No. 15-319

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

REPLY BRIEF IN SUPPORT OF CERTIORARI

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RULE 29.6 DISCLOSURE STATEMENT

The Rule 29.6 disclosure statement in the petition for a writ of certiorari remains accurate.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES:

TABLE OF AUTHORITIES—Continued

STATUTES:

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INTRODUCTION

Denbo's opposition does not dispute the importance of the two questions presented in United's petition, *both* of which have generated circuit splits. Instead, Denbo attempts to minimize the splits by identifying irrelevant distinctions, inventing a vehicle issue, and retreating to the merits. None of these strategies detract from the cert-worthiness of this case. There are two circuit splits that threaten ERISA's carefully balanced system, upsetting the uniformity and predictability that ERISA is supposed to provide. The petition should be granted to resolve those splits.

ARGUMENT

I. THIS COURT SHOULD DECIDE WHO IS A PROPER DEFENDANT UNDER § 502(a)(1)(B).

A. The Circuits Are Deeply Divided On This Fundamental Issue.

The courts of appeals disagree over who may be sued for benefits due under ERISA § 502(a)(1)(B). Four circuits look to the funding source and hold that only the parties contractually responsible for funding payments may be sued. Six circuits hold that a party exercising control over benefits determinations—even a claims administrator who merely processes payments and does not fund them—may be sued. These ten circuits' decisions are irreconcilable. Pet. 11-16.

Denbo disagrees, asserting that all of the circuits focus on the defendants' control over benefits determinations and therefore are not in conflict. Br. in Opp. (BIO) 16-24. But any circuit split disappears when described at a sufficiently high level of generality. What divides the circuits is not whether they consider control over benefits determinations *at all*; it is whether such control *alone* is enough to subject an entity to suit when it is not the funding source for benefits payments.

Denbo also contends that the case law makes no distinction between self-funded plans (where benefits are paid out of the *plan's* assets) and fully insured plans (where benefits are paid out of an *insurer's* assets). *Id.* at 2, 19-21. But the distinction between self-funded and fully insured plans matters because a claims administrator who is also the insurer *is* the funding source for claims payments. Denbo's pur-

ported distinctions aside, the Third, Seventh, Eighth, and Tenth Circuits are in conflict with the decision below, such that the result in this case would have been different if it were decided in those circuits.

1. The Seventh Circuit held in *Larson* v. *United Healthcare Insurance Co.*, 723 F.3d 905 (7th Cir. 2013), for example, that "a cause of action for 'benefits due' must be brought against *the party having the obligation to pay*." *Id.* at 913 (emphasis added). Denbo argues otherwise, accusing United of "distorting *dicta*." BIO 19. But this is *Larson*'s holding; Denbo cannot minimize it, any more than he can untether it from longstanding circuit precedent. *Larson* explained that, in a prior case involving a self-funded plan, the "claims evaluator" was *not* a proper defendant in a "§ 502(a)(1)(B) claim for benefits." *Larson*, 723 F.3d at 911 (quoting *Blickenstaff* v. *R.R. Donnelley & Sons Co. Short Term Disability Plan*, 378 F.3d 669, 674 (7th Cir. 2004)). *Larson* recognized that the calculus is different for a fully insured plan, where a claims administrator has "both the authority to decide all eligibility and benefits questions *and* the obligation to pay the claims." *Id.* at 913 (emphasis in original). The Seventh Circuit therefore held that a claims administrator can be sued for benefits due only when it acts as the plan insurer, with an obligation to pay benefits "out of *its* assets." *Id.* at 915 (emphasis added).

Larson establishes that the distinction between self-funded plans and fully insured plans matters. That is why the result of this case would have been different in the Seventh Circuit. The CBS Plan at issue in the petition is "self-funded." BIO 13; *see also* Pet. App. 25a; C.A. J.A. 180. As Denbo recognizes, when benefits are due under the Plan, they are not

paid out of United's assets. United is responsible only for "*administer*[*ing*] the payment" of plan benefits. C.A. J.A. 181 (emphasis added). CBS itself provides the funds for payment. *Id.* at 179-180; Pet. App. 25a; BIO 8. United therefore is not "the party having the obligation to pay," *Larson*, 723 F.3d at 913, and the Seventh Circuit would dismiss the § 502(a)(1)(B) claim against United.

2. The Eighth Circuit would likewise dismiss the claim against United. That circuit allows § 502(a)(1)(B) suits against claims administrators only when they are the funding source—the insurers of fully insured plans. *See Brown* v. *J.B. Hunt Transp. Servs., Inc.*, 586 F.3d 1079 (8th Cir. 2009).

According to Denbo, however, "[n]othing" about *Brown* "turned on the funding source." BIO 22. That assertion is meritless: *Brown* squarely held that the claims administrator of a fully insured plan could be sued, whereas the plan administrator could not, precisely *because* the claims administrator was also the plan insurer and was "require[d]" to "pay * * * benefits." *Id.* at 1088; *see id.* at 1081. *Brown* thus deemed the funding source dispositive.[1] Because United is not the funding source here, it could not have been sued under § 502(a)(1)(B) in the Eighth Circuit.[2]

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[1] To be sure, *Brown* cited a case on the other side of the circuit split, *Moore* v. *Lafayette Life Insurance Co.*, 458 F.3d 416 (6th Cir. 2006), but *Brown* did not adopt *Moore*'s reasoning. *See* 586 F.3d at 1088.

[2] The Second Circuit thought its opinion was "in accord" with *Larson* and *Brown* because those decisions "held that claims administrators may be sued as defendants under

3. That would also be the result in the Third Circuit. That court also looks to the funding source to identify the proper defendants to a § 502(a)(1)(B) claim. And it has held that proper defendants are the plan or the *plan* administrator. *See Hahnemann Univ. Hosp.* v. *All Shore, Inc.*, 514 F.3d 300, 308-309 (3d Cir. 2008); *Graden* v. *Conexant Sys. Inc.*, 496 F.3d 291, 301 (3d Cir. 2007). The nomenclature matters. A *plan* administrator occupies a statutorily defined role; it may be ordered to pay an award out of plan assets; therefore, it may be sued for payment from those assets. *See* Pet. 5; *Hahnemann*, 514 F.3d at 308. Here, United is a mere *claims* administrator, responsible for deciding claims for benefits. *See* C.A. J.A. 180-181. Because United is neither the plan nor the plan administrator, the § 502(a)(1)(B) claim against it would be dismissed under the Third Circuit's decisions in *Hahnemann* and *Graden*.

Denbo cites *Curcio* v. *John Hancock Mutual Life Insurance Co.*, 33 F.3d 226 (3d Cir. 1994), to argue that the Third Circuit has held that anyone with control over benefits determinations may be sued for benefits claims. BIO 16-17. But *Curcio* did not even involve a § 502(a)(1)(B) claim. *See* 33 F.3d at 235. The language Denbo quotes comes from a part of *Curcio* addressing the distinct question of the meaning of a "fiduciary" under ERISA's definitional provision. *See id.* at 233; BIO 16-17. *Curcio* thus is unilluminating.

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§ 502(a)(1)(B)." Pet. App. 12a. It left out the critical piece of the equation: the claims administrators in those cases could be sued only because they were *also plan insurers*.

4. The same is true in the Tenth Circuit. Under *Geddes* v. *United Staffing Alliance Employee Medical Plan*, 469 F.3d 919 (10th Cir. 2006), "ERISA beneficiaries may bring claims against the plan as an entity and plan administrators," not third-party claims administrators. *Id.* at 931. Denbo attempts to distinguish *Geddes* from the decision below on the ground that the claims administrator in *Geddes* was not a fiduciary, whereas United is. BIO 23-24. But United's fiduciary status was irrelevant to the decision below; the Second Circuit based its decision on United's putative control over benefits determinations, not its status as a fiduciary. Pet. App. 11a-13a.

Geddes held that only the plan or the plan administrator are proper § 502(a)(1)(B) defendants. United is neither. So, like the Third, Seventh, and Eighth Circuits, and again unlike the court below and five other courts of appeals, the Tenth Circuit would dismiss Denbo's § 502(a)(1)(B) claim.

* * *

The disagreement among the circuits is square, frustrating ERISA's core purpose of promoting national uniformity. *See Conkright* v. *Frommert*, 559 U.S. 506, 517 (2010). Nearly all the circuits have weighed in, making further percolation unnecessary. And absent this Court's intervention, plaintiffs will invoke ERISA's broad venue provision to forum-shop and bring suit in the six circuits that have adopted plaintiffs' preferred rule. *See* 29 U.S.C. § 1132(e)(2). There is no reason for this Court to allow this conflict to persist.

B. This Case Is An Ideal Vehicle For Deciding The Question.

1. Denbo next identifies a supposed vehicle issue. He argues that United is challenging only "one aspect of the relief [he] seek[s] under § [502](a)(1)(B)," not the "broad injunctive relief" that is his "principal[]" request. BIO 14-15. Not so. United contests *all* aspects of Denbo's § 502(a)(1)(B) claim—those seeking (1) to "recover benefits due" in the past, (2) to "enforce * * * rights" to benefits due in the present, and (3) to "clarify * * * rights" to benefits due in the "future." 29 U.S.C. § 1132(a)(1)(B). *See* BIO 9. All fall within the first question presented because all are permutations of a § 502(a)(1)(B) claim for benefits due.

2. The denial of certiorari in *UnitedHealthcare of Arizona, Inc.* v. *Spinedex Physical Therapy, U.S.A., Inc.*, No. 14-1286, has no bearing on whether review should be granted here. The respondents in *Spinedex* contended that that case was unsuitable for merits review because the Ninth Circuit remanded "for specific fact-finding" on a core issue. *Spinedex* BIO 14. Here, the relevant facts are undisputed. And unlike the Ninth Circuit in *Spinedex*, the Second Circuit squarely "reject[ed] United's argument that it cannot be sued under § 502(a)(1)(B) in its capacity as a claims administrator." Pet. App. 11a. Accordingly, this petition is an ideal vehicle for deciding the § 502(a)(1)(B) question.

C. The Second Circuit Is Wrong On The Merits.

Finally, Denbo offers several policy arguments why United is a proper defendant under § 502(a)(1)(B). BIO 24-25. Notably, in so doing, he does not discuss

the text of § 502(a)(1)(B) at all. And the statutory text is straightforward. Each subpart of § 502(a)(1)(B) embodies a contractual remedy, to vindicate a right to benefits "under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). The proper defendant in a § 502(a)(1)(B) action is a party with a contractual obligation to provide those benefits. Because United has no such obligation under the CBS Plan, it is not a proper defendant in a § 502(a)(1)(B) action.

This Court should grant certiorari and reverse the Second Circuit's contrary decision.

II. THIS COURT SHOULD RESOLVE THE ACKNOWLEDGED CIRCUIT SPLIT OVER *VARITY*'S APPLICATION TO PLEADINGS.

1. The second question presented—whether an ERISA § 502(a)(3) claim may be dismissed under *Varity Corp.* v. *Howe*, 516 U.S. 489 (1996), if a plaintiff pleads injuries remediable under Section 502(a)(1)(B)—is also the subject of an acknowledged circuit split. *See Korotynska* v. *Metropolitan Life Ins. Co.*, 474 F.3d 101, 106 (4th Cir. 2006). Four circuits will dismiss at the pleading stage. Two circuits will not. Pet. 26-32. Denbo's efforts to reconcile these conflicting cases fail.

a. Denbo first argues that the Fourth Circuit does not recognize any circuit split. BIO 28-29. Here are the Fourth Circuit's own words:

> Although the Second Circuit has held that plaintiffs may seek relief simultaneously under § [502](a)(1)(B) and § [502](a)(3), the great majority of circuit courts have interpreted *Varity* to hold that a claimant whose injury creates a cause of action under § [502](a)(1)(B)

> may not proceed with a claim under § [502](a)(3). [*Korotynska*, 474 F.3d at 106 (citation omitted).]

The Fourth Circuit expressly recognized the split. It then joined the majority approach, breaking from the Second Circuit. *Id.* at 107. Far from being a "misreading" of *Korotynska*, BIO 28, United's discussion of the case (at Pet. 26-27) tracks the language of the decision.[3]

Denbo next tries to tackle the contrary rulings of the Fifth, Sixth, and Eleventh Circuits. He purports to distinguish several cases by observing that they were decided on summary judgment motions (and apparently, following Denbo's logic, not based on the pleadings). BIO 29. To be sure, the decisions sometimes were rendered on summary judgment. But all cited circuits applied *Varity to the pleadings*.

That is what happened in *Hollingshead* v. *Aetna Health Inc.*, 589 F. App'x 732 (5th Cir. 2014). Reviewing the trial court's dismissal of the plaintiff's § 502(a)(3) claim, the Fifth Circuit applied *Varity* to the pleadings by following its decision in *Tolson* v. *Avondale Indus., Inc.*, 141 F.3d 604 (5th Cir. 1998). Denbo contends that *Hollingshead* dismissed the § 502(a)(3) claim for a different reason: because the plaintiff had not stated a claim for equitable relief. BIO 29 n.8. That is incorrect. *Hollingshead* affirmed because the plaintiff had "'adequate redress

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[3] Denbo also suggests that *McCravy* v. *Metropolitan Life Ins. Co.*, 690 F.3d 176 (4th Cir. 2012), undermines *Korotynska*. BIO 28-29. It does not. *McCravy* addressed the unrelated issue of whether surcharge is equitable relief under ERISA § 502(a)(3); the court did not mention *Korotysnka* once.

for disavowed claims through his right to bring suit pursuant to section [502](a)(1).'" 589 F. App'x at 737 (quoting *Tolson*, 141 F.3d at 610).

With respect to the Sixth Circuit, Denbo counters that the court in *Gore* v. *El Paso Energy Corp. Long Term Disability Plan*, 477 F.3d 833 (6th Cir. 2007), and *Hill* v. *Blue Cross & Blue Shield of Mich.*, 409 F.3d 710 (6th Cir. 2005), determined that the plaintiffs' § 502(a)(3) claims survived dismissal because they alleged injuries *not otherwise remediable under ERISA*. *See* BIO 30. That, of course, is the merits resolution of the very question the Second Circuit held could not be reached at the pleadings stage. The fact remains that—in conflict with the court below—the Sixth Circuit has repeatedly applied *Varity* to motions to dismiss. *See, e.g.*, *Moore*, 458 F.3d at 428; *Marks* v. *Newcourt Credit Grp., Inc.*, 342 F.3d 444, 454 (6th Cir. 2003).

Denbo's analysis of Eleventh Circuit law fares no better. In *Katz* v. *Comprehensive Plan of Group Insurance*, 197 F.3d 1084 (11th Cir. 1999), the court agreed with the district court's ruling that "an ERISA plaintiff with an adequate remedy under § [502](a)(1)(B), cannot alternatively plead and proceed under § [502](a)(3)." *Id.* at 1088. Denbo argues that because the court considered the issue at the summary-judgment stage, it "had no reason to discuss pleading standards." BIO 30-31. Yet the pleadings (and only the pleadings) were the basis for *Katz*'s holding. And subsequent panels have applied *Katz* to dismissal decisions. *See, e.g.*, *Helms* v. *General Dynamics Corp.*, 222 F. App'x 821, 834 (11th Cir. 2007); *Jones* v. *American Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1074 (11th Cir. 2004).

b. Denbo cannot reconcile these decisions from the Fourth, Fifth, Sixth, and Eleventh Circuits with the decision below, or with the law of the Eighth Circuit.

He claims that the decision below is not in conflict with the majority view because the panel supposedly distinguished situations where § 502(a)(1)(B) clearly provides all the relief necessary, suggesting dismissal might be appropriate under those circumstances. BIO 27. But the panel never made that distinction. Quite the contrary: the panel reasoned that it was "not clear at the motion-to-dismiss stage" that Denbo's ERISA 502(a)(3) claim should be dismissed *because* "he has not yet succeeded on his § 502(a)(1)(B) claim." Pet. App. 16a. This rationale cannot be reconciled with the majority rule.

Denbo's reading of *Silva* v. *Metropolitan Life Insurance Co.*, 762 F.3d 711 (8th Cir. 2014), is equally misplaced. *See* BIO 31-33. He downplays the conflict between the Fourth and Eighth Circuits by identifying past Eighth Circuit cases that the Fourth Circuit in *Korotynska* cited with approval. *See* BIO 32. But *Silva* distinguished those very cases *because they were not decided at the pleadings stage*. That, of course, is precisely the conflict: *Silva* appears to conclude that summary-judgment precedents are generally inapplicable at the pleadings stage, while the majority of circuits apply the same rules initially developed in summary-judgment decisions to the pleadings. Thus, far from showing an absence of conflict, *Silva* reinforces the conflict's existence.

* * *

The circuit split on the second question has existed for a decade. This case squarely presents the question, and Denbo does not suggest otherwise.

2. On the merits, Denbo devotes a single paragraph to defending the panel's refusal to apply *Varity* to the pleadings. He argues that a contrary rule would "force plaintiffs to bring claims exclusively for legal relief at the outset." BIO 33. That is not so. ERISA § 502(a)(1)(B) does not limit a plaintiff to *legal* remedies; it encompasses the *equitable* relief Denbo seeks, *see* Defs.-Appellees' C.A. Br. 46-47, including relief for his claims under the Parity Act, the requirements of which are incorporated as Plan terms. *See id.* at 59-62; Dep't of Labor C.A. Br. 4. *Contra* BIO 26.

What a plaintiff cannot do is circumvent the limitations inherent in § 502(a)(1)(B) where—as here—the "gravamen" of the § 502(a)(3) claim is "the wrongful denial of benefits." Pet. App. 39a; *see id.* at 21a. Allowing the Second Circuit's contrary ruling to stand would, for example, grant beneficiaries license to artificially plead around the requirement that they exhaust internal claims procedures before bring judicial challenges under Section 502(a)(1)(B). Beneficiaries could also demand discovery that would not otherwise be available to them for Section 502(a)(1)(B) benefits claims. *See* Pet. 31-32.

In response, the best Denbo can muster is the unsupported assertion that such abuses are not "routine[]," and perhaps that they might be avoided through a resource-intensive multi-stage discovery process. BIO 33. The simpler way to avoid abuse is to adopt the rule followed by the majority of circuits, which forecloses those abuses from occurring in the first place.

The Court should grant review and reverse the Second Circuit.

CONCLUSION

For the foregoing reasons, and those in the petition, the petition should be granted.

Respectfully submitted,

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ADDENDUM

ERRATA SHEET FOR OPINION

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

August Term, 2014

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

Docket No. 14-20-cv

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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 subscribers, SHELLEY 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.

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ERRATA

PAGE(S) (Slip Opinion Pages)	LINE	DELETE	INSERT
10	10:7	", both"	
10	10:8-9	"and to prevent inference with their provision of mental health treatment"	

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So Ordered:

/s/ **9/22/15**
Raymond J. Lohier, Jr., Circuit Judge **Date**