, if proven, demonstrate violations of the Parity Act." JA 228. The district court ruled, however, that "[w]hile United . . . may have committed the violations on behalf of the Plans, Congress has decreed that no action lies against it." *Id.* Yet Congress has *never* decreed that a claims administrator like United—which is a fiduciary and has been delegated the sole responsibility for processing and determining whether to pay claims for mental health services for its insureds, JA 38–39, ¶¶ 19, 21; JA 80–81, ¶ 154; JA 89, ¶ 182, and whose acts and practices in exercising that discretion violate substantive provisions of ERISA—is immune from suit for violating ERISA.

The district court offered two bases for its contrary conclusion. JA 226–28. The district court held first that United cannot be sued under § 502(a)(3) because the Parity Act imposes duties only on "group health plans" and offerors of health insurance—of which United is neither. JA 226–27. But that conclusion cannot be squared with the plain language of § 502(a)(3) or the Supreme Court's application of § 502(a)(3) in *Harris Trust & Sav. Bank* v. *Salomon Smith Barney, Inc.*, 530 U.S. 238, 245 (2000).

The district court's second basis for concluding that United could not be sued under § 502(a)(3) for violating the Parity Act was that Plaintiffs had the option to sue other parties—the plan and plan administrator of each plan that United manages—under a different provision, § 502(a)(1)(B), and thereby obtain all necessary relief. This conclusion was wrong because § 502(a)(1)(B) and § 502(a)(3) address different forms of relief. Furthermore, any relief that Plaintiffs could obtain against the plans or plan administrators would be inadequate and could be pursued only through a multitude of inefficient lawsuits aimed—not at the wrongdoer itself—but at employers who are unlikely to have any knowledge about the illegal practices at issue.

A. Anyone, Especially a Plan Fiduciary Such as United, May be Sued Under ERISA § 502(a)(3) for "Any Act or Practice" which Violates ERISA

While the relief available under § 502(a)(3) is limited to certain kinds of *plaintiffs*—a "participant, beneficiary, or fiduciary"—it is *not* limited to certain kinds of *defendants*. Nor does § 502(a)(3) say, or imply, that actions for injunctive or other appropriate equitable relief against claims administrators like United are barred. As the Supreme Court observed in *Harris Trust*: "[Section] 502(a)(3) makes no mention at all of which parties may be proper defendants—the focus, instead, is on redressing the '*act or practice* which violates any provision of [ERISA Title I].'" *Harris Trust*, 530 U.S. at 246 (emphasis in original). *See also Lowen* v. *Tower Asset Mgmt., Inc.*, 829 F.2d 1209, 1220 (2d Cir. 1987) (observing that even a non-fiduciary can be sued under § 502(a)(3)). The natural reading of the statute is that an action lies under § 502(a)(3) against any party that commits a prohibited act or practice, especially when that party is a fiduciary that has been delegated duties by the plan.

Similarly, the substantive ERISA provisions incorporated from the Parity Act and the ACA identify what conduct is prohibited:

discrimination and denial of appeal rights in group health plans rather than all employee benefits plans. But those provisions do not identify which parties may be liable for violations. The district court's conclusion that only group health plans and their insurers could be sued for Parity Act violations is inconsistent with the Supreme Court's holding in *Harris Trust*. In that case, successor plan fiduciaries sued Salomon Brothers, the broker-dealer for an ERISA plan, for violating ERISA by engaging in transactions that harmed the plan. The plan fiduciaries sought equitable relief under § 502(a)(3). *Harris Trust*, 530 U.S. at 243. Salomon Brothers argued that it was not a proper defendant under § 502(a)(3) because the substantive ERISA provision that it was alleged to have violated applied only to plan fiduciaries who caused the harmful transaction, and not to a non-fiduciary who may have facilitated it. *Id.*

In a unanimous decision, the Supreme Court disagreed and held that "§ 502(a)(3) itself imposes certain duties, and therefore . . . liability under that provision does not depend on whether ERISA's substantive provisions impose a specific duty on the party being sued." *Id.* at 245. Thus, § 502(a)(3) imposes a duty on United not to violate the substantive provisions of ERISA—including the Parity Act and ACA

provisions. Because Plaintiffs have pleaded acts and practices *by United* that violate the Parity Act's anti-discrimination mandate and other provisions of ERISA, the district court should have held that United can be sued for injunctive relief under § 502(a)(3)(A), and other appropriate equitable relief under § 502(a)(3)(B).

This conclusion is reinforced by the fact that United had a fiduciary duty to comply with the Parity Act and breached that duty. As the district court properly concluded, JA 221, the Complaint alleged facts sufficient to establish United's status as an ERISA fiduciary as defined by 29 U.S.C. § 1002(21)(A)(iii) (a fiduciary is one who has "any discretionary authority or discretionary responsibility in the administration of" an ERISA plan). *See also Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 220 (2004) ("Classifying any entity with discretionary authority over benefits determinations as anything but a plan fiduciary would . . . conflict with ERISA's statutory and regulatory scheme.").

Because United is an ERISA fiduciary, it is obligated to make benefits determinations in a manner "consistent with the provisions of" ERISA, including the Parity Act. ERISA § 404(a)(1), 29 U.S.C.

§ 1104(a)(1). *See also Kendall* v. *Employees Ret. Plan of Avon Products*, 561 F.3d 112, 120 (2d Cir. 2009) ("There is no doubt that ERISA imposes on plan fiduciaries a duty to [comply with ERISA under 29 U.S.C. § 1104(a)(1)(D)]" because that statute "impose[s] a general fiduciary duty to comply with ERISA"). In fact, because of United's animating role in the discrimination alleged in this action, ERISA imposes this duty upon United even if the district court was correct that "responsibility" for complying with the Parity Act falls directly upon the plans and their designated plan administrators. *See Lee* v. *Burkhart*, 991 F.2d 1004, 1010–11 (2d Cir. 1993) (explaining that a claims administrator of a self-funded ERISA plan is liable for benefits claims if it violates a statutory duty imposed on the plan administrator if the claims administrator has been delegated that statutory duty or has knowledge that the duty was breached by the plan administrator); 29 U.S.C. § 1105(a) ("In addition to any liability which he may have under any other provisions of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan. . . . "); *Smith* v. *Local 819 I.B.T. Pension Plan,* 291 F.3d 236, 241 (2d Cir. 2002) (Section § 1105(a)(2) provides

"that a fiduciary is liable if the fiduciary's failure to exercise reasonable care leads to a co-fiduciary's breach").

In short, because Plaintiffs allege that United is an ERISA fiduciary which has been delegated the duty to administer claims in accordance with ERISA, and which has breached that duty by violating the Parity Act, there should be no question that § 502(a)(3) empowers Plaintiffs to seek an injunction preventing United from continuing to apply its discriminatory policies and procedures.

B. The Relief Plaintiffs Seek Under ERISA § 502(a)(3) Cannot Be Obtained Under ERISA § 502(a)(1)(B)

The district court's second basis for dismissing Plaintiffs' § 502(a)(3) claims—that Plaintiffs could obtain all necessary relief by suing either the plan or plan administrator of each plan under § 502(a)(1)(B)—was wrong for three reasons. First, § 502(a)(1)(B) does not provide for relief against statutory violations. Second, the plans and plan administrators are liable for United's statutory violations only to the extent they were knowing participants in those violations. And third, Plaintiffs cannot obtain adequate relief against any party under § 502(a)(1)(B).

1. Section 502(a)(1)(B) Provides for Relief for Benefits Denials that Result from Plan Violations, Not Injunctions to Remedy Statutory Violations

Sections 502(a)(1)(B) and (a)(3) focus on different types of legal violations and provide for different forms of relief. Plaintiffs sued United based principally on their allegations that United violated the Parity Act's anti-discrimination mandate by imposing internal policies and guidelines on their mental health care claims that are more onerous than those it applies to other claims. Under the plain text of § 502(a), the appropriate subsection under which Plaintiffs could pursue this claim was § 502(a)(3), not § 502(a)(1)(B).

A claimant may sue under § 502(a)(1)(B) only "to recover benefits due to him ***under the terms of the plan***, to enforce his rights ***under the terms of his plan***, or to clarify his rights to future benefits ***under the terms of his plan***." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). Thus, the entire focus of an (a)(1)(B) claim is to enforce *the terms of the plan*, which is why courts refer to it as the equivalent of a breach of contract claim. *See, e.g., Strom* v. *Goldman Sachs & Co.*, 202 F.3d 138, 142 (2d Cir. 1999) (a § 502(a)(1)(B) claim is an "assertion of a contractual right under a benefit plan"); *Massachusetts Mutual Life Ins. Co.* v. *Russell*,

473 U.S. 134, 148 (1985) (a claim "to protect contractually defined benefits"); JA 218 (district court opinion below concluding that "[t]his section provides different remedial options for violations *of plan terms*.") (emphasis added).[3]

In contrast, § 502(a)(3)(A) authorizes an injunction against "any act or practice" which violates "any provision" of subchapter 1 of ERISA itself (which includes the Parity Act's anti-discrimination mandate in 29 U.S.C. § 1185a) as well as the terms of the plan. Section 502(a)(3) therefore authorizes relief that is not available under § 502(a)(1)(B).

The district court avoided the fact that the *injunctive* relief Plaintiffs sought to remedy these *statutory* violations does not fall within § 502(a)(1)(B) by holding that the "'terms' of every ERISA plan" for purposes of § 502(a)(1)(B) include automatically all ERISA provisions. JA 228. But this holding was also erroneous. If a violation of a provision of ERISA was always a violation of the terms of the plan, the "any provision of this subchapter" language in § 502(a)(3)(A) and (B) would be superfluous. *See Corley* v. *United States*, 556 U.S. 303, 314 (2009) ("A statute should be construed so that effect is given to all of its

[3] For instance, Plaintiff Denbo asserted a claim under § 502(a)(1)(B) to remedy violations of his employer's plan. JA 38–39, ¶ 20.

provisions, so that no part will be inoperative or superfluous."). Given the care Congress took to establish a comprehensive remedial scheme with multiple elements, it would be improper to disregard the deliberate difference between the reach of § 502(a)(1)(B), which is limited to the "terms of the plan," and § 502(a)(3), which includes violations "of this subchapter."

Moreover, the district court supported its conclusion that § 502(a)(1)(B) reached statutory violations with only a "*cf.*" citation to the Supreme Court's decision in *Central Laborers' Pension Fund* v. *Heinz*, 541 U.S. 739, 750 (2004). But *Central Laborers'* did not hold that all of ERISA's requirements are included as terms in plans such that related violations can be redressed through a § 502(a)(1)(B) claim. The issue in that case was whether a challenged amendment to a plan violated ERISA, and whether the plaintiff could pursue a claim seeking the benefits of which he was allegedly deprived as a result of that amendment. The Court held that the plan amendment violated 29 U.S.C. § 1053(a), which required that "[e]ach pension plan shall provide that an employee's right to his normal retirement benefit is nonforfeitable upon the attainment of normal retirement age." *Central*

Laborers', 541 U.S. at 750. The Court did not hold that all of ERISA's substantive provisions should be read into the terms of every plan, but rather that an amendment contrary to an ERISA requirement could not become a term of a plan. Furthermore, it did not address the differences between § 502(a)(1)(B) and § 502(a)(3), which of those provisions authorized the plaintiff to pursue the denied benefits, or upon which provision the plaintiff would have needed to rely had it sought injunctive relief.

In sum, the district court erred by concluding that § 502(a)(1)(B) authorizes all of the relief Plaintiffs seek with regard to statutory violations.

2. Plans Can Be Held Liable for Statutory Violations Only if They are Knowing Participants in the Violation

The district court concluded that Plaintiffs could obtain adequate relief against the plans or plan administrators under § 502(a)(1)(B). JA 224–25. That conclusion requires a determination that the plans could be held liable for the ERISA violations alleged, which is not the case here. The district court assumed that a plan or plan administrator could be sued for *United's* violation of ERISA itself (as opposed to the terms of

the plan). Contrary to the district court's analysis, ERISA does not authorize a simple *respondeat superior* claim by a beneficiary against a plan or plan administrator under § 502(a)(3).[4]

Traditional trust law did not impose *respondeat superior* liability on a trustee (here the plan administrator) for the faults of its agent. The rule was that a trustee was not liable to the beneficiary for wrongdoing by agents hired to administer the trust unless the trustee's own conduct was wrongful. RESTATEMENT SECOND OF TRUSTS § 225 (1959); 3 AUSTIN WAKEMAN SCOTT, THE LAW OF TRUSTS § 225, at 1793 (1967) (trustee "is not liable to the beneficiaries for losses resulting from the improper conduct of the agent, unless the trustee is himself guilty of a breach of trust").

Under ERISA, a plan or plan administrator that delegates fiduciary duties to a claims administrator like United can be held liable for the claims administrator's breach of fiduciary duties only to the extent that the plan or plan administrator *knowingly participated* in the breach, or

[4] The district court relied on an unpublished district court decision for this point. *Staten Is. Chiropractic Assocs.* v. *AETNA, Inc.*, 2012 WL 832252, at *12 (E.D.N.Y. Mar. 12, 2012). JA 223. But the § 502(a)(3) claim in that case was based on alleged violation of the terms of the plan, not a violation of "this subchapter."

knew about the breach and did not try to remedy it. *See* 29 U.S.C. § 1105(a) (co-fiduciary responsibility based on knowledge).

The district court erred by concluding that the plans or plan administrators were automatically liable for *United's* violations of the Parity Act.

3. Plaintiffs Cannot Obtain Adequate Relief from Plans or Plan Administrators

The district court also erred by concluding that Plaintiffs could obtain adequate relief from United's wrongdoing by suing the plans or plan administrators. Suing the plans or plan administrators would not be adequate to remedy United's violations because it would not reach the source of the illegal conduct—the internal policies United applies across the board and that are deeply embedded in its system for processing claims. In fact, plans or plan administrators could modify United's internal policies only indirectly, if at all, and employers and their plan administrators are unlikely even to be aware of the disputed policies United is applying.[5] By extension, the plans and plan

[5] Moreover, in holding that Plaintiffs could pursue an injunction under § 502(a)(3)(A) against United's illegal practices only if they could not obtain adequate legal relief, the district court misread *Varity*. In that case, the Supreme Court held that the language in § 502(a)(3)(B)

administrators would not be proper defendants for Plaintiffs' motion for preliminary injunction, which sought to enjoin United from applying its discriminatory policies. JA 17, 248.

Although the district court cited this Court's decision in *Frommert* v. *Conkright*, 433 F.3d 254 (2d Cir. 2006) to support its holding that Plaintiffs' claims could be fully remedied through a benefits action against the plans under § 502(a)(1)(B), *Frommert* demonstrates why the district court's analysis was wrong. The district court was correct that, in *Frommert*, this Court held that the plaintiff could not pursue an award of *benefits* based on the insurer's alleged violation of plan terms

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(authorizing "other appropriate equitable relief") was a mere "catchall" provision that "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy." *Varity Corp.*, 516 U.S. at 512. The Court added that, to the extent other provisions of ERISA provide an adequate remedy, it would not be appropriate to award "other appropriate equitable relief" under § 502(a)(3)(B). *Id.* Unlike § 502(a)(3)(B), however, § 502(a)(3)(A) is not a mere "catchall" provision calling for "other appropriate equitable relief." Rather, it authorizes a civil action to enjoin "any act or practice" which violates ERISA itself. *See Silvernail* v. *Ameritech Pension Plan*, 439 F.3d 355, 358 (7th Cir. 2006) (observing that "courts should take care to interpret ERISA strictly according to its plain language") (internal citations and quotations omitted). In any event, nothing in *Varity* or § 502(a)(3) supports the district court's conclusion that a plaintiff cannot obtain injunctive relief whenever it might be possible to obtain legal relief against other unnamed parties. JA 223.

under § 502(a)(3), if the plaintiff could otherwise seek the recovery of benefits under the terms of his plan under § 502(a)(1)(B). *Frommert*, 433 F.3d at 270 ("The relief that the plaintiffs seek, recalculation of their benefits *consistent with the terms of the Plan*, falls comfortably within the scope of § 502(a)(1)(B)") (emphasis added). Here, Plaintiffs invoke § 502(a)(3) to enjoin violations of ERISA, not to recover benefits based on violations of the terms of their plans, as in *Frommert*.

The district court overlooked the fact that in *Frommert*, this Court *reversed* the dismissal of the plaintiff's § 502(a)(3) claim for equitable relief that could not have been remedied adequately under § 502(a)(1)(B). In fact, this Court "disagree[d] with the district court's conclusion that all of the relief sought by the plaintiffs in their claim for breach of fiduciary duties can be adequately addressed by the relief available under § 502(a)(1)(B)." *Id.* at 272. It remanded to the district court to determine whether the fiduciary had violated its duties under ERISA and, if so, what relief would be appropriate. *Id.* at 271–72. *See also Devlin* v. *Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) ("On remand, the district court should permit a trier of fact to evaluate [the alleged] failure to provide completely accurate plan

information. A trier of fact could find that there was a fiduciary duty and that Empire breached it.").

The district court failed to conduct the kind of careful comparison of the scope of relief authorized under § 502(a)(1)(B) and § 502(a)(3) called for by *Frommert* and *Devlin.* That type of comparison is exemplified by the Seventh Circuit's decision in *Smith* v. *Med. Benefit Adm'rs Grp., Inc.*, 639 F.3d 277, 284 (7th Cir. 2011), where the Court dismissed the § 502(a)(1)(B) benefit claim against the claims administrator, but allowed the § 502(a)(3) claims to proceed after identifying a range of "meaningful declaratory and injunctive relief that might be wholly consistent with ERISA," including "requir[ing] [the claims administrator] to modify its preauthorization practices so as to bring them into conformity with the governing regulations as well as its broader fiduciary obligations to plan participants." *Id.* This is precisely the type of § 502(a)(3) relief Plaintiffs seek here.

As the Sixth Circuit has observed, there is a "difference between correcting the denial of individual claims on a beneficiary-by-beneficiary basis and altering, on a plan-wide basis, the methodology used to process claims for all beneficiaries," *Hill* v. *Blue Cross & Blue Shield of*

Mich., 409 F.3d 710, 718 (6th Cir. 2005). In *Hill*, the plaintiffs challenged a claims administrator's processing of emergency medical treatment expenses. The plaintiffs' central contention was that the claims administrator had used an improper automated claims-processing system that favored the employer by basing claims determinations on the physician's final diagnosis, rather than the claimant's signs and symptoms at the time of treatment. The Sixth Circuit held:

> [A]n award of benefits to a particular Program participant based on an improperly denied claim for emergency-medical-treatment expenses ***will not change the fact that [the claims administrator] is using an allegedly improper methodology*** for handling all of the Program's emergency-medical-treatment claims. ***Only injunctive relief of the type available under § [50]2(a)(3) will provide the complete relief sought*** by Plaintiffs by requiring [the claims administrator] to alter the manner in which it administers all the Program's claims for emergency-medical-treatment expenses.

Id. (emphasis added). Similarly, only injunctive or other appropriate equitable relief against United will adequately remedy United's unlawful acts and practices.[6]

In addition, suing plans or plan administrators for United's wrongdoing would be contrary to Congress's desire to avoid "creat[ing] a system that is so complex that administrative costs, ***or litigation expenses,*** unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.*, 516 U.S. at 497 (emphasis added). Suing each of the plans and plan administrators instead of the primary wrongdoer, would be impractical and ineffective. For example, United

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[6] At the very least, even if the district court was right that Plaintiffs potentially could obtain complete relief under § 502(a)(1)(B), it was premature for the district court to reach that holding at the pleadings stage. As a number of courts have found: "fiduciary duty claims should not be dismissed at the pleadings stage—that is, the claim should be allowed to proceed until it is apparent that the remedies available pursuant to subsection (1)(B) are, in fact, inadequate." *Crummett* v. *Metro. Life Ins. Co.*, 2007 WL 2071704, at *2 (D.D.C. July 16, 2007); *See, e.g., DeVito* v. *Aetna, Inc.*, 536 F. Supp. 2d 523, 534 (D.N.J. 2008) ("[C]laims under § 1132(a)(3) are not properly dismissed at the motion to dismiss stage merely because a plaintiff has also brought a claim under § 1132(a)(1)(B)"); *Zebrowski* v. *Evonik Degussa Corp. Admin. Comm.*, 2011 WL 767444, at *3 (E.D. Pa. Feb. 24, 2011) ("Before discovery, plaintiffs should not be forced to choose between their claims for benefits and their claims for equitable relief."); *Tannenbaum* v. *UNUM Life Ins. Co. of Am.*, 2004 WL 1084658, at *4 (E.D. Pa. Feb. 27, 2004) (same).

made a repayment demand on Dr. Menolascino relating to approximately 100 patients, and then began to deny new claims (involving other patients and other plans) as a means to "recoup" the funds unilaterally without offering any of the notice or appeal rights required by ERISA § 503. If the district court ruling is not reversed, Dr. Menolascino will have to bring as many as 100 separate lawsuits against each of the up to 100 different plans which insured her patients—none of whom would have any firsthand knowledge of the events leading to United's repayment demands and recoupment practices. Put simply, it would be impracticable (perhaps impossible) to redress United's wrongdoing through the sort of piecemeal, pass-through litigation called for by the district court.

For these reasons, the district court erred by dismissing Plaintiffs' § 502(a)(3) claims.

II. United Is a Proper Defendant Under ERISA § 502(a)(1)(B) for Actions to Recover Benefits, and to Enforce and Clarify Rights Under the Terms of the Plans

Not only did the district court hold that United could not be sued under § 502(a)(3), the district court also ruled that United could not be sued under § 502(a)(1)(B), because it is the "wrong party" to sue for such

violations. JA 218. This holding is contrary to the plain language of § 502(a)(1)(B) and the decision of several Circuit Courts, including this Court's decision in *Lee* v. *Burkhart*, 991 F.3d 1004 (2d Cir. 1993).

A. Section 502(a)(1)(B) Does Not Limit the Kinds of Defendants Who May be Sued Under That Provision

Just as § 502(a)(3) does not limit the kinds of defendants who can be sued under that provision, neither does § 502(a)(1)(B). The Supreme Court's reasoning in *Harris Trust* about which parties may be proper defendants for § 502(a)(3) claims applies equally to § 502(a)(1)(B) claims: "[the provision] demonstrates Congress' care in delineating the universe of ***plaintiffs*** who may bring certain civil actions," but "admits of no limit . . . on the universe of possible ***defendants***." *Harris Trust*, 530 U.S. at 246–47 (emphasis added). And the Circuit Courts that have addressed the question have reached the conclusion opposite from that of the district court.

For example, applying *Harris Trust* in *Cyr* v. *Standard Life Ins. Co.*, 642 F.3d 1202, 1207 (9th Cir. 2011) (en banc), the Ninth Circuit expressly overruled its earlier ruling in *Gelardi* v. *Pertec Computer Corp.*, 761 F.2d 1323, 1324 (9th Cir. 1985) that "ERISA permits suits to recover benefits only against the Plan as an entity." The plaintiff in *Cyr*

brought a § 502(a)(1)(B) action against Reliance Standard Life Insurance Company ("Reliance"). Reliance argued that although it controlled the decision whether to honor or deny a claim under the plaintiff's benefits program, it had not been named officially as the formal plan administrator and so it was not a proper defendant under § 502(a)(1)(B). The Ninth Circuit rejected that argument, allowed the claim to proceed against Reliance, and held that "potential liability under 29 U.S.C. § 502(a)(1)(B) is not limited to a benefits plan or the plan administrator." *Cyr* v. *Reliance Standard Life Ins. Co.*, 642 F.3d 1202, 1207 (9th Cir. 2011).

The Fifth Circuit also has recognized that "[t]he plain language of § 1132(a)(1)(B) . . . does not limit the scope of defendants that a claimant may bring a lawsuit against." *LifeCare Mgmt. Servs. LLC* v. *Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 843 (5th Cir. 2013). Accordingly, it has held that "a TPA [a third-party claims administrator] may be held liable only if it exercises 'actual control' over the benefits claims process." *Id.* at 844. *See also Larson* v. *United Healthcare Ins. Co.*, 723 F.3d 905, 913 (7th Cir. 2013) (citing *Cyr* and allowing a § 502(a)(1)(B) claim to proceed against a party other than the plan or plan

administrator); *Gomez-Gonzalez* v. *Rural Opportunities, Inc.*, 626 F.3d 654, 665 (1st Cir. 2010) ("[T]he proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan [and if] an entity or person other than the named plan administrator takes on the responsibilities of the administrator, that entity may also be liable for benefits"); *Layes* v. *Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (permitting suit against insurer who administered claims but not against the employer); *Heffner* v. *Blue Cross & Blue Shield of Ala., Inc.*, 443 F.3d 1330, 1334 (11th Cir. 2006) (holding that insurer who administered claims was proper party in ERISA benefits action).

Here, Plaintiffs have alleged that United controlled the entire benefits process and made all relevant decisions, such that it is a proper defendant under § 502(a)(1)(B). For example, the scope of United's delegated authority over benefits is illustrated by its conduct in seeking to recoup "overpayments." *See e.g.*, JA 38, ¶ 19; JA 134, ¶ 295; JA 139, ¶ 313; JA 141–42, ¶¶ 318, 320. It does so by offsetting deductions from payments United owes with respect to other patients insured by other plans, thereby treating the monetary liabilities as those of United

rather than the respective plans. JA 89, ¶ 257. Under these circumstances, there is no legitimate dispute that a claims administrator seeking the repayment—such as United—is the proper defendant, not the uninvolved plan or formally designated plan administrator, as numerous courts have ruled. *See e.g.*, *Tri3 Enters., LLC* v. *Aetna, Inc.*, 535 Fed. App'x 192 (3d Cir. 2013) (reversing dismissal of ERISA claim brought by provider to challenge repayment demand).[7]

In short, nothing in the language or context of ERISA supports an immunity from liability for a fiduciary like United.

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[7] *See also Pa. Chiropractic Ass'n* v. *Blue Cross Blue Shield Ass'n*, 2014 WL 1276585, at *18 (N.D. Ill. Mar. 29, 2014) (decision following ERISA bench trial, with court finding that Independence Blue Cross had violated ERISA in pursuing repayment demands and that the plaintiff provider association was entitled to a "permanent injunction" to require compliance with ERISA moving forward); *Premier Health Ctr., P.C.* v. *UnitedHealthGroup*, 292 F.R.D. 204, 224 (D.N.J. 2013) (while denying class certification, holding that insurer's repayment demand policy "violate[s] ERISA"); *Blue Cross & Blue Shield of Rhode Island* v. *Korsen*, 945 F. Supp. 2d 268, 270, 283–84 (D.R.I. 2013) (decision following ERISA bench trial, with court finding that insurer's effort to recoup overpaid benefits was "completely preempted by ERISA," that the insurer had violated ERISA in pursuing the repayment demand, and ordering the insurer to return all recouped benefits, with interest).

Under the district court's decision here, none of these cases could stand.

B. This Court's Precedents Do Not Create the Bright Line Rule the District Court Purported to Apply

The plain language of § 502(a)(1)(B) and the Supreme Court's reasoning in *Harris Trust* notwithstanding, the district court rested its holding on a "bright-line rule that only entities that have been formally designated as 'plan administrators' under 29 U.S.C. § 1002(16)(A) are proper 'administrator' defendants in § 502(a)(1)(B) actions." JA 219. While this Court has not addressed directly the impact of *Harris Trust* on the question whether a claims administrator may be sued under § 502(a)(1)(B), the three cases the district court relied on do not create the bright-line rule that it purported to apply. JA 219 (citing *Lee* v. *Burkhart*, 991 F.2d 1004 (2d Cir. 1993); *Crocco* v. *Xerox Corp.*, 137 F.3d 105 (2d Cir. 1998); and *Chapman* v. *ChoiceCare Long Is. Disability Plan*, 288 F.3d 506 (2d Cir. 2002)). To the contrary, this Court's decision in *Lee* demonstrates that a claims administrator can be sued under § 502(a)(1)(B).

In *Lee*, this Court considered a suit against a claims administrator for a self-funded plan based on the claims administrator's failure to notify the participants about the source of the plan's funding. The Court's *holding* was that the claims administrator could not be held

liable under § 502(a)(1)(B) because it had not been delegated the statutory duty to disclose the plan's funding source. ERISA imposes that duty on the plan's formal administrator; and so the claims administrator did not have a statutory duty to make that disclosure. Nor did the claims administrator have a *fiduciary* duty to disclose the plan's funding source because the complaint did not allege that the claims administrator knew about or facilitated the violation.

Thus, the plaintiffs' § 502(a)(1)(B) action in *Lee* against the claims administrator failed. But the *Lee* Court did not hold that a claims administrator could never be sued under § 502(a)(1)(B). Rather, in reaching its holding, this Court explained the circumstances in which a claims administrator *can* be sued under § 502(a)(1)(B) and therefore made liable for benefits owing under a self-funded plan. Indeed, there would have been no reason for this Court to consider whether the claims administrator had been delegated the duty to disclose the plan's funding source or knew about the violation if any sort of bright-line rule precluded suit anyway. *Lee*, 991 F.2d at 1011. Furthermore, the *Lee* Court's statement that "ERISA permits suits to recover benefits only against the Plan as an entity" was described by the Court only as a

"potential impediment," and relied solely on the Ninth Circuit's holding in *Gelardi*, which, as noted, was later overruled expressly by the Ninth Circuit in light of *Harris Trust*. *Cyr*, 642 F.3d at 1207. This Court is not bound by that statement and no longer has any reason to adhere to it as creating any "potential impediment" to liability—especially after *Harris Trust*.

The issue in *Crocco*, was whether an *employer* could be held liable as a "de facto administrator" of a plan, disregarding the separate legal identity of the plan and the designation of a separate plan administrator. That case did not involve the liability of an entity like United that has been delegated the duty to make benefits determinations and is alleged to have done so in violation of ERISA.

The third case the district court cited, and the only one decided after *Harris Trust*, was *Chapman*. The issue there was whether the plan itself was a proper defendant. The case had nothing to do with whether a claims administrator like United could be sued. The Court quoted from *Leonelli* v. *Pennwalt Corp.*, 887 F.2d 1195, 1199 (2d Cir. 1989), where this Court, citing § 502(d)(2), held that "[i]n a recovery of benefits claim, only the plan and the administrators and trustees of the plan in

their capacity as such may be held liable."[8] But *Leonelli* did not draw a bright-line between the designated "plan" administrator and a "claims" administrator like United that has been delegated the duty to make discretionary judgments about benefits. Also *Leonelli* predates both *Lee* and *Harris Trust*, and the quoted language was *dicta* in *Chapman*.

In sum, the district court erred by concluding that United could not be sued under § 502(a)(1)(B).

III. NYSPA Has Standing to Bring Its Claims Against United

In an alternative holding, the district court concluded erroneously that NYSPA—an association plaintiff—lacked standing to sue United for its unlawful mental health treatment policies and procedures. In reaching this decision, the court issued a decision which would effectively preclude *any* provider association from asserting ERISA

[8] In support of its motion to dismiss below, United referred to § 502(d). But § 502(d) provides that judgments obtained against plans are unlike judgments obtained against other kinds of entities such as partnerships. Whereas individual partners may be liable for a judgment imposed against the partnership, entities and individuals other than the plan are not liable for the judgment—unless their liability is established separately. Indeed, that implies that entities and individuals other than the plan may be sued under § 502(a)(1)(B). *See Cyr*, 642 F.3d at 1207 (holding that § 502(d) "necessarily indicates that parties other than plans can be sued for money damages under other provisions of ERISA, such as § 1132(a)(1)(B), as long as that party's individual liability is established").

claims on the basis of assignments of benefits to members of the association, contrary to decisions of other circuits that have adjudicated such claims. The district court thought the assignments created only "indirect" claims, JA 245, which did not give the association members the ability to sue in their "own right." That holding, however, has no support in the law. The Supreme Court has long recognized that an assignee has its own Article III standing and ERISA itself gives an assignee of benefits the direct right to sue. Thus, NYSPA members have their "own" Article III standing, as well as their "own" statutory standing.

A. NYSPA Has Associational Standing to Sue United On Behalf of Its Members Who Themselves Have Standing

An association has standing "to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt*, 432 U.S. at 343. There is no dispute that NYSPA satisfies the second prong of this test. And despite the district court's

conclusion to the contrary, NYSPA easily satisfies the first and third prongs of this test.

1. NYSPA's Members Have Standing to Sue United in Their Own Right Under *Hunt*

Whether an association's members "have standing to sue in their own right" under the first prong of the *Hunt* test turns on whether they possess Article III standing. *United Food & Commercial Workers Union Local 751* v. *Brown Grp, Inc.*, 517 U.S. 544, 554–55 (1996) (noting that "the [*Hunt*] test's first requirement . . . is grounded on Article III as an element of the constitutional requirement of a case or controversy") (internal quotation marks omitted); *Hunt*, 432 U.S. at 344 (equating the first prong with whether there is a "case or controversy"); *Alliance for Open Soc'y Int'l, Inc.* v. *U.S. Agency for Int'l Dev.*, 651 F.3d 218, 228 (2d Cir. 2011) (describing the first prong of the *Hunt* test as whether at least one of the association's members "has constitutional standing"); *Bldg. & Const. Trades Council of Buffalo, New York & Vicinity* v. *Downtown Dev., Inc.*, 448 F.3d 138, 144 (2d Cir. 2006) (holding that association members "have standing to sue in their own right" under the first prong of *Hunt* if they possess Article III standing).

To meet the first prong of the *Hunt* test, an association need only show that *one* of its members is injured by the defendant's conduct. *See Warth* v. *Seldin*, 422 U.S. 490, 511 (1975) ("The association must allege that its members, ***or any one of them***, are suffering immediate or threatened injury. . . . ") (emphasis added); *United Food*, 517 U.S. at 555 (the first prong of the *Hunt* test "require[s] an organization suing as representative to include ***at least one member with standing*** to present, in his or her own right, the claim (or the type of claim) pleaded by the association") (emphasis added). At the pleading stage, the members allegedly injured need not be identified by name at all. *Bldg. & Const. Trades Council of Buffalo*, 448 F.3d at 144. *See also Pa. Psychiatric Soc'y* v. *Green Spring Health Servs., Inc.*, 280 F.3d 278, 292 (3d Cir. 2002) (associations can pursue claims even when "none of the members were themselves party to the suit").

The Complaint plainly alleges that NYSPA's members have Article III standing. It identifies specifically NYSPA member Plaintiff Menolascino, who regularly obtains assignments of benefits from her United patients and has submitted claims to United for services rendered to those patients that United denied or refused to pay. JA 35–

36, ¶¶ 11–14; JA 114–26, ¶¶ 245–75. Furthermore, the Complaint alleges generally that NYSPA's members have patients who are insured by United and that United has subjected the claims filed on behalf of such insureds to the other uniform internal policies and procedures at issue, which have led United to deny coverage for the services rendered by these NYSPA members or reduce the quantity or quality of the services that will be covered. *See, e.g.*, JA 31, 33–34, ¶¶ 5, 7–8; JA 101–6, ¶¶ 208–25. These allegations more than satisfy the requirements for *Hunt's* first prong.

a. NYSPA members have standing to sue as assignees of ERISA benefits

Because NYSPA members are assignees of their patients' benefits and claims against United, NYSPA members have standing to sue "in their own right."

A mental health care provider who has rendered services to an insured of United in exchange for an assignment of benefits and who has not been paid fully for those services has herself suffered a concrete injury, providing a basis for Article III standing. *E.g.*, JA 114–26, ¶¶ 245–75 (alleging specific injuries suffered by Dr. Menolascino based on United's policies and procedures). *Accord Singleton* v. *Wulff*, 428

U.S. 106, 112–13 (1976) (plurality opinion) (physicians had standing to challenge statute limiting Medicaid reimbursements for abortions because there was "no doubt . . . that the respondent–physicians suffer[ed] concrete injury" from the statute, and that "[i]f the physicians prevail in their suit to remove [the statutory] limitation, they will benefit, for they will then receive payment for the abortions"). The Supreme Court has held squarely that assignments satisfy the requirements for Article III standing, stating that "[l]awsuits by assignees . . . are 'cases and controversies of the sort traditionally amenable to, and resolved by, the judicial process.'" *Sprint Commc'ns Co., L.P.* v. *APCC Servs., Inc.*, 554 U.S. 269, 285 (2008) (quoting *Vermont Agency of Natural Res.* v. *United States ex rel. Stevens*, 529 U.S. 765, 777–78 (2000)).

In *Sprint*, the Court held that collection firms that accept assignments of claims from pay phone operators acquired Article III standing to sue, even though the firms pass on any collected money to the payphone operators minus a fee. 554 U.S. at 286–87; *see also id.* at 288 (rejecting the argument that the collection firms, as assignees, "lack a personal stake" in the litigation). NYSPA members have a much

greater interest in assignments of benefits for services they have rendered but for which they have not been paid (or only partially compensated) than the collection assignee in *Sprint*. NYSPA's members suffer a concrete injury from United's unlawful policies and procedures and, if NYSPA prevails, United will be forced to process mental health claims in accordance with ERISA's parity requirements, which will ultimately result in additional payments to NYSPA members.

The district court's analysis went astray when it shifted from Article III injury to statutory standing, i.e., the question whether NYSPA members could sue under ERISA. Although at one point in its opinion the district court recognized that health care providers who have received an assignment of their patients' ERISA claims are entitled to ERISA's protections and to assert legal claims when those protections are not provided, *see* JA 231, the court later stated (in its *Hunt* analysis) that "none of the [NYSPA] members has a personal right to sue under ERISA § 502(a), since only parties enumerated in ERISA—plan participants, beneficiaries, and fiduciaries—may raise such claims." JA 245.

In fact, however, a NYSPA member with an assignment has the "personal right" to sue under ERISA. This is because any "participant or beneficiary" may bring a civil action under ERISA to enforce "the terms of the plan," § 502(a)(1)(B), or to "enjoin any act or practice" which violates ERISA (which incorporates the Parity Act), § 502(a)(3)(A).

ERISA defines a beneficiary as "a person ***designated*** by a participant, or by the terms of an employee benefit plan, ***who is or may become entitled to a benefit thereunder***." 29 U.S.C. 1002(8) (emphasis added). Thus, to the extent a provider is "designated" by a participant as the party that is entitled to receive the insurance benefit (e.g., through an assignment of benefits), that provider is an ERISA "beneficiary," entitled to all of ERISA's protections and entitled to assert legal claims under § 502(a).

As a result, it is unsurprising that courts—including this Court—have recognized overwhelmingly that health care providers with claims assignments have standing to sue under ERISA. *See, e.g.*, *Montefiore Med. Ctr.* v. *Teamsters Local 272*, 642 F.3d 321, 329 (2d Cir. 2011) (health care providers to whom a beneficiary has assigned his claim in

exchange for health care has standing under ERISA); *Pascack Valley Hosp.* v. *Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400 n.7 (3d Cir. 2004) ("Almost every circuit to have considered the question has held that a health care provider can assert a claim under § 502(a) where a beneficiary or participant has assigned to the provider that individual's right to benefits under the plan[.]"); *Sanctuary Surgical Ctr., Inc.* v. *Aetna Inc.*, 2013 WL 5969636, at *4 (11th Cir. 2013) (health care providers to whom a beneficiary has assigned his claim in exchange for health care has standing under ERISA).

Significantly, other Circuit Courts have relied on the statutory interest of member–assignees under ERISA as the basis for associational standing. *See Connecticut State Dental Ass'n* v. *Anthem Health Plans, Inc.*, 591 F.3d 1337, 1353–54 (11th Cir. 2009) ("[O]ther courts have concluded that a trade group may obtain statutory standing under ERISA through associational standing"); *Pa. Psychiatric Soc'y*, 280 F.3d at 291 (upholding standing of state psychiatric association to assert ERISA claims).

b. NYSPA members have standing to sue to prevent interference with their provision of mental health treatment

NYSPA members also suffer cognizable Article III injury due to United's unlawful policies and practices insofar as those policies and practices impede and interfere with the member's provision of treatment to her patients. Each NYSPA member has an interest in providing appropriate care for her patients that is consistent with the member's ethical obligations and aspirations as health care providers.

In *Greene* v. *McElroy*, 360 U.S. 474 (1959), the Supreme Court held that the ability to practice one's profession—in that case, aeronautical engineering—was an interest protected by the due process clause, and therefore the basis for a justiciable controversy over the revocation of a security clearance. A deprivation need not be total to implicate a legally-protected interest. *Supreme Ct. of N.H.* v. *Piper*, 470 U.S. 274 (1985) (residency requirement to practice law violates privileges and immunities clause). NYSPA members' professional interest in being able to provide appropriate treatment to patients without suffering financial injury is at least as significant as the esthetic interest in enjoying wilderness vistas or whale watching that is clearly sufficient

for Article III standing. *E.g., Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 562–63 (1992); *Japan Whaling Assn.* v. *Am. Cetacean Soc'y*, 478 U.S. 221, 230 n.4 (1986); *Denney* v. *Deutsche Bank AG*, 443 F.3d 253, 264 (2d Cir. 2006). The Complaint alleges that United's unlawful policies and practices have hurt NYSPA members' ability to provide professionally appropriate care to their patients. *See, e.g.*, JA 115, ¶ 249 (alleging that United's policies regarding evaluation and management ("E/M") psychiatric services "effectively preclude patients from receiving E/M care" as "demonstrated through Dr. Menolascino's recent experiences with United"); JA 132, ¶ 291 (United's policies "interfer[e] with the ability of mental health care providers to appropriately treat patients."); JA 135–38, ¶¶ 300–06. This injury is sufficient for Article III standing.

c. MainStreet's *discussion of third-party standing concerns has no place in the first prong of the* Hunt *test and, in fact, NYSPA has third-party standing to sue on behalf of patients*

The district court relied almost exclusively on the Seventh Circuit's decision in *MainStreet* to conclude that NYSPA had not satisfied the first prong of the *Hunt* test because NYSPA's members allegedly had no "personal stake" in the claims asserted. JA 244–45. This reliance was

misplaced. *MainStreet* actually confirms that NYSPA members have the Article III standing required to satisfy *Hunt*, and its discussion of distinct prudential third-party standing issues shows that NYSPA also has third-party standing.

In *MainStreet*, the Seventh Circuit considered claims brought by an association of real estate brokers challenging a city ordinance that prohibited the sale of a house without an inspection to determine whether it complied with applicable codes. 505 F.3d at 743. The Court acknowledged that the real estate brokers had established Article III standing because they alleged economic injury (although more attenuated than the injury to NYSPA members here). *Id.* at 744–45. The court then noted, however, that there was a judge-made limitation on standing that generally prevents a plaintiff from suing to remedy an injury that is "derivative from the injury" to the "immediate victim." *Id.* at 745. The court held that the brokers were really suing to enforce the property rights of the owners of residential property, and there was "no hindrance" on the homeowners enforcing their own rights so "there is no reason to allow the brokers into the litigation arena." *Id.* at 747. NYSPA

members, by contrast, are suing as beneficiaries under ERISA to enforce their own rights.

Thus, *MainStreet* demonstrates that NYSPA members do in fact have Article III standing and, that even though the prudential concerns related to third-party standing that preoccupied the *MainStreet* Court have no place in the analysis of *Hunt's* first prong (which properly addresses only Article III standing), additionally, NYSPA members also possess third-party standing.

Indeed, even if NYSPA members' rights were only derivative (which they are not), they would satisfy the third-party standing test applied in *MainStreet*. The Court distinguished the tenuous connection between the brokers and *future* homeowners/clients (which was insufficient to confer third-party standing), and the stronger connection between brokers their *current* homeowners/clients manifested in a "brokerage contract with a homeowner" that gave the broker a "property right" that was being deprived by the ordinance. *Id.* at 746. NYSPA's members' claims are based on their relationship with existing patients.

As this Court has recognized, to establish third-party standing, a plaintiff must demonstrate constitutional standing (i.e., injury-in-fact,

causation, and redressability), as well as "satisfy 'prudential' limitations on standing: (1) a 'close relation with the third-party' and (2) 'some hindrance to the third-party's ability to protect his or her own interests.'" *Lewis* v. *Thompson*, 252 F.3d 567, 584 (2d Cir. 2001). NYSPA's members, as mental health providers, can show both a close relationship to their patients and a hindrance to their patients' direct assertion of parity-based rights.

First, psychiatrists have the kind of close relationship with their patients that permit the advancement of claims on behalf of the patient. Courts have had no trouble finding that physicians may assert the claims of their patients. For example, in the abortion and contraceptive contexts, the Supreme Court has held repeatedly that physicians have standing to challenge restrictions on behalf of patients. *See, e.g.*, *Singleton*, 428 U.S. at 117 (physician can challenge funding restriction); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965) (Planned Parenthood official and physician can raise the constitutional rights of contraceptive users with whom they had professional relationships); *see also Am. Coll. of Obstetricians & Gynecologists* v. *Thornburgh*, 737 F.2d 283, 290 & n.6 (3d Cir. 1984) (collecting cases where physicians were allowed to

assert patients' claims). Here, too, "the relationship between the litigant and the third-party may be such that the former is fully, or very nearly, as effective a proponent of the right as the latter." *Singleton*, 428 U.S. at 115. The "intimate relationship [between psychiatrists and their patients] and the resulting mental health treatment ensures psychiatrists can effectively assert their patients' rights." *Pa. Psychiatric Soc'y*, 280 F.3d at 289 (holding that a state psychiatric association fulfilled the requirements of third-party standing).[9] The *MainStreet* Court likewise pointed to *Craig* v. *Boren*, 429 U.S. 190, 193–94 (1976), as an "illustrative" example of the kind of case where the plaintiff may sue to enforce someone else's legal rights. In that case, a liquor dealer challenged a statute imposing different minimum ages for men and women buying alcohol. As summarized in *MainStreet*, that

[9] The Supreme Court also has repeatedly granted third-party standing to attorneys to sue on behalf of their clients on the basis of their close relationship. *See, e.g.*, *Kowalski* v. *Tesmer*, 543 U.S. 125, 130–31 (2004) (recognizing that the attorney–client relationship confers third-party standing on attorneys suing on behalf of existing clients); *U.S. Dept. of Labor* v. *Triplett*, 494 U.S. 715, 720 (1990) (acknowledging that attorneys could sue on behalf of existing clients); *Sec'y of State of Maryland* v. *Joseph H. Munson Co.*, 467 U.S. 947, 954–58 (1984) (same). If attorneys may sue on behalf of their existing clients, so too may doctors such as NYSPA members sue on behalf of their existing patients.

liquor dealer "had as definite a stake in the vindication of the claim as a doctor forbidden by law to perform an abortion has in vindicating his patients' right to undergo the procedure." 505 F.3d at 746. (Thus, the Seventh Circuit recognized explicitly that a doctor has a direct interest in vindicating his patients' rights, a holding directly applicable here.)

Second, significant hindrances deter mental health patients from bringing suit on their own. Mental health patients must expose intensely private mental health information to bring an individual claim for benefits. As the Third Circuit has recognized, "the stigma associated with receiving mental health services presents a considerable deterrent to litigation." *Pa. Psychiatric Soc'y*, 280 F.3d at 290. Furthermore, patients with significant mental health problems may lack the capacity to recognize or to assert their own claims. *Id.*; *see also Isaacson* v. *Horne*, 716 F.3d 1213, 1221 (9th Cir. 2013) (physicians can sue on behalf of patients to challenge abortion restrictions in light of patients' privacy interests). Indeed, mental health providers are much more likely than individual patients to identify the kinds of unlawful policies and procedures that are at issue here.

2. NYSPA's Claims for Relief Do Not Require the Participation of Individual Members

The third prong of *Hunt's* associational standing test requires that "neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt*, 432 U.S. at 343. This test "depends in substantial measure on the nature of the relief sought." *Warth*, 422 U.S. at 515. The district court acknowledged that "NYSPA requests declaratory and injunctive relief" for its claims, JA–243, but failed to recognize that the broad-based uniform relief from United's unlawful and uniform internal policies and practices would not require the participation of NYSPA members. Indeed, the district court's conclusion that these claims and the relief sought will require the participation of each NYSPA member erroneously conflated the requirements of Rule 23 of the Federal Rules of Civil Procedure for certifying class action damages issues, with those applicable to associational standing, seeking injunctive relief.

Courts consistently have held that the participation of individual association members is not necessary when declaratory or injunctive relief is sought to redress corporate and governmental policies and procedures. *See Warth*, 422 U.S. at 515; *Bldg. & Constr. Trades*, 448

F.3d at 150 ("Here, because the Trades Council seeks civil penalties and injunctive relief only, not money damages, its claims do not require 'individualized proof.'"); *see also Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am.* v. *Brock*, 477 U.S. 274, 287 (1986) (finding associational standing where lawsuit "raises a pure question of law: whether the Secretary properly interpreted the Trade Act's TRA eligibility provisions" and state authorities would adjudicate eligibility of individual claimants).

In *Borrero* v. *United Healthcare of New York, Inc.*, 610 F.3d 1296, 1306 (11th Cir. 2010) for example, medical associations challenged United Healthcare's practices, including improper coding, bundling, downcoding, improper use of guidelines, and poor claims resolution. The associations sought "an alteration of United's methodology, not redress for any specific past decision." *Id.* The Eleventh Circuit held that such claims could be proven with the limited participation of association members and, therefore, the association had standing to pursue the claims. Similarly, the Third Circuit upheld the associational standing of a state psychiatric association, the Pennsylvania Psychiatric Society, which challenged the "*methods the* [managed care organizations]

employ for making decisions." *Pa. Psychiatric Soc'y*, 280 F.3d at 286. Because the association's allegations "concern *how* the [managed care organizations] render these decisions," the Complaint "involves challenges to alleged practices . . . that may be established with sample testimony." *Id.* (internal citation and quotation marks omitted). Here, too, NYSPA challenges United's policies, not individual coverage decisions, and will be able to establish the illegality of United's policies without the "extensive" individual member participation predicted necessary by the district court.

A need for limited participation by a small number of association members is not a bar to associational standing. There is an important difference between the need for some association members to serve as sources of testimony and evidence to sustain the association's case, and the need for all members to participate in order to justify individual relief, as would be true in a class action seeking damages. In *Warth*, the Court wrote that "so long as the nature of the claim and of the relief sought does not make the individual participation of *each* injured party indispensable to proper resolution of the cause, the association may be an appropriate representative of its members entitled to invoke the

court's jurisdiction." 422 U.S. at 511 (emphasis added); *see also Hunt*, 432 U.S. at 343 (same); *Brock*, 477 U.S. at 282 (same). Based on this explanation—which became the basis for the third prong of the *Hunt* test—courts have recognized that some participation by some members of an association does not defeat associational standing as long as the participation of every single member is not necessary. *See, e.g.*, *Pa. Psychiatric Soc'y*, 280 F.3d at 286 ("If the Pennsylvania Psychiatric Society can establish these claims with limited individual participation, it would satisfy the requirements for associational standing."); *N.Y. State Nat'l Org. for Women* v. *Terry*, 886 F.2d 1339, 1349 (2d Cir. 1989) (association warranted standing although evidence from some individual members necessary); *Hosp. Council of W. Pa.* v. *City of Pittsburgh*, 949 F.2d 83, 89–90 (3d Cir. 1991) (Alito, J.) ("[A]n association may assert a claim that requires participation by *some* [association] members"); *Retired Chicago Police Ass'n* v. *City of Chicago*, 7 F.3d 584, 601–02 (7th Cir. 1993); *see also Alliance*, 651 F.3d at 229–30, *aff'd sub nom. Agency for Int'l Dev.* v. *Alliance for Open Soc'y Int'l, Inc.*, 133 S. Ct. 2321 (2013) (holding that, even though "more thorough fact development" will be necessary to establish the extent of the

burden on the associations' members, individualized evidence "would be duplicative and redundant[,] counsel[ing] in favor of granting associational standing in the interests of judicial economy") (internal quotation marks omitted). In a case in which a hospital association challenged alleged governmental practices, then-Circuit Judge Alito held that even if the litigation required "evidence regarding the manner in which the defendants treated individual member hospitals," there was "no ground for denying associational standing," since participation by "each" member hospital was not necessary. *Hosp. Council of W. Pa.*, 949 F.2d at 89–90.

The district court rested its erroneous conclusion that proof of NYSPA's claims would "require[] the participation of individual psychiatrist members" on the faulty premise that individual participation would be required to prove *each* member's standing. JA 246. As set forth above, however, only one member of an association needs to have standing in order for the association to have standing. Thus, the district court's notion that "extensive association member participation," *id.*, would be required to prove standing is wrong as a matter of law. Moreover, the district court's concern about each

members' standing is inconsistent with *Hunt* itself, which upheld the issuance of an injunction sought by an association of Washington State apple farmers without any inquiry into whether any particular farmers had standing to pursue a Commerce Clause challenge to North Carolina's labeling law (e.g., which farmers sold apples in North Carolina) or which farmers suffered injury (e.g., how much it cost each farmer to comply with the law). Resolving these questions would have required resolution of a myriad of individualized issues. Yet, the Supreme Court held that the association had standing and affirmed the issuance of the injunction.

The district court also erred in holding that proving the merits of NYSPA's claims would require extensive NYSPA-member participation "to establish the relevant terms of the thousands of potentially affected benefit plans and patients, and how those plans are operated in practice." JA 246–47. The gravamen of NYSPA's claims is that United has adopted internal policies and procedures that cause it to discriminate against those who suffer from mental illness when making coverage decisions. The relevant evidence in this case is in the possession of *United* and can be discovered through United alone. Thus,

participation of NYSPA's members is not required to establish the facts most relevant to NYSPA's claims.

To the extent that the terms of particular health insurance plans (such as definitions of medical necessity or provisions concerning a pre-authorization requirement) are relevant to NYSPA's claims, United issues or administers all the plans that might be relevant to NYSPA's claims. NYSPA's members do not need to participate in the action to establish what those plans say; indeed, NYSPA members are unlikely to have access to those documents. Similarly, if it becomes necessary to prove that United's application of its internal policies and procedures has actually caused it to deny claims submitted by NYSPA members, such proof also can be obtained most efficiently from United's own documents and testimony or through discovery from third parties. But even if some participation by NYSPA members were to become needed, *some* participation is not grounds to deny associational standing. *See, e.g.*, *Warth*, 422 U.S. at 511; *Hosp. Council of W. Pa.*, 949 F.2d at 89–90 (claim by association requiring "evidence regarding the manner in which the defendants treated individual member hospitals" does not defeat associational standing). As the Third Circuit explained in a very

similar context, claims like those asserted by NYSPA "should not be dismissed before it is given the opportunity to establish the alleged violations without significant individual participation." *Pa. Psychiatric Soc'y*, 280 F.3d at 286.

The district court therefore erred by dismissing NYSPA's standing at this early stage of the proceedings.

IV. The State Claims Should Be Reinstated

Because it dismissed the federal claims, the district court declined to exercise supplemental jurisdiction over Plaintiffs' state law claims (Counts VI–VIII). JA 242. Since the federal claims should be reinstated, this Court's instructions on remand should include reinstatement of the state law claims as well.

CONCLUSION

For all of the reasons discussed above, this Court should reverse the district court's order dismissing Plaintiffs' claims.

Dated: April 15, 2014

Respectfully submitted,

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RULE 32(a)(7)(C) CERTIFICATE OF COMPLIANCE

In conformance with Rule 32(a)(7)(C)(i) of the Federal Rules of Appellate Procedure, I certify that:

1. This brief complies with the type-volume limitation of Rule 32(a)(7)(B)(i) of the Federal Rules of Appellate Procedure. This brief contains 13,860 words, excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Rule 32(a)(5) of the Federal Rules of Appellate Procedure and the type style requirements of Rule 32(a)(6). This brief was prepared in 14 point Century font (a proportionally-spaced typeface) using Microsoft Word 2010.

Dated: April 15, 2014

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CERTIFICATE OF SERVICE

In conformance with Rule 25(d) of the Federal Rules of Appellate Procedure, I certify that on April 21, 2014, I caused the foregoing Brief for Appellants to be filed electronically along with the parties' Joint Appendix with the Clerk of the Court of the United States Court of Appeals for the Second Circuit by using the Court's Case Management/Electronic Case Filing (CM/ECF) system, which will send notification of this filing to all registered counsel of record.

I further certify that I will submit paper copies of Appellants' Brief and Joint Appendix in conformance with Local Rules 30.1(b) and 31.1 and Federal Rules of Appellate Procedure 30(a)(3).

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FRAP 28(f) ADDENDUM

ADDENDUM CONTENTS

PAGE

29 C.F.R. § 2590.712(c)(4)(i)

(c) Parity requirements with respect to financial requirements and treatment limitations--

(4) Nonquantitative treatment limitations--

(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

29 C.F.R. § 2590.712(c)(4)(ii)(F)

(c) Parity requirements with respect to financial requirements and treatment limitations--

(4) Nonquantitative treatment limitations--

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include--

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)

ERISA § 3(8), 29 U.S.C. 1002(8)

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

ERISA § 3(16)(A), 29 U.S.C. § 1002(16)(A)

(16)(A) The term "administrator" means--

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

ERISA § 3(21)(A)(iii), 29 U.S.C. § 1002(21)(A)(iii)

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1)

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

A) for the exclusive purpose of:

i) providing benefits to participants and their beneficiaries; and

ii) defraying reasonable expenses of administering the plan;

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

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

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

ERISA § 405(a), 29 U.S.C. § 1105(a)

(a) Circumstances giving rise to liability

In addition to any liability which he may have under any other provisions of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:

(1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;

(2) if, by his failure to comply with section 1104(a)(1) of this title in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or

(3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

ERISA § 502(a)(1), 29 U.S.C. 1132(a)(1)

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan

ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)

(a) Persons empowered to bring a civil action

A civil action may be brought--

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

ERISA § 502(d), 29 U.S.C. § 1132(d)

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

ERISA § 712a(a)(3)-(4), 29 U.S.C. § 1185a(a)(3)–(4)

(a) In general

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

ERISA § 715d, 29 U.S.C. § 1185d

(a) General rule

Except as provided in subsection (b)--

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.