14-0020

IN THE 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, M.D. SHELLY MENOLASCINO, on Their Own Behalf And in a Representational Capacity on Behalf of Their Beneficiary Patients And on Behalf of All Other Similarly Situated Providers And Their Patients,
Plaintiffs - Appellants,
(*For Continuation of Caption See Inside Cover*)

On Appeal from the United States District Court
for the Southern District of New York (Docket No.: 13-cv-1599)

BRIEF OF THE SECRETARY, UNITED STATES DEPARTMENT OF LABOR, AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANTS AND REQUESTING REVERSAL

M. PATRICIA SMITH
Solicitor of Labor
G. WILLIAM SCOTT
Acting Associate Solicitor for Plan Benefits Security
ELIZABETH HOPKINS
Counsel for Appellate and Special Litigation
NICHOLAS D. BEADLE
Attorney, U.S. Department of Labor
200 Constitution Ave., N.W., Rm. N-2700
Washington, D.C. 20210
(202) 693-5521

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.

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STATEMENT OF THE ISSUES

The Secretary of Labor's brief addresses the following issues:

1. Whether section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., permits a plan participant claiming entitlement to benefits to sue a claims administrator as the fiduciary with sole and final authority to decide claims.

2. Whether a plan participant may bring a claim under section 502(a)(3)(A), 29 U.S.C. § 1132(a)(3)(A), for injunctive relief requiring that a plan be operated in compliance with ERISA simultaneously with a claim for benefits under section 502(a)(1)(B).

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

The Secretary of Labor has primary enforcement and regulatory authority for Title I of ERISA. See, e.g., Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 692–93 (7th Cir. 1986) (en banc). The Secretary has a strong interest in ensuring that plan participants and beneficiaries may sue fiduciaries who control the claims process for plan benefits, as well as for injunctive relief to correct an alleged systemic failure to abide by the requirements of the governing claims regulation and the mental health parity provisions of ERISA. The Secretary files this brief as amicus curiae as of right under Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

1. ERISA is designed to promote and protect the interests of plan participants and their beneficiaries and to secure contractually defined benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989). To this end, ERISA section 502(a)(1)(B) gives participants and beneficiaries a private right of action "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. " 29 U.S.C. § 1132(a)(1)(B). In addition, section 502(a)(3) gives plan participants, beneficiaries, and fiduciaries the right to sue "to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan" or "to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan." Id. § 1132(a)(3).

ERISA, as amended by the Mental Health Parity and Addiction Equity Act ("Parity Act"), requires "group health plan[s]" and "insurance coverage offered in connection with such . . . plan[s]" that offer "both medical and surgical benefits and mental health or substance use disorder benefits" to ensure that

> 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.

29 U.S.C. § 1185a(a)(3)(A)(ii).

The Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively known as the ACA) made certain provisions of the Public Health Service Act, as amended by the ACA, applicable to "group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans." 29 U.S.C. § 1185d.[1] Pursuant to this provision, section 2719 of the Public Health Service Act requires that non-grandfathered[2] group health plans and health insurance issuers must provide an internal claims and appeals process that initially incorporates the internal claims and appeals procedure set forth in the applicable claims procedure regulation, 29 C.F.R. § 2560.503-1,[3] and update such processes in accordance with standards established by the Secretary of Labor. The Secretary of Labor – along with the Secretaries of Health and Human Services and the Treasury – issued interim final

[1] The ACA adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Internal Revenue Code to incorporate the provisions of part A of title XXVII of the Public Health Service Act into ERISA and the Code.

[2] The requirements for internal claims and appeals and external review processes for group health plans and health insurance coverage do not apply to grandfathered health plans under section 1251 of the Affordable Care Act. See also 29 C.F.R. § 2590.715-1251 regarding grandfathered health plan coverage.

[3] Unlike the ACA provisions, some of which do not apply to grandfathered plans, the Department of Labor's claims procedure regulation applies to all ERISA plans, regardless of grandfather status. See also 29 C.F.R. § 2590.715-1251.

regulations relating to internal claims and appeals and external review processes which, among other things, grant plan participants and beneficiaries certain internal claim and appeal rights and the right to continued coverage during a pending appeal. See 75 Fed. Reg. 43,330 (July 23, 2010).

Both the Parity Act and the relevant provision of the ACA are enforced, like other ERISA duties, through ERISA section 502(a), and their requirements should be treated as terms of ERISA-covered plans. Cf. Cent. Laborers' Pension Fund v. Heinz, 541 U.S. 739, 750 (2004) (anti-cutback provision of ERISA "adds a mandatory term" to all ERISA-covered pension plans). ERISA defines a fiduciary as encompassing any person who, among other things, has or exercises "any discretionary authority or discretionary control" or "responsibility" with respect to plan management or administration. 29 U.S.C. § 1002(21)(A). Moreover, ERISA directs plan fiduciaries to act "solely in the interest of the participants and beneficiaries," "for the exclusive purpose" of paying benefits and defraying reasonable administrative expenses under the plan, and in accordance with a prudent man standard of care. Id. § 1104(a)(1)(A).

2. This case was brought by four individual plan participants or beneficiaries, two doctors, and the New York State Psychiatric Association (NYSPA). They assert both individual claims for benefits and a putative class action against UnitedHealth Group and three subsidiaries (collectively "United")

for alleged violations of ERISA based on United's handling of mental and behavioral health claims under their plans and others like them.[4]

According to the complaint, United acts as claims administrator for the self-funded plans described in the complaint, which give United sole discretion to decide whether to grant or deny mental health and substance abuse claims. E.g., Joint Appendix ("JA") 38. Plaintiffs charge that United has instituted policies and procedures that not only violate plan terms, but also violate ERISA's Mental Health Parity Act provision, and some of the ACA claims processing provision incorporated into ERISA. E.g., JA 31, 39.

More specifically, plaintiffs argue that United unlawfully denied mental and behavioral health benefits by subverting the claims process and instituting more onerous procedures and standards of proof for mental health claims than for medical and surgical treatment at equivalent care levels in violation of ERISA's Mental Health Parity Act provision. E.g., JA 59–60. For instance, Plaintiff

[4] The New York State Psychiatric Association (NYSPA) brought this claim in a representational capacity on behalf of its members and their patients. Two doctors with assigned claims sued on their own behalf, and on behalf of their patients, and similarly situated providers. The seven named plaintiffs filed claims for benefits in individual or representative capacities, and they also asserted injunctive claims for similarly situated participants and beneficiaries of ERISA plans whose benefits claims are likewise administered by United. Since the district court issued its decision, United has settled with three of the individual plaintiffs – Mr. Olin, Mr. Smith and Dr. Allender, and only three individual plaintiffs – Mr. Denbo, Mr. Kamins and Dr. Menolascino – as well as the NYSPA, remain as plaintiffs in this appeal.

Jonathan Denbo, an employee of CBS Sports Network and participant in its self-funded plan, alleges that, after prolonged treatment of his depression and anxiety, United determined as a prospective matter that Denbo would no longer be entitled to any psychotherapy, even though the plan provides that mental health benefits are only subject to retrospective review for benefits that have been provided. JA 38–39. Denbo (and the other plaintiffs) also accused United of violating certain procedural requirements (such as providing two levels of review in some cases and independent review at each level) of the interim final claims regulations enacted under the ACA and applicable to group health plans, see 29 U.S.C. § 1185d; 29 C.F.R. § 2590. See JA 142.

Perhaps most significantly, Denbo and the other plaintiffs allege that United systematically violated the Parity Act provisions of ERISA by using more restrictive criteria in determining what mental and behavioral health benefits were necessary than those it applies to medical and surgical benefits. See JA 66. Thus, according to the complaint, United imposes more restrictive limitations on mental health claims than on medical and surgical claims, including by: applying more restrictive guidelines for determining medical necessity for such claims; imposing higher evidentiary burdens on these claims; imposing more stringent utilization review; refusing to pay for treatment pending review; applying less favorable reimbursement standards; and imposing the kind of "fail-first" policy forbidden by

the regulations to deny needed residential treatment. JA 39, 59–60. Alleging that these violations led United to wrongfully deny their claims or the claims of their patients for mental health coverage, the plaintiffs seek either the benefits they believe they were unlawfully denied, or alternatively, an injunction requiring United to re-determine their claims applying proper procedures and standards; and they additionally seek an injunction requiring United to apply proper procedures and standards in deciding future claims for mental health benefits. JA 155–62.

2. The district court granted United's motion to dismiss for failure to state a claim. JA 208. Pointing to Second Circuit precedent on section 502(a)(1)(B) claims, the court held that because United was a claims administrator, and not the plan, formal plan administrator, or trustee, it could not be sued for benefits. JA 219.

Relying on the Supreme Court's decision in Varity v. Howe, 516 U.S. 489 (1996), the court also concluded that the plaintiffs could not simultaneously sue United for benefits under section 502(a)(1)(B) and for injunctive relief under section 502(a)(3). JA 221–22. Although plaintiffs asked the court to enjoin United from continuing to utilize its offending policies and procedures under section 502(a)(3), the court read the complaint to request nothing more than the provision of the denied benefit – a remedy already available under section 502(a)(1)(B), albeit not from United, in the court's view, but from the formal administrators of

their plans. See JA 223 ("[W]here the gravamen of a plaintiff's claim is the wrongful denial of benefits, that harm can be adequately remedied through monetary compensation"). It also reasoned that "[t]here is no need to obtain direct equitable relief against United, because any injunction against the Plan or the Plan Administrator will necessarily bind United, which acts as the agent for the Plans in its alleged capacity as a claims administrator." JA 225.[5]

SUMMARY OF THE ARGUMENT

1. Despite the fact that the terms of section 502(a)(1)(B) place no limits on the list of possible defendants in a claim for benefits, United argues, and the district court held, that no suit for benefits may be brought against United as the entity with the sole discretion to decide claims for benefits because United is not the formal plan administrator or a trustee of the plan. This limiting gloss on section 502(a)(1)(B) cannot be squared with the language of the statute, decisions of the Supreme Court, or case law from other circuits. Nor is this result mandated by the precedent from the Second Circuit. The district court thus erred in dismissing on this basis the claims for benefits asserted against United.

[5] The district court dismissed the claims of the fourth individual plaintiff based on the court's conclusion that his plan was not covered by ERISA, the claims of the two doctors for the same reasons described above as well as for being inadequately pled, and the claims asserted by the NYSPA for lack of standing. JA 231–48. The Secretary does not address these issues in this brief.

2. Similarly, nothing in ERISA forecloses a participant or beneficiary from simultaneously suing a fiduciary for benefits and seeking to enjoin violations of plan terms. The district court's dismissal of the section 502(a)(3) claims turns on a misreading of the Supreme Court's ruling in Varity, which addressed "appropriate equitable relief" under section 502(a)(3)(B), and said nothing about injunctive relief under section 502(a)(3)(A). Moreover, as this Court has held, Varity said nothing about the ability to alternatively plead a claim for benefits and a claim for injunctive relief, but instead focused on the relief available once plaintiffs have proven an ERISA violation. Because the plaintiffs' claims here seek significantly different relief – a payout of wrongfully denied benefits due under their plans and an a prospective injunction requiring United to comply with the procedural and substantive requirements of ERISA – the district court erred in dismissing the section 502(a)(3) claims.

ARGUMENT

I. THE DISTRICT COURT ERRED IN DISMISSING THE BENEFIT CLAIMS AGAINST UNITED BECAUSE NOTHING IN ERISA FORBIDS SUING THE ENTITY WITH EXCLUSIVE AUTHORITY TO DECIDE CLAIMS FOR BENEFITS, NOR DOES THIS COURT'S PRECEDENT REQUIRE SUCH A RESULT

By its plain terms, section 502(a)(1)(B) gives participants and beneficiaries a private right of action "to recover benefits due to [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights

to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). In Harris Trust & Savings Bank v. Salomon Smith Barney, Inc., 530 U.S. 238, 253 (2000), the Supreme Court considered whether another one of ERISA's remedial provisions, section 502(a)(3), allows a suit against nonfiduciaries who have participated in a fiduciary breach. Noting that Congress demonstrated "care in delineating the universe of plaintiffs who may bring certain civil actions" under section 502(a)(3), but made "no mention at all of which parties may be proper defendants" under that section, the Court concluded that section 502(a)(3) "admits of no limit . . . on the universe of possible defendants." Id. at 246–47. Like section 502(a)(3), section 502(a)(1)(B) specifies the proper plaintiffs – participants and beneficiaries – in a suit for plan benefits, but is silent concerning the proper defendants in such a suit, and the same result should pertain. As with section 502(a)(3), in construing section 502(a)(1)(B), courts should "assume that Congress' failure to specify proper defendants . . . was intentional." Harris Trust, 530 U.S. at 247.

Thus, under the reasoning of Harris Trust, there is no reason to limit the proper defendants in a claim for benefits to the plan or its formal trustee or administrator. Although the plan, as the entity with ultimate responsibility under ERISA for the promised benefit, is considered by some courts to be a necessary party defendant for purposes of affording complete relief in a claim for benefits

under ERISA section 502(a)(1)(B), see Fed. R. Civ. P. 19, there is no reason to preclude suit, as the district court's decision does, against the entity that decides the benefit claims simply because that entity is not the formal plan administrator or a formal trustee. Indeed, under ERISA, which sets forth a functional and not merely formal definition of fiduciary, plan fiduciaries need not be charged with formal trusteeship. See Mertens v. Hewitt Assocs., 508 U.S. 248, 262 (1993) (citing 29 U.S.C. § 1002(21)(A)). Indeed, in a welfare plan of the sort at issue here, because there is no requirement for a funded trust, there often are no trustees associated with such plans.

Nor does the definition of plan administrator in section 3(16) of ERISA, 29 U.S.C. 1002(16), shed any light on whom a plan participant may sue for benefits under ERISA section 502(a)(1)(B). The term "administrator" is defined in ERISA section 3(16)(A) to mean the person specifically so designated by the terms of the instrument under which the plan is operated or, in the case where an administrator is not designated, the plan sponsor. The definition's primary function is to work with specific statutory provisions that assign specific duties (regarding the operation of a plan and reporting and disclosure obligations) to the section 3(16) administrator. See 29 U.S.C. § 1021 (imposing on plan administrator specified duties of reporting and disclosure, such as summary plan descriptions and annual reports); id. § 1024 (placing related filing duties on plan administrator); id. § 1166

(notice requirements with regard to events such as death and divorce affecting coverage); id. § 1132(c) (imposing on plan administrators penalties for refusal to supply certain requested information or to file complete annual report); see also 29 C.F.R. § 2509.75-8, Q&A D-3 (plan administrator is a fiduciary).

While the section 3(16) plan administrator also is assigned some specific disclosure and communication obligations under the Department's regulation applicable to benefit claims, 29 C.F.R. § 2560.503-1, neither section 3(16) nor any other statutory or regulatory provision requires that the plan administrator review or decide benefit claims or in any way limits administration of a plan to the single person designated as the plan administrator under section 3(16). Indeed, ERISA section 402(a) makes clear that more than one person can be assigned fiduciary responsibilities in connection with the administration and operation of the plan. 29 U.S.C. § 1102(a). Section 3(21) specifies that anybody who has or exercises discretionary authority respecting plan administration is a fiduciary. 29 U.S.C. § 1002(21). Because the plan documents grant United, not the section 3(16) plan administrator, the sole and final authority decide benefit claims, United's discretionary authority in this regard makes it a fiduciary under section 3(21). And section 503 requires a fiduciary to be responsible for adjudicating benefits without limiting the class of such fiduciaries to the section 3(16) plan administrator. In none of these statutory provisions is there any indication that the section 3(16) plan

administrator is the only plan fiduciary subject to suit in a section 502(a)(1)(B) claim for benefits.

Thus, ERISA clearly allows a plan to assign an insurer or other provider of claims processing services the role of payor and fiduciary claims administrator and to be named as the defendant in a suit for benefits when the plaintiff believes they have improperly processed a claim.

It makes little or no sense to preclude plan participants from suing a person properly assigned responsibility to decide claims under the terms of the plan. If this Court were to affirm the district court's decision, it would lead to the odd result that the participant could not sue the one party that can most directly afford the relief requested: a proper determination of entitlement to benefits under the plan. That would not necessarily mean that the participant has no avenue for relief, but it means that there would be significant and unjustified obstacles to ultimately obtaining that relief.[6]

Precluding a benefit suit against an entity such as United that is charged with interpreting the plan and making benefit determinations and paying benefits is anomalous for another reason. In deciding benefits cases, particularly cases concerning the standard of review applicable to benefit denials, Supreme Court

[6] Thus, we believe that the district court was wrong to assume that it would be a simple matter to sue the plan for benefits and thereby bind United to the proper interpretation and administration of the plan as determined in such a suit. JA 236.

decisions have long assumed that claims under section 502(a)(1)(B) may be brought against the plan fiduciary that makes the benefit determination, and not just formal plan administrators. For instance, in its decision in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115 (emphasis added). Thus, the Supreme Court in cases like Firestone and UNUM Life Insurance Company of America v. Ward, 526 U.S. 358 (1999), and lower courts in countless other cases across the country, have simply and correctly assumed that a plan participant or beneficiary claiming benefits under an ERISA plan could sue the insurer that was making the benefit determination, without ever questioning whether the insurer was the plan administrator. Indeed, under Firestone, courts in the Second Circuit and others deferentially review the decisions of insurers that are granted discretion to interpret plan terms and decide benefit claims, a practice that would make scant sense if such insurers are not proper parties in a suit for benefits merely because they are not the section 3(16) plan administrator.

For these reasons, most courts that have expressly considered the issue have held that benefit claimants may sue any fiduciary charged with determining the

claim. See, e.g., Curcio v. John Hancock Mut. Life Ins. Co., 33 F.3d 226, 233 (3d Cir. 1994); LifeCare Mgmt. Servs. LLC v. Ins. Mgmt. Adm'rs Inc., 703 F.3d 835, 844–46 (5th Cir. 2013) (a third-party claims administrator may be held liable if it exercises "actual control" over the claims process); Musmeci v. Schwegmann Giant Super Mkts., Inc., 332 F.3d 339, 350 (5th Cir. 2003) ("[I]t was indisputably SGSM's decision to deny further vouchers or their cash equivalent to the Plaintiffs. Under these facts, the district court correctly held that SGSM was properly named as a defendant."); Daniel v. Eaton Corp., 839 F.2d 263, 266 (6th Cir. 1988); Mein v. Carus Corp., 241 F.3d 581, 585 (7th Cir. 2001); Layes v. Mead Corp., 132 F.3d 1246, 1249–50 (8th Cir. 1998) (administrator who made claims decisions was a proper defendant); Cyr v. Reliance Standard Life Ins. Co., 642 F.3d 1202, 1207 (9th Cir. 2011) (party with control over benefits was a "logical defendant"); Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 187 (11th Cir. 1997) ("The proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan."); see also Larson v. United Healthcare Ins. Co., 723 F.3d 905, 913 (7th Cir. 2013) (citing Cyr and recognizing that "the insurance company [that] decides contractual eligibility and benefits questions and pays claims" may be sued in a claim for benefits under section 502(a)(1)(B)).

Although this Court has never directly considered whether a claims administrator (like United) with sole discretion to decide claims is a proper

defendant under section 502(a)(1)(B), the district court relied on Second Circuit decisions stating that in a benefits suit, only the plan, plan administrator or trustee are proper defendants. In the earliest such case, Leonelli v. Pennwalt Corp., 887 F.2d 1195 (2d Cir. 1989), a former employee brought state law negligence and breach of contract claims against his employer and two managers at the company, alleging that they failed to inform him about early retirement options and improperly denied him benefits under a salary continuation plan. The Second Circuit refused to allow Leonelli to amend his complaint to allege fiduciary breaches and a claim for benefits under ERISA, noting that he did not name the pension committee that decided benefits claims and did not exhaust the claims procedure as provided by the plan. Id. at 1199. Citing the provision in ERISA that permits a plan to sue or be sued, 29 U.S.C. § 1132(d)(2), and the Ninth Circuit's decision in Gelardi v. Pertec Computer Corp., 761 F.2d 1323, 1324–25 (9th Cir.1985) (per curiam), which now has been overruled by Cyr, the court reasoned 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." Leonelli, 887 F.2d at 1199. This conclusion, however, was not necessary: Leonelli could not have brought suit under section 502(a)(1)(B) because he did not exhaust the claims procedure as provided by the plan. Id. at 1199.

Since Leonelli, this Circuit has repeated that only plans, plan administrators and trustees can be sued for benefits under section 502(a)(1)(B), but has done so mostly in cases where plaintiffs did not establish defendants' discretion over claims or even involvement in the plan's operation. See, e.g., Clark v. World Cable Commc'ns, Inc., No. 98-7088, 1998 WL 907904, at *2 (2d Cir. Dec. 23, 1998) (unpublished) (affirming summary judgment dismissing claim for benefits against former employer because there were no allegations that employer was either "administrator or trustee of the ERISA qualified plan"); Crocco v. Xerox Corp., 137 F.3d 105, 107 (2d Cir. 1998) (denying that employer acts as plan's de facto administrator); Chapman v. ChoiceCare Long Island Term Disability Plan, 288 F.3d 506, 509–10 (2d Cir. 2002) (refusing to dismiss suit for benefits against plan, noting that a plan, along with administrators and trustees of the plan, are proper defendants in a suit for benefits under ERISA); Paneccasio v. Unisource Worldwide, Inc., 532 F.3d 101, 108 n.2 (2d Cir. 2008) (holding that summary judgment for defendants was proper because parent company of former employer and related corporate entities did not have control over benefits and thus were not proper defendants in a suit for benefits under ERISA). None of these cases addressed whether a third-party administrator that has sole authority to decide benefits claims may be a proper defendant in a suit for benefits, as in this case. E.g., JA 215 (imbuing United with final "authority to interpret Plan provisions as

well as facts and other information related to claims and appeals" for one plan). Instead, most of these cases concerned whether to allow parties, such as plan sponsors, that are not ERISA fiduciaries, to be sued. See, e.g., Paneccasio, 532 F.3d at 108 n.2 (disallowing claim against a later owner of former employer and its present corporate permutation when other entities exerted all control over plan); Crocco, 137 F.3d at 107 (rejecting that employer acts as de facto administrator of a plan and thus a proper section 502(a)(1)(B) defendant).

The district court also cited Lee v. Burkhart, 991 F.2d 1004 (2d Cir. 1993), a ruling which did involve a suit against an insurer, Connecticut General, acting as a claims administrator with discretion to decide benefit claims under a self-funded health plan. The plaintiffs, two participants in the plan, sued Connecticut General for benefits under section 502(a)(1)(B) (as well as for fiduciary breach under section 502(a)(3)), but they did not claim that Connecticut General improperly determined their benefit claims. Instead, after Connecticut General informed them that their benefits would not be paid due to the bankruptcy of the plan sponsor responsible for the payment of benefits, 991 F.2d at 1006–07, they sued Connecticut General for the benefits under an estoppel theory. 991 F.2d at 1009. Although this Court, citing the Ninth Circuit's now-overrruled Gelardi decision, noted that the fact that Connecticut General was not the "Plan" was a "potential impediment" to the plaintiffs' recovery, the Court's actual holding was that the facts

alleged by the plaintiffs were "insufficient to support a claim for equitable estoppel." Id. at 1010. Thus, Lee has little or no relevance to the issue in this case.

Because none of the prior decisions from this Court have held that plan participants challenging benefit denials under their plans may not sue the entity that denied these claims, we urge this court to hold, as common sense would dictate, that they may sue such decisionmakers under ERISA's broadly worded claim-for-benefits provision. Thus, we believe that the prior decisions should be limited to their facts. They are best understood as using the terms "trustees" and "administrators" in a non-technical sense to refer to ERISA fiduciaries more broadly, and they are intended to preclude only benefit suits against entities that lacked discretionary control and authority over plan administration. This case offers the Court the opportunity to clarify that not only plan administrators and trustees, but other fiduciary decisionmakers, such as United in this case, may be sued in an ERISA suit for benefits.

II. THE DISTRICT COURT ERRED IN DISMISSING THE PLAINTIFFS' CLAIMS FOR INJUNCTIVE RELIEF UNDER SECTION 502(a)(3) BECAUSE ERISA PLAINTIFFS ARE ENTITLED TO PLEAD INJUNCTIVE RELIEF CLAIMS SIMULTANEOUSLY WITH BENEFIT CLAIMS

Section 502(a)(3) empowers participants, beneficiaries and fiduciaries to sue "(A) to enjoin any act or practice which violates any provision of this title 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 title or the terms of the plan." 29 U.S.C. § 1132(a)(3). Plaintiffs in this case alleged that United administered the plans in a way that violated both specific plan provisions, as well as ERISA's substantive and procedural requirements, and they sought

> a permanent injunction ordering United to cease imposing preauthorization and concurrent review requirements for outpatient mental health treatment, to cease relying on the medical necessity definitions for mental health services as incorporated into the Empire Plan or plans with similar definitions, to pay benefits during the appeal process after denial or reduction of benefits for an ongoing course of mental health treatment, to pay mental health providers for providing mental health services under the E/M codes, based on the amount of time spent providing such services, and to cease offsetting payable claims to apply toward purported overpayments.

JA 168. Although they cited section 502(a)(3) generally, presumably they seek this injunctive relief to enforce plan terms and federal law under subsection (A) of section 502(a)(3).

In ruling that United is not only an improper defendant in a suit for benefits but is also immune from a suit for injunctive relief for its allegedly improper claims processing practices, the district court's decision allows no recourse against United even if, as alleged, it systematically administers the plans at issue in a manner contrary to the requirements of ERISA. Nothing, however, in ERISA bars plaintiffs from simultaneously suing to obtain benefits under section 502(a)(1)(B) and to enjoin violations of ERISA and plan terms under section 502(a)(3)(A).

This district court dismissed the injunctive-relief claims based on a misreading of Varity. In Varity, a group of former beneficiaries sought equitable relief restoring them to a plan after misrepresentations led them to withdraw from it. 516 U.S. at 491–92. The Supreme Court held that the misrepresentations constituted fiduciary breaches and that section 502(a)(3) allowed claims for individual (as opposed to plan) relief. 516 U.S. at 501, 506. Noting that subsection (a)(3)(B) only authorizes "appropriate" equitable relief, the Court reasoned "that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" 516 U.S. at 515 (citation omitted). Because no other part of section 502 could remedy the misrepresentations alleged by the Varity plaintiffs, the Court allowed plaintiffs to proceed with their claim seeking equitable relief placing them in the plan they would have been in but for the fiduciary breach. 516 U.S. at 515.

Contrary to the district court's conclusion, Varity is not an obstacle to the claim for injunctive relief asserted here. First, it is not apparent how the Varity Court's concern that relief would not be "appropriate" under section 502(a)(3)(B) where a plaintiff has another avenue for relief has any relevance in this case. Plaintiffs here are not seeking "appropriate" equitable relief under subsection (B) of section 502(a)(3) for an otherwise un-redressable injury – they are seeking

injunctive relief to enforce plan terms and ERISA, a remedy explicitly provided in subsection (A).

Second, whether plaintiffs have stated a claim for purposes of Rule 12(b)(6) of the Federal Rules of Civil Procedure hinges on whether their complaint sets forth adequate and plausible allegations that, if true, entitle them to relief. E.g., Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009); Pension Ben. Guar. Corp. ex rel. St. Vincent Catholic Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc., 712 F.3d 705, 718 (2d Cir. 2013). Because the individual plaintiffs, who are plan participants, cite numerous examples of United, as a plan fiduciary, administering the plans in ways that conflicted with explicit terms of their plans and the requirements of ERISA, they have stated a claim. See generally JA 25–169. The language in Varity relied on by the district court focused on what relief is appropriate after ERISA violations are proven. See 516 U.S. at 506–08 (finding that defendant's actions violated fiduciary duties and examining whether the relief sought was appropriate). Nothing in ERISA, however, modifies ordinary principles of civil procedure that permit the joinder of alternative – and even inconsistent – claims in a single action. See Fed. R. Civ. P. 8(a)(3), 8(d)(2). Cf. CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1882 (2011) (remanding to allow plaintiffs to proceed with their section 502(a)(3) claim after holding that section 502(a)(1)(B) did not provide the relief they sought).

Varity, therefore, does not establish a special rule for ERISA that prevents plaintiffs from pleading and litigating separate claims based on different theories of breach or appropriate remedy. Rather, as this Court has correctly recognized, "Varity Corp. did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available; instead, the district court's remedy is limited to such equitable relief as is considered appropriate." Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 89–90 (2d Cir. 2001); see Frommert v. Conkright, 433 F.3d 254, 272 (2d Cir. 2006) (holding that district court's determination of "appropriate equitable relief" under section 502(a)(3) must be based on ERISA policy, the special nature and purpose of employee benefit plans, and consideration of what relief, if any, was afforded under section 502(a)(1)(B)). Therefore, the proper question here – as articulated by this Court in Devlin – is whether individual plaintiffs sought different relief in their sections 502(a)(1)(B) and 502(a)(3) claims. See Hall v. LHACO, Inc., 140 F.3d 1190, 1197 (8th Cir. 1998) (allowing section 502(a)(3) claim because it sought significantly different relief – an injunction and an accounting – than that sought in plaintiff's claim for benefits).

Their pleadings make plain that plaintiffs sought to remedy both the wrongfully denied benefits (their section 502(a)(1)(B) claims) and United's ongoing policies and procedures that they claim violate relevant plan terms and

ERISA's mental health and claims processing requirements (their section 502(a)(3)(A) claims for injunctive relief). Even if this Court reverses on the first issue and plaintiffs can and ultimately do obtain benefits under section 502(a)(1)(B), disallowing a section 502(a)(3)(A) claim against United would eliminate plaintiffs' ability to most effectively enforce the requirements of ERISA and the terms of their plans against the entity that administers benefits under those plans. Hill v. Blue Cross Blue Shield of Mich., 409 F.3d 710, 718 (6th Cir. 2005) (noting that only injunctive relief under section 502(a)(3) will provide complete relief to a plaintiff seeking to alter how an entity administers an ERISA-covered plan).

Payouts of denied benefits would not address and correct the allegedly unlawful and discriminatory policies and procedures – for example, United's application of "fail-first" policies to only behavioral benefits claims – that led to those wrongful denials. Cf. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985) (a "plan administrator's refusal to pay contractually authorized benefits" if "willful and part of a larger systematic breach of fiduciary obligations" could entitle ERISA plaintiffs to seek removal of the administrator). Accordingly, because ERISA does not foreclose the simultaneous claims for relief under section 502(a)(1)(B) and section 502(a)(3)(A) to treat different injuries that were

adequately alleged in the complaint, the district court erred in ruling that plaintiffs could not concurrently sue for benefits and injunctive relief.

CONCLUSION

For these reasons, the Secretary requests that the district court's decision be reversed.

Respectfully submitted,

M. PATRICIA SMITH
Solicitor of Labor

G. WILLIAM SCOTT
Acting Associate Solicitor

ELIZABETH HOPKINS
Counsel for Appellate and
Special Litigation

/s/ Nicholas D. Beadle
NICHOLAS D. BEADLE
Attorney
United States Department of Labor
Office of the Solicitor
200 Constitution Ave., N.W., N-2700
Washington, D.C. 20210

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rules of Appellate Procedure 29(c)(5) and (d), and 32(a)(7)(C), I certify the following with respect to the foregoing amicus brief of the Secretary of Labor: I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font.

I further certify that this brief complies with the type-volume limitation set forth in Fed. R. App. P. 29(d) and 32(a)(7)(B) because it contains 5,966 words, excluding exempt material, according to the count of Microsoft Word.

The brief was prepared using Microsoft Word 2010.

DATE: April 22, 2014

/s/ Nicholas D. Beadle
NICHOLAS D. BEADLE
Attorney
United States Department of Labor
Office of the Solicitor
200 Constitution Ave., N.W., N-2700
Washington, D.C. 20210

CERTIFICATE OF SERVICE AND ECF COMPLIANCE

I hereby certify that, on this 22nd day of April 2014, the Brief of the Secretary of Labor, United States Department of Labor, as Amicus Curiae in Support of Plaintiffs-Appellants and Requesting Reversal, was filed electronically with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the Court's appellate CM/ECF system. Counsel of record are registered CM/ECF users and service to them was accomplished by the Court's appellate CM/ECF system.

In addition, I further certify that six copies of the foregoing Brief of the Secretary of Labor, United States Department of Labor, as Amicus Curiae in Support of Plaintiffs-Appellants and Requesting Reversal, which are exact copies of the CM/ECF filing, were sent by prepaid, overnight delivery to the Clerk of the Court for the United States Court of Appeals for the Second Circuit pursuant to Local Rule 31.1.

/s/ Nicholas D. Beadle
NICHOLAS D. BEADLE
Attorney