

13-2114

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MARIANNE GATES,
Individually and On Behalf of All Others Similarly Situated,
Plaintiff-Appellant,

v.

UNITEDHEALTH GROUP INCORPORATED, UNITED HEALTHCARE
INSURANCE COMPANY, ALLIANCEBERNSTEIN L.P., UNITED
HEALTHCARE CHOICE PLUS COPAY PLAN FOR ALLIANCEBERNSTEIN
L.P., ALLIANCEBERNSTEIN L.P. UNITED HEALTHCARE INDEMNITY
PLAN, XYZ ENTITIES 1-100, UNITED HEALTHCARE SERVICES, INC.,
UHC HOLDINGS, INC., UNITED HEALTHCARE INSURANCE COMPANY,
OXFORD HEALTH PLANS LLC, and UNITEDHEALTHCARE, INC.,
Defendants-Appellees.

On Appeal from the United States District Court
for the Southern District of New York (Docket No.: 11-cv-3487)

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

M. PATRICIA SMITH
Solicitor of Labor
TIMOTHY D. HAUSER
Associate Solicitor for Plan Benefits Security
ELIZABETH HOPKINS
Counsel for Appellate and Special Litigation
SYMA AHMAD
Trial Attorney, U.S. Dep't of Labor
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210
(202) 693-5628

TABLE OF CONTENTS

TABLE OF AUTHORITIES	ii
STATEMENT OF INTEREST	1
STATEMENT OF THE ISSUES.....	1
STATEMENT OF THE CASE.....	2
SUMMARY OF ARGUMENT	6
ARGUMENT	7
I. The District Court Erred In Deferring To United's Benefit Determination And In Concluding, On That Basis, That Gates Lacked Constitutional Standing To Bring Her Benefits Claim.....	7
II. Plaintiff Has Constitutional Standing To Bring Claims For Injunctive Relief.....	15
III. Plaintiff May Bring Concurrent Claims For Benefits and For Plan-Wide Injunctive Relief for Claims Procedure Violations.....	19
CONCLUSION.....	29

TABLE OF AUTHORITIES

Federal Cases:

<u>Aetna Health Inc. v. Davila</u> , 542 U.S. 200 (2004)	10
<u>Alfarone v. Bernie Wolff Constr.</u> , 788 F.2d 76 (2d Cir. 1986)	11
<u>Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock</u> , 861 F.2d 1406 (9th Cir. 1988)	26
<u>Auer v. Robbins</u> , 519 U.S. 452 (1997)	11, 12
<u>Bickley v. Caremark RX, Inc.</u> , 461 F.3d 1325 (11th Cir. 2006)	25
<u>Brock v. Robbins</u> , 830 F.2d 640 (7th Cir. 1987)	27, 28
<u>Cent. States Se. & Sw. Areas Health & Welfare Fund v. Merck–Medco Managed Care, L.L.C.</u> , 433 F.3d 181 (2d Cir. 2005)	16, 17
<u>Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.</u> , 467 U.S. 837 (1984)	11, 12
<u>CIGNA Corp. v. Amara</u> , 131 S. Ct. 1866 (2011)	14 n.4, 26, 27
<u>City of Arlington, Tex. v. F.C.C.</u> , 133 S. Ct. 1863 (2013)	12
<u>Devlin v. Empire Blue Cross & Blue Shield</u> , 274 F.3d 76 (2d Cir. 2001)	21, 22
<u>Faber v. Metro. Life Ins. Co.</u> , 648 F.3d 98 (2d Cir. 2011)	8, 16

Federal Cases - (continued):

<u>Firestone Tire & Rubber Co. v. Bruch</u> , 489 U.S. 101 (1989)	14
<u>Frommert v. Conkright</u> , 433 F.3d 254 (2d Cir. 2006)	22
<u>Fujikawa v. Gushiken</u> , 823 F.2d 1341 (9th Cir. 1987)	25
<u>Gillis v. Hoechst Celanese Corp.</u> , 4 F.3d 1137 (3d Cir. 1993)	17
<u>Hall v. LHACO, Inc.</u> , 140 F.3d 1190 (8th Cir. 1998)	22
<u>Harrow v. Prudential Ins. Co. of Am.</u> , 279 F.3d 244 (3d Cir. 2002)	25
<u>Hill v. Blue Cross & Blue Shield of Mich.</u> , 409 F.3d 710 (6th Cir. 2005)	18, 22, 23
<u>Hobson v. Metro. Life Ins. Co.</u> , 574 F.3d 75 (2d Cir. 2009)	14
<u>Horan v. Kaiser Steel Ret. Plan</u> , 947 F.2d 1412 (9th Cir. 1991), <u>overruled on other grounds by</u> <u>Salomaa v. Honda Long Term Disability Plan</u> , 642 F.3d 666 (9th Cir. 2011)	25
<u>Horvath v. Keystone Health Plan East, Inc.</u> , 333 F.3d 450 (3d Cir. 2003)	17, 18, 19
<u>Kendall v. Employees Ret. Plan of Avon Products</u> , 561 F.3d 112 (2d Cir. 2009)	7, 8, 18, 19
<u>Korotynska v. Metro. Life Ins. Co.</u> , 474 F.3d 101 (4th Cir. 2006)	18

Federal Cases - (continued):

<u>LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan,</u> 605 F.3d 789 (10th Cir. 2010).....	15
<u>LaRue v. DeWolff, Boberg & Assoc., Inc.,</u> 552 U.S. 248 (2008)	27
<u>Lindemann v. Mobil Oil Corp.,</u> 79 F.3d 647 (7th Cir. 1996).....	25
<u>Loren v. Blue Cross & Blue Shield of Mich.,</u> 505 F.3d 598 (6th Cir. 2007).....	17, 18
<u>Lujan v. Defenders of Wildlife,</u> 504 U.S. 555 (1992)	8
<u>Mass. Mut. Life Ins. Co. v. Russell,</u> 473 U.S. 134 (1985)	23
<u>Miele v. Pension Plan of New York State Teamsters Conference Pension & Ret. Fund,</u> 72 F. Supp. 2d 88 (E.D.N.Y. 1999).....	22
<u>Milofsky v. Am. Airlines, Inc.,</u> 442 F.3d 311 (5th Cir. 2006) (en banc).....	25
<u>Moeckel v. Caremark RX Inc.,</u> 385 F. Supp. 2d 668 (M.D. Tenn. 2005).....	26
<u>Nichols v. Prudential Ins. Co. of Am.,</u> 406 F.3d 98 (2d Cir. 2005)	15
<u>Smith v. Sydnor,</u> 184 F.3d 356 (4th Cir. 1999).....	25
<u>Tolson v. Avondale Indus., Inc.,</u> 141 F.3d 604 (5th Cir. 1998).....	21

Federal Cases - (continued):

Varity Corp. v. Howe,
516 U.S. 489 (1996) 20, 21, 22

Warth v. Seldin,
422 U.S. 490 (1975) 9

Warzecha v. Nutmeg Cos., Inc.,
48 F. Supp. 2d 151 (D. Conn. 1999) 22

Yellow Trans., Inc. v. Mich.,
537 U.S. 36 (2002) 11

Federal Statutes:

Employee Retirement Income Security Act of 1974 (Title I),
29 U.S.C. § 1001 et. seq.:

Section 409(a), 29 U.S.C. § 1109(a) 5 & passim

Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) 2 & passim

Section 502(a)(2), 29 U.S.C. § 1132(a)(2) 2 & passim

Section 502(a)(3), 29 U.S.C. § 1132(a)(3) 1 & passim

Section 503, 29 U.S.C. § 1133 5, 10, 11

Section 504, 29 U.S.C. § 1134 1

Section 505, 29 U.S.C. § 1135 1

Federal Regulations:

29 C.F.R. § 2560.503-1 1, 10, 14

29 C.F.R. § 2560.503-1(g) 10, 12, 13

29 C.F.R. § 2560.503-1(h) 10

Federal Regulations – (continued):

29 C.F.R. § 2560.503-1(h)(2)(iii) 13

29 C.F.R. § 2560.503-1(j) 10

29 C.F.R. § 2560.503-1(l) 11, 24

29 C.F.R. § 2560.503-1(m)(8) 13

Miscellaneous:

Fed. R. Civ. P. 8(a)(3) 26

 8(d)(2) 26

65 Fed. Reg. 70246 (Nov. 21, 2000) 11, 13

65 Fed. Reg. 70255 (Nov. 21, 2000) 11

http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html 14

STATEMENT OF INTEREST

The Secretary of Labor ("Secretary") has primary regulatory and enforcement authority for Title I of the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C. §§ 1134, 1135. Pursuant to this broad regulatory authority and to an express grant of authority over claims processing in ERISA section 503, 29 U.S.C. § 1133, the Secretary issued regulations applicable to benefit claims under ERISA. 29 C.F.R. § 2560.503-1. The Secretary has a strong interest in ensuring that plan fiduciaries comply with these regulations in deciding benefit claims, and that plan participants are not precluded from suing to challenge benefit denials and to require fiduciary compliance with the claims regulations.

STATEMENT OF THE ISSUES

The Secretary's brief addresses the following issues:

1. Whether, in light of United Healthcare Insurance Company's failure to comply with the claims regulations, the district court erred in deferring to United's interpretation of plan provisions allowing offset for Medicare coverage and in concluding, on this basis, that plaintiff lacked constitutional standing.
2. Whether, regardless of the merits of her benefit claim, plaintiff has standing to bring her claim for injunctive relief under ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3), to remedy alleged plan-wide violations of the claims regulation.

3. Whether plaintiff may bring concurrent claims for benefits under section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and for injunctive relief under sections 502(a)(2) and 502(a)(3), 29 U.S.C. § 1132(a)(2) and (a)(3), to correct the failure of the plan fiduciaries to provide a full and fair claims process in compliance with the claims regulation.

STATEMENT OF THE CASE

This case was brought by Marianne Gates as a putative class action against her former employer, AllianceBernstein L.P. ("Alliance"), a number of ERISA-covered employee benefit plans sponsored by Alliance, and United Healthcare Insurance Company ("United"), the claims administrator for these plans and others like them. When a participant such as Gates becomes eligible for Medicare, the plans at issue reduce the benefits they provide, on the presumption that the participant used or should have used Medicare as the primary provider. The gravamen of Gates' complaint is that the defendants violated ERISA and the terms of her healthcare plan by miscalculating this Medicare offset. She seeks not only to obtain the additional benefits to which she claims to be entitled, but also seeks injunctive relief on behalf of the class requiring United to abide by the claims regulations in deciding claims that turn on a Medicare offset.

While employed by Alliance, Gates was enrolled in the United Healthcare Choice Plus Copay Plan, and she claims she continued to qualify for coverage

under this plan after her departure in 2008. Joint Appendix ("JA") 824.¹ The Copay Plan provides that once a participant is eligible for Medicare, benefits are reduced by the total amount paid by all primary plans, including Medicare. JA 825. Gates enrolled in Medicare on August 1, 2010 and, pursuant to the Copay Plan's terms, her coverage was deemed secondary to Medicare. Id.

The Summary Plan Description ("SPD") of the Copay Plan contains "Coordination of Benefits" provisions which provide that the participant's benefit is calculated by subtracting (1) "the benefit payments paid or provided by all Coverage Plans Primary to this Coverage Plan" (i.e., benefit payments paid by Medicare) from (2) "the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan." (i.e., the benefit payments covered by the Copay Plan if there were no Medicare coverage). JA 177. Furthermore, the SPD states that "Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if: The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules." JA 178.

¹ Effective May 1, 2012, Gates was terminated as a participant in the Copay Plan and enrolled in another of the Alliance Plans, the United Healthcare Indemnity Plan. JA 825. Only one of the claims referenced in the complaint was submitted to this plan. JA 829.

The lawsuit centers on United's "estimating policy," which it employs whenever a participant is Medicare-eligible and receives services from an opt-out provider. See Special Appendix ("SA") 45. In such circumstances, United estimates what Medicare would have paid if a participating Medicare provider had been used and then deducts this amount from the total claim to determine the appropriate amount to pay. SA 47. Rather than using the fee schedule database provided by the Centers for Medicare and Medicaid Services, which itemizes Medicare payment rates, United simply paid a percentage of the amount the provider actually billed. Id. Gates claims that by using this "estimating policy," United overestimates the amounts Medicare would have paid and thereby greatly reduces the total amount that it reimburses claimants under the plans it administers. JA 827-829. Moreover, Gates claims that prior to the commencement of her suit, United never explained in any manner how the estimation policy worked. Plaintiff-Appellant's Brief 13-14.

On seven occasions between July 2010 and February 2011, Gates received medical care from providers who opted-out of Medicare and submitted claims to United. SA 5. Each time, she submitted a claim to United and alleges that United calculated too large an offset of Medicare benefits and that, as a consequence, she received substantially less than the amount to which she was entitled. JA 827-829. Plaintiff appealed the adverse benefit determinations but may not have fully

exhausted available plan remedies after United denied her initial appeals before filing suit in federal court. See SA 31-32.

Plaintiff pleads seven claims. As relevant to the Secretary's brief, the first count challenges United's method for offsetting estimated Medicare payments and on this basis seeks additional benefits. Count three is brought under section 502(a)(3) for injunctive and declaratory relief against the Plans based on their failure to follow section 503 and the claims procedure regulation. The fourth count is brought against United under sections 409(a), 29 U.S.C. § 1109(a), 502(a)(2) and 502(a)(3) for injunctive and declaratory relief to remedy fiduciary breaches in failing to abide by the claims regulations.

The district court entered summary judgment for defendants dismissing the case in its entirety and with prejudice. SA 59. The court held that plaintiff lacked constitutional standing to bring a section 502(a)(1)(B) benefits claim because she failed to plausibly allege any "injury-in-fact." SA 41. The district court held that the language in the Copay Plan referring to the amount that "would have been payable" was ambiguous and therefore subject to interpretation. SA 56. Because the Copay Plan grants United discretion to interpret plan terms and make benefits determinations, the district court applied an arbitrary and capricious standard of review and held that United's interpretation of the method for determining how much Medicare would have paid was reasonable and therefore controlling. SA 55-

59. On this basis, the district court concluded that plaintiff did not have constitutional standing to assert her claim for benefits. Id. Without separate analysis of the remaining claims, the district court disposed of the entire complaint, concluding that "once Count I is dismissed for lack of standing, the remaining claims similarly fail." SA 59.²

Shortly thereafter, the district court issued an order denying plaintiff's motion for reconsideration in which it reiterated its prior holding: "the lack of standing as to Count I deprives plaintiff of any basis to assert Counts II–VI in the SAC." SA 67.

SUMMARY OF ARGUMENT

1. The district court erred in deferring to United's method of calculating Medicare offset amounts for opt-out providers and in concluding on this basis that Gates lacked constitutional standing to bring her section 502(a)(1)(B) claim for benefits. This holding erroneously conflates Gates' Article III standing with the merits of her claim. Moreover, United violated the Secretary's claims regulation by failing to notify Gates of how her benefits were calculated and by depriving her of the information necessary to assess the validity of the Plans' actions. As set

² The district court also stated that the parties "conceded" that if Gates' section 502(a)(1)(B) claim was dismissed for lack of standing, the remaining claims would similarly fail. SA 59. Plaintiff maintains that no such concession was made. Plaintiff-Appellant's Brief 5-6. The Secretary takes no position on this factual dispute.

forth in the preamble to the Secretary's regulation, deference to a benefit determination is not appropriate where, as here, the fiduciary fails to meet the regulatory minimums for a full and fair process. Accordingly, the district court erred in deferring to United's determination, notwithstanding the fact that United was granted discretion to interpret plan terms and make benefit determinations.

2. Even if the district court were correct in concluding that Gates lacked standing to assert her claim for additional plan benefits, it would not follow that she lacks standing to assert her claims for plan-wide injunctive relief requiring the fiduciaries to operate the plan in compliance with the Secretary's claims regulation. This Court and others have correctly recognized that a plaintiff need not demonstrate individualized harm other than an invasion of a statutory right in order to bring a claim for injunctive relief under section 502(a)(3).

3. Finally, nothing in ERISA precludes a plan participant such as Gates from simultaneously seeking additional plan benefits and seeking injunctive relief requiring plan fiduciaries to comply with ERISA's claims procedure regulation.

ARGUMENT

I. THE DISTRICT COURT ERRED IN DEFERRING TO UNITED'S BENEFIT DETERMINATION AND IN CONCLUDING, ON THAT BASIS, THAT GATES LACKED CONSTITUTIONAL STANDING TO BRING HER BENEFITS CLAIM

A plan participant must establish both statutory standing and constitutional standing to file suit under ERISA. Kendall v. Employees Ret. Plan of Avon

Products, 561 F.3d 112, 118 (2d Cir. 2009). Gates has standing to sue for benefits under section 502(a)(1)(B) because she seeks additional plan benefits as a participant in at least one of the Alliance Plans. See 29 U.S.C. § 1132(a)(1)(B) ("[a] civil action may be brought (1) by a participant or beneficiary (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").³

Gates also has constitutional standing to bring her claim for benefits. The "case or controversy" clause of Article III of the U.S. Constitution imposes a minimum constitutional standing requirement on all litigants bringing suit in federal court. See U.S. Const. art. III. "The three elements comprising Article III standing are well established: a plaintiff must show (1) an 'injury in fact'—an invasion of a legally protected interest that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical; (2) a causal connection between the plaintiff's injury and the challenged conduct; and (3) that it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." Faber v. Metro. Life Ins. Co., 648 F.3d 98, 102 (2d Cir. 2011), citing Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992).

³ As explained in footnote 1, supra, Gates was terminated as a participant in the Copay Plan and enrolled in the Indemnity Plan on May 1, 2012, which Gates asserts was administered in the same manner with regard to a Medicare offset. See SA 42, JA 825.

The district court held that Gates' first claim failed to meet the first element of constitutional standing, the "injury-in-fact" requirement. SA 59. The district court found that the claims administrator was granted discretion to interpret plan terms and make benefit determinations and accordingly its interpretations must be reviewed under an "arbitrary and capricious" standard. SA 58. Reasoning that United's interpretation of the relevant plan terms was rational, the court concluded that it was required to defer to this interpretation even though Gates also proffered a rational interpretation of how the offset should work under the Plan terms. Id. On this basis, the court concluded that Gates lacked a constitutionally cognizable injury.

As an initial matter, the district court erred in conflating the merits of Gates' claim for benefits with her standing for Article III purposes. Even if the court were correct in deferring to United's interpretation of the "allowable expenses" provisions, this determination is not determinative of the standing inquiry. Gates' claim that she was wrongly denied benefits under the terms of her plan satisfies the "injury-in-fact" requirement for constitutional standing to raise her claim for benefits even if she ultimately loses. See Warth v. Seldin, 422 U.S. 490, 498-99, 500 (1975) (noting that "the standing question is whether the plaintiff has 'alleged such a personal stake in the outcome of the controversy' as to warrant [] invocation of federal court jurisdiction and to justify exercise of the court's remedial powers

on his behalf," an inquiry that "in no way depends on the merits of the plaintiff's contention that particular conduct is illegal") (citations omitted).

Moreover, the court erred by deferring to United's interpretation without first determining whether, as Gates contends, United failed to meet the requirements of the claims regulations in making its claims determination. ERISA section 503 requires ERISA plans to provide "adequate notice in writing" to any participant or beneficiary whose claim has been denied, and to afford them a "reasonable opportunity for full and fair review" by a named fiduciary of such denial. 29 U.S.C. § 1133. Section 503 expressly delegates to the Secretary of Labor the regulatory authority to define these requirements, which the Secretary has done through detailed regulations governing procedures for processing claims. 29 C.F.R. § 2560.503-1; see also Aetna Health Inc. v. Davila, 542 U.S. 200, 220 (2004) (noting that "[t]he relevant regulations ... establish extensive requirements to ensure full and fair review of benefit denials"). The regulations require ERISA plans to provide specific procedures applicable to a claim for benefits and detail, among other things, the manner and content of the initial notification and any appeal (29 C.F.R. §§ 2560.503-1(g), (j)), and the appeal process necessary to ensure full and fair review of the claim and adverse benefit determination (29 C.F.R. § 2560.503-1(h)). Moreover, although ERISA generally requires exhaustion of a plan's claims process before commencing suit for benefits in

federal court, Alfarone v. Bernie Wolff Constr., 788 F.2d 76, 79 (2d Cir. 1986), under the claims regulations, a claimant is "deemed to have exhausted the administrative remedies available under the plan" and the participant may bring suit under ERISA section 502(a) and "pursue any available remedies" under that section if a plan fails "to establish or follow claims procedures consistent with the requirements" of the regulations. 29 C.F.R. § 2560.503-1(l). And, in the preamble to this regulation, the Secretary stated that this "deemed exhausted" provision was designed "to clarify that the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference." 65 Fed. Reg. 70246, 70255 (Nov. 21, 2000) (emphasis added).

The claims regulation was issued after notice-and-comment rulemaking pursuant to an express delegation of authority to the Secretary to determine procedures for full and fair review of benefit denials. 29 U.S.C. § 1133. Therefore, the regulation's terms govern and are entitled to controlling deference under Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842-44 (1984). Moreover, the Secretary's interpretation of his own regulation, stated in the contemporaneous preamble to the regulation, is entitled to the highest degree of deference. See, e.g., Yellow Trans., Inc. v. Mich., 537 U.S. 36, 45 (2002) (giving Chevron deference to interpretation that was made in regulatory preamble); Auer

v. Robbins, 519 U.S. 452, 462 (1997); cf. City of Arlington, Tex. v. F.C.C., 133 S. Ct. 1863, 1874 (2013) (agency interpretation entitled to Chevron deference where Congress granted general rulemaking authority to agency and "interpretation at issue was promulgated in the exercise of that authority").

Gates alleges not only that United's adverse benefit determinations deprived her of benefits to which she was entitled under the Copay Plan, but also that United failed to explain how it calculated the Medicare offset. Although two of these denials summarily state that United "processed this claim after estimating how much Medicare Parts A and/or B would have covered," JA 1208, 1215, none of them provide any explanation as to how the calculations were actually made, i.e., that United estimated the amount Medicare "would have" paid for opt-out providers by applying the percentage payment rate to the provider's billed charge. See JA 1202-1216. Furthermore, none of these initial denials refer to the particular part of the Copay Plan on which the benefit determinations were based. Id.

In issuing the deficient denials, United violated the regulatory requirements of 29 C.F.R. § 2560.503-1(g) because the denials failed to: (1) state the "specific reason or reasons for the adverse determination;" (2) reference the "specific plan provisions" on which the denials were based; (3) inform Gates of any additional material or information necessary to perfect her claims; and, (4) with one exception

(see JA 1212), failed to inform her of her right to receive a copy of any internal rule or any other similar criterion relied upon in making the adverse benefit determination. Additionally, Gates claims that when she requested information during the claims process about how United made its calculations, it refused to provide her with this information, in violation of 29 C.F.R. §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8).

The claims procedure regulation's express goal is "to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims." See 65 Fed. Reg. 70,246 (Nov. 21, 2000). Critically, the regulation sets forth a broad definition of "relevant" information, as including information that "was relied upon in making the benefit determination." 29 C.F.R. § 2560.503-1(m)(8). Thus, "relevant" information under the regulation clearly encompasses the information that Gates sought here concerning how United calculates the Medicare offset. Indeed, in an earlier order in the case, the district court correctly found that plaintiff's allegations were sufficient to permit a reasonable inference that defendants did not substantially comply with ERISA's claim procedures. SA 33.

A district court must review de novo a denial of benefits challenged pursuant to section 502(a)(1)(B), unless the benefit plan gives the administrator

discretionary authority to determine eligibility for benefits or interpret plan terms, in which case a deferential standard of review generally applies. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Hobson v. Metro. Life Ins. Co., 574 F.3d 75, 82 (2d Cir. 2009). In this case, the SPD for the Copay Plan provides United discretionary authority to interpret terms and make factual determinations related to the Copay Plan and its benefits. See JA 189. Even assuming that the SPD reflects a grant of discretionary authority in the governing plan documents,⁴ however, the district court erred in applying a deferential standard of review to United's interpretation of the Copay Plan because, as detailed supra, United failed to comply with the requirements of 29 C.F.R. § 2560.503-1 in issuing benefit determinations to plaintiff.

The violations asserted here are not inadvertent or harmless deviations.⁵ At no point during the claim process did United explain the methodology it employed in calculating the amount Medicare "would have" paid for the rendered services

⁴ Although United appears to rely on the SPD as setting forth the relevant plan terms, as did the court below, the Supreme Court in CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011), held that an SPD is not a governing plan document for purposes of a benefit claim.

⁵ Thus, these deviations from the regulations are not of the type described by the Secretary in FAQs about the claims regulation, which states that such inadvertent deviations from procedures otherwise "in full conformity with the regulation" will not trigger the deemed exhausted provision where "the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, though internal appeal process or otherwise."

http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

and this fundamental failure permeated the claims procedure and decision-making process by preventing plaintiff from understanding and thus from fully addressing the basis for United's denial of her claims for additional benefits. Under the claims regulations, these violations entitled Gates to de novo review by the district court of her claim for benefits, and the district court's dismissal of her suit based on deference to United's interpretation of the Copay Plan's terms was in error. See Nichols v. Prudential Ins. Co. of Am., 406 F.3d 98, 109 (2d Cir. 2005) (addressing timeliness violations under the prior claims regulation, this Court held that "a 'deemed denied' claim is entitled to de novo review"); see also LaAsmar v. Phelps Dodge Corp. Life, Accidental Death & Dismemberment & Dependent Life Ins. Plan, 605 F.3d 789, 800 (10th Cir. 2010).

II. PLAINTIFF HAS CONSTITUTIONAL STANDING TO BRING CLAIMS FOR INJUNCTIVE RELIEF

Section 502(a)(2) authorizes a civil action "by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under [section 409 of the Act]." 29 U.S.C. § 1132(a)(2). Section 409(a) (entitled "Liability for breach of fiduciary duty") provides in turn that a fiduciary with respect to a plan who breaches the fiduciary duties imposed by the Act "shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits [], and shall be subject to such other equitable or remedial relief as the court may deem appropriate." 29 U.S.C. § 1109(a) (emphasis

added). Section 502(a)(3) authorizes suit "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) (emphasis added). Gates asserts that the claims procedure employed by the defendants violates the claims regulations in various fundamental respects as we have described. On this basis, she seeks injunctive relief under ERISA sections 502(a)(2) and 502(a)(3) requiring the Alliance Plans and United to comply with ERISA section 503 and its accompanying regulations, 29 C.F.R. § 2560.503-1.

Even if the district court were correct in concluding that plaintiff lacked standing to assert her claim for benefits based on its conclusion that it must defer to United's calculation of benefits, it would not follow that plaintiff lacks standing to assert the claims procedure counts seeking injunctive relief, and dismissal on this basis was in error. The Second Circuit has "drawn a distinction" between constitutional standing to seek injunctive relief and constitutional standing to seek other types of relief. Faber, 648 F.3d at 102, citing Cent. States Se. & Sw. Areas Health & Welfare Fund v. Merck–Medco Managed Care, L.L.C., 433 F.3d 181, 199-200 (2d Cir. 2005); Kendall, 561 F.3d at 119-21. In Central States, this Court held that a plaintiff "may have Article III standing to obtain injunctive relief related

to ERISA's disclosure and fiduciary duty requirements without a showing of individual harm[,]" whereas "[o]btaining restitution or disgorgement under ERISA requires that a plaintiff satisfy the strictures of constitutional standing by demonstrating individual loss; to wit, that they have suffered an injury-in-fact." 433 F.3d at 199-200 (citation and internal quotation marks omitted); see also id. ("[The] fiduciary duties contained in ERISA create in [plaintiff] certain rights, including the right[] ... to have [defendant] act in a fiduciary capacity. Thus, [plaintiff] need not demonstrate actual harm in order to have standing to seek injunctive relief requiring that [defendant] satisfy its statutorily-created ... fiduciary responsibilities.") (quoting Horvath v. Keystone Health Plan East, Inc., 333 F.3d 450, 456–57 (3d Cir. 2003)). Other circuits have similarly held that a plaintiff need not demonstrate actual harm in order to have standing to seek injunctive relief requiring a fiduciary to satisfy its statutorily-created fiduciary responsibilities. See, e.g., Loren v. Blue Cross & Blue Shield of Mich., 505 F.3d 598, 610 (6th Cir. 2007); Horvath, 333 F.3d at 456; Gillis v. Hoechst Celanese Corp., 4 F.3d 1137, 1148 (3d Cir. 1993). Thus, even if Gates did not have standing to challenge the benefits determination because she suffered no "injury in fact" based on United's calculation of the Medicare offset, this does not preclude standing to bring suit for injunctive relief with regard to the claims procedure that United employs in making benefits determinations.

The cases most analogous to this one come from the Sixth Circuit. In Loren v. Blue Cross & Blue Shield of Mich., 505 F.3d 598 (6th Cir. 2007), the Sixth Circuit held that the plaintiffs lacked standing to bring benefit claims pursuant to section 502(a)(1)(B) because their alleged injury was too speculative, but found that the plaintiffs had standing to seek injunctive relief based on the fiduciary's breach of ERISA's disclosure and fiduciary responsibilities because a showing of individualized harm was not required. Id. at 609-10, citing Horvath, 333 F.3d at 456. Similarly, in Hill v. Blue Cross & Blue Shield of Mich., 409 F.3d 710 (6th Cir. 2005), the Sixth Circuit allowed claims to proceed for plan-wide injunctive relief under section 502(a)(3) based on systemic faulty claims administration or benefit calculations. Id. at 718. But cf. Korotynska v. Metro. Life Ins. Co., 474 F.3d 101, 103-105 (4th Cir. 2006) (dismissing a section 502(a)(3) claim that defendant "breached its fiduciary duties by engaging in systematically flawed and abusive claims administration procedures" where plaintiff admitted that her purpose in seeking section 502(a)(3) relief was "to enable her to recover the benefits to which she is entitled.").

Thus, the district court's reliance on Kendall v. Employees Ret. Plan of Avon Products, 561 F.3d 112 (2d Cir. 2009), is misplaced. See SA 67. In Kendall, this Court concluded that "[e]ven in cases where plaintiffs need not show an individualized harm, they must still allege some injury in the form of a deprivation

of a right as a result of a breach of fiduciary duty conferred by ERISA." 561 F.3d at 120. Because the plaintiff in Kendall did not allege a deprivation of such a right, the court concluded that she failed to allege an injury-in-fact sufficient for constitutional standing. Id. at 121. Unlike the plaintiff in Kendall, Gates alleged not just a fiduciary breach but that the breach resulted in the deprivation of her right to receive information and a full and fair review of her claims as required by the Department's claims regulation. Therefore, she has alleged a sufficient injury for constitutional standing. See id. at 120-21 (citing Horvath, 333 F.3d at 456, where "the participants did not have to show that they were specifically injured, pecuniarily or otherwise, [but] they did have to show that they were generally harmed by the deprivation of a specific right to receive information").

III. PLAINTIFF MAY BRING CONCURRENT CLAIMS FOR BENEFITS AND FOR PLAN-WIDE INJUNCTIVE RELIEF FOR CLAIMS PROCEDURE VIOLATIONS

In the district court, the Alliance defendants argued that Gates is precluded from simultaneously pleading benefit claims pursuant to section 502(a)(1)(B) along with claims for equitable relief under section 502(a)(3). ECF No. 77 at 13-14. United also claimed that plaintiff could not simultaneously seek injunctive relief under sections 502(a)(2) and 502(a)(3). ECF No. 80 at 17-18. This is not the case.

As an initial matter, the Alliance defendants were not correct that plaintiff "already received all the remedy due to her for an alleged violation of ERISA claims procedure" because the district court deemed exhausted plaintiff's section 502(a)(1)(B) claim and let her proceed with her claim in court. ECF No. 77 at 13. Nor were they correct to rely on Varity Corp. v. Howe, 516 U.S. 489, 512 (1996), to argue that Gates may not "seek any additional equitable remedy pursuant to ERISA § 502(a)(3), which is merely a 'catch-all' remedial provision in circumstances where other ERISA provisions do not adequately remedy a plaintiff's alleged harm." ECF No. 77 at 13, 14.

In Varity, the Court addressed the scope of the phrase "appropriate equitable relief" under section 502(a)(3) in a case where plaintiffs alleged that they had been led to withdraw from their employee benefit plan by misrepresentations that their employer made as a plan fiduciary. In holding that the plaintiffs could pursue such an individual claim for equitable relief in the form of an injunction reinstating them to the plan, the Court cautioned that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" Varity, 516 U.S. at 514-15. Thus, the Court made clear that plaintiffs could not repackage claims that were really 502(a)(1)(B) benefit claims as 502(a)(3) claims for

"appropriate equitable relief," in order to do an end run around the claims process and exhaustion rules that normally apply to benefit claims under 502(a)(1)(B).

In this case, Gates appears to be proceeding not under the "appropriate equitable relief" prong of section 502(a)(3), but under a separate clause authorizing suit by a participant "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan" (namely by not complying with the claims regulation). Seen in this light, Gates' call for injunctive relief under section 502(a)(3) simply does not implicate Varity's concern with whether the "equitable relief" being sought is "appropriate" within the meaning of 502(a)(3). Instead, Gates is entitled to relief under ERISA's unqualified and express authorization "to enjoin any act or practice" which violates the statute, without regard to the scope of ERISA's separate authorization of "appropriate equitable relief."

In any event, although some courts have erroneously applied Varity's logic to dismiss fiduciary breach claims for injunctive relief in circumstances when no remedy is available under 502(a)(1)(B) and the participant challenges more than the mere denial of benefits, e.g., Tolson v. Avondale Indus., Inc., 141 F.3d 604, 610 (5th Cir. 1998), other courts, including the Second Circuit, correctly recognize that a plaintiff may pursue relief under section 502(a)(3) either where no relief is available under section 502(a)(1)(B), or where different relief is sought on the fiduciary claim and the benefit claim. See, e.g., Devlin v. Empire Blue Cross &

Blue Shield, 274 F.3d 76, 89 (2d Cir. 2001); Hall v. LHACO, Inc., 140 F.3d 1190, 1197 (8th Cir. 1998); Miele v. Pension Plan of New York State Teamsters Conference Pension & Ret. Fund, 72 F. Supp. 2d 88, 105 (E.D.N.Y. 1999); Warzecha v. Nutmeg Cos., Inc., 48 F. Supp. 2d 151, 165 (D. Conn. 1999).

In Devlin, the Second Circuit held that "Varity Corp. did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available; instead, the district court's remedy is limited to such equitable relief as is considered appropriate." 274 F.3d at 89-90 (emphasis added). Rather than precluding a plaintiff from simultaneously pleading a 502(a)(1)(B) and 502(a)(3) claim, the Second Circuit held that the district court must simply "fashion appropriate relief" if the 502(a)(3) claim is successful. See 274 F.3d at 90; see also Frommert v. Conkright, 433 F.3d 254, 272 (2d Cir. 2006) (holding that district court's determination of "appropriate equitable relief" must be based on ERISA policy, the special nature and purpose of employee benefits plans, and consideration of any relief afforded under a section 502(a)(1)(B) claim) (internal quotations and citations omitted).

Moreover, a "fiduciary-duty claim based on allegations of systemic, plan-wide claims-administration problems" is distinct from a personal claim for the reimbursement of benefits under section 502(a)(1)(B) because "[o]nly injunctive relief of the type available under [section 502(a)(3)] will provide the complete

relief sought by [p]laintiffs by requiring [Defendant] to alter the manner in which it administers" all the claims. Hill, 409 F.3d at 718. And the Supreme Court has likewise recognized that "a plan administrator's refusal to pay contractually authorized benefits," if "willful and part of a larger systematic breach of fiduciary obligations," could entitle plan fiduciaries to seek removal of the fiduciary under sections 409(a) and 502(a)(2). Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985).

Thus, Gates appropriately brought a benefit claim under section 502(a)(1)(B) and fiduciary breach claim pursuant to section 502(a)(3) because she seeks very different relief on the two claims. Her benefits claim seeks the recovery of benefits that were denied based on United's method for offsetting actual or hypothetical Medicare payments. In contrast, her claim under section 502(a)(3) primarily seeks an order enjoining United and the Alliance Plans to comply with the ERISA claims regulation regarding, among other things, the explanation of any denial of benefits. Thus, plaintiff's claim under section 502(a)(3) is in no sense a disguised or repackaged claim for benefits. Both the basis of the claim (fiduciary violation of claims procedure regulation), and the remedies sought in connection with the fiduciary breach claims (injunctive relief ordering defendants to provide a claims procedure in accordance with ERISA), are wholly distinct from and in addition to her benefit claims.

Defendants nevertheless maintained below that section 502(a)(1)(B) is the sole avenue for challenging violations of the claims regulation, noting that subpart (l) of the claims procedure regulation provides that a participant's claim is "deemed exhausted" if a plan fails to provide procedures that meet the requirements of the regulation. 29 C.F.R. § 2560.503-1(l). In their view, this regulatory provision effectively means that the sole remedy for a violation of the claims procedure regulation is deemed exhaustion and the immediate right to pursue a 502(a)(1)(B) action in federal court. The regulation, however, says no such thing. The "deemed exhausted" provision does not even address how claimants can obtain remedies for systemic violations of the claims regulation, as alleged here. Instead, the provision, like all of the claims regulation, governs the participant's pursuit of her claim to recover benefits, not her claims for equitable relief to redress fiduciaries' statutory violations. As explained above, the import of the "deemed exhausted" provision is simply that claimants may treat the claims process as exhausted if the plan fails to comply with the minimum terms for a full and fair process, so that the claimant may immediately seek the award of benefits in court, which need not defer to the claims administrator's decision.

In this case, the plaintiff does not merely seek an award of benefits. She also seeks injunctive relief for the fiduciaries' violations of the statute and of the claims regulation. The claims regulation governs benefit claims, not claims for injunctive

relief to remedy fiduciary breaches, and the "deemed exhausted" provision is wholly beside the point with respect to these claims. For this reason, numerous courts have correctly held that while exhaustion of a plan's claims procedure is normally required before a participant or beneficiary can bring suit for benefits under section 502(a)(1)(B), there is no such requirement before bringing an ERISA claim of breach of fiduciary duty. See, e.g., Milofsky v. Am. Airlines, Inc., 442 F.3d 311, 312 (5th Cir. 2006) (en banc); Harrow v. Prudential Ins. Co. of Am., 279 F.3d 244, 252-53 (3d Cir. 2002); Smith v. Sydnor, 184 F.3d 356, 364-65 (4th Cir. 1999); Horan v. Kaiser Steel Ret. Plan, 947 F.2d 1412, 1416 n.1 (9th Cir. 1991), overruled on other grounds by Salomaa v. Honda Long Term Disability Plan, 642 F.3d 666 (9th Cir. 2011); Fujikawa v. Gushiken, 823 F.2d 1341, 1345 (9th Cir. 1987); but see Bickley v. Caremark RX, Inc., 461 F.3d 1325, 1328 (11th Cir. 2006) (requiring exhaustion of fiduciary breach claims); Lindemann v. Mobil Oil Corp., 79 F.3d 647, 649-50 (7th Cir. 1996) (court has discretion to require exhaustion of ERISA claims). More importantly, plaintiff's claim that she and the members of the class of participants in similar plans are injured by the defendants' failure to abide by the claims regulation would not be in any way remedied by an award of benefits.⁶ Thus, the "deemed exhausted" provision of the claims regulation is

⁶ The Secretary does not take any position on whether Gates is entitled to represent this class.

irrelevant with regard to plaintiff's 502(a)(3) claims in the third count of her complaint.

Similarly, nothing in ERISA precludes Gates from simultaneously asking for injunctive relief under ERISA section 502(a)(3) and seeking similar relief under sections 409(a) and 502(a)(2). Gates was permitted to bring her fourth claim for equitable relief pursuant to both sections 502(a)(2) and 502(a)(3) because, as an Alliance plan participant, she "explicitly comes within the class of persons that ERISA contemplates as bringing breach of fiduciary duty claims under both provisions." Moeckel v. Caremark RX Inc., 385 F. Supp. 2d 668, 677-78 (M.D. Tenn. 2005) (holding that plaintiff participant and beneficiary of prescription drug plan could bring fiduciary breach claims under both sections 502(a)(2) and 502(a)(3)); see also Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock, 861 F.2d 1406, 1417 (9th Cir. 1988) (holding that plaintiffs could seek constructive trust on ill-gotten profits in favor of all plan participants under either section 502(a)(2) or section 502(a)(3)). Ordinary principles of civil procedure permit the joinder of alternative – and even inconsistent – claims in a single action. See Fed. R. Civ. P. 8(a)(3), 8(d)(2). Nothing in ERISA modifies this black letter rule. If, for example, the court affirms dismissal of plaintiff's fourth claim to the extent that it is brought under section 502(a)(2), she should still be entitled to litigate her claim pursuant to section 502(a)(3). Cf. CIGNA Corp. v. Amara, 131

S. Ct. 1866, 1882 (2011) (remanding to allow ERISA plaintiffs to proceed with their section 502(a)(3) claim after holding that section 502(a)(1)(B) did not provide the relief sought).

Nor are defendants correct to suggest, as they did below, that Gates' claim under section 502(a)(2) must be dismissed because she did not allege any losses to the Alliance Plans. Section 502(a)(2) authorizes equitable relief on behalf of the plan itself, as well as monetary recovery to compensate for a plan's losses or to disgorge improper profits from a fiduciary. See LaRue v. DeWolff, Boberg & Associates, Inc., 552 U.S. 248, 251 (2008) ("Section 502(a)(2) provides for suits to enforce the liability-creating provisions of § 409, concerning breaches of fiduciary duties that harm plans."). The relief available under section 502(a)(2) is not limited, as is section 502(a)(3), to "appropriate equitable relief." Instead, through reference to section 409(a), section 502(a)(2) permits courts to impose personal liability on breaching fiduciaries for plan "losses," to require fiduciaries to restore to the plan any improper "profits" made by plan fiduciaries, and to subject them to "such other equitable or remedial relief as the court may deem appropriate." See 29 U.S.C. § 1109(a). Under the express terms of these provisions, the available relief encompasses not only the return of losses suffered by a plan, but also other appropriate "equitable or remedial relief," including an injunction, removal, or an accounting. See Brock v. Robbins, 830 F.2d 640, 647-48 (7th Cir. 1987) (even

where imprudence does not result in loss to plan, "other remedies such as injunctive relief can further the statutory interests"). Therefore, plaintiff is not required to plead plan losses in order to allege fiduciary breach under section 502(a)(2) because by its terms, ERISA does not require the plaintiff to demonstrate loss where the desired relief is not monetary damages. See 29 U.S.C. § 1109(a).

CONCLUSION

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

Respectfully submitted,

M. PATRICIA SMITH
Solicitor of Labor

TIMOTHY D. HAUSER
Associate Solicitor

ELIZABETH HOPKINS
Counsel for Appellate and
Special Litigation

/s/ Syma Ahmad
SYMA AHMAD
Trial Attorney
United States Department of Labor
Plan Benefits Security Division
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(d) and 32(a)(7)(B)-(C), I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains 6,634 words.

Dated: September 19, 2013

/s/ Syma Ahmad
SYMA AHMAD
Trial Attorney
United States Department of Labor
Plan Benefits Security Division
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210

CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of September, 2013, I electronically filed the foregoing Brief of The Secretary, United States Department of Labor, as Amicus Curiae, in Support of Plaintiff-Appellant and Requesting Reversal, with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Syma Ahmad
SYMA AHMAD
Trial Attorney
United States Department of Labor
Plan Benefits Security Division
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210