No. 12-17604

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SPINEDEX PHYSICAL THERAPY USA INCORPORATED, et al.,
Plaintiffs-Appellants

v.

UNITED HEALTHCARE OF ARIZONA, INC., et al.,
Defendants-Appellees

Appeal from the United States District Court
for the District of Arizona, Phoenix
Case No. 2:08-CV-00457-ROS

BRIEF OF SETH D. HARRIS, ACTING SECRETARY OF LABOR, AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANTS AND REQUESTING REVERSAL

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STATEMENT OF THE ISSUES

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

1. Whether the district court erred in holding that plaintiffs, participants in various health care plans and their assignee medical providers, lacked standing to assert their claims for benefits under ERISA, on the ground that their assignee medical providers had not demonstrated that they planned to collect the unpaid medical bills from the participants.

2. Whether plaintiffs should be deemed to have exhausted their plans' procedures for review of benefit claims because defendants failed to follow a reasonable claim procedure as required by the Secretary of Labor's claims-processing regulation.

3. Whether the district court erred in dismissing plaintiffs' fiduciary breach claims challenging systematic, plan-wide violations of the Secretary's claims-processing regulation and of ERISA's prohibited transaction provisions, on the ground that plaintiffs had not administratively exhausted those claims.

STATEMENT OF IDENTITY, INTEREST AND AUTHORITY TO FILE

The Secretary of Labor ("Secretary") has primary regulatory and enforcement authority for Title I of ERISA. See 29 U.S.C. §§ 1134, 1135. Pursuant to that authority and to ERISA section 503, 29 U.S.C. § 1133, which expressly delegates to the Secretary rulemaking authority with respect to the "full and fair review" of benefit claims that the statute mandates, the Secretary issued a regulation that governs claims procedures applicable to such claims. See 29 C.F.R. § 2560.503-1(l).

Plaintiffs – plan participants, beneficiaries, and their physical therapy provider assignees – allege that the plan participants and beneficiaries validly assigned their benefit claims to their providers and that both the assignors and their assignees may bring a civil action challenging United Healthcare's benefit denials which were determined under a process that systematically violated the claims regulation. The district court found that the fiduciaries "regularly" failed to comply with numerous claims regulation provisions, but nevertheless granted defendants summary judgment on Article III standing grounds – concluding that plaintiffs suffered no injury-in-fact – because the provider-assignees had not pursued their patient-assignors for the unpaid medical bills and because some participants had not exhausted their plans' claims procedures.

The Secretary has a strong interest in ensuring that providers are not barred from pursuing their claims merely because they have not billed their patients directly. The Secretary also has a strong interest in ensuring that plans are operated in compliance with regulatory requirements designed to ensure a full and fair review process and that, consequently, participants are excused from the requirement to exhaust a claims process that fails to comply with the regulatory requirements. Likewise, the Secretary has a strong interest in ensuring that, because the claims process was not intended or designed to apply to fiduciary breach claims, plaintiffs are not required to invoke or exhaust this process before suing for fiduciary breach.

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

STATEMENT OF THE CASE

I. Factual Background

Plaintiffs challenge certain systematic and wide-spread claims processing practices by United Healthcare of Arizona and its affiliates (collectively "United"), as well as denials or partial denials of thousands of benefit claims for physical therapy received by patients of Spinedex Physical Therapy, U.S.A., Inc. ("Spinedex") and of members the Arizona Chiropractic Society ("ACS"). Except for Count V (a statutory penalties

claim), plaintiffs' claims were brought as a putative class action by Spinedex, ACS, two named participants (Aragon and Adams), and over 50 unnamed participants and beneficiaries on behalf of the participants and beneficiaries of 45 named group health ERISA plans administered and insured by United, and other plans covering similarly situated participants and beneficiaries.

Count I alleges that defendants violated ERISA sections 404, 29 U.S.C. § 1104, and 503 by systematically violating numerous requirements for claims determinations mandated by ERISA section 503 and its implementing regulation. 7 Excerpts of Record ("ER") 1672-79 (alleging, among other things, that United improperly requires more than two appeals of adverse benefit determinations, fails to provide relevant, requested materials to claimants, and fails to issue decisions that contain mandated information and that meet regulatory time limits).

Count II alleges that, to increase their profits, defendants violated ERISA section 406, 29 U.S.C. § 1106, by systematically delaying benefit payments due and owing under the plans' terms and by selecting their own subsidiary, Ingenix, to make flawed determinations of usual and customary reimbursement rates. 7 ER 1679-80.

Count IV alleges that defendants violated ERISA section 502(a)(1)(B) by denying or improperly calculating reimbursement rates for physical therapy benefit claims. 7 ER 1681-82. Plaintiffs seek the improperly denied benefits (id.) and clarification of their right to recover benefits under the plans. Id. at 1681. Plaintiffs also allege that they exhausted their plan procedures even though exhaustion was both futile and excused under 29 C.F.R. § 2560.503-1(l) because defendants did not establish and follow reasonable claims procedures and systematically violated the claims regulation. 7 ER 1682.

In the "Prayer for Relief," the complaint seeks not only an award of benefits and declaratory relief under section 502(a)(1)(B), but also injunctive and "appropriate equitable relief" under ERISA sections 502(a)(2) and 502(a)(3), 29 U.S.C. §§ 1132(a)(2), 1132(a)(3). 7 ER 1684-85.

At the time of treatment, each participant executed a "functionally identical" assignment to Spinedex which stated, in relevant part:

> For the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to [Spinedex], and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

1 ER 4. Seven of the 45 plans include terms that restrict or preclude assignment; however, the remaining 38 plans contain no provision restricting assignment. 7 ER 1500-01, and 1532.

II. Procedural History and Rulings

The rulings at issue were made in two unpublished orders granting defendants summary judgment issued on March 30, 2011 and October 24, 2012. The March 30, 2011 Order had four key rulings. First, it dismissed plaintiffs' benefit claims on standing grounds, ruling that neither Spinedex, as assignee of unnamed Participant 1, nor participants Adams or Aragon had suffered an injury in fact because they did not prove that Spinedex had or would seek to collect and enforce the unpaid benefit claims against its patients. 1 ER 15. Second, it ruled that Participant 1's assignment was insufficient to convey the right to bring fiduciary breach claims. Id. at 21.[1] Third, it ruled that Participants 2, 4, 5, Adams, and Aragon failed to exhaust their plan procedures and did not show that exhaustion would be futile or that such procedures should be "deemed exhausted" under 29 C.F.R. § 2560.503-1(l). Id. at 22-23. While finding that defendants "regularly"

[1] The court also ruled that the text of the assignment here was insufficient to assign fiduciary breach claims, 1 ER 7, an issue that the Secretary does not address.

violated certain claims regulation provisions by failing to cite the plan provision that purportedly supported claim denials and by failing to provide clear notice of the right of the participant to file suit under ERISA, the court ruled that defendants' noncompliance was "harmless." Id. at 23-24, n. 12. On this basis, the court concluded that, even if the plaintiffs had standing, they failed to exhaust their plan procedures and dismissal was also warranted on that basis. Id. at 23-25. Fourth, it ruled that plaintiffs' fiduciary breach claims were "disguised" benefit claims and, therefore, plaintiffs were required, but had failed, to exhaust plan procedures for those claims. Id. at 26. The court explained that the fiduciary breach claims "depend upon Defendants' alleged 'improper claims determinations,' " and thus "are inextricably linked to the merits" of the benefit claims. Id. On these rationales, the court granted defendants summary judgment on plaintiffs' fiduciary beach claims. Id.

The district court later issued a second order dismissing the remaining benefit claims on standing grounds. 1 ER 3. Because the court found no "evidence that collection efforts were 'certainly impending,'" id. at 3 (quoting Whitmore v. Arkansas, 495 U.S. 149, 159 (1990)), it concluded that plaintiffs suffered no injury for constitutional standing purposes. Id. The court then dismissed Spinedex as assignee on the same basis, concluding

that because the participants lack standing, "Spinedex lacks standing to sue on their behalf." Id.

Moreover, it granted defendants summary judgment against Aragon's fiduciary breach claims (which it termed "statutory claims") on grounds that he failed to exhaust plan procedures. Id. at 7. The court also held that his benefit determination was made within the applicable time limits, concluding that the administrator sent a valid notice requesting a 15-day extension under 29 C.F.R. § 2560.503-1(f)(2)(iii)(B). Id.

SUMMARY OF THE ARGUMENT

1. Both the individual plan participants whose claims for medical benefits were denied, and their assignees, who provided medical care with the apparent understanding that they could obtain reimbursement from United as administrator and insurer of the various ERISA-covered health care plans, have constitutional standing to sue for denied benefits under ERISA. Whether or not the medical providers are likely to sue the participants directly for their services, the participants are injured in the requisite sense not only because they retain an unextinguished debt, but more fundamentally because they have the statutory right to have their promised medical benefits paid. The medical providers also clearly are injured because they have provided unreimbursed care. Given that this

Court and others have long recognized the rights of medical assignees to sue for ERISA benefits, United's insistence that the providers sue or threaten to sue plan participants before demanding that United pay the providers directly for covered services, flies in the face of common sense and ERISA's protective purposes. The district court therefore erred in dismissing the plaintiffs' benefit claims for lack of Article III standing.

2. The district court also erred in insisting that the plan participants exhaust claims procedures that they allege and that the district court found failed to meet numerous requirements set forth in the Secretary's claims processing regulation. In the preamble to and text of the claims regulation, the Secretary determined that failure to provide a claims procedure that meets the regulatory requirement entitles the plan participant to treat the deficient claims process as having been exhausted. This regulatory pronouncement and the Secretary's interpretation of the regulation to excuse any failure to exhaust in this case are entitled to the highest level of deference.

3. Even if plan participants were required to exhaust a deficient process for determining benefit claims before they could sue for benefits, no such exhaustion is required of their claims that United breached its fiduciary duties in systematically violating the claims regulation, delaying payments

and using its own subsidiary to incorrectly set reimbursement rates. This Court has held that exhaustion of a plan's claims review process is only required for benefit claims. The claims here of systematic, plan-wide claims-administration problems are not simply disguised benefit claims and the district court therefore erred in dismissing them for failure to exhaust.

ARGUMENT

I. The District Court Erred In Ruling that Plaintiffs Lacked Constitutional Standing to Bring Their Benefits Claims

Article III of the United States Constitution requires a party invoking federal court jurisdiction to show an "injury in fact," a causal relationship between the injury and the challenged conduct, and likelihood of redressibility. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992). "Injury in fact" exists when: (1) there is "an invasion of a legally protected interest"; (2) that" is "concrete and particularized"; and (3) is "actual or imminent, not conjectural or hypothetical." Lujan, 504 U.S. at 560; see Glanton v. AdvancePCS, Inc., 465 F.3d 1123, 1125 (9th Cir. 2006).

The district court erred in ruling that the individual participants suffered no cognizable injuries, and therefore lacked Article III standing to assert their benefit claims, because they failed to prove that Spinedex was likely to sue them for the medical bills their plans refused to pay. When Congress gave participants statutory standing to sue for benefits due to them

"under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B), and the right to a "full and fair" review of their claims, 29 U.S.C. § 1133, it gave plaintiffs all the personal stake in this dispute necessary to render a judicial resolution. In alleging that they were denied contractually promised benefits and that their claims were reviewed under plan procedures that denied them the minimum procedures mandated by section 503 and § 2560.503-1, plaintiffs met all justiciability requirements for a "case or controversy" and presented the court with a factual context that was "concrete and particularized," not "conjectural or hypothetical." Lujan, 504 U.S. at 560.

Although Spinedex sought reimbursement from United rather than directly billing patients, and on this basis United argues the debt has been extinguished, the unrebutted evidence indicates that Spinedex routinely informed its patients at the start of treatment that they were ultimately responsible for paying their medical bills and that some participants received communications to that effect. 13 ER 2903-3045; 14 ER 3047-3242; 15 ER3453, 3455-58, 3460; 15 ER3451; 19 ER4652-53. If this evidence is credited, individual participants are left with an unextinguished debt to Spinedex on which it could collect. Their continued indebtedness to Spinedex is a direct injury and is sufficient to establish Article III standing, whether or not Spinedex produced ledgers showing a balance due from each

patient, as United incorrectly argued it was required to do. See James v. City of Dallas, Tex., 254 F.3d 551, 564 (5th Cir. 2001) (the "continued threat of collection actions . . . based on the unpaid debt also suffices to demonstrate the likelihood of real and immediate future injury" for Article III purposes).[2]

Moreover, a medical care provider like Spinedex can sue for benefits under section 502 as assignee. The relevant injury is caused by the plan's failure to pay for covered services at the plan's promised rate. See 29 U.S.C. § 1132(a)(1)(B) (authorizing a participant to sue to "enforce his rights under the terms of the plan"). Although ERISA expressly authorizes only participants or beneficiaries to sue for such payments, courts, including the Ninth Circuit, have uniformly recognized that medical provider assignees have derivative standing to sue for these benefits. See, e.g., Davidowitz v. Delta Dental Plan, Inc., 946 F.2d 1476, 1477 (9th Cir. 1991) ("[a] health care provider with an allegedly valid assignment has the same standing [as the beneficiary]" and may sue under ERISA); Misic v. Building Serv. Employees Health & Welfare Trust, 789 F.2d 1374, 1739 (9th Cir. 1986)

[2] Even were the debt expressly forgiven, participants likely would still have standing based on their liability for federal income tax on the amount of the forgiven debt. See 26 U.S.C. 61(a)(12) ("[i]ncome from discharge of indebtedness" included in definition of gross income for income tax purposes).

(provider assignee has standing under section 502(a)(1)(B) to recover unpaid benefits); cf. Sprint Communications v. APCC Servs., 554 U.S. 269, 287-88 (2008) (holding that "an assignee can sue based on his assignor's injury," and standing for collection exists even when relief will not run to party suing as when trustees sue "to benefit their trusts"). To the extent that the plans at issue here did not prohibit such assignments, the participants had every reason to believe that the plans would make direct payments to their medical providers if they did assign their claims. Thus, both the participants and the providers are injured if the plan does not pay their claims as assignee.

Given these principles, the only circuit to address constitutional standing in this context correctly concluded that medical provider assignees have ERISA standing to sue for unpaid benefits without first pursuing or "balance billing" patients for unpaid benefits. HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co., 240 F.3d 982, 991 (11th Cir. 2001). The Eleventh Circuit reasoned that because the "'provider-assignees can sue … an assignment will transfer the burden of bringing suit from plan participants to providers, [who] are better situated and financed to pursue an action for benefits owed services.'" HCA, 240 F.3d at 991 (quoting Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997)).

ERISA is designed to promote the interests of plan participants and beneficiaries, and to protect contractually defined benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-14 (1989). The Eleventh Circuit's ruling furthers ERISA's remedial purposes by allowing medical providers to obtain reimbursement for covered services without first billing participants. See HCA, 240 F.3d at 991 n. 19 (noting that one reason "for allowing provider assignees derivative standing is so that providers will not balance bill participants, thereby requiring participants to bring suit against their insurance company for unpaid benefits"); see also Misic, 789 F.2d at 1377 (in upholding benefit claim assignments to providers, court observed that assignment would facilitate receipt of health care benefits by making "it unnecessary for [] providers to evaluate the solvency of patients before commencing medical treatment" and sparing them the burden of paying potentially large medical bills while waiting for reimbursement from their plans).

Accordingly, both the participant plaintiffs and the provider-assignee of their claims have a direct, pecuniary interest in the case sufficient to satisfy the Article III "injury in fact" requirement for standing. But, more generally, their constitutional standing is also established under Supreme Court and Ninth Circuit precedents recognizing that the "injury required by

Article III may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing.'" Lujan, 504 U.S. at 578 (quoting Warth v. Seldin, 422 U.S. 490, 500 (1975); see Edwards v. First American Corp., 610 F.3d 514, 517-18 (9th Cir. 2010) (recognizing that the "invasion of a statutory right," without further injury, constituted an injury in fact under Real Estate Settlement Procedures Act ("RESPA"), 12 U.S.C. § 2601, sufficient to create Article III standing), cert. granted in part, 131 S. Ct. 3022 (2011), cert. dismissed as improvidently granted, 132 S. Ct. 2536 (2012). Thus, the invasion of plaintiffs' statutory right to have their benefit claims determined in accordance with their plan terms and the minimum procedures mandated by section 503 and § 2560.503-1, and to have their covered benefits paid, gave them a concrete, personal stake in this case and, thus, for that reason alone, the "injury in fact" required for Article III standing.

Havens Realty Corp. v. Coleman, 455 U.S. 363 (1982), best illustrates this principle. There, the Supreme Court considered whether "testers" who posed as renters or real estate buyers to gather evidence of "unlawful steering practices" had Article III standing to sue under the Fair Housing Act (FHA), 42 U.S.C. § 3604, when they were falsely told that housing was unavailable. Id. at 373. The Court explained that the FHA "conferred on all 'persons' a legal right to truthful information about available housing." Id.

Because an Article III injury can exist "solely" by virtue of "'statutes creating legal rights,'" and the "tester" has "suffered an injury in precisely the form the statute was intended to guard against," id., the Court held that a tester who "alleged injury to her statutorily created right to truthful housing information" had Article III standing, even if she never intended to rent or buy the property. Id. at 374.

Similarly, in Edwards, the Ninth Circuit ruled that a purchaser of real estate settlement services met the "injury in fact" element of Article III standing to assert a claim that a bank providing those services on her mortgage violated RESPA by paying illegal kickbacks for exclusive mortgage referrals, even if she was not overcharged. Citing Warth, 422 U.S. at 500, the Court reasoned that "the standing question … is whether the constitutional or statutory provision on which the claim rests properly can be understood as granting persons in the plaintiff's position a right to judicial relief." Edwards, 610 F.3d at 517. Because the "damages provision in RESPA gives rise to a statutory cause of action whether or not an overcharge occurred," the Ninth Circuit concluded that plaintiff had proved an injury sufficient to satisfy Article III. Edwards, 610 F.3d at 517. When the statutory text is "'unambiguous,'" the court held, its "inquiry begins with the

statutory text, and ends there." Id. (quoting Satterfield v. Simon & Schuster, Inc., 569 F.3d 946, 951 (9th Cir. 2009)).

Like RESPA's damages provision, the text of sections 502(a)(1)(B) and 503 is clear; those provisions give participants an interest in the benefits promised under their plans and the right to have their claims determined under plan procedures that comply with the minimum procedures mandated by section 503 and § 2560.503-1. Congress has identified the injury it seeks to vindicate, i.e., improper denial of benefits, 29 U.S.C. § 1132, and related the injury to the class of persons entitled to bring suit, i.e., participants and beneficiaries, id. § 1132(a)(1)(B). Like RESPA, ERISA plainly and unambiguously permits a federal action by a participant or beneficiary "to recover benefits due" under a plan's terms, "to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of plan," see Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53 (1987) (under section 502(a)(1)(B), relief may include "accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits"), an action the Ninth Circuit has long held may be assigned. Misic, 789 F.2d at 1377. The statutory text is "unambiguous" that a participant or beneficiary may sue to obtain benefits due under a plan (or indeed to obtain clarification that benefits are or will be

due) and that should be the beginning and end of the inquiry. Edwards, 610 F.3d at 517.

The district court ignored the clear import of Edwards by distinguishing between benefit claims and other ERISA claims. 1 ER 3, n.3. It reasoned that Edwards has "no application in the context of an ERISA claim for benefits because … [u]nlike RESPA, ERISA 502(a)(1)(B) does not create a claim (i.e., a statutory injury) which otherwise would not exist; it merely provides that claims for employee benefits, which previously would have been presented under common law theories such as breach of contract, are preempted." Id. (emphasis in original). This is not true. ERISA does more than preempt state law in the benefits context, and while the plan terms define substantive benefits, it is federal law that creates the federal cause of action to enforce or clarify the right to promised benefits. Chappel v. Lab. Corp. of Am., 232 F.3d 719, 724 (9th Cir. 2000) (noting the distinction between rights and benefits accorded "by the statutory provisions of ERISA itself" and rights and benefits provided "by the contractual terms of the benefits plan").

Likewise, the district court incorrectly distinguished HCA Health Services on the basis that, unlike the medical providers there, Spinedex wrote off the accounts and provided no evidence "of an intent to reinstate"

them. 1 ER 16. Not only is this counter-factual, it subverts ERISA's protective purposes by leading to the anomalous result that only the hapless participant or beneficiary unlucky enough to be sued or likely to be sued by his healthcare provider has standing to pursue a civil action under section 502(a)(1)(B) against a fiduciary that wrongly denied benefits due to him under his plan terms. This contradicts the plain text of 502(a)(1)(B) and ERISA's statutory purposes. Central Laborers' Pension Fund v. Heinz, 541 U.S. 739, 743 (2004) (ERISA's primary goal is "protecting employees' justified expectations of receiving the benefits their employers promise.").

For these reasons, the district court erred in characterizing this dispute as speculative under Article III.[3] It is not. The participant who is promised

[3] The court inaptly relies on Whitmore v. Arkansas, 495 U.S. 149 (1990), for this point. Whitmore involved a third party asserting a claim as next friend to a death row inmate based on an invasion of federal rights that had not yet occurred and would not occur unless three improbable events (grant of habeas corpus, retrial and conviction for murder, and reimposition of the death penalty) all occurred first. 495 U.S. at 151, 165-66. This case is readily distinguishable in that it does not concern speculative injuries claimed by third parties that have not yet occurred and are unlikely to occur. It is undisputed that Spinedex provided medical care for which it was not paid or was underpaid. The other cases the court cited are also entirely distinguishable. Owen v. Regence Bluecross Blueshield of Utah, 388 F. Supp. 2d 1318, 1328-29 (D. Utah 2005) (plaintiff lacked standing under ERISA where she was not covered by policy at issue, had no definite intention to buy it, and could identify no "legally-protected interest"); Ross v. Albany Med. Ctr., 916 F. Supp. 196, 200 (N.D. N.Y. 1996) (Medicare beneficiary lacked standing to seek relief based on "speculative" fear that expressly forgiven debt might be reinstated), aff'd, No. 96-6019, 1996 WL

that the plan will pay for covered health care and receives care from a provider that may forego direct collection from the participant (and may refuse to provide such services in the future without advanced payment) is injured because he has not received the "benefits due under the plan." And the assignee stepping into the participant's shoes is even more obviously injured because the plan denied payment for services provided.

II. Because The Fiduciaries Did Not Follow The Claims Procedures Mandated by Regulation, Plaintiffs Are Deemed To Have Exhausted These Procedures With Respect To Their Benefit Claims

ERISA itself does not explicitly require claimants to exhaust plan procedures before filing a civil action to obtain benefits under a plan. Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008). In this, as in every other Circuit, however, a claimant generally "must exhaust available administrative remedies" before filing suit for benefits. Barboza v. Cal. Ass'n of Prof'l Firefighters, 651 F.3d 1073, 1076 (9th Cir. 2011). "However, when a [plan] fails to establish or follow 'reasonable claims procedures' consistent with the requirements of ERISA, a

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626349 (2d Cir. Oct. 30, 1996); Bryant v. American Seafoods Co., No. 08-35690, 2009 WL 3241904 (9th Cir. Oct. 9, 2009) (seaman lacked standing to pursue personal injury claims where no "medical provider was dissatisfied with [the] initial payment").

claimant need not exhaust because his claims will be deemed exhausted." Id. (quoting 29 C.F.R. § 2560.503–1(l)).

Thus, the exhaustion requirement presupposes that a plan has provided a "full and fair review," as required by section 503 of ERISA, 29 U.S.C. § 1133, and the claims regulation implementing section 503 and defining the minimum elements of a full and fair review process. When a plan fails to provide the required process, section (l) of the claims regulation explicitly authorizes claimants to file suit:

> In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

29 C.F.R. § 2560.503-l (l). As courts have correctly recognized, this "'deemed exhausted' provision was plainly designed to give claimants faced with inadequate claims procedures a fast track into court." Eastman Kodak Co. v. STWB, Inc., 452 F.3d 215, 221 (2d Cir. 2006); accord Barboza, 651 F.3d at 1078 (under regulation, plan procedures are "deemed exhausted" and plaintiffs may sue without further resort to the process where plan fails to give a claimant a timely determination); Linder v. BYK Chemie USA Inc., 313 F.Supp.2d 88, 94 (D. Conn. 2004) ("regulation is unequivocal that any

failure to adhere to a proper claims procedure is sufficient to deem administrative remedies exhausted").

The Secretary designed § 2560.503-l (l) to ensure that specified minimum requirements are followed by plan fiduciaries in deciding benefit claims under ERISA, including: (1) that notice of the plan term upon which the decision was based be given to the claimant (§ 2560.503-l(g)(1)(ii)); (2) that a decision denying or partially denying a claim contain a "description of the plan's review procedure and the time limits applicable to such procedure, including a statement of the claimant's right to bring a civil action under section 502 of [ERISA] following an adverse benefit determination on review" (§ 2560.503-1(g)(1)(iv)); and (3) that claims be decided within specified time limits unless the fiduciary deciding the claims properly extends the time for doing so (§ 2560.503-1(f)(2)(iii)(B)).

Here, the district court imposed an exhaustion requirement despite finding that defendants "regularly" disregarded these and other core provisions of the claims regulation. 1 ER 23-24, n.12. Section 503 and the regulation would be undermined if plans could ignore these provisions (and others, as plaintiff allege) while still holding claimants to an inadequate process. Without confronting the impact of its finding that defendants "regularly" violated multiple claims regulation provisions, the court ruled

that defendants "substantially complied" with the claims regulation. Id. at 23, citing Robinson v. Aetna Life Ins. Co., 443 F.3d 389, 392-93 (5th Cir. 2006). As the Secretary's interpretive guidance explains, however, while inadvertent and harmless deviations from the claims regulation do not permit a participant to abandon plan procedures, "systematic deviations from the plan procedures, or deviations not susceptible to meaningful correction through plan procedures, such as the failure to include a description of the plan's review procedures in a notice of an adverse benefit determination, would justify a court determination that the plan failed to provide a reasonable procedure." FAQ F-2, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

Thus, while de minimis deviations may be excused in certain circumstances, nothing excuses the behavior at issue here, particularly given the district court's own finding that United "regularly" violated multiple provisions. See Barboza, 651 F.3d at 1076 ("when [a plan] fails to establish or follow 'reasonable claims procedures' …, a claimant need not exhaust because his claims will be deemed exhausted. 29 C.F.R. § 2560.503–1(l)"), citing Eastman Kodak, 452 F.3d at 223 (ruling that plaintiff's ERISA claim should have been deemed exhausted under section 2560.503–1(l) and concluding that "substantial compliance" is insufficient) and Vaught, 546

F.3d at 633 (same). For this reason, the Robinson decision relied upon by the district court in no way supports its conclusion that United's deviations from the regulation should be excused. See, e.g., Robinson, 443 F.3d at 394 (insurance company did not "substantially comply" with section 503 where its shifting justifications for denial and its failure to disclose the identity of its expert "amount to more than mere technical noncompliance or a *de minimis* violation").

Instead, the regulation, issued pursuant to notice-and-comment rulemaking under an express delegation of authority in ERISA section 503, clearly establishes that such deviations are not harmless but instead deprive claimants of the notice and full and fair claims procedure to which they are statutorily entitled. As the preamble states, "[a] plan's failure to provide procedures consistent with [the regulation's] standards would effectively deny a claimant access to the administrative review process mandated by [ERISA]. . . . At a minimum, claimants denied access to the statutory administrative review process should be entitled to take that claim to court … for a full and fair hearing on the merits of the claim." 65 Fed. Reg. 70246, 70256 (Nov. 21, 2000). The Secretary has thus logically concluded that a claimant need not engage in such a deficient process but may, instead, proceed directly to court to assert his or her claim for benefits.

Ninth Circuit and Supreme Court precedent make clear that the Secretary's regulatory choices under ERISA are entitled to controlling deference provided they are reasonable. Tibble v. Edison Intern'l, 711 F.3d 1061, 1071 (9th Cir. 2013) (citing Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984)). See also City of Arlington Tex. V. FCC, --- S. Ct. ---, 2013 WL 2149789, at *10 (May 20, 2013) ("preconditions to Chevron deference are satisfied because Congress unambiguously vested the [government agency] with general authority to administer the [federal] Act through rulemaking and adjudication and the agency interpretation at issue was promulgated in the exercise of that authority"). On this basis, the Ninth Circuit, citing the preamble statement and claims regulation, has correctly ruled that failure to comply with a single regulatory requirement is sufficient to deem plan procedures exhausted and allow a claimant to sue for benefits. Barboza, 651 F.3d at 1079 (ruling that plan procedures were deemed exhausted when it failed to meet the time deadlines for disability claims established by § 2560.503–1(i)); cf. Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997) (no deference due to denial that failed to provide information mandated under the regulation).

Here, the multiple procedural violations are no less significant than the timeliness issue in Barboza, and the same failure to communicate addressed in Booton is also present here. Further exhaustion of the deficient process therefore was not required, and plaintiffs' action should not have been dismissed on exhaustion grounds. The Secretary's reasonable interpretation of her own regulation in this regard is entitled to the highest degree of deference. See, e.g., Yellow Trans., Inc. v. Michigan, 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) (same for interpretation presented in brief).

III. The District Court Erred In Dismissing The Fiduciary Breach Claims For Failure To Exhaust Claims Procedures

Even if any failure to exhaust were not excused by United's deficient claims review procedure, plaintiffs were not required in any event to exhaust this procedure before filing suit for fiduciary breaches. The district court thus erred when it dismissed Adams' and Aragon's prudence and loyalty claims (Count I), and their prohibited transaction claims (Count II), given well settled Ninth Circuit precedent holding that fiduciary breach claims are not subject to an exhaustion requirement. See, e.g., Horan v. Kaiser Steel

Retirement Plan, 947 F.2d 1412, 1416 n.1 (9th Cir. 1991); Fujikawa v. Gushiken, 823 F.2d 1341, 1345 (9th Cir. 1987).[4]

The district court recognized that fiduciary breach claims are not subject to exhaustion requirements in the Ninth Circuit but nevertheless concluded that the particular claims made by Adams and Aragon were "inextricably linked to the merits" of their benefit claims and therefore subject to an exhaustion requirement as "disguised" benefit claims. 1 ER 26. This is not so.

As discussed, plaintiffs alleged – and the court found – that defendants "regularly" violated critical claims regulation provisions. Accordingly, the plaintiffs seek not only recovery of their benefits, but also injunctive relief enjoining United from further violations of ERISA and the claims regulation and from serving as ERISA fiduciaries. Such a "fiduciary-duty claim based on allegations of systemic, plan-wide claims-

[4] As these courts and others have recognized, in the context of benefit claims, the exhaustion requirement is rooted in an express statutory provision, section 503, requiring plans to adopt procedures ensuring full and fair review of benefit claims in conformance with the Secretary of Labor's regulations. In contrast, no provision of ERISA expressly or implicitly requires exhaustion of plan procedures before a participant may bring suit in federal court alleging that plan fiduciaries have breached their statutory duties. Moreover, requiring exhaustion would be particularly pointless here where some of the fiduciary breaches complained of revolve around the failure to provide the full and fair process that the statute and regulations require.

administration problems" is distinct from an individual benefit claim under section 502(a)(1)(B) because "[o]nly injunctive relief … available under § 1132(a)(3) will provide the complete relief sought by Plaintiffs by requiring [defendant] to alter the manner in which it administers all … claims." Hill v. Blue Cross & Blue Shield of Mich., 409 F.3d 710, 711 (6th Cir. 2005). As the Supreme Court has explained, "a plan administrator's refusal to pay contractually authorized benefits," if "willful and part of a larger systematic breach of fiduciary obligations," may support an action for injunctive relief, such as removal of the breaching fiduciary under sections 409(a) and 502(a)(2), 29 U.S.C. §§ 1104(a), 1132(a)(2). Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 147 (1985).

Unlike a section 502(a)(1)(B) benefit claim where the participant alleges procedural violations affecting only his individual claim, plaintiffs here seek relief for fiduciary breaches under sections 502(a)(2) and 502(a)(3) based on assertions of procedural violations that are "systemic, plan-wide claims-administration problems." Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc., 661 F. Supp. 2d 1076, 1089 (D. Az. 2009) (citing Russell, 473 U.S. at 147; Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008)). As the district court acknowledged, where procedural violations common to individual benefit claims are "part

of a larger systematic" design, they may constitute a "breach of fiduciary obligations" separate and apart from section 502(a)(1)(B) benefits claims. Spinedex, 661 F. Supp. 2d at 1098.

Because the fiduciary breach claims here are primarily based on systematic violations of the claims regulation, the district court erred in relying on Diaz v. United Agricultural Employee Welfare Ben. Plan & Trust, 50 F.3d 1478, 1484 (9th Cir. 1995). In the district court's view, Diaz was dispositive because the validity of the fiduciary breach claims turns "on the merits of Plaintiffs' claim that the benefit claims were improperly denied," and they are thus merely "disguised" claims for benefits. 1 ER 25-26. But the plaintiffs' claims for injunctive relief for repeated violations of the claims regulation in this case in no way depends on a determination of whether any of the individual plaintiffs were entitled to benefits. In Diaz, the participant sought to recover his individual benefits under section 502(a)(1)(B) despite his failure to exhaust the plan's appeal procedures based on the fiduciary plan administrator's failure to give him notice of his appeal rights in Spanish. Here, by contrast, in addition to their claims for benefits, plaintiffs assert and the court found that United "regularly" violated multiple provisions of the claims regulation with respect to numerous participants, and the plaintiffs seek systematic reform of the plans' procedures. Compare

Korotynska v. MetLife Ins. Co., 474 F.3d 101, 103-05 (4th Cir. 2006) (dismissing section 502(a)(3) claim that defendant "breached its fiduciary duties by engaging in systematically flawed … procedures" where plaintiff admitted that she sought section 502(a)(3) relief to recover her benefits), with Hill, 409 F.3d at 711 (distinguishing fiduciary-duty claim based on "allegations of systemic, plan-wide claims-administration problems" from individual section 502(a)(1)(B) benefit claims).

Furthermore, in their prohibited transaction claim (Count II), plaintiffs allege that United Healthcare violated section 406, 29 U.S.C. § 1106, by selecting its own subsidiary to determine claims and reimbursement rates. 7 ER 1680-81. Other than the identity of the parties, this claim does not share any common facts with the claims for benefits. And with regard to both Counts I and II, the basis of these claims (fiduciary breaches and prohibited transactions) and some of the relief sought (injunctive relief ordering defendants to operate in compliance with ERISA, prohibiting them from serving as fiduciaries and equitable relief undoing the prohibited transactions), are wholly distinct from and in addition to the benefit claims. Thus, the court had no factual basis for finding that these fiduciary breach claims were merely "disguised" benefit claims or that they were "inextricably linked to the merits" of plaintiff's claims for benefits, and

therefore had no legal basis for dismissing Counts I and II for failure to exhaust.

CONCLUSION

The Secretary respectfully requests that the district court's decision be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE OF BRIEFS
AND VIRUS CHECK

Pursuant to Rules 32(a)(7)(B) and (C), Fed. R. App. P., I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains 6,609 words.

I certify that the digital version and hard copies of the Secretary's Brief are identical. I further certify that a virus scan was performed on the Brief using McAfee, and that no viruses were detected.

Dated: June 5, 2012

/s/ Marcia Bove
MARCIA BOVE
Senior Trial Attorney

CERTIFICATE OF SERVICE

I hereby certify that on the 5th day of June, 2013, true and correct copies of the foregoing - THE SECRETARY OF LABOR'S AMICUS CURIAE BRIEF IN SUPPORT OF PLAINTIFFS-APPELLANTS-were filed electronically with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system and served electronically via email to the Participants in the case who are registered CM/ECF users of the appellate CM/ECF system.

I further certify that one of the participants in the case is not a registered CM/ECF user. I have mailed the foregoing document by First-Class Mail, postage prepaid, to the following participant:

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