No. 20-1639

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

N.R., by and through his parents and guardians, S.R. and T.R., individually and on behalf of all others similarly situated, and derivatively on behalf of the Raytheon Health Benefits Plan,

Plaintiff-Appellant,

v.

RAYTHEON COMPANY, RAYTHEON HEALTH BENEFITS PLAN, and WILLIAM M. BULL,

Defendants-Appellees.

On Appeal from the United States District Court for the
District of Massachusetts, Case No. 1:20-cv-10153-RGS

BRIEF OF THE SECRETARY OF LABOR, AS AMICUS CURIAE SUPPORTING PLAINTIFF-APPELLANT

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STATEMENT OF THE ISSUES

N.R., a beneficiary in Raytheon Company's ("Raytheon") self-funded health plan, is a five-year old boy diagnosed with autism spectrum disorder ("ASD") who received speech therapy services as an ASD treatment. The plan's claims administrator, United Healthcare, denied coverage for the speech therapy, finding it was non-restorative (not intended to regain a previously intact level of speech) and therefore excluded under the terms of the plan.

N.R.'s parents, on his behalf, brought a putative class-action complaint against Raytheon, the plan, and the plan administrator, asserting that the defendants' application of the non-restorative exclusion was designed to eliminate coverage of services for developmental mental health conditions, in violation of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., and the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or the "Parity Act"), which amended ERISA. As relevant here, the complaint asserts a claim for benefits under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and alleges the plan violated the Department of Labor's regulations under ERISA by failing to provide information about mental health parity in response to a request.

The district court dismissed N.R.'s ERISA section 502(a)(1)(B) claim, holding that N.R.'s claim was not made for benefits due under the "terms of the plan." N.R. v. Raytheon, No. 20-10153-RGS, 2020 WL 3065415, at *7 (D. Mass. June 9, 2020).

According to the district court, participants who have been denied mental health benefits in violation of MHPAEA's protections "'may enforce their Parity Act rights only through Section 502(a)(3),'" a claim it dismissed in this case. Id. (quoting Christine S. v. Blue Cross Blue Shield of N.M., No. 2:18-cv-00874-JNP-DBP, 2019 WL 6974772, at *13 (D. Utah Dec. 19, 2019)).

The Secretary's brief only addresses the following issues:[1]

1. Whether a beneficiary who alleges that a plan denied a benefit that would be due under the plan but for the plan's enforcing of an exclusion that violates MHPAEA's parity requirements can bring a claim under ERISA section 502(a)(1)(B)?

2. Whether, in a section 502(a)(1)(B) claim asserting that benefits have been denied in violation of MHPAEA's parity requirements, a plan's violation of the Department's regulation requiring it to provide information about the treatment limitation underlying the denial is significantly prejudicial to warrant relief?

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

The Secretary of Labor has primary enforcement, interpretive, and regulatory authority with respect to Title I of ERISA. See 29 U.S.C. §§ 1001, 1134, 1135; Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 688-91 (7th Cir. 1986) (en banc). The Secretary's interests include promoting uniformity of law, protecting beneficiaries, enforcing fiduciary standards, and ensuring that courts correctly interpret ERISA. Id. at 692-93.

[1] The Secretary does not address other questions that may be raised on appeal.

The issues addressed by the Secretary in this case affect his enforcement responsibilities and powers. The Secretary's role in enforcing ERISA requires that he ensure plan terms comply with the "minimum" requirements ERISA prescribes, including those guaranteed through ERISA's incorporation of MHPAEA and the Department's implementing regulation. See ERISA section 712, 29 U.S.C. § 1185a ("Parity In Mental Health and Substance Use Disorder Benefits"); 29 C.F.R. § 2590.712 ("Parity in mental health and substance use disorder benefits").[2] The Department of Labor has "primary enforcement jurisdiction over MHPAEA for approximately 2.4 million group health plans covering roughly 135 million Americans." See United States Department of Labor, Secretary Scalia's 2020 Report to Congress, Parity Partnerships: Working Together at 5, available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf. The Secretary has an interest in protecting the right of those roughly 135 million Americans to ensure their benefits comply with MHPAEA and ERISA's other minimum requirements pursuant to ERISA section 502(a)(1)(B). Additionally, in

[2] See also, e.g., ERISA Part 7, section 701, et. seq., 29 U.S.C. § 1181 ("Group Health Plan Portability, Access, and Renewability Requirements"); 29 C.F.R. § 2530.200a-1 (participation and vesting regulations describe ERISA's requirements as a "minimum" standard for plan terms); ERISA section 503, 29 U.S.C. § 1133 (minimum requirements for claims procedures in plans); ERISA Part 6, 29 U.S.C. §§ 1161-1169 ("COBRA" continuation of coverage requirements for Group Health Plans).

connection with the second issue presented, the district court did not consider whether the claims administrator violated its MHPAEA-related disclosure obligations during claims processing. The Secretary's interest in protecting rights granted by ERISA and MHPAEA also supports a remand to consider the prejudice from a violation of the Department's regulations.

The Secretary files this brief as amicus curiae pursuant to Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

A. Background

1. MHPAEA's Protections Regarding Treatment Limitations

"Congress enacted the MHPAEA to end discrimination in the provision of insurance coverage for mental health and substance use disorders as compared to coverage for medical and surgical conditions in employer-sponsored group health plans." Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., 821 F.3d 352, 356 (2d Cir. 2016) (internal citation omitted). To that end, ERISA section 712 (which incorporates MHPAEA's requirements into ERISA) provides that where a group health plan provides both medical/surgical benefits and mental health or substance use disorder ("MH/SUD") benefits, the plan must ensure that "treatment limitations" on coverage for MH/SUD benefits "are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan," and that "there are no separate treatment limitations that are

applicable only with respect to mental health or substance use disorder benefits." 29 U.S.C. § 1185a(a)(3)(A)(ii).

Under the Department's implementing regulation, the standard for determining whether a treatment limitation on MH/SUD benefits is "no more restrictive" than the predominant limitation on medical/surgical benefits depends on the type of treatment limitation at issue. The regulation distinguishes between "quantitative treatment limitations," such as an annual limitation in the number of covered visits for a given service, and "nonquantitative treatment limitations" ("NQTLs"), such as preauthorization requirements and medical management standards.[3] 29 C.F.R. § 2590.712(a). The Department's regulation states that an MH/SUD treatment limitation is compliant if "any processes, strategies, evidentiary standards, or other factors used in applying" the limitation to the MH/SUD benefit within a particular category are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation" to medical/surgical benefits in that same category. Id. § 2590.712(c)(4).

Additionally, the Department's MHPAEA regulation makes clear that, upon request, a claimant is entitled to information related to the processes, strategies, and factors underlying a plan's application of treatment limitations in connection with

[3] Unless otherwise noted, the term "treatment limitations" as used herein refers to nonquantitative treatment limitations.

MH/SUD claims under 29 C.F.R. §§ 2560.503–1 and 2590.715–2719 as part of the claims process. 29 C.F.R. § 2590.712(d)(3).[4] Accordingly, the Department has consistently emphasized that plans have a responsibility to provide this information to claimants as part of the claims process.[5]

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[4] The regulations require plans to produce "the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan." 29 C.F.R. § 2590.712(d)(3).

[5] See FAQs About Affordable Care Act Implementation (PART XVII) And Mental Health Parity Implementation, Department of Labor, Q8 (Nov. 8, 2013), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf; Template Form to Request Documentation From an Employer-Sponsored Health Plan or a Group or Individual Market Insurer Concerning Treatment Limitations, Department of Labor, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf (last visited Sept. 10, 2020) (noting that the Parity Act entitles claimants to request, inter alia, "the factors used in the development of the limitation," "the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified," "the methods and analysis used in the development of the limitation(s);" and "any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits"); Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), Department of Labor, 15, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf ("If only certain benefits are subject to an NQTL … plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits"); id. at 16 ("Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL for MH/SUD services and medical/surgical services are comparable").

2. N.R.'s Benefit Claim And Request For Information Related To Whether The Plan's Application Of The Non-Restorative Exclusions Complies With The Parity Act

Plaintiff N.R. is the five-year-old son of S.R. and T.R. A-6, ¶ 1.[6] Pursuant to T.R.'s employment with Raytheon, N.R. is a beneficiary of the Raytheon Health Benefit Plan ("Plan"), an ERISA-covered employee welfare benefit plan that provides health benefits for Raytheon employees and their dependents such as N.R. A-6 – A-7, ¶¶ 1-2. Raytheon, the plan sponsor, is also alleged to be a named fiduciary. A-7, ¶ 3. William M. Bull, a Raytheon vice-president, is alleged to be the "plan administrator," and a named fiduciary of the Plan. Id. ¶ 4.

In 2017, N.R.'s physician diagnosed him with ASD and recommended speech therapy services as treatment. N.R., 2020 WL 3065415, at *1. N.R. subsequently received speech therapy from a licensed speech pathologist as treatment for ASD. Id. N.R. sought coverage for the pathologist's treatment, but the Plan's claims administrator, United Healthcare, denied the request because the service was "not covered for the diagnosis listed on the claim." Id.

N.R.'s parents appealed United Healthcare's denial in April 2019, arguing the speech therapy N.R. received was a medically necessary mental health service covered under the Plan, and United Healthcare's "restriction of covering only 'restorative speech therapy'" violated the Parity Act. Id. United Healthcare rejected

[6] Citations to the Joint Appendix are noted with the abbreviation "A-_".

the appeal, quoting Plan terms stating that "habilitative services . . . are not covered," and that "[t]o be considered covered services, speech and nonverbal communication services must comply with restorative-only requirements. To be considered restorative, the speech or nonverbal communication function must have been previously intact." Id. at *2. United Healthcare also noted that while the Plan covered some treatments for mental health conditions (including ASD), the Plan excluded from such coverage both "[h]abilitative services," and "[s]peech therapy for non-restorative purposes." Id. The response did not address the appeal's parity argument. Id. N.R.'s parents made a second-level appeal, providing additional medical necessity evidence. Id. United Healthcare denied the second-level appeal, again on the basis of the non-restorative exclusion, and again "without addressing the issue of medical necessity or the ramifications of the Parity Act." Id. at *2-3.

After United Healthcare denied the second-level appeal, N.R.'s parents contacted Raytheon and United Healthcare to obtain two categories of information related to whether the non-restorative exclusion complied with the Parity Act's requirements: (1) "the list of non-mental health conditions to which the Plan applies the 'non-restorative' speech therapy exclusion" and (2) "the 'medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply' the 'non-restorative speech therapy' exclusion, the 'non-restorative ABA speech therapy' exclusion and the exclusion of 'habilitative

services' under the Plan." N.R., 2020 WL 3065415, at *3. According to Raytheon, N.R.'s parents were instructed to direct their information requests to United Healthcare. A-488 – A-490. Neither Raytheon nor United Healthcare provided the requested documents. N.R., 2020 WL 3065415, at *3; A-16, ¶ 48.

B. Proceedings Before The District Court

In January 2020, N.R.'s parents, on his behalf, brought a putative class-action complaint against the Plan, Raytheon, and William Bull, under ERISA sections 502(a)(2), (a)(1)(B), (a)(3), and (a)(1)(A). A-19 – A-22, ¶¶ 61-77. The first three counts of the complaint challenge the defendants' use of the non-restorative exclusions to deny benefits, while the fourth count seeks statutory sanctions for the defendants' failure to produce the requested documents. The complaint generally alleges that the defendants violated ERISA and the Parity Act by "exclud[ing] all coverage of medically necessary speech therapy to treat developmental mental health conditions" based solely on the Plan's "Non-Restorative Exclusions," which the complaint asserts "are aimed at eliminating coverage of speech therapy and other services for developmental mental health conditions." A-8, ¶ 9. Accordingly, the complaint alleges that "the Exclusions are a proxy for disability discrimination, and improperly exclude coverage of medically necessary services to enrollees with developmental mental health conditions." Id. The complaint further alleges that, contrary to the Plan's assertion that the non-restorative exclusions apply to all benefits under the Plan, and in violation of the Parity Act, the Plan provides coverage

for certain types of medical/surgical benefits that are non-restorative, citing the Plan's coverage of medical/surgical benefits for congenital heart disease and infertility conditions. A-17, ¶ 54.

On June 9, 2020, the district court issued a memorandum and order granting defendants' motion to dismiss. See N.R., 2020 WL 3065415, at *12. The district court dismissed N.R.'s section 502(a)(1)(B) claim with prejudice, on the ground that participants and beneficiaries like N.R. "may enforce their Parity Act rights *only* through Section 502(a)(3)." Id. at *7 (internal citation omitted). The district court did not address the claim administrator's alleged violation of disclosure obligations during the claims administration process.

The district court dismissed the section 502(a)(3) claim, holding the plaintiff failed to plausibly allege sufficient facts to sustain either a facial or as-applied violation of the Parity Act, and dismissed the claim without prejudice. Id. at *8-10. Finally, the district court dismissed N.R.'s disclosure claim without prejudice, holding the statutory penalties N.R. sought under section 502(c)(1) are available only from the "plan administrator," and N.R. had failed to plead "facts sufficient to suggest that his document requests were directed to the true Plan Administrator," i.e., Mr. Bull. Id. at *11.

N.R. timely appealed the decision.

SUMMARY OF ARGUMENT

1. Where a beneficiary alleges he was denied covered mental health benefits because his plan applied an exclusion or limitation in violation of ERISA's parity requirements, he is authorized to bring a claim for those benefits under ERISA section 502(a)(1)(B), and the only enforceable terms of the plan relevant to that action are those that comply with ERISA. The district court's contrary holding, and its conclusion that MHPAEA's parity requirements may be enforced only through section 502(a)(3), was in error.

ERISA section 502(a)(1)(B) authorizes a beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Courts routinely hold that that retirement plan terms that are inconsistent with ERISA's statutory requirements for those plans are unenforceable, and the same principle applies to ERISA's mandatory plan requirements for health plans. Accordingly, just as a pension plan participant may bring a section 502(a)(1)(B) claim to vindicate her rights under her plan without regard to any provisions that fail to comply with statutory requirements, so too may a beneficiary bring a 502(a)(1)(B) claim to allege he has been denied a benefit as a result of an exclusion in violation of ERISA's parity requirements.

The district court did not grapple with this contrary authority, instead reasoning that deeming ERISA's statutory requirements as plan terms could place

fiduciaries in a "Catch 22," in which they could be subject to suit either for failing to follow a plan's terms or for failing to follow the law. N.R., 2020 WL 3065415, at *7 n.3 (internal citations omitted). But this rationale ignores that ERISA requires fiduciaries to resolve benefit claims in a manner that is "consistent with" ERISA's statutory provisions. 29 U.S.C. § 1104(a)(1)(D); see also Fifth Third Bancorp. v. Dudenhoeffer, 573 U.S. 409, 422 (2014) ("trust documents cannot excuse trustees from their duties under ERISA") (citations and internal quotation marks omitted). The district court's holding should be reversed.

2. The right of beneficiaries to bring a section 502(a)(1)(B) claim for covered benefits in these circumstances is also consistent with the Department's regulatory requirements for the claims the review process that precedes the 502(a)(1)(B) claim. These regulations provide that, in connection with the claims process, beneficiaries have the right to obtain information from their plans demonstrating whether treatment limitations like the non-restorative exclusions at issue in this case have been applied in violation of MHPAEA. 29 C.F.R. § 2590.712(d)(3). That disclosure allows beneficiaries to better understand and effectively challenge a claims denial. Here, the Plan failed to provide this information to N.R.'s parents in connection with the claims process despite their request, a failure which detrimentally impacted N.R.'s ability to plead a parity claim with the factual detail necessary to satisfy the district court. By incorrectly dismissing the section 502(a)(1)(B) claim, the district court did not address the significance of the information request in light of the

Department's regulation or its potential prejudice to N.R.'s MHPAEA claim. The Court should vacate the district court's dismissal of N.R.'s section 502(a)(1)(B) claim and also remand to determine whether the Plan's failure to provide this information prejudiced N.R.'s claim and whether that prejudice was so significant as to warrant a remedy.

ARGUMENT

I. A Beneficiary Alleging He Was Denied A Benefit That Would Otherwise Be Covered By The Terms Of An ERISA Plan Based On An Exclusion That Violates ERISA's Parity Requirements Is Authorized To Bring A Claim For Benefits Under ERISA Section 502(a)(1)(B)

ERISA, as amended by MHPAEA, sets standards for group health plans and issuers with respect to parity requirements. E.g., Coal. for Parity, Inc. v. Sebelius, 709 F. Supp. 2d 10, 13 (D.D.C. 2010). The statute works to end arbitrary or discriminatory differences in the provision of coverage for mental health conditions as compared to medical or surgical benefits. Id. These standards are designed to "'assur[e] the equitable character'" of employee benefit plans, Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 364 (2002) (quoting 29 U.S.C. § 1001(a)), and are central to fulfilling ERISA's "object of protecting employees' justified expectations of receiving the benefits their employers promise them." Central

Laborers' Pension Fund v. Heinz, 541 U.S. 739, 743 (2004); see also Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 510 n.5 (1981).

"Congress intended [section] 502(a) to be the exclusive remedy for rights guaranteed under ERISA." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 144 (1990) (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987)). One of those provisions, ERISA section 502(a)(1)(B), allows a participant or beneficiary to bring a civil action "to recover benefits due to him under the *terms of his plan*, to enforce his rights 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) (emphasis added). Contrary to the district court's opinion, where, as here, a beneficiary alleges that he would be entitled to coverage under a plan's terms but for its application of an exclusion or limitation that violates ERISA's parity requirements, those plan terms that exclude or limit mental health benefits are essentially void, and he is authorized to bring a claim for those benefits under section 502(a)(1)(B).

A. Courts Reviewing Section 502(a)(1)(B) Claims In Retirement Plans Must Disregard Plan Terms That Violate ERISA In Determining The Benefits Due Under The Plan

It is well established that retirement plan terms that are inconsistent with ERISA's statutory requirements for those plans are unenforceable. As the Second Circuit held in Esden v. Bank of Boston, 229 F.3d 154, 172 (2d Cir. 2000), "[e]mployers do not have to provide pension plans, but when they do, those plans must comply with Title I of ERISA." Accordingly, while "[it] is correct [to say] that

a pension benefit is defined according to the terms of the plan," "ERISA is quite explicit that those terms are circumscribed by statutory requirements and restrictions. The Plan cannot contract around the statute." Id. at 173. Accordingly, "[c]ourts are required to enforce ERISA plans as written," including any limitations or exclusions, unless those terms contravene a requirement in ERISA. Bauer v. Summit Bancorp, 325 F.3d 155, 160 (3d Cir. 2003). And while an ERISA plan could typically rely on the plan's exclusions or limitations to defeat a beneficiary's efforts "to recover benefits due to him under the *terms of his plan*," 29 U.S.C. § 1132(a)(1)(B) (emphasis added), it may do so only if those exclusions and limitations on those benefits "comply with ERISA." West v. AK Steel Corp., 484 F.3d 395, 405 (6th Cir. 2007).

Consistent with these authorities, the First Circuit in Kolling v. American Power Conversion Corp., 347 F.3d 11 (1st Cir. 2003), noted that "*[w]ithin limits*, ERISA affords employers broad discretion to limit participation in their employee benefit plans—even where such an exclusion affects common law employees." Id. at 14 (emphasis added, noting that ERISA constrains this discretion by prohibiting discrimination based on age or length of service). Accord Edes v. Verizon Commc'ns, Inc., 288 F. Supp. 2d 55, 62 (D. Mass. 2003), aff'd, 417 F.3d 133 (1st Cir. 2005) (relying on Bauer, 325 F.3d at 160); cf. Bard v. Boston Shipping Association, 471 F.3d 229, 239 n.11 (1st Cir. 2006) (noting that the ERISA claims

procedure regulations, which apply to all plans, govern plan procedures, and the *only* deviations allowed in plans are deviations the regulation would permit).

B. The Same Principle Applies To Exclusions And Limitations That Violate ERISA's Requirements For Health Plans, Including MHPAEA's Parity Requirements

Like the requirements imposed on pension plans discussed above, Congress also imposes MHPAEA's requirements directly on the plan itself, mandating that covered health plans comply with minimum parity standards with respect to the benefits for the treatment of mental health and substance use disorder conditions offered under such plans.[7] Section 712(a) thus requires ERISA plans that offer MH/SUD benefits "*shall ensure* that . . ." plans provide MH/SUD benefits in parity with medical/surgical benefits. 29 U.S.C. § 1185a(a)(3)(ii). As with ERISA's provisions that impose minimum standards on pension plans, ERISA's minimum

[7] Compare, e.g., ERISA section 203(a), 29 U.S.C. § 1053(a) ("[e]ach pension plan *shall provide* that an employee's right to his normal retirement benefit is nonforfeitable upon the attainment of normal retirement age …") (emphasis added); ERISA section 204(g), 29 U.S.C. § 1054(g) ("the accrued benefit of a participant under a plan *may not be decreased by an amendment of the plan* . . .") (emphasis added); ERISA section 204(c)(3), 29 U.S.C. § 1054(c)(3) (if a participant retires early, his "accrued benefit . . . *shall be* the actuarial equivalent of" an annuity commencing at normal retirement age) (emphasis added) with ERISA section 712(a)(3)(ii), 29 U.S.C. § 1185a(a)(3)(ii), (group health plans "*shall ensure* that . . . the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan . . . and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits") (emphasis added).

requirements for health plans govern the plan and any exclusions or limitations that violate ERISA are unenforceable.

The conclusion that exclusions or limitations that fail to comply with ERISA's mandatory requirements are unenforceable also follows from the Supreme Court's preemption jurisprudence. For example, in UNUM v. Ward, 526 U.S. 358 (1999), the Court, in deciding whether a state insurance law was saved from preemption by that provision's insurance-savings clause under ERISA section 514, 29 U.S.C. § 1144, noted that the state rule in question "changes the bargain between insurer and insured." Id. at 374. The MHPAEA parity requirements imposed on plans similarly change the bargain between the plan and the beneficiary, such that in a section 502(a)(1)(B) claim courts must disregard any plan terms that violate those statutory requirements.

C. Because Exclusions And Limitations That Violate MHPAEA Must Be Disregarded, A Beneficiary May Bring A Claim Under Section 502(a)(1)(B) For Benefits That Would Be Due But For The Unlawful Exclusion Or Limitation

Because courts must disregard any plan terms that violate ERISA's requirements, a beneficiary claiming he was denied benefits that would be available under the terms of the plan but for the application of an unlawful exclusion or limitation is seeking "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) (emphasis added).

Accordingly, a number of district courts have allowed a section 502(a)(1)(B) claim to proceed based on an allegation that benefits were denied in violation of MHPAEA's parity requirements, although without much analysis. See K.H.B. by & through Kristopher D.B. v. UnitedHealthcare Ins. Co., No. 2.18-CV-000795-DN, 2019 WL 4736801, at *5 (D. Utah Sept. 27, 2019); Smith v. United Healthcare Ins. Co., No. 18-CV-06336-HSG, 2019 WL 3238918, at *2-7 (N.D. Cal. July 18, 2019) (allowing allegation that defendant violated Parity Act in denying claim to proceed under section 502(a)(1)(B)). See also New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp., 798 F.3d 125, 131-32 (2d Cir. 2015) (allowing plaintiff to proceed with section 502(a)(1)(B) claim for benefits that alleged defendant claims administrator breached the terms of the health plan by applying policies and guidelines that violated ERISA's parity requirements).

Moreover, appellant also notes that an alternative ground to reverse the district court's dismissal of the section 502(a)(1)(B) claim is that a beneficiary "may properly pursue claims under both ERISA [sections] 502(a)(1)(B) and (a)(3) in order to obtain a complete remedy." Appellant's Br. at 30. The Second Circuit recently employed this sort of two-step procedure in a case where the plaintiff brought a section 502(a)(1)(B) claim for statutorily mandated benefits that were not reflected in the plan's terms. See Laurent v. PricewaterhouseCoopers LLP, 945 F.3d 739, 747-49 (2d Cir. 2019), petition for cert. pending, No. 20-28 (filed July 10, 2020). In Laurent, the Second Circuit held that the plaintiff was entitled to the equitable

remedy of plan reformation to redress an illegal plan term under section 502(a)(3), and then had the right to enforce the reformed plan term under section 502(a)(1)(B). Id. at 747-49. The Department has previously taken the position that section 502(a)(3)'s equitable remedies provide an alternative mechanism to ensure relief is available to redress reliance on plan terms that violate ERISA in appropriate cases. See, e.g., Brief for the U.S. Secretary of Labor as Amicus Curiae Supporting Plaintiff-Appellants, Laurent v. PricewaterhouseCoopers, 2018 WL 4182345, at *17-21 (2d Cir. Aug. 22, 2018)).

D. The District Court's Reasoning Ignores ERISA's Text And Structure

The district court did not engage with the authority discussed above in holding NR could not bring a section 502(a)(1)(B) claim for benefits. The district court largely rested its determination on an observation made by another district court as to why "incorporation" of state law requirements into ERISA plans seems to place fiduciaries in a difficult position.

> [Incorporation] is problematic in that it does not address the fact that it would seem to place a plan administrator in a Catch 22. That is, if there were an explicit plan term that arguably conflicted with state law, the plan administrator would have to decide whether to follow the express plan term because if it did not, then it could be sued for breach of fiduciary duty for failure to comply with the plan terms; however, if it did comply with the express plan term, then it could still be sued for failing to follow state law impliedly incorporated in the plan terms.

N.R., 2020 WL 3065415, at *7 n.3 (quoting Cromwell v. Kaiser Found. Health Plan, No. 18-cv-06187-EMC, 2019 WL 1493337, at *4 n.3 (N.D. Cal. Apr. 4, 2019)).

The problem with this analysis is that it ignores that neither plan administrators nor courts can properly resolve benefit claims without regard to ERISA's provisions, because ERISA specifies that plan terms are operative only to the extent that they "are consistent with" the statutory provisions. 29 U.S.C. § 1104(a)(1)(D) ("a fiduciary shall discharge his duties . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter [i.e., subchapter I] and subchapter III of this chapter."). Put differently, "trust documents cannot excuse trustees from their duties under ERISA," Dudenhoeffer, 573 U.S. at 422 (citations and internal quotation marks omitted); see also Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc., 472 U.S. 559, 568 (1985). Multiple circuit courts agree that plan terms cannot override fiduciary duties. In re Citigroup ERISA Litigation, 662 F.3d 128, 139 (2d Cir. 2011) (plan terms do not override ERISA's fiduciary requirements); Eisenrich v. Minneapolis Retail Meat Cutters & Food Handlers Pension Plan, 574 F.3d 644, 648 (8th Cir. 2009); Laborer's Nat'l Pension Fund v. Northern Trust Quantitative Advisors, Inc., 173 F.3d 313, 322 (5th Cir. 1999); Herman v. NationsBank Trust Co., 126 F.3d 1354, 1368-69 & n.15 (11th Cir. 1997); Coleman v. Interco Inc. Divisions' Plans, 933 F.2d 550, 551 (7th Cir. 1991) ("ERISA trumps" divergent plan language). Regardless of the stated terms in a plan document, therefore, fiduciaries *always* retain a duty under the statute to disregard plan terms that are inconsistent with statutory requirements. The result is effectively

to enforce ERISA's requirements imposed on plan terms into ERISA plans by barring the enforcement of plan exclusions and limitations that violate ERISA for covered mental health benefits in section 502(a)(1)(B) proceedings. See Winer v. Edison Bros. Stores Pension Plan, 593 F.2d 307, 314 (8th Cir. 1979) (agreeing with DOL's position that fiduciaries violated ERISA sections 404(a)(1)(B) and (D) by following "bad boy clauses" in the plan terms that were contrary to section 203's vesting provisions).[8]

II. The Department's Regulatory Guidance Supports Enforcement of MHPAEA Through Section 502(a)(1)(B) And Defendants' Alleged Violation Of The Regulation Provides A Basis To Vacate And Remand

The availability of a section 502(a)(1)(B) claim is consistent with the Department's MHPAEA regulation. Exhaustion of administrative remedies is not required to bring a claim for statutory violations, including violations of MHPAEA, see, e.g., Hitchcock v. Cumberland Univ. 403(b) DC Plan, 851 F.3d 552, 564 (6th Cir. 2017); Stephens v. Pension Ben. Guar. Corp., 755 F.3d 959, 965 (D.C. Cir. 2014) (discussing majority rule). But the Department recognized the possibility that some participants would exercise their right to choose to exhaust claims procedures when alleging MHPAEA claims, which is consistent with their further right to

[8] The Government has consistently taken this position. The Government has argued that terms that are contrary to ERISA's requirements are "unenforceable." See Cent. States, 472 U.S. at 567 n.7, 579 n.20. Therefore, fiduciaries may not rely on unenforceable terms in any section 502(a) action. See Br. for the United States as Amicus Curiae, AK Steel Corp. v. West, 2008 WL 5083082, at *10-11.

judicial review of a claims decision under section 502(a)(1)(B). This is clear because the regulation gives participants the right to documents relating to how the plan performed the parity analysis, and the participant can challenge that analysis in the claims process. See 29 C.F.R. § 2590.712(d)(3); Preamble, Final Rules, 78 Fed. Reg. at 68247-48 (noting that plans must provide documents "with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an [nonquantitative treatment limitation] with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan."); cf., e.g., Rush Prudential, 536 U.S. at 380 & n.10 (noting right under section 502(a)(1)(B) to review the claims process resulting in the denial).

N.R.'s parents chose to exhaust their administrative remedies. In connection with reviewing the claim, the Plan failed to provide information they requested about the processes, strategies, evidentiary standards and other factors used to apply the non-restorative exclusions, which takes on additional significance in undermining N.R.'s parents' ability to plead that claim with sufficient facts. N.R., 2020 WL 3065415, at *3; A-16, ¶ 48. Under the Department's regulations, N.R. was entitled to this information during the claims process, and it is directly relevant to whether a violation has occurred. See 29 C.F.R. § 2590.712(d)(3).[9] The district court's

[9] The regulation states:

determination that he failed to state a plausible violation of the Parity Act stemmed from the court's determination that the claim lacked sufficient "theories or factual allegations," N.R., 2020 WL 3065415, at *9 n.7, a deficiency that arguably stemmed, in turn, from the Plan's failure to provide N.R. the information he requested that would have demonstrated whether the Plan imposed this limitation in compliance with the Department's regulation.

Where a beneficiary can show that a plan's violation of the Department's regulation was so significant as to prejudice the review of her claim, a remedy may be appropriate. See, e.g., Bard, 471 F.3d at 240-41; DiGregorio v. Hartford Comprehensive Employee Ben. Serv. Co., 423 F.3d 6, 15-16 (2005); Terry v. Bayer Corp., 145 F.3d 28, 38 (1998). In egregious cases, where "serious" procedural irregularities led to the denial of benefits to which the participant was entitled, the

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> [Sections] 2560.503–1 and 2590.715–2719 of this chapter set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

29 C.F.R. § 2590.712(d)(3).

First Circuit has gone so far as to order the plan to pay the benefits. See Bard, 471 F.3d at 246.

Here, the district court erred by not considering whether the alleged procedural deficiency prejudiced N.R.'s claim so significant as to warrant a remedy. Again, pursuant to the Department's MHPAEA regulation, plans may not impose a treatment limitation on mental health benefits in a given classification (such as outpatient, in-network mental health) unless under the terms of the plan as written and in operation, the "processes, strategies, evidentiary standards, or other factors used in applying the limitation to [MH/SUD] benefits in the classification are comparable to, and are applied no more stringently than" those used in applying the limitation to medical/surgical benefits in the classification. 29 C.F.R. § 2590.712(c)(4)(i). The Plan and the Plan's claims administrator were the only entities in possession of the information about whether the Plan's limitation complied with this regulation, and they were obligated to provide it to N.R. upon request. 29 C.F.R. §§ 2590.712(d)(3), 2560.503–1, and 2590.715–2719. Nonetheless, beyond repeating the plan terms at issue in this litigation, neither the Plan nor its claims administrator discussed this information with N.R., nor did they produce any of the underlying documents N.R. requested, see A-488 – A-490 and AR-16, ¶ 48, in violation of N.R.'s right to have "the claims administrator engage in a meaningful dialogue" about his claim. Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc., 813 F.3d 420, 426 (1st Cir. 2016). Affirming the dismissal would

condone the Plan's "unseemly argument" that N.R.'s claim "was insufficiently supported when [the Plan's] own failure to maintain reasonable claims procedures as required by the ERISA regulations made obtaining further supporting [information] impossible." Scibelli v. Prudential Ins. Co. of Am., 666 F.3d 32, 44 (1st Cir. 2012).

This wholesale refusal may have undermined N.R.'s parents' ability to prosecute this claim. Yet after incorrectly dismissing the section 502(a)(1)(B) claim, the district court did not address the significance of the information request in light of the Department's regulation or its potential prejudice to N.R.'s MHPAEA claim. The Department tailored the regulations on disclosure in the MHPAEA context, in part, to respond to concerns about "the lack of health plan transparency," and the difficulty in "understand[ing] whether a plan complies with the NQTL provisions without information showing that the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health or substance use disorder benefits and medical/surgical benefits are comparable, impairing plan participants' means of ensuring compliance with MHPAEA." Preamble, Final Rules, 78 Fed. Reg. 68240-01, 68247-48 (Nov. 13, 2013). Accordingly, the Secretary respectfully requests that the Court vacate the dismissal of the section 502(a)(1)(B) claim and remand for further consideration of the extent to which the Plan's failure to provide this information prejudiced N.R.'s claim and what relief, if any, is warranted.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests the Court reverse the district court's holding that a beneficiary who alleges his plan denied him a benefit in violation of MHPAEA's parity requirements cannot bring a claim under ERISA section 502(a)(1)(B) and vacate the district court's dismissal of N.R.'s section 502(a)(1)(B) claim, remanding for further consideration of the extent to which the Plan's failure to provide information about the factors it used in applying the treatment limitation underlying the denial is significantly prejudicial to warrant relief.

DATED: October 7, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the attached brief complies with FED. R. APP. P. 29(a)(4)-(5), FED. R. APP. P. 32(a)(5) and FED. R. APP. P. 32(a)(6), because it has been prepared in proportionately spaced typeface using Microsoft Word in 14 point Times New Roman, and excluding the parts of the document exempted by FED. R. APP. P. 32(f), it contains 6,235 words.

I further certify that on October 7, 2020, I electronically filed the foregoing document with the United States Court of Appeals for the First Circuit by using the CM/ECF system. I certify that the following parties or their counsel of record are registered as ECF Filers and that they will be served by the CM/ECF system:

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