No. 15-

IN THE
Supreme Court of the United States

UNITEDHEALTH GROUP INCORPORATED, *et al.*,
Petitioners,
v.

JONATHAN DENBO, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA) authorizes an ERISA plan participant to bring suit "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). If the remedy under § 502(a)(1)(B) is inadequate, the participant may seek "appropriate equitable relief" under § 502(a)(3). *Id.* § 1132(a)(3).

Jonathan Denbo is an ERISA plan participant who alleges that he was wrongfully denied benefits. He filed suit under ERISA—but he did not sue any party with an obligation to pay benefits, like the plan or the plan administrator. Rather, he sued UnitedHealth Group Incorporated and several of its subsidiaries (collectively, United). United is a claims administrator. It is hired to *process* claims for benefits, not to pay them.

The Second Circuit nevertheless held that United could be sued "to recover benefits due" under § 502(a)(1)(B), creating a 6-to-4 circuit conflict over whether a § 502(a)(1)(B) suit may be brought against a party with no obligation to *pay* benefits. The court also refused to dismiss Denbo's § 502(a)(3) claim, holding that it was too early to tell whether relief against a proper defendant under § 502(a)(1)(B) would be adequate and thereby aligning with the minority view in a 4-to-2 circuit split.

The questions presented are:

1. Whether a claims administrator with no obligation to pay benefits under an ERISA plan is a proper defendant in a § 502(a)(1)(B) action for benefits due under that plan.

2. Whether a § 502(a)(3) claim can be dismissed on the pleadings because a proper § 502(a)(1)(B) claim would fully remedy the plaintiff's injury.

PARTIES TO THE PROCEEDINGS

1. UnitedHealth Group Incorporated, UHC Insurance Company, UnitedHealthcare Insurance Company of New York, and United Behavioral Health, petitioners on review, were defendants-appellees below.

2. Jonathan Denbo, Michael A. Kamins, Shelly Menolascino, and the New York State Psychiatric Association, Inc., respondents on review, were plaintiffs-appellants below.

RULE 29.6 DISCLOSURE STATEMENT

UnitedHealth Group Incorporated is a publicly held corporation. It has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

Although "UHC Insurance Company" is a named defendant in this case, there is no such entity. The actual defendant is UnitedHealthcare Service LLC. UnitedHealthcare Service LLC is a wholly owned subsidiary of UnitedHealthcare Insurance Company, which is a wholly owned subsidiary of UHIC Holdings, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

UnitedHealthcare Insurance Company of New York is a wholly owned subsidiary of UnitedHealthcare Insurance Company, which is a wholly owned subsidiary of UHIC Holdings, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

United Behavioral Health is a wholly owned subsidiary of OptumHealth Holdings, LLC, which is a wholly owned subsidiary of Optum, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

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Petitioners UnitedHealth Group Incorporated and several of its subsidiaries (collectively, United) respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The Second Circuit's opinion is not yet published in the *Federal Reporter*, but is available at 2015 WL 4940352. Pet. App. 1a-19a. The District Court's order is reported at 980 F. Supp. 2d 527. Pet. App. 20a-70a.

JURISDICTION

The Second Circuit entered judgment on August 20, 2015. Pet. App. 2a. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the appendix to this petition. Pet. App. 71a-78a.

INTRODUCTION

This petition raises two important questions regarding ERISA's civil enforcement scheme. The first question concerns the interpretation of ERISA § 502(a)(1)(B), which authorizes plan participants and beneficiaries to sue to recover benefits due under an ERISA plan. The Second Circuit's decision in this case deepens an entrenched divide over who may be sued under § 502(a)(1)(B). Four circuits hold that only parties responsible for paying benefits may be sued. Six other circuits, including the Second, disagree. They hold that any party that exercises a certain level of control over benefits determinations may be sued, even if the party has no obligation to pay. This split undermines ERISA's goal of national uniformity, and it has no chance of going away on its own. It implicates a frequently recurring issue, with significant consequences for plans, participants, and claims administrators alike; indeed, the exact same issue is the subject of a recently filed petition for certiorari in *UnitedHealthcare of Arizona, Inc.* v. *Spinedex Physical Therapy, U.S.A., Inc.*, No. 14-1286. *See infra* note 2. And the Second Circuit's decision joins the wrong side of the split, adopting an interpretation of § 502(a)(1)(B) with no basis in the statutory text or common sense.

The second question concerns the interpretation of ERISA § 502(a)(3), which authorizes "appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy." *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996). The circuits are split over whether a § 502(a)(3) claim can be dismissed on the pleadings because a proper § 502(a)(1)(B) claim would fully remedy the plaintiff's injury. Four circuits have held that that question can be decided on the pleadings. Two other circuits, including the Second, have concluded the opposite. Those two circuits are wrong: When, as here, the gravamen of both the plaintiff's § 502(a)(1)(B) claim and his § 502(a)(3) claim are the same, the § 502(a)(3) claim may properly be dismissed at the pleading stage.

Finally, this case offers a proper vehicle for deciding both questions presented. The questions were pressed and passed upon below. Had this case arisen elsewhere, the outcome would have been different: Four circuits would have dismissed the plaintiff's § 502(a)(1)(B) claim, and four others would have dismissed his § 502(a)(3) claim.

Accordingly, this Court should grant certiorari to resolve both questions presented.

STATEMENT

A. Statutory Background

"Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place." *Conkright* v. *Frommert*, 559 U.S. 506, 516 (2010). Nor did Congress dictate to employers what benefits to include in their plans. *See Black & Decker Disability Plan* v. *Nord*,

538 U.S. 822, 833 (2003) ("[E]mployers have large leeway to design * * * welfare plans as they see fit."). Instead, "ERISA induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Conkright*, 559 U.S. at 517 (quotation marks and brackets omitted).

As part of this uniform regulatory regime, ERISA requires that "'[e]very employee benefit plan * * * be established and maintained *pursuant to a written instrument*.'" *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 83 (1995) (quoting 29 U.S.C. § 1102(a)(1)). That written instrument is a "contract" that sets forth the terms of the benefit plan. *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1877 (2011).

ERISA provides a cause of action to enforce that contract. Section 502(a)(1)(B) authorizes a plan "participant or beneficiary" to bring suit "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). ERISA also contains a "'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*, 516 U.S. at 512. That provision—§ 502(a)(3)—authorizes a plan "participant, beneficiary, or fiduciary" "(A) to enjoin any act or practice which violates any provision of [ERISA Title I] 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 [ERISA Title I] or the terms of the plan." 29 U.S.C. § 1132(a)(3).

B. Factual And Procedural Background

1. The CBS Medical Plan is a health benefit plan offered by the CBS Sports Network to its employees. Pet. App. 25a. When participants in the Plan receive health care services, they may seek payment of benefits under the Plan. If the Plan covers those services, it pays the benefits due.

United is a *claims* administrator for the CBS Plan. C.A. J.A. 180-181. CBS contracted with United to fill that role. As a claims administrator, United processes claims for benefits and determines whether benefits are owed by the Plan, in much the same way an accountant determines whether taxes are owed by a taxpayer. *Id.* at 181.

United's role is different from that of the *plan* administrator. *See* 29 U.S.C. § 1002(16). As defined by statute, the plan administrator is "a trustee-like fiduciary" that "manages the plan, follows its terms in doing so, and provides participants with the summary documents that describe the plan (and modifications) in readily understandable form." *Amara*, 131 S. Ct. at 1877 (citing 29 U.S.C. §§ 1002(21)(A), 1021(a), 1022, 1024). The CBS Plan specifically designates a CBS-related entity—the CBS Retirement Committee—as the plan administrator. Pet. App. 25a; *see* C.A. J.A. 180; 29 U.S.C. § 1002(16)(A). United is therefore not the plan administrator.

Nor is United the Plan's insurer. The CBS Plan is self-funded, which means that "CBS itself pays all the benefits due to plan participants under the terms of the plan." Pet. App. 25a; *see* C.A. J.A. 179-180. "CBS does not purchase insurance, from United or anyone else, in order to cover the cost of benefits

owed to employees." Pet. App. 25a; *see also FMC Corp.* v. *Holliday*, 498 U.S. 52, 54 (1990) (explaining that a "self-funded" plan is one that "does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants"). Thus, when a participant submits a claim for benefits under the Plan, the obligation to fund the payment lies with the Plan itself, not United.

2. Respondent Jonathan Denbo is an employee of the CBS Sports Network and a participant in the CBS Plan. Pet. App. 5a. For approximately five years beginning in 2007, Denbo saw a therapist for anxiety and depression. C.A. J.A. 38, 66-67. He attended therapy sessions on a weekly and, later, twice-weekly basis. *Id.* Upon being billed for those sessions, Denbo sought payment under the Plan. *Id.* at 66.

In May 2012, a United psychologist contacted Denbo's therapist to discuss his condition and the treatment he was receiving. *Id.* United subsequently advised Denbo and his therapist that going forward, the CBS Plan would not cover Denbo's therapy. *Id.* In a letter denying coverage, United explained that "there has been an adequate reduction" in Denbo's "clinical symptoms," and that "[d]espite [his] marked improvement," he "continued to be seen twice weekly * * * since 2007 without a discharge plan in place." *Id.* at 67. Because Denbo's "remaining treatment goals [could] be self-managed," his continued therapy was "not consistent with generally accepted national standards of medical practice." *Id.* United authorized payment under the Plan for three additional therapy sessions before Denbo would have to pay for the sessions himself. *Id.*

Denbo's therapist appealed United's determination on Denbo's behalf. *Id.* at 67-73. Among other things, Denbo's therapist argued that the terms of the CBS Plan allowed United to perform only "retrospective" review, precluding any denial of his benefits on a prospective basis. *Id.* at 68-69. United affirmed its decision. Pet. App. 6a.

In 2013, Denbo and other plaintiffs brought suit in federal district court. C.A. J.A. 8. In an amended complaint, Denbo challenged United's decision to deny payment of benefits for his therapy sessions. According to Denbo, United violated the federal Parity Act, 29 U.S.C. § 1185a, by treating his claims for mental-health treatment less favorably than claims for medical or surgical care. Pet. App. 6a; *see* C.A. J.A. 155-156. Denbo also alleged that United violated the terms of the CBS Plan by subjecting his mental-health claims to "preauthorization or concurrent" review. Pet. App. 7a; *see* C.A. J.A. 158. Denbo sought relief under ERISA § 502(a)(1)(B) and (a)(3), "request[ing] that United reprocess and reimburse benefits that were denied or reduced as a result of such policies." C.A. J.A. 159; *see id.* at 156; Pet. App. 4a n.2.

3. The District Court granted United's motion to dismiss. Pet. App. 23a. The court held that the amended complaint suffered from a fundamental defect: Denbo was "suing the wrong party." *Id.* at 33a. Citing circuit precedent, the court explained that "only ERISA plans, ERISA plan trustees, and ERISA plan administrators" may be sued for benefits due under § 502(a)(1)(B). *Id.* at 34a. And because "United acts as a '*claims* administrator'"—not a *plan* administrator—United is not the proper defendant in

a § 502(a)(1)(B) suit alleging a denial of benefits. *Id.* at 36a (emphasis added).

The court held that Denbo could not avoid dismissal by the mere expedient of invoking § 502(a)(3). The court explained that § 502(a)(3) is a "'catchall' enforcement mechanism" that may be invoked only when "equitable relief" is "appropriate under the circumstances." *Id.* at 37a. Where, as here, "the gravamen of a plaintiff's claim is the wrongful denial of benefits, that harm can be adequately remedied through monetary compensation under § 502(a)(1)(B)" by suing a proper defendant, such as the plan administrator or the plan itself. *Id.* at 39a. Thus, the court concluded that "additional equitable relief under § 502(a)(3) * * * would not qualify as 'appropriate.'" *Id.*

It did not matter that Denbo was seeking relief under § 502(a)(3) for alleged violations of the Parity Act. As an initial matter, the court held that the Parity Act applies only to a "group health plan" or "health insurance coverage offered in connection with such a plan." 29 U.S.C. § 1185a(a); *see* Pet. App. 44a. The court concluded that United could not be sued under either theory: As a claims administrator for a self-funded plan, United is not itself a "group health plan," and it "does not sell coverage." Pet. App. 44a-45a. Moreover, the court held, any violation of the Parity Act in this case could be redressed by suing a proper defendant for benefits due under § 502(a)(1)(B). *Id.* at 46a. So while Denbo could "have recourse against United's principals"—the plan administrator or the plan itself—his suit against United had to be dismissed. *Id.*

4. A three-judge panel of the Second Circuit vacated the dismissal of Denbo's claims, and remanded for further proceedings. *Id.* at 18a. The court first held that a claims administrator may be sued under § 502(a)(1)(B) "when a claims administrator exercises total control over claims for benefits under the terms of the plan." *Id.* at 11a. The court determined that United exercised such control under the CBS Plan: United "enjoyed 'sole and absolute discretion' to deny benefits and make 'final and binding' decisions as to appeals of those denials." *Id.* at 11a-12a (quoting C.A. J.A. 65, 181). Accordingly, the court concluded that United is "an appropriate defendant for Denbo's claim under § 502(a)(1)(B)." *Id.* at 12a.

The court next held that "United is a proper defendant for Denbo's Parity Act claim under § 502(a)(3)." *Id.* at 14a. The court explained that "'§ 502(a)(3) makes no mention at all of which parties may be proper defendants,' but rather allows a plaintiff to bring suit based on 'the *act or practice* which violates any provision of ERISA Title I.'" *Id.* (quoting *Harris Tr. & Sav. Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238, 246 (2000)). The relevant provisions of the Parity Act here are found in ERISA Title I. Thus, the court concluded that even if the Parity Act itself does not "directly impose" any obligations on United, United could still be held liable for a violation of the Parity Act under § 502(a)(3). *Id.*

Finally, the court refused "to affirm the dismissal of Denbo's § 502(a)(3) claims on the ground that adequate relief is available under § 502(a)(1)(B)." *Id.* at 15a. The court acknowledged that § 502(a)(3) is a "'catchall' provision," "'offering appropriate equitable relief for injuries caused by violations that § 502 does

not elsewhere adequately remedy.'" *Id.* (quoting *Varity Corp.*, 516 U.S. at 512). But the court concluded that "it is too early to tell" whether "monetary benefits under § 502(a)(1)(B) alone will provide [Denbo] a sufficient remedy" for the alleged violations underlying his § 502(a)(3) claims.[1]

This petition followed.

REASONS FOR GRANTING THE PETITION

I. THIS COURT SHOULD GRANT REVIEW TO DECIDE WHETHER A MERE CLAIMS ADMINISTRATOR MAY BE SUED UNDER ERISA § 502(a)(1)(B) FOR BENEFITS DUE.

A. The Courts Of Appeals Are Deeply Divided Over This Question.

The Second Circuit's decision takes sides in an already entrenched split over who may be sued in an action to recover benefits under ERISA § 502(a)(1)(B). Four courts of appeals—the Third, Seventh, Eighth, and Tenth Circuits—have held that only parties responsible for paying benefits may be sued. In those circuits, a third-party claims administrator with no obligation to pay is not a proper defendant. By contrast, six other courts of appeals—the First, Second, Fifth, Sixth, Ninth, and Eleventh Circuits—have held that anyone who exercises a certain level of control over benefits determinations may be sued, regardless of obligation to pay. In

[1] The Second Circuit also held that the New York State Psychiatric Association, Inc., alleged facts sufficient to support associational standing, Pet. App. 8a-10a, that Shelly Menolascino had not adequately pleaded her claims, *id.* at 18a-19a, and that Michael A. Kamins had abandoned his claims, *id.* at 3a n.1. Those holdings are not at issue in this petition.

those circuits, whether a third-party claims administrator is a proper defendant depends on the extent of its authority in deciding benefits claims.

The circuits have acknowledged their differences, and this split will persist without this Court's intervention. *See Leister* v. *Dovetail, Inc.*, 546 F.3d 875, 879 (7th Cir. 2008) (acknowledging differences); *Hall* v. *LHACO, Inc.*, 140 F.3d 1190, 1194-1195 (8th Cir. 1998) (same). Certiorari should be granted to bring national uniformity to this important question.[2]

1. Begin with the four circuits that have held that the only parties that may be sued under § 502(a)(1)(B) are parties responsible for paying benefits. Even within these circuits, there is disagreement about precisely which parties fit that description.

a. In one camp are the Third and Tenth Circuits. In these circuits, the only proper defendant in a suit to recover benefits is the plan itself or the plan "administrator" as defined by ERISA. The rationale behind this rule is straightforward: The plans and their plan administrators are ultimately responsible for making payments out of the plans' assets. "Thus,

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[2] Currently before this Court is another petition for certiorari, filed by some of the same petitioners and counsel, and presenting the same question whether a mere claims administrator is a proper defendant under § 502(a)(1)(B). *See UnitedHealthcare of Arizona, Inc.* v. *Spinedex Physical Therapy, U.S.A., Inc.*, No. 14-1286 (pet. for cert. filed Apr. 24, 2015). The Court may wish to consider this petition alongside the petition in *Spinedex*. The Court may then grant both petitions and consolidate the two cases. Alternatively, if this Court grants the petition in *Spinedex*, it may hold this petition pending the outcome of that case.

if entitlement to benefits is established, the court can direct the plan administrator to pay them from the assets of the plan, much as a trustee may be compelled to satisfy a trust obligation from trust assets." *Hahnemann Univ. Hosp.* v. *All Shore, Inc.*, 514 F.3d 300, 308 (3d Cir. 2008).

For example, in *Geddes* v. *United Staffing Alliance Employee Medical Plan*, 469 F.3d 919 (10th Cir. 2006), a plan beneficiary sued to recover unpaid benefits from the plan, the plan administrator, and a third-party claims administrator. *Id.* at 922-923. The Tenth Circuit held that "[t]he ERISA statute is clear: ERISA beneficiaries may bring claims against the plan as an entity and plan administrators." *Id.* at 931. Because the third-party claims administrator was neither, it could not be sued for benefits due. *Id.*

The Third Circuit has adopted the same rule. In *Graden* v. *Conexant Systems, Inc.*, 496 F.3d 291 (3d Cir. 2007), it concluded that, in a § 502(a)(1)(B) action, "the defendant is the plan itself (or plan administrators in their official capacities only)." *Id.* at 301. Even when a plan administrator is sued in its individual capacity, it is a proper defendant only insofar as it breached a fiduciary duty "by *refusing to pay* the claim." *Hahnemann*, 514 F.3d at 309 (emphasis added).

b. The Seventh and Eighth Circuits agree with the Third and Tenth Circuits that the only parties that may be sued under § 502(a)(1)(B) are parties with an obligation to pay, but they nonetheless disagree about precisely which parties fall into that category. According to the Seventh and Eighth Circuits, plans and plan administrators are not the only parties that

might have an obligation to pay. When a plan is "insured"—that is, when it "contracts with an insurance company to bear the financial risk of paying its [members'] health insurance claims," *Geneva Coll.* v. *Secretary of U.S. Dep't of Health & Human Servs.*, 778 F.3d 422, 427 n.1 (3d Cir. 2015), *pet. for cert. filed*, No. 15-191 (U.S. Aug. 12, 2015)—the Seventh and Eighth Circuits hold that the insurance company is a proper defendant under § 502(a)(1)(B). The reason, according to these circuits, is that when an insurance company serves as the plan's insurer, it assumes the obligation to pay benefits. *See Larson* v. *United Healthcare Ins. Co.*, 723 F.3d 905, 913 (7th Cir. 2013).

For instance, in *Larson*, plan participants sued various insurance companies acting as the plan's insurers; the insurers had "both the authority to decide all eligibility and benefits questions *and* the obligation to pay claims." *Id.* at 908-909, 913. The Seventh Circuit held that the insurers could be sued under § 502(a)(1)(B). *Id.* at 913. It explained that "a cause of action for 'benefits due' must be brought against the party having the obligation to pay." *Id.* And although "[t]ypically the plan owes the benefits and is the right defendant," the court concluded that "[w]hen an employee-benefits plan is implemented by insurance and the insurance company * * * pays the claims, an action against the insurer for benefits due is precisely the civil action authorized by § [502](a)(1)(B)." *Id.* (quotation marks omitted).

The Eighth Circuit agrees. In *Brown* v. *J.B. Hunt Transport Services, Inc.*, 586 F.3d 1079 (8th Cir. 2009), a plan participant sued two parties for benefits due under § 502(a)(1)(B): Hunt, the plan administrator; and Prudential Insurance Co., which "in-

sured the Plan and served as claims administrator." *Id.* at 1081, 1083. "Prudential, not Hunt, was responsible for processing claims, determining eligibility, and paying benefits under the Plan." *Id.* at 1081. Because "the Plan require[d] Prudential, not Hunt, to pay * * * benefits," the Eighth Circuit held that Prudential was the only proper defendant. *Id.* at 1088.

2. Six other circuits—the First, Second, Fifth, Sixth, Ninth, and Eleventh Circuits—apply a totally different test for who may be sued under § 502(a)(1)(B). In those circuits, whether a party has an obligation to *pay* is not dispositive; even absent such an obligation, a party may be sued if it exercises a certain level of *control* over benefits determinations.

In the decision below, for example, the Second Circuit accepted that United is a "claims administrator of a *self-funded* plan," with no responsibility to pay benefits. Pet. App. 13a. And yet, the Second Circuit held that United may be sued under § 502(a)(1)(B) because United "exercised total control over the CBS Plan's claims process." *Id.*

The Ninth Circuit has adopted the same interpretation of § 502(a)(1)(B). In *Spinedex Physical Therapy, U.S.A., Inc.* v. *UnitedHealthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014), *pet. for cert. filed*, No. 14-1286 (U.S. Apr. 24, 2015), a health care provider brought a § 502(a)(1)(B) suit on behalf of plan beneficiaries against United, a third-party claims administrator. *Id.* at 1287-1288. The plan at issue was "self-insured," and the Ninth Circuit acknowledged that United had no "responsibility to pay benefits." *Id.* at 1298. Nevertheless, the Ninth

Circuit held that United could be sued under § 502(a)(1)(B) if United "exercise[d] any discretionary authority or discretionary control respecting management of [the] plan." *Id.* (quotation marks omitted).

The Fifth Circuit has read § 502(a)(1)(B) in the same way. In *LifeCare Management Services LLC* v. *Insurance Management Administrators Inc.*, 703 F.3d 835 (5th Cir. 2013), a health care provider sued a third-party claims administrator on behalf of plan participants. *Id.* at 840 & n.3. The Fifth Circuit held that the claims administrator was a proper defendant under § 502(a)(1)(B). *Id.* at 846. According to the Fifth Circuit, "[w]here a [third-party claims administrator] exercises control over a plan's benefits claims process, and exerts that control to deny a claim by incorrectly interpreting a plan in a way that amounts to an abuse of discretion, liability may attach." *Id.* at 845.

The Sixth Circuit's decision in *Moore* v. *Lafayette Life Insurance Co.*, 458 F.3d 416 (6th Cir. 2006), is to the same effect. The plan participant in that case sued his employer, the Michigan Tooling Association (MTA), and Lafayette. The parties agreed that "while MTA [was] the *plan* administrator, Lafayette [was] the *claims* administrator and exercised full authority in adjudicating Plaintiff's claim for benefits." *Id.* at 438. The Sixth Circuit held that "anyone * * * who exercises discretionary control or authority over a plan's management, administration, or assets" may be sued on a "denial of benefits" claim. *Id.* Because "[i]t was Lafayette who made a decision with respect to Plaintiff's benefits," the Sixth Circuit concluded that "Lafayette, and not MTA, [was] the

proper party defendant for a denial of benefits claim." *Id.*

The Eleventh Circuit reached a similar conclusion in *Heffner* v. *Blue Cross & Blue Shield of Alabama, Inc.*, 443 F.3d 1330 (11th Cir. 2006). There, a putative class of participants and beneficiaries of various plans sued their common claims administrator, Blue Cross. *Id.* at 1333. Many of the plans were "self-funded plans in which the employer or plan sponsor [was] responsible for paying claims." *Id.* at 1334. The Eleventh Circuit nevertheless held that, "[a]s the party that controls administration of the plan, Blue Cross is the proper party defendant in an action concerning ERISA benefits." *Id.* (quotation marks and brackets omitted).

The rule is the same in the First Circuit. The First Circuit has held that "[t]he proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan." *Gómez-González* v. *Rural Opportunities, Inc.*, 626 F.3d 654, 665 (1st Cir. 2010) (quotation marks omitted). "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." *Id.* Thus, to the extent third-party claims administrators "control[] administration of the plan," they may be sued in the First Circuit under § 502(a)(1)(B). *Id.* (quotation marks omitted).

3. In sum, the ten circuits that have addressed the issue are deeply divided: Four circuits hold that whether a party is a proper defendant under § 502(a)(1)(B) depends on whether the party has an obligation to pay benefits; six other circuits, by contrast, hold that even if a party does not have an

obligation to pay, it may be sued if it exercises a certain level of control over benefits determinations. Thus, in some parts of the country, third-party claims administrators with no responsibility for paying benefits may not be sued for benefits due; in other parts, they may be sued depending on the extent of their authority in deciding benefits claims.

This divide cannot be expected to resolve itself. Almost all the circuits have spoken, and there are simply too many on each side of the issue for the split to go away on its own. Moreover, the differences among the circuits strike at the very purpose of ERISA: to "assur[e] a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Conkright*, 559 U.S. at 517 (quotation marks omitted). And given ERISA's broad venue provision—which allows suit to be brought "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found," 29 U.S.C. § 1132(e)(2)—this conflict will inevitably result in forum-shopping, as plaintiffs elect to sue claims administrators in jurisdictions where they can be held liable without regard to their obligation to pay. Indeed, given that United does business across the country, plaintiffs can hand-pick the venue simply by naming United.

Because the split in this case is deep, entrenched, and untenable—particularly given ERISA's goal of "national uniformity," *Raymond B. Yates, M.D., P.C. Profit Sharing Plan* v. *Hendon*, 541 U.S. 1, 17 (2004)—this Court should grant certiorari to resolve the question presented.

B. This Question Raises A Frequently Recurring Issue Of National Importance.

Certiorari should also be granted because this case raises a frequently recurring issue of national importance. Indeed, courts are regularly called upon to decide whether a party may be sued in an action to recover benefits under § 502(a)(1)(B). *See, e.g.*, *Cyr* v. *Reliance Standard Life Ins. Co.*, 642 F.3d 1202, 1207 (9th Cir. 2011) (en banc); *Feinberg* v. *RM Acquisition, LLC*, 629 F.3d 671, 673 (7th Cir. 2011); *Evans* v. *Akers*, 534 F.3d 65, 72 (1st Cir. 2008); *Mote* v. *Aetna Life Ins. Co.*, 502 F.3d 601, 610-611 (7th Cir. 2007); *Muscemi* v. *Schwegmann Giant Super Markets, Inc.*, 332 F.3d 339, 349-350 (5th Cir. 2003); *Yoon* v. *Fordham Univ. Faculty & Admin. Ret. Plan*, 263 F.3d 196, 207 (2d Cir. 2001); *Mein* v. *Carus Corp.*, 241 F.3d 581, 584-585 (7th Cir. 2001); *Layes* v. *Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996); *Rosen* v. *TRW, Inc.*, 979 F.2d 191, 193-194 (11th Cir. 1992); *Sweet* v. *Consol. Aluminum Corp.*, 913 F.2d 268, 272 (6th Cir. 1990); *Leonelli* v. *Pennwalt Corp.*, 887 F.2d 1195, 1199 (2d Cir. 1989); *Daniel* v. *Eaton Corp.*, 839 F.2d 263, 265-266 (6th Cir. 1988); *OSF Healthcare Sys.* v. *Insperity Grp. Health Plan*, No. 1:14-cv1135, 2015 WL 1117776, at *2-4 (C.D. Ill. Mar. 10, 2015).

When the issue arises, the party in question is often a third-party claims administrator. *See, e.g.*, *Spinedex*, 770 F.3d at 1287, 1298; *Oliver* v. *Coca Cola Co.*, 497 F.3d 1181, 1193-1195 (11th Cir. 2007), *vacated in part on other grounds*, 506 F.3d 1316 (11th Cir. 2007); *Garren* v. *John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997); *Lee* v.

Burkhart, 991 F.2d 1004, 1009-1011 (2d Cir. 1993); *Baker* v. *Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 290 (11th Cir. 1990); *Gelardi* v. *Pertec Computer Corp.*, 761 F.2d 1323, 1324-1325 (9th Cir. 1985) (per curiam), *overruled by Cyr*, 642 F.3d 1202; *Jones* v. *Life Ins. Co. of N. Am.*, No. 08-cv-3971, 2015 WL 1433998, at *2-3 (N.D. Cal. Mar. 30, 2015); *Hammonds* v. *Aetna Life Ins. Co.*, No. 2:13-cv-310, 2015 WL 1299515, at *4 (S.D. Ohio Mar. 23, 2015); *Van Loo* v. *Cajun Operating Co.*, No. 14-cv-10604, 2014 WL 6750453, at *5-6 (E.D. Mich. Dec. 1, 2014); *Oliver* v. *Aetna Life Ins. Co.*, No. 4:13-cv-1947, 2014 WL 5460855, at *16 (N.D. Ala. Oct. 27, 2014); *Meguerditchian* v. *Aetna Life Ins. Co.*, 999 F. Supp. 2d 1180, 1185-1186 (C.D. Cal. 2014); *Braden* v. *Aetna Life Ins. Co.*, No. 8:13-cv-535, 2013 WL 6086460, at *3 (M.D. Fla. Nov. 19, 2013); *Anderson* v. *Blue Cross & Blue Shield*, No. 3:13-cv-402, 2013 WL 5674510, at *1-2 (S.D. Miss. Oct. 17, 2013); *Downey Surgical Clinic, Inc.* v. *Ingenix, Inc.*, No. 09-cv-5457 (C.D. Cal. Mar. 12, 2013), ECF No. 155; *Crocco* v. *Xerox Corp.*, 956 F. Supp. 129, 136-137 (D. Conn. 1997), *aff'd in part, rev'd in part on other grounds*, 137 F.3d 105 (2d Cir. 1998).

That should come as no surprise. Plan sponsors often enter into administrative services agreements with third parties such as United. The reason is simple: Administering benefit claims requires significant investments of time and effort. Third parties can alleviate these burdens by performing valuable functions, "such as developing networks of providers, negotiating payment rates, processing claims, and so forth." Cong. Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 6 (2008). And they can often perform these functions in a more

cost-effective manner; many claims administrators are insurance companies or their affiliates, which already provide such services on a broader scale. Accordingly, plan sponsors have every incentive to hire third-party claims administrators.

Plaintiffs, for their part, have every incentive to *sue* such claims administrators. That is because claims administrators typically process claims for more than one plan. And so by suing a single claims administrator for the denial of a particular benefit, participants and providers alike can seek to wrestle into a single lawsuit benefit determinations under hundreds of different plans—simply by asserting that the claims administrator is denying that benefit across the board for the same reason.

That is precisely what Denbo and his co-plaintiffs sought to do here. United is a third-party claims administrator of hundreds of plans. So when Denbo was denied benefits for mental-health treatment, he filed suit seeking to represent a class of participants denied mental-health benefits under *all* "United Plans governed by ERISA." C.A. J.A. 151. A doctors' association joined his effort, purporting to file suit "in a representational capacity on behalf of its members and their patients." *Id.* at 30. The result is a lawsuit of extraordinary scope, involving potentially thousands of allegations against United for mishandling benefits claims. *See id.* at 154; Pet. App. 24a (District Court describing this case as an "amalgamat[ion]" of "seven different lawsuits * * * in a single caption"). Similar actions against third-party claims administrators are increasingly common. *See, e.g.*, *North Cypress Med. Ctr. Operating Co.* v. *Cigna Healthcare*, 781 F.3d 182, 187 (5th Cir. 2015); *Heffner*, 443 F.3d at 1333. Indeed, several such

actions beyond this case have been filed against UnitedHealth Group Incorporated and its subsidiaries in various jurisdictions. *See, e.g.*, *Spinedex*, 770 F.3d at 1287-1288; *Almont Ambulatory Surgery Ctr., LLC* v. *UnitedHealth Grp., Inc.*, No. 14-cv-2139, 2015 WL 1608991 (C.D. Cal. Apr. 10, 2015); *Premier Health Ctr., P.C.* v. *UnitedHealth Grp.*, No. 11-cv-425, 2014 WL 7073439 (D.N.J. Dec. 15, 2014); *Lipstein* v. *UnitedHealth Grp.*, 296 F.R.D. 279 (D.N.J. 2013); *Sanctuary Surgical Ctr., Inc.* v. *UnitedHealth Grp., Inc.*, No. 10-cv-81589, 2013 WL 149356 (S.D. Fla. Jan. 14, 2013); *Advanced Rehab., LLC* v. *Unitedhealth Grp., Inc.*, No. 10-cv-263, 2011 WL 995960 (D.N.J. Mar. 17, 2011).

The question presented thus has profound consequences for plans, participants, providers, and third-party claims administrators alike. If claims administrators who are not responsible for paying benefits can be named as defendants in massive multi-plan actions, they will be less likely to agree to perform administrative services in the first place—or will be willing to do so only for a greater fee. Either way, the result will be higher costs for plans and ultimately their participants. *See* Br. for *Amici Curiae* America's Health Insurance Plans & the American Benefits Council in Support of Pet'rs 4-5, 20, *UnitedHealthcare of Arizona, Inc.* v. *Spinedex Physical Therapy, U.S.A., Inc.* (No. 14-1286) (U.S. May 26, 2015). Because the question presented has significant implications for the administration of benefits plans across the country, certiorari should be granted.

C. The Second Circuit's Decision Is Incorrect.

Finally, this Court should grant review because the Second Circuit's decision is incorrect. Under ERISA § 502(a)(1)(B), only parties obligated to pay benefits may be sued for benefits due.

1. ERISA recognizes that plans are contracts. For the most part, ERISA does not dictate what terms a plan must include. *See Black & Decker*, 538 U.S. at 833. But the statute does require that "'[e]very employee benefit plan * * * be established and maintained *pursuant to a written instrument*.'" *Curtiss-Wright*, 514 U.S. at 83 (quoting 29 U.S.C. § 1102(a)(1)). And it also provides a cause of action to enforce the terms of that written instrument.

That cause of action is found in § 502(a)(1)(B). Section 502(a)(1)(B) authorizes "a participant or beneficiary" to bring suit "to recover benefits due 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) (emphases added). As the text of this provision makes clear, a "cause of action for benefits is * * * bound up with the written instrument." *Heimeshoff* v. *Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, 612 (2013). The only parties that may sue for benefits are the parties *to whom contractual obligations are owed*—the "participant[s]" and "beneficiar[ies]" of the plan. 29 U.S.C. § 1132(a)(1). And the only benefits they may seek to recover are the benefits they have *a contractual right to receive*—the "benefits due * * * under the terms of the plan." *Id.* § 1132(a)(1)(B).

It follows that the only parties that may be sued for benefits are the parties who have *a contractual obligation to pay*. Those parties include the plan itself, which is bound by the written instrument it entered into. They also include the plan administrator, who, as a "trustee-like fiduciary," *Amara*, 131 S. Ct. at 1877, may be directed to pay benefits from plan assets, "much as a trustee may be compelled to satisfy a trust obligation from trust assets," *Hahnemann*, 514 F.3d at 308.

But the proper defendants do not include mere claims administrators who, as third parties, bear no obligation to pay benefits under the written instrument. Because third-party claims administrators owe no benefits under the contract, they cannot be sued for "benefits due" under that contract. To order such third parties to pay benefits under § 502(a)(1)(B) would be to order relief outside the plan. And this Court has made clear that that would be impermissible: Section 502(a)(1)(B) "says nothing about the recovery of extracontractual damages." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 144 (1985). Thus, the Third, Seventh, Eighth, and Tenth Circuits are correct: Only parties responsible for paying benefits may be sued under § 502(a)(1)(B).[3]

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[3] Because United is undisputedly not the CBS Plan's insurer, this case does not present the question whether the Seventh and Eighth Circuits are correct to hold that a plan insurer may be sued under § 502(a)(1)(B). *See supra* pp. 12-14. The question presented here is whether a claims administrator with *no* obligation to pay may be sued—a question whose answer the Third, Seventh, Eighth, and Tenth Circuits all agree is no.

This Court's decision in *Harris Trust & Savings Bank* v. *Salomon Smith Barney Inc.*, 530 U.S. 238 (2000), is not to the contrary. That case dealt with a different ERISA provision, § 502(a)(3), authorizing "a participant, beneficiary, or fiduciary" to bring suit "to enjoin any act or practice which violates any provision of [ERISA Title I] or the terms of the plan." 29 U.S.C. § 1132(a)(3). The Court held that any party who participates in such a violation may be the subject of such a suit, even if he is not a fiduciary. *Harris Tr.*, 530 U.S. at 241. That makes sense, because the "focus" of § 502(a)(3) "is on redressing the '*act or practice* which violates any provision of [ERISA Title I].'" *Id.* at 246 (quoting 29 U.S.C. § 1132(a)(3) (emphasis added)). What matters for purposes of § 502(a)(3), then, is whether the defendant *participated* in that "act or practice"; if he did, he may be enjoined, regardless of his fiduciary status.

Section 502(a)(1)(B) is different. Its focus is on "recovering the *benefits due* * * * under the terms of [the] plan." 29 U.S.C. § 1132(a)(1)(B) (emphasis added). What matters, then, is whether the defendant is responsible for *paying* the benefits due under the plan. If he is, he may be sued. But if he is not, no liability under § 502(a)(1)(B) may lie. Accordingly, the only proper defendants under § 502(a)(1)(B) are parties with an obligation to pay the benefits due. *See Larson*, 723 F.3d at 913.

2. The Second Circuit's decision cannot be reconciled with this straightforward reading of the statutory text. The Second Circuit held that United is a proper defendant because it "exercised total control over the CBS Plan's claims process." Pet. App. 13a. But whether United has "total control" over benefits determinations has nothing to do with whether it has

an obligation to pay benefits under the Plan. Indeed, there is no dispute in this case that United has no responsibility to pay benefits. *Id.* at 25a. Thus, if allowed to stand, the Second Circuit's decision will have the effect of exposing United and other third-party claims administrators to "extracontractual" liability. *Russell*, 473 U.S. at 144. And that liability will only deter companies from becoming claims administrators in the first place, harming the countless plans across the country that rely on them to reduce the costs of processing claims.

This is not to say that mere claims administrators could never be sued under ERISA. So, for example, if a claims administrator stole plan funds and used them for an illegitimate purpose, it would be liable to reimburse the plan for breach of a fiduciary duty under ERISA § 502(a)(2). But ordering a mere claims administrator to pay a participant's benefits is like ordering an accountant to pay his client's taxes. Even if the accountant's error results in underpayment, it is still the taxpayer who must pay the balance due. Similarly, even if a claims administrator's error results in a wrongful denial of benefits, it is still the plan (or some other party responsible for paying benefits) that must make good on the obligation. When claims administrators owe no benefits, they cannot be sued for "benefits due." This Court should grant certiorari to reverse the contrary conclusion of the Second Circuit.

II. THIS COURT SHOULD GRANT REVIEW TO DECIDE WHETHER A PARTICIPANT STATES A CLAIM UNDER § 502(a)(3) WHEN THE PARTICIPANT'S ALLEGED INJURY CAN BE FULLY REMEDIED UNDER § 502(a)(1)(B).

A. The Courts of Appeals Are Divided Over This Important And Recurring Question Of ERISA Law.

The second question presented addresses this Court's holding in *Varity*, 516 U.S. at 512, that equitable relief is "appropriate" under ERISA § 502(a)(3) only "for injuries caused by violations that § 502 does not elsewhere adequately remedy." The courts of appeals are divided over whether *Varity* creates a pleading standard allowing courts to dispose of § 502(a)(3) claims on motions to dismiss. Four courts of appeals—the Fourth, Fifth, Sixth, and Eleventh Circuits—have answered yes: *Varity* applies at the pleading stage, and it can and should be invoked to dismiss § 502(a)(3) claims for injuries that may be remedied elsewhere in § 502. Two other courts of appeals—the Second and Eighth Circuits—have reached a different conclusion: A motion to dismiss is generally too early to apply *Varity* because it is not yet clear whether a plaintiff's injuries can be remedied under other ERISA provisions.

This conflict has existed for over a decade, yet shows no signs of resolving itself. *See Korotynska* v. *Metropolitan Life Ins. Co.*, 474 F.3d 101, 106 (4th Cir. 2006) (acknowledging break from Second Circuit); *Tannenbaum* v. *UNUM Life Ins. Co. of Am.*, No. CIV.A. 03-CV-1410, 2004 WL 1084658, at *3 (E.D. Pa. Feb. 27, 2004) (recognizing circuit split).

And because this acknowledged and intractable split involves an issue of recurring importance to ERISA litigants, the Court should grant review to resolve it, as well.

1. In *Korotynska*, for example, the Fourth Circuit affirmed judgment on the pleadings against a participant's § 502(a)(3) claim for breach of fiduciary duty. The participant had alleged that the plan insurer's "improper claims procedures injured her by leading to the denial of benefits to which she was rightly entitled." *Korotynska*, 474 F.3d at 106. Recognizing that "§ [502](a)(1)(B) affords the plaintiff adequate relief for her benefits claim," the court ruled that "a cause of action under § [502](a)(3) is thus not appropriate." *Id.* at 107.

The Fifth Circuit applies the same rule. In *Tolson* v. *Avondale Industries, Inc.*, 141 F.3d 604 (5th Cir. 1998), the Fifth Circuit held that where a participant "has adequate relief available for [an] alleged improper denial of benefits through his right to sue the Plans directly under section [502](a)(1), relief through the application of Section [502](a)(3) would be inappropriate." *Id.* at 610 (adopting district court's analysis). The Fifth Circuit then affirmed the dismissal of a § 502(a)(3) claim for that very reason in *Hollingshead* v. *Aetna Health Inc.*, 589 F. App'x 732, 737 (5th Cir. 2014) (per curiam).

The Sixth Circuit has similarly held that if "§ [502](a)(1)(B) provides a remedy for [a beneficiary's] alleged injury that allows him to bring a lawsuit to challenge the Plan Administrator's denial of benefits to which he believes he is entitled, he does not have a right to a cause of action for breach of fiduciary duty pursuant to § [502](a)(3)." *Wilkins* v.

Baptist Healthcare Sys., Inc., 150 F.3d 609, 615 (6th Cir. 1998); *see also Rochow* v. *Life Ins. Co. of N. Am.*, 780 F.3d 364, 372 (6th Cir. 2015) (en banc) (discussing *Wilkins*), *pet. for cert. filed*, No. 15-163 (U.S. Aug. 3, 2015). And the Sixth Circuit has applied that analysis in reviewing a district court's decision on a motion to dismiss. *Gore* v. *El Paso Energy Corp. Long Term Disability Plan*, 477 F.3d 833, 838-842 (6th Cir. 2007); *see also Flatt* v. *Aetna Life Ins. Co. of Hartford, Conn.*, No. 14-1060, 2014 WL 6673910, at *5 (W.D. Tenn. Nov. 24, 2014) (dismissing § 502(a)(3) claims under *Wilkins* because they were "merely repackaged § [502](a)(1)(B) denial-of-benefit claims").

Finally, the Eleventh Circuit is in accord with the Fourth, Fifth, and Sixth Circuits. *See, e.g.*, *Ogden* v. *Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284, 1287-1288 (11th Cir. 2003); *Katz* v. *Comprehensive Plan of Grp. Ins.*, 197 F.3d 1084, 1088-1089 (11th Cir. 1999). In *Katz*, for example, the Eleventh Circuit affirmed the dismissal of a plan participant's § 502(a)(3) breach-of-fiduciary-duty claim because her alleged benefits-related injury was remediable under § 502(a)(1)(B). *See* 197 F.3d at 1088-1089. The court reached this conclusion even though the participant's § 502(a)(1)(B) claim later proved unsuccessful on the merits. The court explained: "[T]he availability of an adequate remedy under the law for *Varity* purposes, does not mean, nor does it guarantee, an adjudication in one's favor." *Id.* at 1089.[4]

[4] Both the First Circuit and the Ninth Circuit have issued decisions applying *Varity* at the summary-judgment stage, and their broad reasoning applies equally at the pleadings stage. *See Ford* v. *MCI Commc'ns Corp. Health & Welfare Plan*, 399 F.3d 1076, 1083 (9th Cir. 2005) ("Because Ford asserted specific

2. Two circuits disagree with the majority view on *Varity*: the Second Circuit and the Eighth Circuit.

The Second Circuit below put its own gloss on the decision, reasoning that "'*Varity Corp.* did not eliminate a private *cause of action* for breach of fiduciary duty when another potential remedy is available.'" Pet. App. 15a (quoting *Devlin* v. *Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) (emphasis added by court below)). "Instead, we have instructed, if a plaintiff 'succeeds on both claims the district court's *remedy* is limited to such equitable relief as is considered appropriate.'" *Id.* (quoting *Devlin*, 274 F.3d at 89-90 (emphasis added by court below)). Because of this, the Second Circuit held, "it is too early to tell" "at the motion-to-dismiss state of the litigation" whether a § 502(a)(1)(B) claim will "sufficient[ly] remedy" a plaintiff's injury. Pet. App. 16a.

The Eighth Circuit shares a similar view. In *Silva* v. *Metropolitan Life Ins. Co.*, 762 F.3d 711 (8th Cir. 2014), it read *Varity* only to "prohibit duplicate *recoveries* when a more specific section of the statute, such as § [502](a)(1)(B), provides a remedy similar to what the plaintiff seeks under the equitable catchall

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claims under 29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(2), she cannot obtain relief under 29 U.S.C. § 1132(a)(3), ERISA's 'catchall' provision."), *overruled in other part by Cyr*, 642 F.3d 1202; *LaRocca* v. *Borden, Inc.*, 276 F.3d 22, 28 (1st Cir. 2002) ("[I]f a plaintiff can pursue benefits under the plan pursuant to Section a(1), there is an adequate remedy under the plan which bars a further remedy under Section a(3)."). But because those two courts of appeals do not appear to have applied *Varity* specifically to a dismissal decision, we do not include them in the circuit split.

provision, § [502](a)(3)." *Id.* at 726 (emphasis added). According to the Eighth Circuit, "*Varity* does not limit the number of ways a party can initially seek relief at the motion to dismiss stage." *Id.*; *see also id.* at 727 (explaining that seemingly contrary prior precedent involved cases decided at the summary-judgment stage).

As these recent decisions from the Second and Eighth Circuits demonstrate, the courts of appeals are firmly divided over *Varity*'s place in evaluating motions to dismiss. Therefore, just as with the first question presented, this Court's intervention is desperately needed to bring uniformity to this important ERISA issue.

B. The Second Circuit's Decision Is Wrong.

1. Review should also be granted because the Second Circuit's decision is wrong, plain and simple. Although the Second Circuit took no issue with the District Court's conclusion that the "gravamen" of Denbo's § 502(a)(3) claims was "the wrongful denial of benefits," Pet. App. 39a, it nonetheless reversed dismissal of those claims because, according to the Second Circuit, "it is too early to tell if" they "are in effect repackaged claims under § 502(a)(1)(B)." *Id.* at 16a. Not so. The complaint makes clear that Denbo alleges only one underlying harm—United's alleged failure to pay plan benefits. *See, e.g.*, C.A. J.A. 156, 159 (First Am. Compl. ¶¶ 358, 370) ("request[ing] that United reprocess and reimburse benefits that were denied or reduced," and seeking declaratory and injunctive relief requiring that his future benefits be properly calculated).

Under *Varity*, the result should have been a quick affirmance of the District Court's dismissal because

"Congress elsewhere provided adequate relief for [Denbo's] injury," *Varity*, 516 U.S. at 515—namely, in § 502(a)(1)(B). Under that provision, he can sue the plan or plan administrator to "recover benefits due," "enforce his rights under the terms of the plan," and "clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B); *see Larson,* 723 F.3d at 913 (noting that a § 502(a)(1)(B) claim "offers typical contract forms of relief, including recovery of benefits accrued or otherwise due, declaratory judgments, and injunctions against future denials of benefits," and that statutory benefit mandates are enforceable as implied plan terms under § 502(a)(1)(B)). Because Denbo has an adequate remedy under § 502(a)(1)(B), he has no § 502(a)(3) claim.

2. The Second Circuit held otherwise, leaving for another day whether Denbo's § 502(a)(3) claim seeks equitable relief that is "appropriate" in light of § 502(a)(1)(B). The consequences of the Second Circuit's decision are troubling. By taking away *Varity*'s check on § 502(a)(3) claims at the pleadings stage, the decision encourages litigants to try "to avoid the implications of section 502(a)(1)(B) by artful pleading." *Coyne & Delany Co.* v. *Blue Cross & Blue Shield of Va., Inc.*, 102 F.3d 712, 714 (4th Cir. 1996). Already, litigants can and do attempt to game the system by recasting their § 502(a)(1)(B) denial-of-benefits claims as § 502(a)(3) breach-of-fiduciary duty claims. They do so to try to circumvent ERISA's requirement that they exhaust administrative remedies through their plans' internal procedures before bringing an ERISA action challenging a denial of benefits. *Id.* at 716. They do so to take advantage of longer limitations periods that apply to § 502(a)(3)

claims. *Corsini* v. *United HealthCare Corp.*, 51 F. Supp. 2d 103, 106 (D.R.I. 1999). And they do so in an attempt to obtain discovery that would not be available to them for a denial-of-benefits claim. *Samuelson* v. *Covenant Healthcare Sys.*, No. 10-13422-BC, 2011 WL 2261319, at *1 (E.D. Mich. June 8, 2011); *see also Tompkins* v. *Central Laborers' Pension Fund,* No. 09-cv-4004, 2009 WL 3836893, at *6 (C.D. Ill. Nov. 16, 2009) (contrasting the discovery available under § 502(a)(1)(B) and (a)(3)).

The Second Circuit's rule thus introduces all kinds of mischief into the proceedings and turns § 502(a)(3) into the very opposite of the "catchall" "safety net" that this Court described in *Varity*. 516 U.S. at 512. As the Fourth Circuit explained, "*Varity* allows equitable relief when the available remedy is inadequate, not when the legal framework for obtaining that remedy is, to the plaintiff's mind, undesirable." *Korotynska*, 474 F.3d at 108. The Second Circuit allows litigants to repurpose § 502(a)(3) as a means to avoid the limitations Congress adopted for denial-of-benefits claims under § 502(a)(1)(B). Its decision cannot be left to stand.

III. THIS CASE IS A PROPER VEHICLE FOR DECIDING BOTH QUESTIONS.

This case presents two pressing questions of critical importance to ERISA's civil enforcement scheme. The courts of appeals are hopelessly divided on both issues: A 6-to-4 split exists on the first, and a 4-to-2 split on the second. This case is a proper vehicle for resolving both questions.

The first question—whether a claims administrator is a proper defendant to a § 502(a)(1)(B) suit—was pressed and passed upon below. Pet. App. 11a-13a;

Defs.-Appellees' C.A. Br. 31-41. And this case is ripe for this Court's review. There is no dispute that United has no obligation to pay benefits: It is not the plan, the plan administrator, or the plan insurer. *See supra* pp. 5-6. Thus, if United had been sued under § 502(a)(1)(B) in the Third, Seventh, Eighth, or Tenth Circuits, the outcome would have been different: The suit would have been dismissed.

The second question—whether *Varity* establishes a pleading standard for § 502(a)(3) claims—was also pressed and passed upon below. Pet. App. 13a-18; Defs.-Appellees' C.A. Br. 42-48. And it, too, is ripe for this Court's review. In the Fourth, Fifth, Sixth, and Eleventh Circuits, Denbo's § 502(a)(3) claim would have been dismissed because his alleged injuries are remediable under § 502(a)(1)(B). But because the Second Circuit has decided that *Varity* determinations cannot be made on a motion to dismiss, Denbo's claim was allowed to proceed. Indeed, this petition presents this question at the only stage in the proceedings allowing for review: following the District Court's grant of a motion to dismiss. At any later stage, the pleading question would not be presented. This case therefore arrives at the perfect posture for the Court to resolve this issue.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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September 2015

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Docket No. 14-20-cv

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 on 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, SHELLY MENOLASCINO, M.D., on her own behalf and in a representational capacity on behalf of her beneficiary patients and on behalf of all other similarly situated providers and their patients,

Plaintiffs-Appellants,

v.

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

Defendants-Appellees.[*]

[*]The Clerk of the Court is directed to amend the caption of this case as set forth above.

August Term, 2014

(Argued: December 15, 2014
Final Submission: February 20, 2015
Decided: August 20, 2015)

Before:

JACOBS, LIVINGSTON, and LOHIER,
Circuit Judges.

Plaintiffs New York State Psychiatric Association, Inc. ("NYSPA"), Jonathan Denbo, and Dr. Shelly Menolascino sued Defendants UnitedHealth Group, UHC Insurance Company, United Healthcare Insurance Company of New York, and United Behavioral Health (collectively, "United"). Relying on §§ 502(a)(1)(B) and 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), the plaintiffs claimed that United violated the Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act), United's fiduciary duties under ERISA, and the terms of ERISA-governed health insurance plans administered by United. The United States District Court for the Southern District of New York (McMahon, *J.*) dismissed the plaintiffs' amended complaint, holding principally that NYSPA lacked associational standing to sue on behalf of its members; as a claims administrator, United could not be sued under § 502(a)(3) for alleged violations of the Parity Act or under § 502(a)(1)(B); and relief under § 502(a)(3) would not be "appropriate" because the plaintiffs' alleged injuries could be remedied under § 502(a)(1)(B). We **AFFIRM** in part and **VACATE** in part and **REMAND.**

D. BRIAN HUFFORD, Zuckerman Spaeder LLP, New York, NY (Jason S. Cowart, Zuckerman Spaeder LLP, New York, NY; Conor B. O'Croinin, Zuckerman Spaeder LLP, Baltimore, MD; Meiram Bendat, Psych-Appeal, Inc., West Hollywood, CA; Anthony F. Maul, The Maul Firm, Brooklyn, NY, *on the brief), for Plaintiffs-Appellants.*

CATHERINE E. STETSON, Hogan Lovells US LLP, Washington, DC (Mary Helen Wimberly, Hogan Lovells US LLP, Washington, DC; Richard H. Silberberg, Dorsey & Whitney LLP, New York, NY; Steven P. Lucke, Andrew Holly, Dorsey & Whitney LLP, Minneapolis, MN, *on the brief), for Defendants-Appellees.*

LOHIER, *Circuit Judge*:

Plaintiffs New York State Psychiatric Association, Inc. ("NYSPA"), Jonathan Denbo, and Dr. Shelly Menolascino sued UnitedHealth Group, UHC Insurance Company, United Healthcare Insurance Company of New York, and United Behavioral Health (collectively, "United"). [1] Relying on §§ 502(a)(1)(B) and 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1132(a)(1)(B), (a)(3), the plaintiffs claimed that United had violated its fiduciary duties under ERISA, the terms of ERISA-governed health insurance plans administered by United, and the Mental Health Parity and Addiction Equity Act of

[1] A fourth plaintiff, Michael A. Kamins, brought claims against United pursuant to New York and California State law. Kamins has abandoned his challenge to the District Court's refusal to exercise supplemental jurisdiction over his claims.

2008 (the Parity Act),[2] which requires group health plans and health insurance issuers to ensure that the financial requirements (deductibles, copays, etc.) and treatment limitations applied to mental health benefits be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan or insurance, *see* 29 U.S.C. § 1185a(a)(3)(A). NYSPA also brought three additional counts under New York State law.[3]

United moved to dismiss the amended complaint, arguing that NYSPA did not have associational standing to sue on behalf of its members, that United could not be sued under § 502(a)(3) for alleged violations of the Parity Act or under § 502(a)(1)(B), and that in any event it would not be "appropriate" for the plaintiffs to obtain relief under § 502(a)(3) if § 502(a)(1)(B) offered an adequate remedy. The United States District Court for the Southern District of New York (McMahon, *J.*) granted United's motion to dismiss. Because we conclude that NYSPA has standing at this stage of the litigation and that Denbo's claims, but not Dr. Menolascino's claims, should be permitted to proceed, we affirm in part and vacate in part and remand.

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[2]Although Count I of the amended complaint cites only to the Parity Act, we agree with the District Court that the plaintiffs brought Count I pursuant to § 502(a)(3).

[3]The plaintiffs have abandoned their appeal of the dismissal of Counts IV and V of the amended complaint. Although the plaintiffs' reply brief addresses Count IV in a footnote, "[w]e do not consider an argument mentioned only in a footnote to be adequately raised or preserved for appellate review." *Dow Jones & Co. v. Int'l Sec. Exch., Inc.*, 451 F.3d 295, 301 n.7 (2d Cir. 2006).

BACKGROUND

1. The Plaintiffs

In describing each plaintiff, we draw the following facts from the allegations in the plaintiffs' amended complaint and documents incorporated by reference therein. *See Eades v. Kennedy, PC Law Offices*, No. 14-104-cv, 2015 WL 3498784, at *1 (2d Cir. June 4, 2015).

a. NYSPA

NYSPA is a professional organization of psychiatrists practicing in New York State. It alleges that United unlawfully imposed financial requirements and treatment limitations on mental health benefits for patients of NYSPA members. That said, NYSPA's only specific allegations relate to an insurance plan that is not subject to ERISA, and its other allegations are generalized recitations of its members' complaints about United.

b. Denbo

Denbo, an employee of the CBS Sports Network, has health insurance benefits through the CBS Medical Plan (the "CBS Plan"), which incorporates the requirements of ERISA and the Parity Act. As the claims administrator for the CBS Plan, United administers claims for behavioral health benefits, such as mental health benefits, and for medical health benefits. Under the terms of the CBS Plan, United has "exclusive authority and sole and absolute discretion to interpret and to apply the rules of the Plan to determine claims for Plan benefits." Joint App'x 181. As required by ERISA, the CBS Plan has an appeals process for adverse benefits determinations, pursuant to which United decides

any appeals of its benefits determinations. United's appeal "decision[s] [are] final and binding, and no further appeal is available."[4] Joint App'x 65. The CBS Plan also describes what plan participants must do to file suit against United and how to serve United with legal process.

Denbo, who suffers from dysthymic disorder and generalized anxiety disorder, submitted benefits claims to United for his weekly and, later, semiweekly outpatient psychotherapy sessions with an out-of-network psychologist. Although United initially granted Denbo's claims, it conducted a concurrent medical necessity review while Denbo was still undergoing treatment but after he submitted claims for twelve sessions within six weeks. As a result of that review, in May 2012 United told Denbo that his treatment plan was not medically necessary and that United would no longer provide benefits for his psychotherapy sessions. United upheld its decision on appeal.

In the amended complaint, Denbo alleges that United improperly administered the CBS Plan by treating claims submitted for routine, outpatient, out-of-network medical/surgical care ("medical claims") more favorably than claims for ongoing, routine, outpatient, out-of-network psychotherapy sessions ("mental health claims"), in violation of the Parity Act. For example, United subjected the mental health claims, but not the medical claims, of CBS Plan participants to preauthorization requirements or concurrent review. In determining

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[4]After a participant exhausts the appeals process, an optional "external review program" is available for certain types of claim denials.

the medical necessity of Denbo's psychotherapy sessions, moreover, United applied review standards that were more restrictive than both generally accepted mental health standards and the standards United applied to medical claims under the CBS Plan. Denbo also claimed that United contravened the terms of the CBS Plan itself. Among other things, Denbo alleges, the CBS Plan expressly permits retrospective review of submitted mental health claims for sessions lasting less than fifty minutes, but does not appear to sanction either preauthorization or concurrent review of such claims. And Denbo claimed that some of United's conduct in administering the CBS Plan violated both the Parity Act and the terms of the plan—for example, conducting a concurrent review of mental health claims based solely on the frequency of mental health office visits is, Denbo claimed, neither endorsed by the CBS Plan nor done with medical claims.

c. Dr. Menolascino

Dr. Menolascino, a psychiatrist, provides psychopharmacology "evaluation and management" services to United plan beneficiaries, who in turn assign their plan benefits to her. United denied or reduced benefits to Dr. Menolascino for these services. But the amended complaint does not specify how United treated "evaluation and management" services for medical/surgical care. Nor does it identify the health insurance plans of Dr. Menolascino's patients (or even the terms of those plans).

2. Procedural History

On December 4, 2013, the District Court granted United's motion to dismiss the amended complaint in

its entirety, holding principally that NYSPA lacked associational standing to sue on behalf of its members; as a claims administrator, United could not be sued under § 502(a)(3) for alleged violations of the Parity Act or under § 502(a)(1)(B); and relief under § 502(a)(3) would not be "appropriate" because the plaintiffs' alleged injuries could be fully remedied under § 502(a)(1)(B). This appeal followed.

DISCUSSION

1. NYSPA's Standing

We first consider whether NYSPA has properly pleaded associational 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 v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977). By contrast, an association "lacks standing to assert claims of injunctive relief on behalf of its members where the fact and extent of the injury that gives rise to the claims for injunctive relief would require individualized proof." *All. for Open Soc'y Intl, Inc. v. U.S. Agency for Int'l Dev.*, 651 F.3d 218, 229-30 (2d Cir. 2011), *aff'd*, 133 S. Ct. 2321 (2013). This is not to say that the participation of a limited number of individual members will negate standing: the association will maintain standing if "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." *United Food & Commercial Workers Union Local 751*

v. Brown Grp., Inc., 517 U.S. 544, 552 (1996); *see also N.Y. State Nat'l Org. for Women v. Terry*, 886 F.2d 1339, 1349 (2d Cir. 1989).

NYSPA alleges, and there is no serious dispute on appeal, that its members have standing to sue United in their own right, both as assignees of ERISA benefits and to prevent interference with their provision of mental health treatment. There is also no serious dispute that this action implicates interests germane to NYSPA's purpose. The parties dispute only whether at the motion to dismiss stage NYSPA has plausibly alleged that its claims do not require individualized proof. It has. NYSPA challenges United's systemic policies and practices insofar as they violate ERISA and the Parity Act, and it seeks only injunctive and declaratory relief. *See All. for Open Soc'y Int'l*, 651 F.3d at 229. At this stage in the litigation, it remains plausible that the participation of a limited number of NYSPA members will allow NYSPA to prove that United's practices violate the relevant statutes. If at summary judgment or at trial NYSPA's claims require significant individual participation or proof, the District Court may dismiss NYSPA for lack of standing at that point. *See Borrero v. United HealthCare of N.Y., Inc.*, 610 F.3d 1296, 1306 n.3 (11th Cir. 2010); *Pa. Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 286-87 (3d Cir. 2002).

Having dismissed NYSPA on standing grounds, the District Court did not consider whether NYSPA alleged facts sufficient to state a plausible claim for relief. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). We vacate the District Court's dismissal of NYSPA's claims and remand for it to consider in

the first instance whether NYSPA's pleadings can survive the pleading standard set forth in *Twombly*. *See Nat'l Org. for Marriage, Inc. v. Walsh*, 714 F.3d 682, 692 (2d Cir. 2013). Of course, nothing in this opinion precludes NYSPA, on remand, from moving for leave to amend the complaint. But we leave resolution of any such motion to the discretion of the District Court.

2. Denbo's Claims Under §§ 502(a)(1)(B) and 502(a)(3)

As we have previously described, Denbo claims that United breached the terms of the CBS Plan and violated its fiduciary duty to Denbo by, first, applying preauthorization and concurrent review policies to mental health claims but not to medical claims, and, second, determining the medical necessity of mental health care using guidelines that were more restrictive than those used by either the mental health community or United when it determined the medical necessity of medical claims. *See Kendall v. Emps. Ret. Plan of Avon Prods.*, 561 F.3d 112, 120 (2d Cir. 2009) ("There is no doubt that ERISA imposes on plan fiduciaries a duty to act 'in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA].' 29 U.S.C. § 1104(a)(1)(D). The statute . . . impose[s] a general fiduciary duty to comply with ERISA." (first alteration in original)). There is no serious dispute that Denbo's claims are both adequately and plausibly alleged in the amended complaint. The only question as to these claims is whether United may be held liable under §§ 502(a)(1)(B) or 502(a)(3) in its capacity as an ERISA claims administrator.

a. Section 502(a)(1)(B)

We ultimately reject United's argument that it cannot be sued under § 502(a)(1)(B) in its capacity as a claims administrator. By its plain terms, § 502(a)(1)(B) does not preclude suits against claims administrators. It simply states that "[a] civil action may be brought . . . by a participant or beneficiary . . . 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). Indeed, when a claims administrator exercises total control over claims for benefits under the terms of the plan, that administrator is a logical defendant in the type of suit contemplated by § 502(a)(1)(B)—a suit "to recover benefits," "to enforce . . . rights," "or to clarify . . . rights to future benefits under the terms of the plan." *Id.*; *see Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202, 1205-07 (9th Cir. 2011) (en banc). Even if the statutory text were ambiguous, United fails to point us to any legislative history or agency interpretation that refutes our understanding of the statute as it applies to claims administrators who exercise total control over the benefits claims process.

Here, United appears to have exercised *total* control over the CBS Plan's benefits denial process. It enjoyed "sole and absolute discretion" to deny benefits and make "final and binding" decisions as to appeals of those denials. Joint App'x 65, 181. And assuming that United's actions violated Denbo's rights under ERISA, United is the only entity capable of providing direct relief to Denbo. We therefore hold that where the claims administrator has "sole and absolute discretion" to deny benefits

and makes "final and binding" decisions as to appeals of those denials, the claims administrator exercises total control over claims for benefits and is an appropriate defendant in a § 502(a)(1)(B) action for benefits.[5] United is such an administrator and is accordingly an appropriate defendant for Denbo's claim under § 502(a)(1)(B).

Our holding is in accord with six of our sister circuits, which have held that claims administrators may be sued as defendants under § 502(a)(1)(B). *See Larson v. United Healthcare Ins. Co.*, 723 F.3d 905, 913-16 (7th Cir. 2013); *LifeCare Mgmt. Servs. LLC v. Ins. Mgmt. Adm'rs Inc.*, 703 F.3d 835, 843-46 (5th Cir. 2013); *Cyr*, 642 F.3d at 1205-07; *Brown v. J.B. Hunt Transp. Servs., Inc.*, 586 F.3d 1079, 1081, 1088 (8th Cir. 2009); *Moore v. Lafayette Life Ins. Co.*, 458 F.3d 416, 438 (6th Cir. 2006); *Heffner v. Blue Cross & Blue Shield of Ala., Inc.*, 443 F.3d 1330, 1333-34 (11th Cir. 2006). Our holding also follows from the Supreme Court's holding in *Harris Trust & Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000), that non-plan defendants may be sued under § 502(a)(3). That holding was premised in part on the observation that "§ 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 [ERISA]." *Harris Tr. & Sav. Bank*, 530 U.S. at 246.

Leonelli v. Pennwalt Corp., 887 F.2d 1195 (2d Cir. 1989), which United cites in support of its position, is

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[5] We need not and do not decide whether a claims administrator that exercises less than total control over the benefits denial process is an appropriate defendant under § 502(a)(1)(B).

not to the contrary. True, in *Leonelli* we stated that "only the plan and the administrators and trustees of the plan in their capacity as such may be held liable" under § 502(a)(1)(B). *Leonelli*, 887 F.2d at 1199. But we never specifically addressed or considered whether a claims administrator that exercises total control over the plan claims process may be sued pursuant to § 502(a)(1)(B). *Id.* And since *Leonelli*, we have not held or even suggested that a claims administrator is an improper defendant under § 502(a)(1)(B). Because United, as claims administrator, exercised total control over the CBS Plan's claims process, we hold that it is a proper defendant under § 502(a)(1)(B).

b. Section 502(a)(3)

We turn, then, to § 502(a)(3). United first argues that it cannot be held liable under § 502(a)(3) for violations of the Parity Act because it is the claims administrator of a *self-funded* plan. The Parity Act provides as follows:

> 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 . . . benefits, such plan or coverage shall ensure that . . . the financial requirements [and treatment limitations] applicable to such mental health . . . benefits are no more restrictive than the predominant financial requirements [and treatment limitations] applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements [or treatment

> limitations] that are applicable only with respect to mental health . . . benefits.

29 U.S.C. § 1185a(a)(3)(A). Based on this language, United argues that the Parity Act does not apply directly to it, because it is not a "group health plan" and did not offer health insurance coverage to Denbo. Denbo responds that United's Parity Act obligation is imposed on it not by the Parity Act itself, but rather by § 502(a)(3). Denbo's argument is based on *Harris Trust*, in which the Supreme Court interpreted § 502(a)(3) as "itself impos[ing] certain duties" that are not otherwise imposed by statute, such that "liability under that provision does not depend on whether ERISA's substantive provisions impose a specific duty on the party being sued." *Harris Tr. & Sav. Bank*, 530 U.S. at 245. In contrast to "[o]ther provisions of ERISA" that "do expressly address who may be a defendant," the Court explained that "§ 502(a)(3) makes no mention at all of which parties may be proper defendants," but rather allows a plaintiff to bring suit based on the "the *act or practice* which violates any provision of ERISA Title I." *Id.* at 246 (quotation marks omitted). The Court's interpretation of ERISA "refutes the notion that § 502(a)(3) . . . liability hinges on whether the particular defendant labors under a duty expressly imposed by the substantive provisions" of that statute. *Id.* at 249. In light of that interpretation, § 502(a)(3) may impose a fiduciary duty arising indirectly from the Parity Act even if the Parity Act does not directly impose such a duty. For that reason, and because "§ 502(a)(3) admits of no limit . . . on the universe of possible defendants," *id.* at 246, we hold that United is a proper defendant for Denbo's Parity Act claim under § 502(a)(3).

United next urges us to affirm the dismissal of Denbo's § 502(a)(3) claims on the ground that adequate relief is available under § 502(a)(1)(B). We disagree with that ground for dismissal, but only because we think that the District Court's dismissal on this basis was premature. Section 502(a)(3) states:

> A civil action may be brought . . . 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.

29 U.S.C. § 1132(a)(3). As the Supreme Court explained in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), this "catchall" provision "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. So "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.'" *Id.* at 515. But it is important to distinguish between a cause of action and a remedy under § 502(a)(3). "*Varity Corp.* did not eliminate a private *cause of action* for breach of fiduciary duty when another potential remedy is available." *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) (emphasis added). Instead, we have instructed, if a plaintiff "succeed[s] on both claims . . . the district court's *remedy* is limited to such equitable relief as is considered appropriate." *Id.* at

89-90 (emphasis added). Thus in *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006), we vacated the district court's dismissal of the plaintiffs' § 502(a)(3) breach of fiduciary duty claim on the basis that dismissal was premature, and we affirmed the dismissal of the plaintiffs' other § 502(a)(3) claim only after holding that the defendants had violated ERISA, that most plaintiffs were therefore entitled to relief under § 502(a)(1)(B), and that the remaining plaintiffs' § 502(a)(3) claim failed on the merits. *Frommert*, 433 F.3d at 268-70, 272.

Here, Denbo's § 502(a)(3) claims are for breach of fiduciary duty, he has not yet succeeded on his § 502(a)(1)(B) claim, and it is not clear at the motion-to-dismiss stage of the litigation that monetary benefits under § 502(a)(1)(B) alone will provide him a sufficient remedy. In other words, it is too early to tell if his claims under § 502(a)(3) are in effect repackaged claims under § 502(a)(1)(B). We therefore hold that the District Court prematurely dismissed Denbo's claims under § 502(a)(3) on the ground that § 502(a)(1)(B) provides Denbo with adequate relief. *See Varity Corp.*, 516 U.S. at 515 (granting a remedy where no other remedy is available "is consistent with the literal language of [ERISA], [ERISA's] purposes, and pre-existing trust law"); *Devlin*, 274 F.3d at 89 ("*Varity Corp.* evidences a clear intention to avoid construing ERISA in a manner that would leave beneficiaries without any remedy at all." (quotation marks omitted)). If, on remand, Denbo prevails on his claims under both § 502(a)(1)(B) and § 502(a)(3), the District Court should then determine whether equitable relief under § 502(a)(3) is appropriate. *See Devlin*, 274 F.3d at 89-90.

We add that where, as here, a plan participant brings suit against a "plan fiduciary (whom ERISA typically treats as a trustee)" for breach of fiduciary duty relating to the terms of a plan, any resulting injunction coupled with "surcharge"—"monetary 'compensation' for a loss resulting from a [fiduciary's] breach of duty, or to prevent the [fiduciary's] unjust enrichment"—constitutes equitable relief under § 502(a)(3). *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1879-80 (2011). Every sister circuit that has considered the issue is in accord. *See Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 963 (9th Cir. 2014); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 724-25 (8th Cir. 2014); *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 882 (7th Cir. 2013); *Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 452 (5th Cir. 2013); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 181-82 (4th Cir. 2012). And so we hold that to the extent Denbo seeks redress for United's past breaches of fiduciary duty or seeks to enjoin United from committing future breaches, the relief sought would count as "equitable relief" under § 502(a)(3). *Amara*, 131 S. Ct. at 1879-80. As such, it is to be distinguished from the relief sought in *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96 (2d Cir. 2005), where we affirmed a dismissal of the plaintiff's § 502(a)(3) claims because it was clear that "any harm to [the plaintiff could] be compensated by money damages" entirely and she "[could not] satisfy the conditions required for injunctive relief." *Nechis*, 421 F.3d at 103.

Based on our review of the amended complaint, Denbo appears to request monetary compensation for any losses resulting from United's violations of the Parity Act and ERISA, and declaratory and

injunctive relief prohibiting United from violating the Parity Act and ERISA in the future. These forms of relief "closely resemble[]" the traditional equitable remedies of injunctive relief and surcharge. *Amara*, 131 S. Ct. at 1879. But the amended complaint is not altogether clear about the source of Denbo's monetary losses. If Denbo seeks true equitable relief—such as losses flowing from United's breach of fiduciary duty—the relief sought would "resemble[]" the remedy of surcharge, and would therefore be available to him under § 502(a)(3), ERISA's provision for equitable remedies. *See id.* at 1880. If, on the other hand, the relief Denbo seeks is merely monetary compensation resembling legal damages—such as compensation that would neither redress a loss flowing from United's breach of fiduciary duty nor prevent United's unjust enrichment—the relief sought would be unavailable as an equitable remedy under § 502(a)(3). Of course, the availability of injunctive relief and surcharge does not mean they are necessarily appropriate, and we leave the fashioning of appropriate remedies, if any, to the District Court. *See, e.g., Kenseth*, 722 F.3d at 883.

For these reasons, we vacate the District Court's dismissal of Denbo's claims and remand.

3. Dr. Menolascino's Claims

By contrast, we affirm the District Court's dismissal of Dr. Menolascino's claims because the amended complaint's allegations relating to those claims fail to satisfy the *Twombly* pleading standard. *See Twombly*, 550 U.S. at 570. In particular, as to Dr. Menolascino's claims, the amended complaint fails specifically to allege how United treated "evaluation and management" services for

medical/surgical care, fails plausibly to allege that United's treatment of such services for mental health care violated the Parity Act, fails to identify her patients' plans or the terms of their plans, and fails to allege facts making it plausible that United reduced or denied benefits for medically necessary services "without any basis" under the terms of those plans. Joint App'x 157. Faced with such inadequate pleading, the District Court did not err in dismissing Dr. Menolascino's claims.

CONCLUSION

We have considered the parties' remaining arguments and conclude that they are without merit. For the foregoing reasons, we AFFIRM in part and VACATE in part and REMAND for further proceedings consistent with this opinion.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 13 Civ. 1599 (CM)

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

-against-

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

Defendants.

DECISION AND ORDER GRANTING DEFENDANTS' MOTION TO DISMISS AND DENYING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

McMahon, J.:

PRELIMINARY STATEMENT

This is essentially a denial of benefits case under the Employee Retirement Income Security Act ("ERISA") (29 U.S.C. § 1001 *et. seq*). It is brought by a polyglot group of unrelated plaintiffs who either (1) applied to their employer-sponsored health plans (and in one case, to a non-ERISA plan offered by the State of New York) for reimbursement of the cost of mental health care or substance abuse treatment (plaintiffs Denbo, Smith, Olin, and Kamins), or (2) provided mental health care for which their patients were not fully reimbursed by their employer-sponsored health plans (plaintiffs Allender, Menolascino, and the New York State Psychiatric Association ("NYSPA")). In each instance, Defendants UnitedHealth Group Incorporated ("UHG") or one of three subsidiaries, UnitedHealthcare Insurance Company ("UHIC"), UnitedHealthcare Insurance Company of New York ("UHIC-NY"), and United Behavioral Health ("UBH") (collectively, "United") had something to do with the denial of benefits sought. Plaintiffs bring a

variety of claims against United, alleging violations of ERISA, the Mental Health Parity and Addiction Equity Act ("Parity Act") (Pub. L. No. 110-343, § 511 *et. seq*), the Patient Protection and Affordable Care Act ("ACA") (Pub. L. No. 111-148), the New York Parity Act (N.Y. Ins. Law § 3221(1)(5), *et seq.*), the New York Deceptive Trade Practices Act (N.Y. G.B.L. § 349), and the New York Prompt Pay Statute (N.Y. Ins. Law § 3224-a). All of the individual plaintiffs charge that United applies a different standard to requests for reimbursement of the cost of mental health and substance abuse treatment, as opposed to medical or surgical treatment, and that United wrongly denied them or their assignors mental health benefits to which they were entitled under their health plans. Some plaintiffs claim that they were not allowed to take appeals from denials of benefits, or that inadequate procedures were followed in appeals.

Plaintiffs seek money damages and an injunction requiring United to treat mental health or substance abuse benefits no less favorably than it treats medical or surgical benefits when it assesses whether claims are reimbursable under various employer-sponsored health plans.

United moves to dismiss all the claims asserted against it pursuant to Federal Rules of Civil Procedure 12(b)(6) and 12(b)(1). Defendants argue that every plaintiff fails to state a claim against it, and that the NYSPA lacks standing to pursue any claim. Plaintiffs cross-move for a preliminary injunction under Rule 65(a) seeking to enjoin United's practices that allegedly violate mental health parity laws.

As to all claims, the motion to dismiss is granted. In view of the outcome of the motion to dismiss, the motion for preliminary injunction is denied as moot.

Standard of Review

In deciding a motion to dismiss pursuant to Rule 12(b)(6), the Court must liberally construe all claims, accept all factual allegations in the complaint as true, and draw all reasonable inferences in favor of the plaintiff. *See Cargo Partner AG v. Albatrans, Inc.*, 352 F.3d 41, 44 (2d Cir. 2003); *see also Roth v. Jennings*, 489 F.3d 499, 510 (2d Cir. 2007).

However, to survive a motion to dismiss, "a complaint must contain sufficient factual matter . . . to 'state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (citing *Twombly*, 550 U.S. at 556). "While a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, a plaintiff's obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555 (internal quotations, citations, and alterations omitted). Thus, unless a plaintiff's well-pleaded allegations have "nudged [its] claims across the line from conceivable to plausible, [the plaintiffs] complaint must be dismissed." *Id.* at 570; *see also Iqbal*, 129 S. Ct. at 1950-51.

On a motion to dismiss, the well-pleaded allegations of the complaint are presumed true. *See id.* at 1949-50. Conclusory allegations of fact and allegations of law are not. *See id.* Additionally, any document that is pleaded or relied upon by a plaintiff in a complaint is deemed incorporated into that complaint—even if it is not physically appended to the complaint—and the entire text of that document may be considered on the motion to dismiss without converting the motion to a motion for summary judgment. *See Rothman v. Gregor*, 220 F.3d 81, 88-89 (2d Cir. 2000) (citing *Cortec Indus. Inc. v. Sum Holding L.P.*, 949 F.2d 42, 47-48 (2d Cir. 1991)); *San Leandro Emergency Med. Group Profit Sharing Plan v. Philip Morris Cos.*, 75 F.3d 801, 808 (2d Cir. 1996).

To survive a motion to dismiss for lack of subject-matter jurisdiction based on standing pursuant to Rule 12(b)(1), the plaintiff "must allege facts that affirmatively and plausibly suggest that it has standing to sue." *Amidax Trading Grp. v. S.W.I.F.T. SCRL*, 671 F.3d 140, 145 (2d Cir. 2011). If the defendants challenge only the legal sufficiency of the jurisdictional allegations, "the court must take all facts alleged in the complaint as true and draw all reasonable inferences in favor of plaintiff." *Robinson v. Gov't of Malaysia*, 269 F.3d 133, 140 (2d Cir. 2001). Where the defendants place jurisdictional facts in dispute, however, the court may properly consider "evidence relevant to the jurisdictional question [that] is before the court." *Robinson*, 269 F.3d at 140; *see also Amidax*, 671 F.3d at 145.

CONCLUSIONS OF LAW

This is really seven different lawsuits amalgamated (inappropriately) in a single caption.

In order to assess the merits of the motion to dismiss, the case must be broken into its component parts, each of which must be analyzed separately.

A. The Claims of Plaintiffs Denbo, Smith, and Olin Are Dismissed.

1. The Plaintiffs

Denbo: Plaintiff Jonathan Denbo is an employee of CBS Sports Network ("CBS") and receives health insurance through the CBS Medical Plan ("CBS Plan"). *See* FAC ¶ 19. The CBS Plan covers outpatient mental health services, subject to retrospective reviews, which are reviews that occur after treatment has been provided to determine whether it was medically necessary and thus covered by the plan. *See id* ¶¶ 120, 100-01. The CBS Plan is a self-insured plan, which means that CBS itself pays all the benefits due to plan participants under the terms of the plan; CBS does not purchase insurance, from United or anyone else, in order to cover the cost of benefits owed to employees. *See* Pennington Decl. Ex. A at 150-52.

According to the Plan Document, the "Plan Administrator" for the CBS Plan is a CBS-related entity—the CBS Retirement Committee. *See id*. at 151. "Administrator" is a term of art under ERISA. It is defined as "the person specifically so designated by the terms of the instrument under which the plan is operated" or "if an administrator is not so designated, the plan sponsor." 29 U.S.C. § 1002(16)(A).

The FAC alleges that Defendant UHIC is the "Claims Administrator" of the CBS Plan. *See* FAC ¶ 35. The Plan Document states that a Claims Administrator has "exclusive authority and sole and

absolute discretion to interpret and to apply the rules of the Plan to determine claims for Plan benefits." *See* Pennington Decl, Ex. A at 152. It further states that the Claims Administrator "determines whether [a beneficiary has] incurred a covered expense for which benefits are payable from the Plan and determines the amount of, and administers the payment of, any such benefits based on information contained in the written claim." *See id.*

The FAC alleges that Denbo obtained medically necessary mental health treatment—psychotherapy—for depressive and anxiety disorders. *See* FAC ¶ 20. He submitted claims for coverage to United, which processed the claims through UHIC and UBH. *See id.* at 14, 34-45. Denbo contends that his claims were improperly subjected to concurrent and prospective (rather than retrospective) reviews, meaning that United intervened to review the medical necessity of care contemporaneously with treatment and to make claims determinations for ongoing and future treatment before that treatment was provided. *See id.* at 34-45. Specifically, a representative of United contacted Denbo's health care provider to discuss his ongoing outpatient mental health treatment, and two days later the representative told the provider that United would no longer cover such treatment. *See id.* ¶ 108. On May 18, 2012, United allegedly sent Denbo a letter, informing him that United had reviewed his ongoing treatment plan and that the plan "does not meet UBH criteria for benefit coverage at this time." *See id.* ¶ 108. The letter informed Denbo that, given his "adequate reduction/resolution in clinical symptoms," United

would cover only three more treatment sessions. *See id.* Denbo and his provider appealed this decision to no avail. *See id* at 38-43. United responded to the appeal on May 30, 2012, stating that the "benefit coverage is not available for outpatient therapy sessions beginning 05/11/2012 and forward . . ." *See id.* ¶ 111. United allegedly refused to consider the second appeal letter submitted by Denbo's provider. *See id.* ¶ 119.

Denbo contends that United's prospective and concurrent reviews violated the terms of the CBS Plan, which permits only retrospective reviews of coverage. *See id.* ¶¶ 100-01, 109. The FAC also alleges that "United" did not provide Denbo with a second level of appeal, to which he was allegedly entitled under the terms of the Plan. *See id.* at 42-43.

Smith: Plaintiff Brad Smith is an employee of SYSCO Seattle, Inc., a subsidiary of SYSCO Corporation ("SYSCO"). He and his family receive health insurance through the SYSCO Corporation Group Benefits Plan ("SYSCO Plan"). *See id.* ¶ 21. Like the CBS Plan, the SYSCO Plan is self-insured. *See* Strange Decl. Ex. A at 11-12. As with the CBS Plan, a SYSCO-related entity, the SYSCO Administrative Committee, is designated in the Plan Document as the Plan Administrator. *See id.* at 12. Defendant UBH is the claims administrator for the SYSCO Plan's mental health benefits, and Blue Cross Blue Shield of Illinois ("BCBS") is the claims administrator for the Plan's medical and surgical benefits. *See id.* at 18, 114; FAC ¶ 21.

The SYSCO Plan provides coverage for medically necessary mental health treatment. *See id.* ¶ 22;

Strange Decl. Ex. A at 114-16. As a claims administrator, UBH is given "discretionary authority to (i) construe and interpret the terms of the Plan, and (ii) determine the validity of charges submitted to [United] under the Plan." FAC ¶ 21; *see also* Strange Decl. Ex. A at 12-13. The SYSCO Plan also gives UBH discretion to determine what care is medically necessary. *See id* at 105; FAC ¶¶ 22, 151. The SYSCO plan confers on UBH full responsibility for the review of "urgent" and "concurrent" care claims. *See id.* at 49-50; Strange Decl. Ex. A at 16. An urgent care claim is "any pre-service claim or concurrent care decision . . . that must be reviewed quickly in order to avoid jeopardizing your life, health, or ability to regain maximum function . . ." FAC at ¶ 147. A concurrent care claim is one that concerns "an *ongoing* course of treatment that is to be provided over a period of time or for a specified number of treatments . . ." *Id.* at ¶ 148 (emphasis added).

If a claim is denied, plan participants have a right to appeal; the plan provides for one level of appeal for "urgent" and "concurrent" care claims. *See id.* at 49-50; Strange Decl. Ex. A at 16.

The FAC alleges that Smith's son "Daniel,"[1] a beneficiary under Smith's policy, has been treated for severe mental illness since 2005. *See* FAC ¶ 23. His care has included medication, outpatient psychotherapy, and residential psychiatric treatment. *See id.* The FAC asserts that UBH uses a definition of "medical necessity" in assessing mental health claims that gives it "far greater discretion to deny care" than the definition BCBS

[1]"Daniel" is not his real name.

uses when assessing medical claims. *See id.* at 50-51. BCBS's definition is allegedly tied to "generally accepted standards of medical practice," whereas UBH's definition relies on "internally-developed guidelines." *See id.* at ¶¶ 152-54. According to the FAC, UBH also imposed something called a "fail-first" policy on applications for mental health benefits. "Fail-first" means that the Plan will not reimburse for a particular level of care until less intensive levels of care are tried first, and fail. *See id.* at 11, 52.

Smith alleges that UBH prematurely terminated coverage for his son's residential mental health treatment. *See id.* at 48. On April 2, 2012, UBH sent Smith a letter stating that coverage was not available for Daniel's ongoing residential treatment "from 3/29/12 forward" and that "treatment could be safely and effectively delivered at a lower level of care" on an outpatient basis. *See id.* at 54; Massey Decl. Ex. A at 1. According to Smith, no such outpatient treatment is available in the community in which the Smith family lives. *See* FAC at 53, 57. Daniel's provider appealed, and UBH issued a "Final Adverse Determination of [Smith's] internal appeal." *See id.* at 55-57; Massey Decl. Ex. B at 3. UBH also denied coverage for Daniel's outpatient treatment, allegedly without providing any explanation. *See* FAC ¶ 168; Maul Decl. Ex. 4.

Olin: Plaintiff Jordan Olin is an employee of Oracle Corporation ("Oracle"). *See* FAC ¶ 25. He and his family receive health insurance through the Oracle Corporation Flexible Benefits Plan ("Oracle Plan"). *See id.* The Oracle Plan is a self-insured plan which designates the employer (Oracle) as the

Plan Administrator. *See* Percoski Decl. Ex. A at 147-48. United (through UHIC) is designated as a "Third Party Administrator and Claims Fiduciary" for the Oracle Plan. *See id.* at 149. The Plan Document states that UHIC has "discretion and authority to determine on Oracle's behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined." *See id.* at 151. UHIC also "serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals . . ." *See id.* As a claims administrator, UHIC determines benefits claims and processes appeals for Plan participants. *See id.*

The Oracle Plan provides mental health coverage. *See id.* at 30-32; FAC ¶ 181. The FAC alleges that Olin's son "Sean,"[2] who is a beneficiary under Olin's policy, suffers from severe mental illness and substance abuse problems. *See id.* ¶¶ 28, 169-74. Sean was admitted to two separate residential treatment centers in November 2012 and March 2013. *See id.* at 58-60. Both times, UHIC allegedly refused to authorize coverage for the residential treatment, stating that Sean's condition did not meet its guidelines for such a high level of care. *See id.* at 61-64; Hufford Decl. Ex. 45 at 1; Hunt Decl. at 2; Massey Decl. Ex. F at 2. United's case notes from the March 2013 denial cite "no evidence of further deterioration" and conclude that Sean "could be treated safely and effectively at the mental health/dual diagnosis partial hospital level of care;" given these findings, United determined that

[2]"Sean" is not his real name.

residential care was unnecessary and not covered by the Plan. *See id.*

UHIC also rejected first-level appeals in November 2012 and March 2013 and allegedly failed to offer Olin the second-level appeals required by the Oracle Plan terms. *See* FAC at 61-71. Olin states that United referred his March 2013 appeal of his benefit denial to an "independent review organization," an external entity sometimes employed by a claims administrator to assist in processing appeals. *See id.* at 71-72. These reviewers allegedly delayed their reviews in violation of plan terms and failed to conduct *de novo* reviews. *See id.*

Based on these events, Olin claims that UHIC applied strict treatment limitations, such as fail-first policies, to mental health claims that it did not apply to medical claims. *See id.* at 65-67. He also asserts that UHIC did not adjudicate his appeals in accordance with federal law.

2. The Claims Brought By Denbo, Smith, and Olin

Denbo, Smith, and Olin bring three claims (Counts 1, 3, and 5) against United, all of which essentially allege that United improperly denied them benefits in violation of the terms of their respective ERISA plans and of federal law.

Count 1 charges United with violating its fiduciary duty to Denbo, Smith, and Olin by failing to comply with the Mental Health Parity and Addiction Equity Act ("Parity Act"), *see* FAC at 126-27, which, generally speaking, requires ERISA plans that offer coverage of mental health care to do so on par with their coverage of medical and surgical care. *See* 29 U.S.C. § 1185a. The fiduciary duty allegedly

imposed on United derives from ERISA § 404(a)(1), which provides "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA Subchapter I]." *Id.* § 1104(a). Plaintiffs seek to enforce this fiduciary duty through ERISA § 502(a)(3).

Count 3 charges United with violating the terms of the CBS, SYSCO, and Oracle Plans by denying the plaintiffs benefits to which they were entitled, in violation of §§ 502(a)(1)(B) and (a)(3) of ERISA. *See* FAC at 129-30. Specifically, plaintiffs assert that United violated plan terms by under-reimbursing mental health claims, failing to adhere to general standards of medical necessity, and performing prospective and concurrent reviews (as opposed to retrospective reviews) in instances when not authorized to do so by relevant plan terms.[3] *See id.* at 129-30. They claim that United is liable to them under § 502(a)(1)(B) because it was an

[3]As I read Count 3, the plaintiffs do not raise United's alleged failure to provide the appeal rights to which the plaintiffs were entitled under the terms of their Plans as one of the factual bases for their claim. *See* FAC ¶¶ 364-70. For example, Denbo states that United denied him the second-level appeal required by his Plan. *See id.* at 42-43. This factual allegation could have been the basis for an ERISA § 502(a)(1)(B) claim "to enforce his rights under the terms of the plan," *see* 29 U.S.C. § 1132(a)(1)(B), since appeal rights are a term of his Plan. Instead, in Count 5, plaintiffs assert that such denials of appeal rights violated the Affordable Care Act and its corresponding regulations. *See* FAC ¶¶ 320-21. This theory is discussed below. *See infra* at § A.5.

"administrator" of the three Plans. *See id.* at 14-15; *see also* Pl. Br. at 12-16. Alternatively, plaintiffs urge that United, as claims administrator under each of the three Plans, owed plaintiffs a fiduciary duty, which it breached by preventing them from receiving benefits to which they were entitled under the terms of the respective Plans, again in violation of ERISA § 502(a)(3). *See* FAC at 109, 129; *see also* Pl. Br. at 6-8.

Count 5, like Count 1, charges United with violating its fiduciary duty under ERISA to the three plaintiffs, *see* FAC at 111-14, 132-33; Pl. Br. at 6-7, this time by violating provisions of the Affordable Care Act and its corresponding regulations, which grant ERISA plan participants certain procedural rights during the appeal of a benefit denial. *See* 29 U.S.C. § 1185d; 75 Fed. Reg. 43330 (July 23, 2010).

3. Count 3 Fails to State a Claim Against United and Is Dismissed.

As discussed above, plaintiffs allege that United should be held responsible for denying them benefits under two separate theories: (1) they have a direct claim against United for denial of benefits to which they were entitled under ERISA § 502(a)(1)(B), or (2) United's decisions, which resulted in the denial of benefits, violated United's fiduciary duty to plaintiffs under ER1SA § 502(a)(3).

Neither theory works. Plaintiffs are suing the wrong party.

ERISA provides a comprehensive enforcement scheme in § 502(a), the exclusive remedy for ERISA violations. *See* 29 U.S.C. § 1132(a); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-54 (1987). This section

provides multiple avenues for relief for ERISA violations. Section 502(a)(1)(B) affords relief when benefits claims are denied in violation of ERISA plan terms. *See* 29 U.S.C. § 1132(a)(1)(B). Section 502(a)(3) "catchall" claims provide relief for ERISA violations not remedied elsewhere in § 502(a). *See id.* § 1132(a)(3); *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996).

Under ERISA § 502(a)(1)(B), "A civil action may be brought . . . by a participant or beneficiary . . . 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). This section provides different remedial options for violations of plan terms. A participant or beneficiary may seek to "recover accrued benefits, to obtain a declaratory judgment that she is entitled to benefits under the provisions of the plan contract, and to enjoin the [defendant] from improperly refusing to pay benefits in the future." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985); *see also* 29 U.S.C. § 1132(a)(1)(B). Similarly, a plan participant whose rights under the terms of the plan have been violated can sue for injunctive relief compelling the plan to provide him the rights to which he is entitled under the terms of the plan. *See Cicio v. Does*, 321 F.3d 83, 95-96 (2d Cir. 2003), *vacated on other grounds*, 542 U.S. 933 (2004). These are the types of relief that plaintiffs seek against United under Count 3.

The Second Circuit has held that only ERISA plans, ERISA plan trustees, and ERISA plan administrators may be sued under ERISA § 502(a)(1)(B). *See Chapman v. Choicecare Long*

Island Disability Plan, 288 F.3d 506, 509 (2d Cir. 2002); *Crocco v. Xerox Corp.*, 137 F.3d 105, 107-08 (2d Cir. 1998); *Lee v. Burkhart*, 991 F.2d 1004, 1009 (2d Cir. 1993). Two of my colleagues have held that entities not formally designated as "plan administrators" under 29 U.S.C. § 1002(16)(A), such as third-party claims administrators, may be sued under ERISA § 502(a)(1)(B), as long as they "actually controlled the distribution of funds and decided whether or not to grant benefits . . ." *Am. Med. Ass'n v. United Healthcare Corp.*, No. 00 Civ. 2800 (LMM)(GWG), 2002 WL 31413668, at *6 (S.D.N.Y. Oct. 23, 2002); *see also Sheehan v. Met. Life Ins. Co.*, No. 01 Civ. 9182 (CSH), 2002 WL 1424592, at *2 (S.D.N.Y. June 28, 2002). However, the larger number of judges on this and other Second Circuit courts adhere to 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. *See Gates v. United Health Group Inc.*, No. 11 Civ. 3487 (KBF), 2012 WL 2953050, at *10 (S.D.N.Y. July 16, 2012); *Hills v. Praxair, Inc.*, No. 11 Civ. 678S, 2012 WL 1935207, at *18-19 (W.D.N.Y. May 29, 2012); *Staten Island Chiropractic Assocs. v. AETNA, Inc.*, No. 09 Civ. 2276, 2012 WL 832252, at *11 (E.D.N.Y. Mar. 12, 2012); *Warren Pearl Const. Corp. v. Guardian Life Ins. Co. of America*, 639 F. Supp. 2d 371, 380 (S.D.N.Y. 2009); *Schnur v. CTC Comm'ns Corp.,* 621 F. Supp. 2d 96, 109 (S.D.N.Y. 2008); *Stevenson v. Tyco Intl (US) Inc. Supplemental Executive Retirement Plan*, No. 04 Civ. 4037 (KMK), 2006 WL 2827635, at *4 (S.D.N.Y. 2006). This Court falls into the latter group. *See Del Greco v. CVS*

Corp., 354 F. Supp. 2d 381, 384 (S.D.N.Y. 2005), *aff'd*, 164 Fed. App'x. 75 (2d Cir. 2006).

Denbo, Smith, and Olin have not alleged that United is the "plan administrator" of any of their Plans—nor could they, since their respective Plan Documents name the CBS Retirement Committee, the SYSCO Administrative Committee, and Oracle as the Plan Administrators. The plaintiffs assert that United acts as a "claims administrator," *see* FAC at 14-15; Pl. Br. at 1, 12, but § 502(a)(1)(B) claims do not lie against any and every "administrator" associated with a Plan. They lie only against the "plan administrator" designated pursuant to 29 U.S.C. § 1002(16)(A). United is thus not the proper defendant for the benefits claims asserted under § 502(a)(1)(B) in Count 3.

In Count 3, plaintiffs Denbo, Smith, and Olin also seek equitable remedies against United pursuant to § 502(a)(3), ERISA's "catchall" provision, under a breach of fiduciary duty theory. I will assume that United meets the definition of a "fiduciary" under ERISA. Nonetheless, this alternative theory of liability fails, because § 502(a)(1)(B) claims against the statutorily-designated defendants would provide adequate relief to plaintiffs.

Entities other than Plans, Plan trustees, and formally designated Plan Administrators may have obligations to ERISA plan participants and beneficiaries. As stated above, ERISA § 404(a)(1) requires a "fiduciary" to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are

consistent with the provisions of [ERISA Subchapter I]." 29 U.S.C. § 1104(a). An entity qualifies as a "fiduciary" if it has "any discretionary authority or discretionary responsibility in the administration of" an ERISA plan. *Id.* § 1002(21)(A)(iii). Fiduciaries must fulfill their duties under ERISA § 404(a)(1) to act in the interests of participants and to act in accordance with plan terms.

Under ERISA's "catchall" enforcement mechanism—§ 502(a)(3)—plan participants may bring claims against fiduciaries for breaching their duties. *See Varity*, 516 U.S. at 512; *Devlin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001). In such suits, participants may seek "to enjoin any act or practice which violates any provision of [ERISA Subchapter I] or the terms of the plan, or . . . to obtain other *appropriate* equitable relief" to redress such violations. 29 U.S.C. § 1132(a)(3) (emphasis added). Thus, for a fiduciary duty claim to lie under § 502(a)(3), a plaintiff must point to a specific violation of ERISA or plan terms committed by the fiduciary himself, and equitable relief must be appropriate under the circumstances.

Here, plaintiffs Denbo, Smith, and Olin allege that United is a fiduciary within the meaning of 29 U.S.C. § 1002(21)(A)(iii), and they buttress this claim with factual contentions that United has discretionary authority and responsibility in the administration of their respective ERISA plans—allegations that I assume to be true for purposes of this motion. They also allege that they were entitled to receive particular benefits in accordance with the terms of their respective Plans. Therefore, an action for breach of fiduciary duty would seem to lie against

United if it failed to act in accordance with plan terms, or in the interest of plan participants.

However, the matter is not so simple. In *Varity v. Howe*, 516 U.S. at 512, the United States Supreme Court characterized § 502(a)(3) as a "safety net" that offers "appropriate equitable relief for injuries caused by violations *that § 502 does not elsewhere adequately remedy."* (emphasis added). It cautioned: "Where Congress elsewhere providers] 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.'" *Id*. at 515.

Varity "did not eliminate the possibility of a plaintiff successfully asserting a claim under both § 502(a)(1)(B), to enforce the terms of a plan, and § 502(a)(3) for breach of fiduciary duty," *Devlin,* 274 F.3d 76 at 89 (citing *Varity*, 516 U.S. at 515), but the Court flatly stated that courts should not "normally" grant equitable relief for a breach of fiduciary duty if a plaintiff can obtain adequate relief under other sections of the statute. *See Varity*, 516 U.S. at 515. Thus, breach of fiduciary duty claims brought under § 502(a)(3) will only survive a motion to dismiss if they seek relief that could not be obtained by bringing an action under some other subsection of § 502(a). *See Biomed Pharmaceuticals, Inc. v. Oxford Health Plans (N.Y.), Inc.*, 775 F. Supp. 2d 730, 738 (S.D.N.Y. 2011).

Where, as here, a plaintiff is seeking to redress the wrongful denial of benefits, courts have consistently rejected claims for equitable relief under § 502(a)(3) that would effectively order the provision of benefits, on the grounds that adequate monetary relief is available to plaintiffs under § 502(a)(1)(B). *See*

Frommert v. Conkright, 433 F.3d 254, 256 (2d Cir. 2006); *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 102 (2d Cir. 2005); *Staten Island*, 2012 WL 832252, at *10. For example, in *Frommert v. Conkright,* the plaintiffs claimed that their ERISA plan administrator had improperly calculated their benefits. *See* 433 F.3d at 256. They sought a declaration that the method of calculation violated ERISA and an injunction against its future use. Despite the plaintiffs' characterization of their benefits claims as equitable in nature, the Second Circuit concluded that the "gravamen" of the action was a claim for the money they had been denied. The court stated that the relief the plaintiffs sought—recalculation of benefits—fell "comfortably" within the scope of § 502(a)(1)(B). *Id.* As a result, there was no need for additional equitable relief under § 502(a)(3). *See id.*

Similarly, in *Nechis v. Oxford Health Plans, Inc.*, the plaintiff sought equitable relief under § 502(a)(3) to reform allegedly illegal procedures for resolving benefits claims and appealing adverse decisions. *See* 421 F.3d at 102. The Second Circuit held that the plaintiff s harm could be adequately compensated by monetary damages under § 502(a)(1)(B) and dismissed the claim for equitable relief. *Id.* at 103.

In short, where the gravamen of a plaintiff's claim is the wrongful denial of benefits, that harm can be adequately remedied through monetary compensation under § 502(a)(1)(B), and courts should not grant additional equitable relief under § 502(a)(3)—such equitable relief would not qualify as "appropriate" equitable relief.

In determining whether relief available under § 502(a)(1)(B) renders § 502(a)(3) relief "inappropriate," courts take into account claims that can be brought against defendants other than the alleged fiduciary. *See Staten Island*, 2012 WL 832252, at *11; *cf. Gates*, 2012 WL 2953050, at n.10. In *Staten Island Chiropractic Associates, PLLC v. Aetna, Inc.*, for example, the plaintiffs brought claims against an entity under §§ 502(a)(1)(B) and (a)(3) based on its alleged improper denial of benefits. 2012 WL 832252, at *3-11. Because the court determined that the § 502(a)(1)(B) claims were not brought against proper defendants—plans, plan trustees, or formally designated plan administrators—it rejected those claims. *Id.* at *4-6. The court then turned to the question of whether it could grant declaratory and injunctive relief under § 502(a)(3) against the named defendant to enforce plan terms and to clarify rights to future benefits. *Id.* at *10. It stated: "The thrust of the complaint . . . is that the defendants have failed to follow proper procedures in denying the [plaintiffs'] claim[s] for benefits . . ." *Id.* The court concluded that adequate relief for such claims was "plainly available" under § 502(a)(1)(3). *Id.* at *11. It went on to say: "The fact that the plaintiffs have currently brought their [§ 502(a)(1)(B)] claims against the *wrong defendant* does not alter the fact that relief was available to them under that section." *Id.* (emphasis added). The court stated that the plaintiffs could not "evade the requirements" of § 502(a)(1)(B)—including "the rules regarding proper defendants"—by recharacterizing such claims as breach of fiduciary duty claims against collateral fiduciaries under § 502(a)(3). The

court dismissed the claims for equitable relief. *See id.*

The rule, then, is that claims for equitable relief under § 502(a)(3) must be dismissed if the plaintiff has adequate remedies under § 502(a)(1)(B)—even if those remedies lie against defendants other than the named defendant.

This case is very similar to *Staten Island*. Plaintiffs have in essence brought a denial of benefits claim. As was true in *Staten Island*, *Frommert*, and *Nechis*, the crux of plaintiffs' claim is for monetary relief—the benefits they were denied. Such a claim lies only against the self-insured Plans, any Plan trustees, and their respective 29 U.S.C. § 1002(16)(A) Plan Administrators—the CBS Retirement Committee, the SYSCO Administrative Committee, and Oracle.

In addition to monetary relief under ERISA § 502(a)(1)(B), plaintiffs request declaratory and injunctive relief requiring adherence to plan terms and to statutory mandates relating to the provision of benefits. But they can obtain such relief against the Plans and the Plan Administrators, who can be sued under § 502(a)(1)(B) for declaratory judgments that plaintiffs are entitled to benefits under plan terms, injunctions to prevent the improper denial of benefits in the future, and injunctions compelling the provision of other rights to which plaintiffs are entitled under the terms of their Plans. *See* 29 U.S.C. § 1132(a)(1)(B); *Russell*, 473 U.S. at 146-47; *Cicio* v. *Does*, 321 F.3d at 95-96. There 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. *See* FED. R. CIV. P. 65(d)(2); *Regal Knitwear Co. v. N.L.R.B.*, 324 U.S. 9, 14 (1945). This renders an injunction against United as a fiduciary under § 502(a)(3) "inappropriate" equitable relief under existing precedent. *See Varity*, 516 U.S. at 515.

Denbo, Smith, and Olin's claims in Count 3 must be dismissed. Because amendment cannot cure the defects inherent in these claims, they are dismissed with prejudice.

4. Count 1 Is Dismissed.

Count 1 alleges that United failed to provide both "quantitative [and] nonquantitative parity between coverage for mental health care and medical/surgical services" in its role as claims administrator for the plans. *See* FAC ¶¶ 356, 361. Plaintiffs also assert that United subjected mental health benefits to more restrictive coverage and review policies than those used for medical benefits. *See id.* at 126-29. As a result, plaintiffs were denied benefits to which they claim they were entitled under the terms of their plans.

Plaintiffs allege that the practices that resulted in a denial of their benefits violated the Parity Act, 29 U.S.C. § 1185a. *See id.* at 126-27. They ask that United be required to reprocess their claims in accordance with law and request monetary relief (in the form of increased benefits), as well as declaratory and injunctive relief that will require United to act in accordance with the Parity Act. *See id.* at 127. Plaintiffs sue United in its capacity as a fiduciary under § 502(a)(3); they do not purport to bring this claim against United as an "administrator" under

§ 502(a)(1)(B), as was the case with Count 3. *See id.* at 97, 109; *see also* Pl. Br. at 5-8.

The provisions of the Parity Act at issue in this case are incorporated into ERISA Subchapter I. *See* 29 U.S.C. § 1185a. Consequently, these Parity Act provisions are enforceable solely through ERISA § 502(a), the exclusive civil remedy under ERISA. *See Davila*, 542 U.S. at 208. There is no independent cause of action available to ERISA plan participants for violations of the Parity Act. *See* 29 U.S.C. § 1185a.

The Parity Act was "designed to end discrimination in the provision of [insurance] coverage for mental health and substance use disorders as compared to medical and surgical conditions . . ." *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010). Under the statute, ERISA plans that choose to offer mental health coverage must apply similar coverage policies for both *mental* health benefits and *physical* health benefits. *See id.*; 29 U.S.C. § 1185a. The "financial requirements" and "treatment limitations" applicable to mental health benefits must be "no more restrictive" than the "predominant" requirements or limitations applicable to medical and surgical benefits covered by the plan. *See id. §* 1185a(a)(3), The Parity Act defines "treatment limitations" as including "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." *See id.* Additionally, the Parity Act regulations explain that the Act bars "nonquantitative" treatment limitations, which are limitations that are "not expressed numerically, but otherwise limit[] the scope or duration of benefits for treatment." 75 Fed. Reg. 5410-01 (Feb. 2, 2010).

Essentially, ERISA plans must treat sicknesses of the mind in the same way that they would a broken bone.

Count 1 must be dismissed because, in its capacity as a claims administrator of self-insured ERISA plans, United is not a party to which the Parity Act applies.

According to its terms, the Parity Act applies to 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 . . ." *See* 29 U.S.C. § 1185a (emphasis added). For ERISA purposes, a "group health plan" is defined as an "employee welfare benefit plan to the extent that the plan provides medical care . . ." *Id.* § 1191d(a)(1). The CBS, SYSCO, and Oracle Plans are all "group health plans" within the meaning of the statute; plaintiffs do not contend that United qualifies as a group health plan under § 1185a.

Nor do plaintiffs contend that United "offer[s]" "health insurance coverage . . . in connection with" a group health plan under § 1185a in its capacity as a claims administrator for the CBS, SYSCO, and Oracle Plans. Indeed, plaintiffs could not reasonably make this argument. Though the Parity Act does not elaborate on what it means to "offer" insurance coverage "in connection with" a group health plan, the plain import of this language is that offering coverage in connection with a plan means selling insurance coverage to the plan or sponsoring employer to cover the costs of benefits paid out to beneficiaries. In fact, the Parity Act "Fact Sheet" published on the Department of Labor website states

that the statute "applies to health insurance issuers who *sell coverage to employers* . . ." *See* U.S. Department of Labor, "Fact Sheet, The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", http://www.dol.goviebsa/newsroom/fsmhpaea.html (last visited Oct. 28, 2013) (emphasis added). Thus, the Department likewise interprets "offering" coverage to mean "sell find coverage" to the employer-sponsored plans.

Because United does not sell coverage to the self-funded plans in this case, United does not "offer" coverage to the plans. United's only alleged connection to these plans is its role as their claims administrator; it processes claims and makes coverage determinations. An entity that is processing claims and making coverage determinations that will be paid with someone else's money is not an entity that is "offering" coverage "in connection with" that Plan or "sell[ing] coverage" for purposes of that Plan. Thus, the ERISA § 502(a)(3) breach of fiduciary duty claims raised in Count 1 based on alleged Parity Act violations must be dismissed.

Alternatively, plaintiffs' claims could be characterized as challenges to violations of the "terms of [their] plan[s]." *See* 29 U.S.C. § 1132(a)(I)(B). Since the Parity Act has been incorporated into ERISA, its requirements automatically become "terms" of every ERISA plan. *Cf. Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 750 (2004) (stating that ERISA § 203(a) "adds a *mandatory term* to all retirement packages that a company might offer" by requiring that pension plans "provide that an employee's right to his normal retirement benefit is nonforfeitable upon

the attainment of normal retirement age . . .”). Any violation of these terms—by applying stricter standards to mental health benefits than to physical health benefits—would be remediable under ERISA § 502(a)(1)(B). However, any such claim would have to be brought against a proper § 502(a)(1)(B) defendant—the Plans, Plan trustees, or their designated § 1002(16)(A) Plan Administrators. United cannot be sued on such a claim.

Plaintiffs have pleaded facts that, if proven, demonstrate violations of the Parity Act. These violations can be redressed by suing their Plans or § 1002(16)(A) Plan Administrators under § 502(a)(1)(B). While United, as an agent of the Plans, may have committed the violations on behalf of the Plans, Congress has decreed that no action lies against it. Plaintiffs have recourse against United’s principals; United would be bound by any judgment against them.

Count 1 has been brought against an improper defendant. The claims of plaintiffs Denbo, Smith, and Olin under this count are dismissed—with prejudice, since no amendment can cure the defect in the pleading.

5. Count 5 Is Dismissed.

Count 5, like Counts 1 and 3, must be dismissed because it has been brought against the wrong defendant.

The FAC alleges that United violated the ACA, and its corresponding ERISA regulations, by “adjudicating appeals of adverse benefit determinations relating to mental health care services contrary to the requirements under the Act and ERISA regulations . . .” FAC ¶ 382. Specifically,

plaintiffs allege that United violated these provisions by (1) failing to use independent reviewers in appeals, and (2) failing to provide continuing coverage pending the outcome of appeals. *See id.* ¶¶ 314-322. Plaintiffs also assert that United violated the ACA by failing to provide Denbo and Olin with two levels of appeals, as required by their plans. *See id.* ¶¶ 320-21. Plaintiffs argue that United breached its fiduciary duty to plaintiffs by violating the ACA, and they seek injunctive relief under ERISA § 502(a)(3). *See id.* ¶¶ 314, 384; Pl. Br. at 5-8.

The ACA and its corresponding regulations grant ERISA plan participants certain minimum procedural rights during an appeal of a benefits denial. *See* 29 U.S.C. § 1185d; 75 Fed. Reg. 43330-01 (July 23, 2010). Under the ACA regulations, appeals must be "adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision." *Id.* at 43333. Plan participants are also entitled to "continued coverage pending the outcome of an internal appeal." *Id.* at 43334. These appeal rights are in addition to any that may be set forth in plan documents.

Like the Parity Act, the ACA does not provide for any independent private right of action to enforce its provisions. *See* 29 U.S.C. § 1185d. It is incorporated into ERISA and so is enforceable by ERISA plan participants only in accordance with the terms of ERISA § 502(a). *See Davila,* 542 U.S. at 208.

The ACA requirements incorporated into ERISA "apply to *group health plans,* and health insurance issuers providing *health insurance coverage* in connection with group health plans." *See* 29 U.S.C.

§ 1185d (emphasis added). Entities "providing health insurance coverage in connection with group health plans" are those which are selling coverage to the plans to cover the cost of benefits paid out to beneficiaries. *See supra* at § A.4.

As with the Parity Act claims in Count 1, Count 5 must be dismissed. Only "group health plans" or entities "providing health insurance coverage in connection with group health plans" are liable for violations of the ACA, *see* 29 U.S.C. § 1185d, and United is neither. It is a fiduciary, but under the ERISA enforcement scheme United (as an agent) can only be bound by an injunction against a principal that is liable under the ACA, such as the plaintiffs' Plans. The breach of fiduciary duty claim against United in Count 5 fails.

As discussed above, the ACA is incorporated into ERISA, *see* 29 U.S.C. § 1185d, and the fair import of this is that ACA appeal rights, like Parity Act requirements, become implicit terms incorporated into every ERISA plan. *See supra* at § A.4. Thus, for example, if a plan document provided for appeal rights that were not at least as favorable as the appeal rights granted by the ACA, that plan would be deemed amended to provide rights equivalent to the ACA standard. Obviously, if a plan provided more generous appeal rights, those would control.

Because ACA appeal rights are implicit terms of ERISA plans, plan participants may "enforce [their] rights under the terms of the plan" by suing an appropriate party or parties. *See* 29 U.S.C. § 1132(a)(1)(B). As with all § 502(a)(1)(B) claims, however, the only appropriate defendants are Plans, Plan trustees, or § 1002(16)(A) Plan Administrators.

United, as a third-party claims administrator for the CBS, SYSCO, and Oracle Plans, is not a proper defendant on a § 502(a)(1)(B) claim based on violations of implicit plan terms.

Count 5 is therefore dismissed, with prejudice.

B. Plaintiff Allender's Claims Under Counts 1 and 5 Are Dismissed.

Dr. Julie Ann Allender is a mental health care provider. *See* FAC ¶ 10. She alleges that she is "currently treating a United Insured patient whose benefits are sponsored by a large-group health plan." *Id.* Allender asserts that her patient wishes to remain anonymous; she does not explicitly identify his employer or the Plan pursuant to which he is insured. *See id.* It does, however, appear that some of the redacted exhibits submitted by Allender reveal the names of her patient's plan and employer—the "Alcatel-Lucent" Plan and the Alcatel Lucent Company. *See* Hufford Decl. Ex. 36 at 2; Allender Supp. Decl. Ex. B at 1. Allender also asserts that the plan is self-insured, *See* Allender Decl. ¶ 11. Allender does not provide plan documents that specify the Alcatel-Lucent Plan's terms.

Allender's patient has allegedly assigned his right to assert claims under ERISA to Allender. *See* FAC ¶ 243; Hufford Decl. Ex. 35. ERISA plan beneficiaries may properly assign ERISA claims to providers in exchange for health care. If they do so, the providers then have standing to enforce the beneficiaries' rights under ERISA. *See Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 329 (2d Cir. 2011). Thus, Allender may bring any claims under ERISA § 502(a) that her patient could properly bring as a "beneficiary." *See* 29 U.S.C. § 1132(a).

Though Allender does not explicitly identify United's role with respect to the Alcatel-Lucent Plan, her description of the functions performed by Defendant UBH suggests that it is a third-party claims administrator for the Plan—*i.e.*, that UBH processes claims and makes determinations regarding coverage and appeals, *See* FAC ¶¶ 226-43; Allender Decl. ¶¶ 11-30; Allender Supp. Decl. ¶¶ 2-30; Hufford Decl. Ex. 36 at 1.[4] Allender does not provide sufficient information for this Court to determine whether United is the Alcatel-Lucent Plan's designated 29 U.S.C. § 1002(16)(A) Plan Administrator, though I imagine that if United were the § 1002(16)(A) Plan Administrator, Allender would have stated as much. It appears that United stands in the same shoes as to Allender's patient as it does to Denbo, Smith, and Olin.

On behalf of her patient, Allender joins plaintiffs Denbo, Smith, and Olin in Counts 1 and 5, bringing breach of fiduciary duty claims under ERISA § 502(a)(3) for United's alleged violations of the Parity Act and the ACA. *See* FAC at 109, 126-27, 132-33, 244. Allender alleges violations of the Parity Act (Count 1) based on United's imposition of strict limitations on her patient's mental health benefits. *See id.* at 77-85. She states that United subjected her patient's claims to precertification and concurrent reviews (reviews of ongoing and future treatment) and used a "clear and compelling

[4]The plaintiffs' brief in opposition to the motion to dismiss also describes United as a "claims administrator" with respect to all plaintiffs' health insurance plans. *See* Pl. Br. at 1. The brief is not the pleading and does not amend the pleading, Neither is it evidence.

evidence" standard for determining the medical necessity of treatment. *See id*. ¶¶ 226-29. Allender also asserts that United required her to provide a discharge plan for mental health treatment, which is contrary to generally accepted standards of medical care. *See id.* at ¶ 230. According to the FAC, these requirements were more onerous than the requirements imposed in connection with claims for medical and surgical benefits. *See id.* ¶¶ 241, 355-58.

Allender also alleges violations of the ACA (Count 5) based on United's failure to properly adjudicate her patient's appeals. *See id.* at 80-84, 111-14, 132-33. She states that United never responded to appeals of benefit denials that she submitted on August 6, 2012 and March 19, 2013. *See id.* at 80-83.

Allender's claims on behalf of her anonymous patient are subject to dismissal for the same reason that Denbo's, Smith's, and Olin's claims per Counts 1 and 5 were dismissed. *See supra* at A.4 and A.5.

The Parity Act and the ACA requirements cited in Counts 1 and 5 do not apply to United in its role as a claims administrator for the self-insured Alcatel-Lucent Plan. The FAC does not plead that United is either the anonymous patient's "group health plan" or that United "offers" or "provides" coverage in connection with the Plan. *See* 29 U.S.C. §§ 1185a, 1185d. As explained above, *see supra* at §§ A.4 and A.5, only certain "group health plans" and "health insurance coverage offered in connection with such [plans]" are subject to the provisions of the Parity Act and the ACA that are incorporated into ERISA. *See* 29 U.S.C. § 1185a; *see also id.* § 1185d. It appears

from the evidence submitted by Allender that her patient's "group health plan" is the Alcatel-Lucent Plan. *See* Hufford Decl, Ex. 36 at 2. And because the Plan is self-insured, *see* Allender Decl. ¶ 11, United does not sell coverage to the plan, and thus does not "offer" or "provide" coverage within the meaning of the Parity Act or the ACA. Allender thus fails to state a claim under Counts 1 and 5 on behalf of her patient.

Furthermore, Allender (on behalf of her patient) could not succeed in bringing Counts 1 and 5 under ERISA § 502(a)(1)(B) on the basis that United violated her patient's plan terms. Though Allender's Parity Act and ACA claims could properly be raised under § 502(a)(1)(B) as claims to redress plan term violations, *see supra* at §§ A.4 and A.5, United would not be a proper defendant to such claims since the evidence indicates that it is not a Plan, Plan trustee, or 29 U.S.C. § 1002(16)(A) Plan Administrator.

At this point, dismissal is without prejudice, but only due to the Court's ignorance about whether United is the § 1002(16)(A) Plan Administrator for Allender's patient's plan. If Allender wishes to file an amended complaint, she will have to identify her patient, her patient's employer, the relevant Plan, the name of the designated § 1002(16)(A) Plan Administrator, and the entire scope of United's role with respect to that Plan. She may file under seal in order to preserve her patient's anonymity, with the publicly filed counterpart redacting the patient's name and nothing else; the identity of the patient's employer and the Plan, however, must be publicly available. Obviously, if the Plan that forms the basis of Allender's claims is, like the CBS, SYSCO, and Oracle Plans, a self-insured plan for which United is

not the § 1002(16)(A) Plan Administrator, amendment would be futile, and any effort to amend would violate Fed. R. Civ. P. 11.

Any proposed amendment of Allender's claims must be filed within ten days of the date of this decision. If no amendment is filed, the court will assume that Allender's patient's claim stands in the same position as those of Denbo, Smith, and Olin, and will convert the dismissal to dismissal with prejudice.

C. Plaintiff Menolascino's Claims Under Counts 1, 2, 4, and 5 Are Dismissed.

Dr. Shelly Menolascino is, like Dr. Allender, a mental health care provider. *See* FAC ¶ 245. She alleges that she treats many patients whose health plans involve benefits determinations made by United. *See id.* ¶¶ 13, 245-72. Like Allender, she takes assignments of claims from those patients; indeed Menolascino specifically pleads that she follows a standard practice of acquiring ERISA claim assignments from her patients. *See id.* ¶¶ 273-74. Assuming that Menolascino has valid assignments, she may bring any claims under ERISA § 502(a) that each of her assigning patients could properly bring as a beneficiary. *See Montefiore,* 642 F.3d at 329; 29 U.S.C. § 1132(a).

Menolascino asserts four ERISA claims against United, purportedly on behalf of certain of her patients. The FAC does not identify those patients, their employers, their employer-sponsored Plans, the designated Plan Administrators of those Plans, or United's precise role in each patient's plan. *See* FAC at 85-97. Like the other plaintiffs, Menolascino describes United's responsibilities as those of a third-

party claims administrator—United "process[es] claims for mental health benefits" and makes coverage determinations. *See id.* ¶¶ 13, 249-75,

Menolascino joins the other plaintiffs in bringing Counts 1 and 5, the breach of fiduciary duty claims for alleged violations of the Parity Act and the ACA. *See id.* at 126-27, 132-33. Based on the allegations in the FAC, Menolascino's claims under those counts are dismissed as well, because United is not alleged to be a proper party defendant. *See supra* at §§ A.4, A.5, B. As was the case with Allender, the dismissal is at least temporarily without prejudice; any amended pleading is due ten days from the date of this opinion, and must disclose all of the information that the court would need to determine whether her patients' claims, like the claims of Denbo, Smith, and Olin, must be dismissed with prejudice: for each patient, the identity of the patient (under seal), the relevant employer, the Plan, the name of the designated Plan Administrator specified in the Plan, and the relationship United bears to the Plan. If United is merely a third-party claims administrator, amendment would plainly violate Rule 11.

Menolascino also pleads two other claims against United. Both must be dismissed.

In Count 2, she asserts ERISA denial of benefits and breach of fiduciary duty claims under §§ 502(a)(1)(B) and (a)(3). *See* FAC at 128-29. Menolascino alleges that United disputed the correctness of the billing codes Menolascino used when she submitted claims for counseling sessions with her patients, insisting that she should have billed under a different code or codes, for which lesser reimbursement was offered under the Plans.

See id. at 86-96. After auditing 100 of Menolascino's bills, United determined that "overpayments" had been made to Menolascino. *See id.* ¶¶ 250-55. The FAC states that United unilaterally recouped those "overpayments" to Menolascino by subtracting money from payments made on later claims submitted on behalf of different patients—thereby denying the patients benefits to which they were allegedly entitled under the (undisclosed) terms of their respective Plans, in violation of ERISA. *See id.* at ¶¶ 256-59, 360-63.

In addition, Menolascino contends that United's application of certain billing codes for counseling sessions led to a disparate impact between coverage for mental health benefits and coverage for medical and surgical benefits, in violation of the Parity Act, 29 U.S.C. § 1185a. *See id.* at 128-29.

Menolascino's § 502(a)(1)(B) denial of benefits claim in Count 2, as well as her claim for equitable relief pursuant to § 502(a)(3), must be dismissed if United is neither the Plan, the 29 U.S.C. § 1002(16)(A) Plan Administrator, nor a trustee of her patients' Plans-the only appropriate defendants on a § 502(a)(1)(B) denial of benefits claim. Furthermore, because adequate equitable relief is available against statutorily-designated § 502(a)(1)(B) defendants that will bind United as their agent, no claim for equitable relief lies, either. *See supra* at § A.3. This is a determination that must be made on a case-by-case basis for each of Menolascino's patients. But such case-by-case analysis cannot be done, because Count 2 as presently pleaded omits all the information that would allow such a determination to be made. Count 2 as pleaded is thus dismissed under *Twombly*/*Iqbal*, because it fails to plead facts

necessary to ascertain whether the complaint states a claim "on its face" on behalf of any of her patients. *Iqbal*, 129 S. Ct. at 1949; *Twombly*, 550 U.S. at 570.

If Menolascino believes that United is the Plan, Plan trustee, or § 1002(16)(A) Plan Administrator for any of her patients, she has ten days to file an amended complaint so alleging. Otherwise, ten days from the date of this opinion, dismissal will be with prejudice.

In Count 4, Menolascino brings a so-called "full and fair review" claim pursuant to ERISA §§ 502(a)(1)(B) and (a)(3). *See* FAC at 110, 130-31.

Plan participants' "full and fair review" procedural rights are set forth in ERISA § 503 and its corresponding regulations. *See* 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1. Section 503 requires an "employee benefit plan" to "provide adequate notice in writing" about the specific reason(s) why a particular claim for benefits was denied, as well as to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a *full and fair review* by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133 (emphasis added). According to the FAC, United's refusals to fully reimburse Menolascino's patients' claims for their counseling sessions, and its recoupments of "overpayments" allegedly made in connection with earlier allowed claims, constituted ERISA benefit denials, thereby triggering her patients' § 503 procedural rights. *See* FAC ¶ 313. Menolascino alleges that her patients were not "provid[ed] ERISA-compliant full and fair reviews" for these benefit denials. *See id.* In keeping with her overbroad approach to pleading, she does not

specifically assert what each individual Plan's appeal procedures were—they may well have been different, some may have been one-level appeals while others provided for two-level appeals—nor does she identify, for each patient and each Plan, who was designated to hear appeals.

Count 4 fails as against United, and so must be dismissed, because ERISA § 503 imposes obligations only upon the "employee benefits plan[s]" themselves. *See* 29 U.S.C. § 1133; *see also Gates*, 2012 WL 2953050, at *10; *Am. Med. Ass'n*, 2002 WL 31413668, at *9-10. Menolascino does not allege that United is the "plan" for any of her patients—and it is inconceivable that she could so allege—so she fails to properly plead a violation of § 503.

Menolascino argues that she is not bringing ER1SA § 503 claims, but instead bringing claims to enforce her patients' full and fair review rights under §§ 502(a)(1)(B) and (a)(3). *See* Pl. Br. at 38. But couching such claims in the language of §§ 502(a)(1)(B) and (a)(3) does not allow Menolascino to avoid the indisputable fact that the full and fair review requirements are imposed by § 503, not by §§ 502(a)(I)(B) or (a)(3), and in any event, for the reasons discussed exhaustively above, no claim lies against United under these sections. *See supra* at § A.3. Count 4 is dismissed, temporarily without prejudice, as discussed above.

I should note that this Court rejects the argument advanced by Defendants that Menolascino's claims in Counts 1, 2, 4, and 5 are anything other than properly assigned ERISA benefits claims brought on behalf of her patients. *See* Def. Br. at 36-39. A plaintiff states a colorable claim under ERISA

"where the claim implicates coverage and benefit determinations as set forth *by the terms of the ERISA benefit plan . . .*" *Montefiore*, 642 F.3d at 325 (emphasis added); *see also Korman v. Consol. Edison Co. of New York, Inc.*, 915 F. Supp. 2d 359, 366-67 (E.D.N.Y. 2013). Menolascino disputes the existence and extent of benefit coverage under the terms of her patients' ERISA plans, and she alleges violations of her patients' procedural rights under ERISA. Such claims fall within the scope of the civil enforcement mechanisms of ERISA § 502(a), and so are cognizable-provided, of course, they are asserted against a proper party defendant.

D. This Court Lacks Subject Matter Jurisdiction over the Claims Brought by Plaintiff Kamins.

There is one more individual plaintiff—Michael Kamins. He stands in a different position than the other individual defendants, because his health insurance plan is not subject to ERISA. Kamins pleads that he is a New York state employee through the State University of New York, Stony Brook. *See* FAC ¶ 15. He receives health insurance for himself and his family through the Empire Plan, a government-sponsored employee benefits plan. *See id.* Such plans are statutorily exempt from ERISA, *see* 29 U.S.C. § 1003(b)(1), and are governed by, in this case, New York law. *See* FAC ¶¶ 15-16, 385-94; Ewing Decl. Ex. A. Kamins alleges that United, through Defendant UHIC-NY, "insures and administers the Empire Plan." *See* FAC ¶ 36. He also asserts that UBH performs claims administration for the Plan. *See id.* ¶ 37.

Kamins's son "John,"[5] who is an Empire Plan beneficiary, has suffered from severe mental illness since 2011. *See id.* at 16-17. John has required treatments such as medication, frequent psychotherapy, and occasional hospitalization. *See id.* at 16-29. Kamins holds a durable power of attorney for his son and sues as John's attorney-in-fact. *See id*. ¶ 16. He brings three New York state law claims on John's behalf.

The Empire Plan covers "medically necessary" mental health treatment. *See id.* Kamins asserts that United applied discriminatory policies—specifically, preauthorization, concurrent reviews, disparate fee schedules, coverage exclusions, and a restrictive definition of "medical necessity"—when reviewing and allowing or disallowing claims for coverage of John's mental health treatment. *See id.* at 114-16, 133-34. As a result, the mental health benefits available under the Empire Plan are allegedly inferior to the benefits offered for medical and surgical treatment. *See id.* Kamins claims that this lack of parity in coverage violates the New York Parity Act (N.Y. Ins. Law § 3221(1)(5)) ("NYPA"). (Count 6) *See id.* at 133-34.

Kamins also claims that United deceived its customers in violation of the New York Deceptive Trade Practices Act, N.Y. G.B.L. § 349 by failing to disclose its actual discriminatory policies. (Count 7) *See id.* at 134-35.

Finally, he brings a claim under the New York Prompt Pay Statute (N.Y. Ins. Law § 3224-a), alleging that United failed to pay benefit claims

[5] "John" is not his real name.

submitted on John's behalf within 45 days of receipt, as required by that statute. (Count 8) *See id.* at 135-36.

Though Kamins originally joined the other plaintiffs in asserting ERISA claims under Counts 1 and 5, and brought two additional claims under California law (Counts 9 and 10), he has (wisely) elected not to pursue these claims. *See id.* at 126-27, 132-33, 136-38; Pl. Br. at 21. Accordingly, they are deemed withdrawn, with prejudice. Only claims arising under New York law remain-Counts 6, 7, and 8. Because Kamins has abandoned his federal claims, this Court lacks federal question jurisdiction over Kamins's claims under 28 U.S.C. § 1331.

Kamins cannot rely on diversity jurisdiction to pursue his state law claims here. A party seeking to invoke this Court's diversity jurisdiction under 28 U.S.C. § 1332 has the burden of proving that (1) complete diversity of citizenship exists between the parties, and (2) the amount in controversy exceeds $75,000. *See McNutt v. General Motors Acceptance Corp. of Indiana*, 298 U.S. 178, 189 (1936). Complete diversity of citizenship exists where every plaintiff is a citizen of a different state than every defendant. *See Strawbridge v. Curtiss,* 7 U.S. (3 Cranch) 267, 2 L.Ed. 435 (1806).

Kamins has failed to allege both prongs of diversity jurisdiction. A corporation is "deemed to be a citizen of every State and foreign state by which it has been incorporated and of the State or foreign state where it has its principal place of business." 28 U.S.C. § 1332(c)(1). A natural person is a citizen of the state in which he is domiciled. *See Newman-Green, Inc. v. Alfonzo-Larrain*, 490 U.S. 826, 828 (1989). According

to the FAC, Kamins and John reside in California, and Defendant UBH is incorporated and headquartered in California. *See* FAC ¶¶ 15, 37.

Kamins has also not pled that his claims meets the amount in controversy requirement of § 1332. The FAC does not specify the amounts in controversy for Counts 6, 7, and 8. *See id.* at 133-36.

So Kamins asserts that his state law claims should be entertained under 28 U.S.C. § 1367.

In a case where a federal district court has original jurisdiction over federal question claims, § 1367(a) confers supplemental jurisdiction over "all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United State Constitution." 28 U.S.C. § 1367(a).

Kamins's three remaining claims arise under state statutes that are not identical to the ERISA provisions at issue and so are "related" only in the sense that both sets of statutes concern the same subject matter. His state law claims are not "so related" to the other individual plaintiffs' federal claims as to "form part of the same case or controversy" as the ERISA claims. *See* 28 U.S.C. § 1367(a). The purported common thread is that all claims are asserted against United and arise out of decisions made by United. But as discussed above, the federal claims cannot be brought against United. Whether the state law claims can be asserted against United is purely a matter of state law. Thus, Kamins's claims do not fall within § 1367.

Even if Kamins's claims did form part of the same case or controversy as the other claims, I would decline to exercise jurisdiction over his non-federal

question claims under § 1367(c)(3), which permits this Court to take such action if it has "dismissed all claims over which it has original jurisdiction." *Id.* § 1367(c)(3). No federal question claims remain to which Kamins's state law claims could be deemed supplemental; the ERISA claims in Counts 1-5 have been dismissed as to all other plaintiffs.[6] It would be inappropriate for me to exercise supplemental jurisdiction over the claims arising under state law. It is early in the case; there has been no discovery or other merits-related activity. Furthermore, on issues of state law—particularly the NYPA (N.Y. Ins. Law § 3221(1)(5)), which passed in 2006, has never been interpreted by any New York court, and has never been addressed by New York's highest court—I defer to my state court colleagues in their area of expertise and decline to exercise jurisdiction over Kamins's state law claims.

Counts 6, 7, and 8 are hereby dismissed, without prejudice to their being asserted in the New York State Supreme Court or in a California state court.

E. The New York State Psychiatric Association's Claims Are Dismissed Because the Association Lacks Standing to Bring the Claims of Its Members.

The New York State Psychiatric Association ("NYSPA") joins with the other plaintiffs in bringing eight of the causes of action in the FAC: Counts 1-8. *See* FAC at 72-77. On behalf of its psychiatrist members and their patients, the association objects to the practices and procedures used by United in

[6] As discussed below, *see infra* § E, the New York State Psychiatric Association lacks standing to pursue its ERISA claims, and they are dismissed.

processing claims. *See id.* The NYSPA lacks standing to sue, however, because it has not shown either that (1) its members personally have standing to bring ERISA claims, or (2) proving the eight claims will not require the participation of individual association members.

The NYSPA is a professional association of psychiatrists practicing in New York. *See id.* ¶ 7. Menolascino is a member of the NYSPA. *See id.* ¶ 11. The FAC states that many of the NYSPA's members "provide mental health services to United Insured patients, and are thereby subjected to United's policies and procedures regarding mental health coverage determinations." *Id.* ¶ 7. It asserts that United's "improper and overly restrictive policies applied to deny or reduce coverage for mental health care, in violation of federal and state parity and related laws." *Id.* ¶ 208. The NYSPA challenges United's medical necessity definitions and preauthorization requirements under the various plans, among other things. *See id.* at 72-77.

The NYSPA joins other plaintiffs in bringing Counts 1-8 on behalf of its psychiatrist association members and their patients. *See id.* at 126-36. As discussed above, Counts 1-5 arise under ERISA. Count 6, 7, and 8 arise under New York state law, claiming violations of the NYPA (N.Y. Ins. Law § 3221(1)(5)), the Deceptive Trade Practices Act (N.Y. G.B.L. § 349), and the Prompt Pay Statute (N.Y. Ins. Law § 3224-a). The NYSPA requests declaratory and injunctive relief for these eight claims. *See id.* at 126-36.

Even if the NYSPA had associational standing to pursue these claims, they would have to be dismissed

for the reasons discussed above. But the NYSPA lacks associational standing.

An association has derivative 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." *Rent Stabilization Ass'n of City of New York v. Dinkins*, 5 F.3d 591, 596 (2d Cir. 1993) (quoting *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977)).

1. The NYSPA Members Do Not Have Standing to Sue in Their Own Right Under ERISA.

The NYSPA lacks associational standing for a variety of reasons. First, it has not pleaded facts sufficient to demonstrate that its members would otherwise have standing to sue under ERISA in their own right. To satisfy this first element of standing, an association must show that its members have a personal stake in the outcome of the proceeding. *See Goode v. City of Philadelphia*, 539 F.3d 311, 325 (3d Cir. 2008). The association cannot derive standing from its members unless the members have standing themselves. Because the NYSPA brings claims to enforce the ERISA rights of its members' *patients*, it fails to allege that the members have an adequate personal stake in those claims.

In *MainStreet Organization of Realtors v. Calumet City, Ill.*, an association of realtors challenged an ordinance that made it more difficult for the realtors' clients to sell their homes. *See* 505 F.3d 742, 743-44

(7th Cir. 2007). The association claimed that the ordinance violated the clients' due process rights. *See id.* at 744. In analyzing the association's standing, the Seventh Circuit first set forth the general rule that one may not bring suit to enforce another's rights. *See id.* at 746. Though the court acknowledged exceptions to this rule, it concluded that no exception was warranted in that case. *See id.* at 746-47. It stated: "As there is no hindrance to the *primary victims'* enforcing their rights, there is no reason to allow the [realtors] into the litigation arena." *Id* at 747 (emphasis added). For this reason, the Seventh Circuit held that, although the realtors may indirectly suffer injuries from their clients' inability to sell their homes, the realtors nonetheless lacked standing to raise their clients' due process rights. *See id.* at 744-47. Because the association's standing would have been derived from its realtor members' standing, the association lacked standing as well. *See id.* at 744.

Here, the primary victims of United's alleged ERISA violations are the mental health patients, not the psychiatrist members of the NYSPA. In fact, none of the 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. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 27 (1983). As in *MainStreet*, the association members at most suffer indirect harms, and there is no hindrance to the primary victims' ability to bring suit themselves. On the contrary, the FAC raises claims by several patients to enforce their own rights under ERISA. Thus, the general rule controls this case: the association members may not

sue to enforce another's rights. *See MainStreet*, 505 F.3d at 746-47. No exception is warranted here. Because the association members have no personal standing to sue on behalf of their patients under ERISA, the NYSPA lacks derivative standing as well. *See id.* at 744.

An individual member of the NYSPA could acquire standing to pursue an ERISA claim by obtaining a valid assignment from a patient. *See Montefiore*, 642 F.3d at 329. Even then, however, the member would lack the standing "to sue in [her] own right" that is required for an association to derive standing from its members. *See Hunt*, 432 U.S. at 343. As an assignee, the member would merely be standing in the shoes of her patient to represent the patient's interests. Because association members with assignments would not have standing to sue in their own right, the association would not gain derivative standing under those circumstances.

2. The NYSPA's Claims Require the Participation of Individual Members.

Second, and perhaps more important, the NYSPA lacks associational standing for all its federal and state claims because it is clear that the claims asserted and the relief requested will require the participation of its individual members. To satisfy this element of associational standing, a plaintiff's claims and relief cannot require "individualized proof' and must be able to be "resolved in a group context." *Hunt*, 432 U.S. at 344. Here, the NYSPA's "many psychiatrists" challenge United's practices with regards to an unknown number of patients under an unknown number of plans. *See* FAC ¶ 208. The plaintiffs argue that they can prove these claims

with limited or no participation from association members. *See* Pl. Br. at 41-45. This is plainly not the case.

Proof of the association's claims cannot be offered "in a group context," *Hunt*, 432 U.S. at 344, but instead requires the participation of the individual psychiatrist members. First, even if NYSPA members pursued ERISA claims on the basis of assignments from their patients, the members would need to establish each patient's valid assignment in order to have standing. *See Am. Med. Ass'n v. United HealthCare Corp.*, No. 00 Civ. 2800 (LMM), 2007 WL 1771498, at *21 (S.D.N.Y. June 18, 2007). Thus, merely proving standing would require the participation of individual psychiatrists. *See id.* In addition, the members would need to prove that each patient exhausted his administrative remedies, since exhaustion is a pre-requisite to suits under ERISA. *See id.* (citing *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 219 (2d Cir. 2006)). This "detailed and fact-specific inquiry" would require extensive association member participation. *See id.*

Second, proving the merits of the Parity Act (29 U.S.C. § 1185a) and NYPA (N.Y. Ins. Law § 3221(1)(5)) challenges will require NYSPA member participation. Like the Parity Act, the NYPA requires parity in insurance coverage of mental health care as compared to medical care. *See* N.Y. Ins. Law § 3221(1)(5). Proving violations of these two parity laws will necessitate a comparison of the standards governing mental health benefits with those governing medical and surgical benefits under each patient plan. The NYSPA will need its members to establish the relevant terms of the thousands of potentially affected benefit plans and

patients, and how those plans are operated in practice. The medical necessity definitions the NYSPA challenges, for example, would need to be established based on circumstances and language unique to each plan. The NYSPA also challenges the preauthorization requirements used by the different plans, *see* FAC ¶¶ 356, 368, but each plan likely has its own distinct preauthorization process. Further, for certain plans mentioned in the FAC, United is alleged to process only the mental health benefit claims, whereas a separate entity processes the medical benefits. *See id.*¶ 21. This is likely the case for some of the members' patients' plans as well. Proving that there is a lack of parity in coverage in the various plans will require evidence from association members of the practices used by each entity involved in administration of each plan. This is exactly the sort of individualized proof that precludes an association from raising claims on behalf of its members.

Third, proving that United violated ERISA and the ACA by failing to provide proper appeals would necessitate the participation of association members. The FAC spends several pages detailing Menolascino's appeals of claim denials and explaining how United did not provide proper procedural rights. *See id.* at 85-96, 130-32. Similar individualized proof would be required to demonstrate that the patients of NYSPA members were each denied full and fair reviews under their plans.

Fourth, the NYSPA's claims under the New York Prompt Pay Statute, N.Y. Ins. Law § 3224-a, will likewise require individualized proof. Under the statute, insurers must pay benefits to policyholders

or to health care providers within 45 days of receiving a benefits claim. *See* N.Y. Ins. Law § 3224-a. To show a violation of this law, association members would need to detail each effort to submit a claim for a patient's treatment and United's corresponding failure to pay in a timely manner.

Fifth, the claims under the New York Deceptive Trade Practices Act, N.Y. G.B.L. § 349, cannot be proven in a group context. This statute bars "[d]eceptive acts or practices in the conduct of any business, trade or commerce." The NYSPA asserts that United deceived consumers by engaging in practices that violated the terms of plan documents. *See* FAC at 116-19. Because United's actual practices were contrary to those represented to consumers in plan documents, the NYSPA argues, United engaged in deceptive practices within the meaning of § 349. *See id.*; Pl. Br. at 29-30. Demonstrating United's actual practices will require individualized proof of how it operates with respect to particular patients' coverage and appeals.

Finally, the relief requested by the NYSPA will require association member participation. The NYSPA seeks declaratory and injunctive relief to change how United processes mental health benefits claims in the future. Crafting such relief will require an examination of the facts relating to the multitude of plans and patients in this case.

Because the NYSPA needs individualized proof from association members to prove its claims and to obtain relief, associational standing is precluded in this case.

To the extent plaintiffs move for leave to amend the FAC, they cannot overcome the NYSPA's lack of

standing. The motion for leave to amend is denied and dismissal of the NYSPA's claims is with prejudice.

F. The Motion for a Preliminary Injunction Is Denied.

Because all claims are dismissed, the motion for a preliminary injunction is denied as moot.

CONCLUSION

The clerk of the court is directed to dismiss all claims and to remove all pending motions from the Court's list of open motions. If no amended pleadings are filed within 10 business days, I will direct the clerk to enter judgment dismissing the complaint and to close the file.

Dated: October 31, 2013

/s/
U.S.D.J.

BY ECF TO ALL COUNSEL

APPENDIX C

STATUTORY PROVISIONS INVOLVED

ERISA § 502, 29 U.S.C. § 1132, provides in pertinent part:

(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;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(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;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice

which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

* * * *

Parity Act, 29 U.S.C. § 1185a, provides in pertinent part:

(a) In general

(1) Aggregate lifetime limits

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—

(A) No lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical

benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

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—

(A) No annual limit

If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical

and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(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),[1]

(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

[1]So in original. The comma probably should be a period.

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.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network

providers in a manner that is consistent with the requirements of this section.

* * * *