

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION**

CASE NO.: 19-21258-CIV-GAYLES

RICHARD COLE, on behalf
of himself and all others similarly
situated,

Plaintiff,

v.

UNITED HEALTHCARE
INSURANCE COMPANY,

Defendant.

DEFENDANT'S MOTION TO DISMISS PLAINTIFF'S AMENDED COMPLAINT

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Pursuant to Federal Rule of Civil Procedure 12(b)(6), Defendant UnitedHealthcare Insurance Company (“UHIC”) respectfully moves the Court for the entry of an Order dismissing Counts I, III, and IV Plaintiff’s Amended Complaint for failure to state a claim.¹

INTRODUCTION

In his Amended Complaint, Plaintiff brings claims pursuant to ERISA sections 502(a)(1)(b) and 502(a)(3), codified at 29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(3). Am. Compl. ¶¶ 92, 104, 109, 112. The Supreme Court has described the civil enforcement provisions of § 1132(a) as “carefully integrated” and as an “interlocking, interrelated and interdependent” part of a “comprehensive and reticulated statute.” *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

ERISA’s civil enforcement scheme has different subsections that give rise to separate and distinguishable causes of action, demand proof of different elements, are available against only certain defendants, and provide various and differing forms of relief. *LaRue v. DeWolff, Boberg & Assoc., Inc.* 552 U.S. 248, 258-59 (2008) (Roberts, J. concurring) (discussing distinctions between §§ 1132(a)(1)(B), (a)(2), and (a)(3)). As relevant here, § 1132(a) allows a participant (or beneficiary) of an ERISA-governed plan to bring a civil action (1) to recover benefits due

¹ While this motion does not seek dismissal of Plaintiff’s ERISA section 1132(a)(1)(B) claim (Count II), UHIC reserves the right to challenge that claim, and any other claim that may survive the instant Motion, at the appropriate time, including challenging Plaintiff’s entitlement to reimbursement under his health benefits plan or other relief sought on behalf of himself or a class, or that this action may proceed as a class action. *See, e.g., Ferk v. Mitchell*, No. 14-CV-21916, 2014 WL 7369646, at *1 (S.D. Fla. Dec. 29, 2014) (permitting defendant to file answer after partial motion to dismiss was decided); *Beaulieu v. Bd. of Trustees of Univ. of W. Fla.*, No. 07-cv-30, 2007 WL 2020161, at *2 (N.D. Fla. July 9, 2007) (collecting cases examining Rule 12(a)(4) and Rule 12(b)(6) and concluding that “a party need not file an answer while a partial motion to dismiss is pending” as “Defendant’s motion to dismiss . . . automatically extends its time to answer under Rule 12(a)(4) until after the court has ruled on Defendant’s motion to dismiss”).

under, enforce rights under, or clarify rights to future benefits under the terms of the plan; (2) to enjoin any act or practice which violates any provision of ERISA or the terms of the plan; and (3) to obtain “other appropriate equitable relief (i) to redress [] violations [of ERISA] or the terms of the plan or (ii) to enforce any provisions of [ERISA] or the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B), (a)(3)(A), (a)(3)(B). As the Supreme Court has recognized, this detailed remedial scheme reflects a “careful balancing” between “competing congressional purposes,” *Varity Corp. v. Howe*, 516 U.S. 489, 497, 538 (1996), which must be taken into account when addressing ERISA claims:

ERISA represents a careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. . . . ERISA induces employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.

Conkright v. Frommert, 559 U.S. 506, 517 (2010) (quotations and citations omitted); *see also Aetna Health v. Davila*, 542 U.S. 200, 215 (2004) (recognizing that “limited remedies available under ERISA are an inherent part of the ‘careful balancing’ between” competing goals).

Accordingly, the Supreme Court has declined to tamper with “an enforcement scheme crafted with such evident care as the one in ERISA.” *Mass. Mut.*, 473 U.S. at 147; *see also Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-64 (1993) (*see also Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-64 (1993) (declining to expand liability to non-fiduciaries and describing ERISA as “an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs.”).

Against this backdrop, Plaintiff’s claims ignore a number of important ERISA pleading requirements. First, Plaintiff asks this Court to impose an independent fiduciary obligation on UHIC in connection with its development of coverage policies, independent of UHIC’s **application** of those policies in making determinations about claims for benefits under the plan

terms. To the extent Plaintiff asserts that theory in his breach of fiduciary duty claim in Count I, it should be dismissed because no such independent obligation exists under ERISA § 1132(a)(1)(B). Second, to the extent that Plaintiff seeks to represent beneficiaries of self-funded plans for which UHIC functions only as a third-party administrator, Plaintiff has not sufficiently pled that UHIC is a fiduciary of those self-funded plans as necessary to state an ERISA claim. Third, Counts III and IV for equitable relief under § 1132(a)(3) are impermissibly duplicative of Plaintiff's claim for damages brought in Count II under § 1132(a)(1)(b). And fourth, Plaintiff's Count IV likewise does not state a claim for surcharge, restitution, or disgorgement because Plaintiff's only alleged injury is a denial of benefits that is indistinct from his claim brought in Count II under § 1132(a)(1)(B). For these reasons, the Court should dismiss Counts I, III, and IV of Plaintiff's Amended Complaint.

SUMMARY OF ALLEGATIONS IN AMENDED COMPLAINT

Each of Plaintiff's four, overlapping Counts is based on the allegation that UHIC "denied" requests or claims for plan benefits for Proton Beam Radiation Therapy ("PBRT") through its "application of an arbitrary medical policy." Am. Compl. ¶ 1; *see also id.* ¶¶ 95, 105, 109, 112-113. Plaintiff was issued a Certificate of Coverage ("COC") as a beneficiary of a fully insured plan administered by UHIC. *Id.* ¶ 42.² The COC excludes coverage for services that are not "medically necessary" or which are "experimental or investigational or unproven." *Id.* ¶¶ 42-44. Plaintiff quotes and incorporates provisions of the COC into his Complaint.

² Generally, for a fully-insured employer-sponsored health plan the insurance carrier pays health care claims based on the coverage benefits outline in the policy that the employer purchased, while for a self-insured health plan the employer operate their own plan and ultimately is responsibly for making benefit payments. Self-funded plans often use a third-party administrator to provide claims processing or other services for the plan. *See generally* Am. Compl. ¶¶ 22, 66.

Plaintiff alleges that UHIC had authority under his fully insured plan to interpret plan terms and determine benefits in its “sole discretion.” *See, e.g., id.* ¶¶ 21, 41-42. Plaintiff alleges that UHIC abused its discretion by denying his claim for benefits with regard to PBRT, which Plaintiff sought for treatment of the prostate cancer with which he was diagnosed in April 2018. *See, e.g., id.* ¶¶ 4, 32, 35, 63, 100 (alleging that an “arbitrary and capricious” standard applies to determinations that UHIC made within its discretion). Plaintiff alleges that UHIC denied his request for pre-authorization of PBRT and upheld this decision in response to an internal appeal submitted by Plaintiffs’ provider. *See, id.* ¶¶ 51-54. As alleged, Plaintiff also requested “an external review,” in which an outside company also determined that PBRT was not a covered service under his plan. *See, e.g., id.* ¶¶ 55, 61.

Plaintiff alleges that UHIC denied his request for PBRT pursuant to a policy in place prior to January 1, 2019, under which UHIC allegedly categorically denied coverage for PBRT to treat prostate cancer in persons aged 19 or older. *Id.* ¶ 7, 34. Plaintiff alleges that UHIC’s development and application of the policy was arbitrary and capricious because “peer-reviewed studies have validated the safety and effectiveness of PBRT,” that “PBRT is safe and effective and is a generally accepted standard of medical practice,” and that “its use is entirely consistent with prevailing medical research.” *Id.* ¶¶ 27, 28, 65. But Plaintiff does not identify these “peer-reviewed” studies or even whether the studies analyzed PBRT in relation to prostate cancer. Nonetheless, Plaintiff also conclusorily alleges that “PBRT has been recognized for decades by the medical community as an established, medically appropriate treatment for cancer, including prostate cancer,” that “[t]here is overwhelming evidence that PBRT is safe and effective,” and that it is “effective for treatment” of prostate cancer. *Id.* ¶¶ 5, 27, 65. Plaintiff likewise does not, however, support these conclusions with specific, plausible factual allegations.

In his Amended Complaint, Plaintiff alleges both individual and class claims for denial of plan benefits and equitable relief under ERISA. *Id.* ¶¶ 101, 106, 109, 115. Plaintiff defines the putative class as consisting of “[a]ll participants or beneficiaries in ERISA Plans underwritten or administered by [UHIC] who, based on the application of [the] PBRT Policy in effect prior to January 1, 2019, were denied health insurance coverage for [PBRT] to treat prostate cancer, on grounds that the assertion that it was ‘experimental or investigational.’” *Id.* ¶ 74.

LEGAL STANDARD

A complaint should be dismissed when it fails to allege sufficient factual matter to state a claim to relief that is plausible on its face. Fed. R. Civ. P. 12(b)(6); *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A complaint “must contain either direct or inferential allegations respecting all the material elements to sustain a recovery under some viable legal theory.” *Randall v. Scott*, 610 F.3d 701, 708 n.2 (11th Cir. 2010). Although in considering a motion to dismiss the Court must accept the facts alleged as true, mere “labels and conclusions,” a “formulaic recitation of the elements of a cause of action,” and “naked assertions devoid of further factual enhancement” are insufficient to state a claim. *Iqbal*, 556 U.S. at 678-79. In addition, any factual allegations still must be tested for facial plausibility – that is, there must be “more than a sheer possibility that a defendant has acted unlawfully.” *Id.* at 678; *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 55 (2007).

An ERISA plaintiff must satisfy these same pleading standards. Notably, consistent with *Twombly* and *Iqbal*, the Supreme Court has emphasized that courts have an obligation to scrutinize ERISA class actions at the pleading stage, where the motion to dismiss for failure to state a claim is an “important mechanism for weeding out meritless claims.” *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). This requires a reviewing court to engage

in a “careful, context-sensitive scrutiny of a complaint’s allegations” to ensure that, prior to engaging in costly discovery, the complaint properly states a claim for relief. *Id.*

ARGUMENT

I. To the Extent Count I Asserts an ERISA Breach of Fiduciary Duty Claim That Is Not Based on a Denial of Plan Benefits, It Should Be Dismissed for Failure to State a Claim.

Against ERISA’s carefully integrated and crafted remedial scheme, Plaintiff styles Count I as a claim for “Violations of Fiduciary Obligations” under 1132(a)(1)(B). Am. Compl., ¶ 92. To state a claim for breach of fiduciary duty under ERISA, a plaintiff must plausibly allege that: (1) defendant was a fiduciary of an ERISA-governed plan; (2) defendant was engaged in conduct constituting a breach of its fiduciary duty; (3) defendant’s conduct was within the scope of its capacity as a fiduciary; and (4) defendant’s conduct caused harm to the plan or the plan beneficiary. *Dupree v. Prudential Ins. Co. of Am.*, No. 99-8337-CIV.-JORDAN, 2007 WL 2263892, at *37 (S.D. Fla. Aug. 7, 2007), *as amended* (Aug. 10, 2007)) (same).

Count I is based on the core allegation that UHIC purportedly violated fiduciary duties “by adopting and implementing *a policy* to deny coverage for PBRT based on the experimental and investigational exclusions under its plans, when such a finding was contrary to generally accepted practices and to the terms of the plans.” Am. Compl. ¶ 95 (emphasis added). Plaintiff alleges that “in doing so” UHIC violated its fiduciary obligations under ERISA § 1104(a) to act “solely in the interest of the participants and beneficiaries [] for the exclusive purpose of providing benefits to plan participants and their beneficiaries” and to use “reasonable care, skill, prudence, and diligence [] in accordance with the terms of the plans it administers.” *Id.* ¶¶ 94, 96 (quoting 1104(a)) (internal quotations omitted). Plaintiff thus appears to ask this Court to impose an independent fiduciary obligation on UHIC that separates development of the

guidelines at issue from UHIC’s application of them in making determinations about claims for benefits under the plan terms. To the extent Plaintiff asserts that theory in Count I, it should be dismissed because no such independent obligation exists under ERISA § 1132(a)(1)(B).³

ERISA § 1132(a)(1)(B) allows a plan participant “*to recover benefits* due to him under the terms of his plan, *to enforce his rights* under the terms of the plan, or *to clarify his rights to future benefits* under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B) (emphases added); *see also Varity*, 506 U.S. at 512 (stating that the specific focus of 1132(a)(1) is the “wrongful denial of benefits and information”). Notably, each of these avenues of relief is specifically anchored to the “terms of the plan.” *Nothing* in ERISA’s civil enforcement scheme supports Plaintiff’s effort to allege a breach of fiduciary duty that is distinct from an actual claim for benefits under the terms of the plan itself. *Id.* (discussing remedies under 1132(a)(1)(B) for claims for plan benefits and for “breaches of fiduciary duty with respect to interpretation of plan documents and payment of claims).

This makes sense under ERISA’s statutory framework, which provides that an actor “is a fiduciary with respect to a plan to the extent he exercises any discretionary control respecting management of such plan” or “he has any discretionary authority or discretionary responsibility in the administration of such plan.” 29 U.S.C. § 1002(21)(A). Fiduciary status under ERISA is functional: regardless of status or title, “a party is a fiduciary only ‘to the extent’ that it performs a fiduciary function.” *Cotton v. Massachusetts Mut. Life Ins. Co.*, 402 F.3d 1267, 1277 (11th Cir. 2005) (citing 29 U.S.C. § 1002(21)(A)). Specifically relevant here, “[a] plan administrator

³ To the extent Count I could be construed as challenging UHIC’s application of the PBRT policy in making benefit determinations under Plaintiff’s and putative class members’ plans, it is duplicative of Count II—which purports to assert a claim for “improper denial of benefits” under 1132(a)(1)(B), Am. Compl. ¶¶108-110—and should be dismissed for the reasons set forth in Sections II and III *infra*.

engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents.” *Varity*, 516 U.S. at 511. Accordingly, in assessing whether plaintiff has stated a claim for breach of fiduciary duty, a court should carefully assess whether the defendant was “performing a fiduciary function [under the terms of the relevant plan] when taking the action subject to complaint.” *Pegram v. Herdich*, 530 U.S. 211, 226 (2000).

Here, Plaintiff alleges UHIC violated fiduciary duties in the ***development*** of guidelines for evaluating claims for PBRT for prostate cancer. Am. Compl. ¶¶ 95-96. But simply “adopting” a policy of general applicability is not an independent fiduciary act. *See Johns v. Blue Cross Blue Shield of Michigan*, No. 08-CV-12272, 2009 WL 646636, at *5 (E.D. Mich. Mar. 10, 2009) (noting that plaintiff must allege how the claims procedure itself was improper—not simply that defendant has a “policy” of denying payments). To the extent Count I challenges the PBRT policy ***without regard to UHIC’s interpretation and application of plan terms***, it fails to sufficiently allege that UHIC was exercising discretion in administering the plan as required to plead that UHIC was acting in a fiduciary capacity. *See Larson v. United Healthcare Ins. Co.*, 723 F.3d 905, 917 (7th Cir. 2013) (affirming dismissal of plaintiffs’ breach of fiduciary duty claims that did “not attack the discretionary aspects of claims administration [i.e.,] individual eligibility and benefits determinations” but instead, challenged “decisionmaking about policy terms”—specifically, defendant’s decisions to require copays for chiropractic care in violation of Wisconsin’s chiropractic mandate law—which “are not themselves fiduciary acts”) (internal citation omitted).

Plaintiff’s allegations regarding UHIC’s development of medical policies of supposed general applicability across plans are the sort of non-fiduciary “business decisions” that do not

state a claim for breach of fiduciary duty. *See Am. Psychiatric Assoc. v. Anthem Health Plans*, 50 F. Supp. 3d 157, 169-70 (D. Conn. 2014) (dismissing § 1132(a)(3) fiduciary duty claims “challeng[ing] [defendants’] rate setting on a ‘system-wide’ basis ‘regardless of the particulars of the individual plan’”) (citation omitted); *see also DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 747 (6th Cir. 2010) (holding that insurer was “clearly” “not acting as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefits plan at issue here but were generally applicable to a broad range of health-care consumers”).

Here, the non-fiduciary nature of adopting the PBRT Medical Policy is clear on its face, because the undisputed documents in effect at the time when Plaintiff’s request for authorization of PBRT was denied state plainly the Policy is an interpretative tool and ***did not*** control over the specific terms of any individual beneficiary’s member-specific benefit plan:

This Medical Policy provides ***assistance in interpreting UnitedHealthcare benefit plans***. When deciding coverage, ***the member specific benefit plan document must be referenced***. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Medical Policy is based. In the event of a conflict, ***the member specific benefit plan document supersedes*** this Medical Policy.

See PBRT Medical Policy Effective March 1, 2018 (attached as Exhibit 1-A), at 1; PBRT Medical Policy Effective July 1, 2018 (attached as Exhibit 1-B), at 1 (emphases added).⁴ The act

⁴ Plaintiff’s Amended Complaint specifically invokes UHIC’s Medical Policy regarding PBRT, which is central to Plaintiff’s theory of liability. Am. Compl. ¶¶ 31-36. Plaintiff alleges that his request for authorization of PBRT was denied on March 30, 2018, and that Plaintiff’s appeal of the denial occurred on August 28, 2018. *Id.* ¶¶ 51, 53. Exhibits 1-A and 1-B show the UHIC Medical Policy as it existed on those dates. “[T]he court may consider a document attached to a motion to dismiss without converting the motion into one for summary judgment if the attached

of *adopting* the Policy itself therefore cannot be an independent breach of fiduciary duty actionable under ERISA. The lack of an independent basis for Count I is further evident from the only alleged harm associated with the purported breaches of fiduciary duties: “*denial of coverage* for PBRT” “because their *claims* have been subjected improperly to the E/I Exclusion when PBRT is actually a Covered Health Care Service *within the definition of [UHIC] plans*.” Am. Compl. ¶ 101 (emphases added); *see also id.* ¶ 97 (“UHC artificially decreased the number and value of covered claims”). Thus, as pled, the Amended Complaint implicitly acknowledges that the breach of fiduciary duty claim could only be actionable under § 1132(a)(1)(B) (which is alleged in Count II) when the conduct at issue relates to benefit determinations.

Because Plaintiff’s ERISA breach of fiduciary duty claim challenges UHIC’s adoption of policies rather than the adjudication of benefits under the applicable ERISA plan terms, it is not actionable under § 1132(a)(1)(B), and Count I should be dismissed for failure to state a claim.

II. To the Extent Plaintiff Seeks to Represent Beneficiaries of Plans for Which UHIC Serves Only as a Third-Party Administrator, the Amended Complaint Fails to State a § 1132(a)(1)(B) Claim.

In his Amended Complaint, Plaintiff seeks to represent not only beneficiaries of fully-insured plans, but also self-funded plans for which UHIC functions only as a third-party administrator. Am. Compl. ¶¶ 22-24. Because the Amended Complaint contains only conclusory assertions lumping together these disparate types of plans, and lacks any allegations of fact that UHIC is a fiduciary of self-funded plans, to the extent Plaintiff seeks to represent

document is (1) central to the plaintiff’s claim and (2) undisputed. In this context, ‘undisputed’ means that the authenticity of the document is not challenged.” *Day v. Taylor*, 400 F.3d 1272, 1276 (11th Cir. 2005). “[A] document need not be physically attached to a pleading to be incorporated by reference into it; if the document’s contents are alleged in a complaint and no party questions those contents, we may consider such a document provided it meets the centrality requirement.” *Id.*

participants and beneficiaries of plans for which UHIC acts as a third-party administrator for such plans, those portions of Plaintiff's Counts I and II should be dismissed.

For a plaintiff to state a claim for recovery of benefits under § 1132(a)(1)(B), an entity must do more than decide claims; instead the defendant must have discretion to interpret plan terms and award the benefits at issue. *See generally Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) (holding that the “proper party defendant in an action concerning ERISA benefits is the party that controls administration of the plan” and thus finding third-party claims administrator could not be liable because it had not been delegated any discretionary authority); *Herdrich*, 530 U.S. at 226 (“the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint”); *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288, 289 (11th Cir. 1989) (“ERISA does not regulate the duties of non-fiduciary plan administrators. As such, non-fiduciaries cannot be held liable under ERISA.”).

Here, the Amended Complaint quotes from Plaintiff's “Employer Plan,” which as alleged is a “fully insured plan.” Am. Compl. ¶¶ 3, 41-44. The Amended Complaint does not allege any specific plan language for self-funded plans whatsoever, let alone any plan language that plausibly shows that when UHIC is a third-party administrator for a self-funded plan, it is anything more than a non-fiduciary service provider. *Id.* ¶¶ 22-24, 66, 93. Instead, Plaintiff's allegations merely lump together self-funded plans with Plaintiff's own fully insured plan. *Id.* Thus, Plaintiff's allegation that UHIC “made all the relevant decisions and wielded the authority to issue benefit checks under the ERISA plans” is wholly conclusory and overbroad to the extent

that Plaintiff seeks to involve plans for which UHIC functions as a third-party administrator without discretionary authority to interpret plan terms and to administer each of those plans. *Id.* ¶¶ 22-24.

Plaintiff's effort to obscure this critical distinction through his assertion that UHIC "nevertheless continues to control these accounts" of self-funded clients, *id.* ¶ 23, is patently deficient. *See Ashcroft*, 556 U.S. at 681 (conclusory statements are not entitled to a presumption of truth). A third-party administrator of self-funded plans does not become a fiduciary merely by providing administrative services, such as processing claims, calculating benefits, and issuing checks on behalf of a self-funded plan. *See Useden v. Acker*, 947 F.2d 1563, 1577 (11th Cir. 1991); *Oliver v. Coca Cola Company*, 497 F.3d 1181, 1186 (11th Cir. 2007), *vacated in part on petition for reh'g*, 506 F.3d 1316 (11th Cir. 2007) (holding that third-party administrator "is not a proper defendant in this action," otherwise "we would undercut the ability of employers to contract out the administrative tasks associated with operating an ERISA plan, a practice we upheld in *Baker [v. Big Star Div. of the Grand Union Co.]*, 893 F. 2d 288, 290 (11th Cir. 1989)"]).

The Amended Complaint is entirely devoid of any factual allegations showing that UHIC is a fiduciary under self-funded plans. The Amended Complaint references no plan language from any self-funded plans to plausibly show that UHIC was delegated discretionary authority in plan management for self-funded plans. The Amended Complaint likewise asserts no facts sufficient to show that UHIC exercised that discretion as to self-funded plans. *See, e.g., Waxman v. Equitable Life Assurance Soc'y of the United States*, No. 08-60657-CIV, 2009 WL 10701021, at *3 (S.D. Fla. Apr. 10, 2009) (dismissing (a)(1)(B) claim where plaintiff failed to allege "Defendant is a named fiduciary or acts as a fiduciary of the Plan" and "failed to attached the Plan . . . to the complaint to enable this Court to [make this] determin[ation]") (citing *inter alia*

Baker, 893 F.2d at 289); *Response Oncology, Inc. v. MetraHealth Ins. Co.*, 978 F. Supp. 1052, 1064-65 (S.D. Fla. 1997), *order clarified on reconsideration on other grounds*, No. 96-1772-CIV, 1997 WL 33123678 (S.D. Fla. Nov. 6, 1997) (dismissing ERISA § 1132(a)(1)(B) claim against defendant alleged to be claims administrator because “[a] ‘claims administrator’ that simply processes claims does not have any specific discretionary authority” and “Plaintiff has failed to allege that [defendant] is a fiduciary”). And, given the range in types of plans, the court would need to analyze both the specific benefit plan and the particular alleged facts relating to each class member to determine the extent to which the employer plan sponsor may have delegated authority to UHIC or retained ultimate authority for administration of the plan.

For these reasons, to the extent Plaintiff seeks to represent participants and beneficiaries of self-funded plans for which UHIC acts as a third-party administrator, those portions of Plaintiff’s Counts I and II should be dismissed. Plaintiff simply has pointed to no plan language or other facts that could support these claims.

III. Counts III and IV Brought Under § 1132(a)(3) Are Duplicative of Count II Brought Under § 1132(a)(1)(b) and Should Be Dismissed.

Counts III and IV fail to allege any new facts or theories, but Plaintiff explicitly states that these counts are “brought pursuant to 29 U.S.C. § 1132(a)(3)(A)” and “(a)(3)(B)” “only to the extent that the Court finds that the injunctive relief” and “equitable relief” sought in Counts I and II are “unavailable pursuant to 29 U.S.C. § 1132(a)(1)(B).” Am. Comp. ¶¶ 109, 111. Because there is ample authority that claims brought under § 1132(a)(3) should be dismissed when, like here, they are duplicative of claims under § 1132(a)(1)(b), Counts III and IV should be dismissed.

The Eleventh Circuit has held that an ERISA plaintiff who has an adequate remedy under § 1132(a)(1)(B) cannot alternatively plead and proceed under § 1132(a)(3). *Ogden v. Blue Bell*

Creameries U.S.A., Inc., 348 F.3d 1284, 1287 (11th Cir. 2003). This is true “regardless of the relief sought, and irrespective of [plaintiff’s] allegations supporting [the] other claims.” *Stewart v. Hartford Life & Accident Ins. Co.*, No. 17-CV-01423-KOB, 2018 WL 3241213, at *1 (N.D. Ala. July 3, 2018) (citing *Jones v. Am. Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1073-74 (11th Cir. 2004) (upholding, on reconsideration, its initial decision to dismiss a plaintiff’s breach of fiduciary duty claim under § 1132(a)(3), finding that § 1132(a)(1)(B) provided the plaintiff with an adequate remedy). The fact that a § 1132(a)(1)(B) claim may not be successful is irrelevant. *Ogden*, 348 F.3d at 1287 (finding that ERISA plaintiffs could not assert a § 1132(a)(3) claim even if their § 1132 (a)(1)(B) claim would be lost, and the “court’s only proper course of action would [be] to dismiss their Section 502(a)(3) claim without considering its merits); *see also Katz v. Comprehensive Plan of Grp. Ins.*, 197 F.3d 1084, 1089 (11th Cir. 1999) (affirming a district court’s holding that, pursuant to the Supreme Court’s holding in *Varity Corp.*, an ERISA plaintiff could not state a valid claim for equitable relief when § 1132 (a)(1)(B) afforded her with an adequate remedy, even though her § 1132 (a)(1)(B) claim was subsequently lost on the merits).⁵ For these reasons, as a matter of law, the denial of benefits by an ERISA fiduciary, standing alone, cannot support a § 1132(a)(3) claim. *See Johns*, No. 08-CV-12272, 2009 WL 646636, at *5 (finding that “even if [plaintiff] dismissed his (a)(1)(B) claim, the (a)(3) denial-of-benefits claim would still not be viable”).

⁵ Courts outside the Eleventh Circuit likewise have held that subsection (a)(3) provides for equitable relief and may be invoked only if an adequate remedy is not available under subsection (a)(1)(B). *Corsini v. United HealthCare Servs., Inc.*, 145 F. Supp. 2d 184, 192 (D.R.I. 2001). Put another way, “subsection (a)(3) does not create an alternative theory” upon which suits alleging ERISA violations may be brought. *Id.* Rather, it is designed to deal with violations “for which no other remedy exists.” *Id.*

Here, Plaintiff's § 1132(a)(3) claims impermissibly duplicate his § 1132(a)(1)(B) claims in Counts I and II because they are based on a single alleged injury—wrongful denial of plan benefits⁶—for which § 1132(a)(1)(B) provides an adequate remedy. In particular, § 1132(a)(1)(B) allows a suit to recover benefits due under the plan, to enforce rights under the terms of the plan, and to obtain a declaratory judgment of future entitlement to benefits under the provisions of the plan contract—all of which Plaintiff seeks. *Compare Firestone Tire & Rubber Co. & Bruch*, 489 U.S. 101, 108 (1989)) and *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985) (holding that § 1132(a)(1)(B) allows a plaintiff “to recover accrued benefits, to obtain a declaratory judgment that she is entitled to benefits under the provisions of the plan contract, and to enjoin the plan administrator from improperly refusing to pay benefits in the future”) with Am. Compl., Prayer for Relief ¶¶ B, C, D. Moreover, § 1132(a)(1)(B) permits recovery of pre-judgment interest and attorneys’ fees, which Plaintiff seeks here as well. *Compare Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372, 374 (6th Cir. 2015) with Am. Compl., Prayer for Relief ¶¶ D, E.

Therefore, because § 1132(a)(1)(B) “provides an adequate and appropriate remedy” for the alleged failure to pay plan benefits, Plaintiff is precluded from slapping an equitable label on his request in an effort to pursue equitable relief under § 1132(a)(3) to redress that same alleged injury. *See, e.g., Stewart*, 2018 WL 3241213, at *2 (finding that plaintiff’s allegations for her §

⁶ Counts III and IV state that “Plaintiff and the Class have been harmed by UHC’s breaches of fiduciary duty described above.” *See* Am. Compl. ¶¶ 110, 113. As alleged and discussed above, the purported breach of fiduciary duty only harms Plaintiff and putative class by “deny[ing] coverage for PBRT” allegedly owed under their plans. Am. Comp. ¶ 95; *see also id.* ¶ 97 (“By adhering to an incorrect and outdated policy with regard to PBRT, UHC artificially decreased the number and value of covered claims”); ¶ 101 (“Plaintiff and Class Members have been harmed by breaches of fiduciary duty of UHC because their claims have been subjected improperly to the E/I Exclusion, leading to denials of coverage, when PBRT is actually a Covered Health Care Service within the definition of the UHC plans.”).

502(a)(3) claim were not “substantively different” from the benefits sought under her § 502(a)(1)(B) claim); *Meyer v. Unum Life Ins. Co.*, No. 12-1134-KHV, 2013 WL 1411776, at *6-*7 (D. Kan. Apr. 8, 2013) (concluding that plaintiff’s ostensibly separate §1132(a)(3) claim for injunctive relief arose from an injury for which plaintiff “could be made whole,” that could be wholly redressed under 1132(a)(1)(B) and that, therefore, was “indisputably a claim for . . . benefits”).

IV. Count IV Should Be Dismissed Because Plaintiff Cannot State a Claim for Surcharge, Restitution, or Disgorgement

In Count IV, Plaintiff requests surcharge, restitution or disgorgement expressly seeking “to *remedy* . . . *harms* [to] Plaintiff and the Class.” Am. Compl. ¶ 115 (emphases added). Plaintiff requests such relief in the form of “benefits” that UHIC allegedly “avoided paying” and “fees” that UHIC allegedly charged its self-funded plan customers” “for serving as claims administrator.” But as stated *supra* in Section III, Plaintiff’s only alleged injury is wrongful denial of benefits. Because Plaintiff’s claim for equitable relief in the form of recovery of amounts Defendant may have improperly gained from the alleged breach of fiduciary duty in denying plan benefits is at bottom indistinct from his 1132(a)(1)(B) claim seeking payment of benefits, dismissal is proper as a matter of law. *Lefler v. United Healthcare of Utah, Inc.*, 72 F. App’x 818 (10th Cir. 2003).

An equitable request for surcharge is based on a constructive trust theory. *See generally CIGNA Corp. v. Amara*, 563 U.S. 421, 441-42 (2011)). But Plaintiff’s requests for restitution, disgorgement, or surcharge for alleged savings (funds not paid out of its own or its self-funded client’s accounts), *id.* ¶ 114, necessarily fail because they seek compensation for unpaid benefits—not specifically identifiable funds that were gained by UHIC and that are distinct from UHIC’s general assets. *Callery v. U.S. Life Ins. Co. in City of New York*, 392 F.3d 401, 406

(10th Cir. 2004) (rejecting equitable restitution claim under § 1132(a)(3) where plaintiff did not seek “to regain particular funds or property” but instead the full value of her insurance policy benefits); *see also Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) (“[F]or restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant’s possession”). Similarly, with regard to the fees UHIC receives as a claims administrator, the Amended Complaint makes no factual allegations of “ill-gotten gains” that “accrued” to UHIC “as a result of the sort of maladministration alleged.” *Barnes v. Blue Cross & Blue Shield of Mich.*, No. 03-cv-40025, 2009 WL 909551, at *12 (E.D. Mich. Mar. 31, 2009).

Plaintiff’s claims therefore are properly construed as a request for compensatory damages that are unavailable through equitable relief. *See generally Mertens v. Hewitt Assocs.*, 508 U.S. at 255 (“Although they often dance around the word, what petitioners in fact seek is nothing other than compensatory *damages*—monetary relief for all losses their plan sustained as a result of the alleged breach of fiduciary duties. Money damages are, of course, the classic form of *legal* relief.”) (emphases in original). In *Varity Corp.*, “the Supreme Court emphasized that Section 502(a)(3) is a ‘catchall’ provision that provides relief only for injuries that are not otherwise adequately provided for by ERISA.” 516 U.S. at 515; *see also Lefler*, 72 F. App’x at 826 (“We agree with the district court that consideration of a claim under 29 U.S.C. § 1132(a)(3) is improper when the Class, as here, states a cognizable claim under 29 U.S.C. § 1132(a)(1)(B), a provision which provides adequate relief for alleged class injury. We should expect 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.’”) (internal citation omitted); *Wallace v. Blue Cross & Blue Shield of Alabama*, No. CIV.A. 14-

0119-CG-C, 2014 WL 5335823, at *8 (S.D. Ala. Oct. 20, 2014) (finding that Plaintiffs' section 502(a)(3) claim for equitable relief could be redressed under section 502(a)(1)(B), and that the section 502(a)(3) claim was essentially a recasting of that claim as both claims are based on the same allegations and seek the same relief). Because Plaintiff's claim for such money damages is indistinct from his § 1132(a)(1)(B) claim seeking payment for denied benefits, Count IV should be dismissed.

CONCLUSION

For the foregoing reasons, UHIC respectfully requests that the Court enter an Order granting this Motion and dismissing Counts I, III, and IV of Plaintiff's Amended Complaint.

Dated: July 8, 2019

Respectfully submitted,

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Counsel for Defendant UnitedHealthcare Insurance Company

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on July 8, 2019, a true and correct copy of the foregoing was electronically filed with the Clerk of Court using CM/ECF. Copies of the foregoing document will be served upon interested counsel via transmission of Notices of Electronic Filing generated by CM/ECF.

By: /s/ Allen P. Pegg