**UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF NEW YORK**

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| CAROL DaCOSTA, WAYNE COOPER, M.D., DANA DiCOCCO and MELANIE GREEN, individually and on behalf of all others similarly situated,<br><br>*Plaintiffs*,<br><br>vs.<br><br>THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,<br><br>*Defendant*. | 10-cv-00720 (JS) (ARL)<br><br>Electronically Filed |

**DEFENDANT THE PRUDENTIAL INSURANCE COMPANY OF AMERICA'S CORRECTED MEMORANDUM OF LAW IN SUPPORT OF MOTION TO DISMISS PURSUANT TO RULES 12(b)(1) AND 12(b)(6) OF THE FEDERAL RULES OF CIVIL PROCEDURE**

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Defendant The Prudential Insurance Company of America ("Prudential") respectfully submits this corrected memorandum of law in support of its motion to dismiss plaintiffs' two-count Class Action Complaint ("Complaint"), in its entirety and with prejudice, pursuant to Rules 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure.

## PRELIMINARY STATEMENT

In this action, plaintiffs seek rights and remedies that do not exist under the Employee Retirement Income Security Act, as amended ("ERISA") and for that reason their complaint should be dismissed. Plaintiffs' employers engaged Prudential to adjudicate claims for long term disability benefits under plaintiffs' employee benefit plans, and in that capacity it considered plaintiffs' claims, found them to be unsupported by the medical evidence and denied them. Plaintiffs make no challenge to the correctness of Prudential's long term disability benefit determinations or mandatory appeals procedures. Instead, plaintiffs allege that they voluntarily requested an additional level of review from Prudential, and that these voluntary appeals should be governed by the same set of procedures as their mandatory appeals. Not so. Plaintiffs' interpretation of the regulatory scheme is at odds with ERISA, the regulations and informal guidance from the Secretary of Labor. None of these contemplates that voluntary appeals would be governed by the same review process as a mandatory appeal. Indeed, the text and structure of the regulations draw a plain distinction between the two types of appeals, placing explicit requirements on the mandatory appeal process, but permitting flexibility for voluntary appeals.

Plaintiffs also contend they are entitled to relief because Prudential failed to provide information about the voluntary appeal process. But the Complaint itself establishes that plaintiffs did receive information about the voluntary appeals process, and neither plaintiffs nor their counsel ever indicated to Prudential that they thought Prudential's descriptions of the voluntary appeal process were inadequate or misleading; and they do not allege that Prudential

would have refused to provide even greater details upon request. Moreover, plaintiffs lack Constitutional standing to pursue this information claim because they cannot assert that disclosure of the information would have led them to pursue a voluntary appeal (they all did pursue such an appeal) or would otherwise have affected the ultimately adverse determination of their claim in any way. Even if they had standing, they are not entitled to relief in light of Prudential's "substantial compliance" with ERISA's regulatory pronouncements.

As the Supreme Court recently recognized, ERISA is "already complicated enough without adding 'special procedural or evidentiary rules' to the mix." *Conkright v. Frommert*, 559 U.S. __, __, No. 08-810, slip op. at 5 (U.S. Apr. 21, 2010).[1] The Complaint should be dismissed with prejudice.

## STATEMENT OF FACTS

Plaintiffs are four individuals who allege that they are disabled and entitled to long term disability benefits under their respective employers' ERISA-covered plans. (*See* Compl. ¶¶ 5-13 (plaintiff Carol DaCosta); ¶¶ 14-21 (plaintiff Wayne Cooper, M.D.); ¶¶ 22-32 (plaintiff Dana DiCocco); ¶¶ 33-42 (plaintiff Melanie Green).) Prudential was engaged by their employers to administer benefit claims under their plans, and in that capacity it considered plaintiffs' claims, found them to be unsupported by the medical evidence and denied them. (*Id.* ¶¶ 44-50.) Plaintiffs do not here challenge the correctness of Prudential's benefit determinations or

[1] In *Conkright,* the Supreme Court reversed the Second Circuit's decision to circumscribe deference afforded to ERISA plan administrators in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989). According to the Court, Congress intended ERISA to promote the "resolution of benefits disputes through internal administrative proceedings rather than costly litigation," and ERISA imposes a duty to preserve limited plan assets for all beneficiaries by preventing "windfalls for particular employees." 559 U.S. at __ (slip op. at 9, 12). Applying these principles, the Court remanded the case to the district court for further proceedings to determine on the merits whether the plan administrators' interpretation of the plan documents was an abuse of discretion.

At issue in *Conkright* was the question of whether certain retirement benefits under the Xerox Corporation plan were properly adjusted for the time value of money. The district court had held that the plan did not permit an adjustment for the time value of money, a proposition that the Court noted is "heresy, and highly unforeseeable" in the accounting world, and could create a windfall for a few participants at the expense of the rest of the plan beneficiaries. *See id.* at __ (slip op. at 12).

mandatory appeals procedures. Instead, they have filed a class action complaint "on behalf of themselves and all persons similarly situated within the United States," (*id.* at 1) in which they allege that their procedural rights to a *voluntary* appeal have been violated, and that they are therefore entitled to injunctive relief, damages, and attorney's fees and costs.

Plaintiffs undisputedly received all of the process to which they were entitled during the initial review and mandatory appeal of their claims. (*See id.* ¶¶ 56-58.) Prudential provided a robust initial review of their claims, by both consulting with medical professionals and carefully considering all of plaintiffs' submitted evidence. And each plaintiff sought and received a "full and fair review" of the initial determination during a mandatory appeal: the person who reviewed their claims was not the person who made the initial determination, new medical professionals were consulted, and no deference was provided to the initial determination. *See* 29 C.F.R. § 2560.503-1(h) (providing that an appeal will constitute "full and fair review" only if it meets these requirements). Nothing in plaintiffs' Complaint casts doubt on either the appropriateness of the procedures used during those reviews, or on the validity of Prudential's initial benefit determination or decision on the mandatory appeal.

Instead, plaintiffs' Complaint is limited to a challenge of Prudential's voluntary-appeal process, a process which ERISA does not require and which plaintiffs had no obligation to exhaust before proceeding to court. The Complaint points to two supposed procedural violations in Prudential's voluntary appeals. *First*, it alleges that Prudential improperly streamlined the process, supposedly to maximize corporate profits, by allowing the person who performed the mandatory appeal to also conduct the voluntary appeal, and by permitting the reviewer to accord deference to the prior denials. (*See* Compl. ¶¶ 55, 59-60.) The Complaint's position is that a claim administrator must either provide the same set of procedures at the voluntary-appeal stage

as the mandatory appeal, or it must decline to provide any voluntary-appeal process at all. (*Id.* ¶¶ 1, 59-60, 70.) *Second*, plaintiffs allege that Prudential breached an obligation to provide them with information about the scope and structure of the voluntary-appeal process. (*Id.* ¶ 70.) They allege that they sent Prudential letters requesting copies of their case files and asking for information about the voluntary appeal. And they allege that Prudential failed to respond, after which each of the plaintiffs decided to pursue a voluntary appeal anyway—and the initial denial was reaffirmed in every case. (*See id.* ¶¶ 10-13, 19-21, 30-32, 39-41.)

Notably, the Complaint does not allege that any of the plaintiffs would have declined to file a voluntary appeal had they received further information. And it does not allege that plaintiffs' use of the voluntary-appeal process somehow caused the denial of their claim; after all, there is no dispute that Prudential had already properly adjudicated their claims during an initial-review process and correctly affirmed those decisions at the mandatory-appeal stage.

Furthermore, the Complaint establishes that plaintiffs *did* receive accurate information about the voluntary-appeal process. *First*, Prudential's Summary of Material Modifications of Claims Procedures ("SMM")—of which plaintiffs received copies, and which they have attached as exhibits to their Complaint, (*see* Compl. Ex. D)—explains that plaintiffs will be afforded a review of their claims at the mandatory-appeal stage by individuals not involved in the earlier benefit determination and who will not afford deference to the initial determination, but makes no such representations about the voluntary review process.[2] *Second*, as the Complaint alleges, following the initial review and plaintiffs' mandatory appeal, Prudential notified plaintiffs of its

[2] (*See* Compl. Ex. D, at 2 (noting that during the mandatory-appeal review, "[a] full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination," and that "[t]his review will not afford any deference to the initial benefit determination"); *id.* at 3 (explaining, with respect to voluntary appeals, that "[y]our decision to submit a benefit dispute to this voluntary second level of appeal has no affect on your right to any other benefits under this plan," and that Prudential will waive its exhaustion and tolling defenses if a claimant chooses to use the process; and making no promise of the same procedures during this voluntary, second-level review).)

decision and, in each decision letter, informed them of the option of submitting to a voluntary appeal.[3] (*See e.g.*, Compl. ¶ 17.) Each of the decision letters made clear that the claim examiner who conducted the mandatory-appeal review could be responsible for handling the voluntary appeal as well. (*See* Declaration of Jeffrey Kohn in Support of Motion to Dismiss ("Kohn Decl."), ¶¶ 2-5, and Exhibits 1-4 (Prudential letters to each plaintiff explaining the option of filing a voluntary appeal, and that such an appeal should be forwarded to the same individual who had conducted the mandatory appeal).)[4]

Following Prudential's decisions at the voluntary-appeal stage, plaintiffs filed this lawsuit. Their Complaint contains two counts. In Count I, brought pursuant to ERISA §§ 404 and § 502(a)(3); 29 U.S.C. §§ 1104 and 1132(a)(3), plaintiffs allege that Prudential is in breach of its ERISA fiduciary duties for implementing a voluntary appeal process and failing to provide more information about the voluntary appeal than is already disclosed in the SMMs and denial letters. Plaintiffs request "appropriate declaratory and equitable relief under [§ 502(a)(3)] to obtain appropriate injunctive relief" to remedy these alleged breaches of fiduciary duty. (Compl. ¶ 91.) Count II, brought pursuant to § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B), and styled as a "claim for benefits," (*id.* ¶ 94), rests on the same allegations as Count I, but plaintiffs do not specify the relief they request. In their prayer for relief, which applies to both Counts I and II, plaintiffs seek "damages," the injunctive relief specified in Count I, a re-evaluation by Prudential or an independent fiduciary of "all of the denied, terminated or suspended claims of PLAINTIFFS and The Class in full compliance with ERISA providing a full and fair review of

[3] These letters are incorporated by reference into the Complaint, and thus may be considered at the motion to dismiss stage. *See Chambers v. Time Warner, Inc.*, 282 F.3d 147, 153 n.3 (2d Cir. 2002) (courts may consider any "materials referred to in the plaintiff's complaint and … central to [its] claim" (quoting *Collins v. Morgan Stanley Dean Witter*, 224 F.3d 496, 498-99 (5th Cir. 2000))).

[4] As explained in the Kohn Decl., ¶¶ 2-5, the letters have been redacted of personal and private information.

each claim and rendering disability payments to all such individuals whose adverse claim decisions are reversed upon re-evaluation," and attorney's fees. (Compl. at 24-25.)

## STANDARD OF REVIEW

A motion to dismiss, under Rule 12(b)(6) of the Federal Rules of Civil Procedure, must be granted if the complaint fails to "assert 'enough facts to state a claim to relief that is plausible on its face.'" *Fishbein v. Miranda*, 670 F. Supp. 2d 264, 271 (S.D.N.Y. 2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads *factual* content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009) (emphasis added). While the Court must accept the complaint's "well-pleaded factual allegations" as true, the "conclusory nature" of an allegation will "disentitle[] [it] to the presumption of truth." *Id.* at 1950, 1951. Moreover, to the extent plaintiffs accuse Prudential of having misled or defrauded them, their Complaint is subject to the heightened pleading standards of Fed. R. Civ. P. 9(b).

Furthermore, a claim is "properly dismissed for lack of subject matter jurisdiction under [Federal Rule of Civil Procedure] 12(b)(1) when the district court lacks the statutory or constitutional power to adjudicate it." *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000). In reviewing a Rule 12(b)(1) motion to dismiss for lack of constitutional standing, "this Court accepts as true all material allegations of the complaint and construes the complaint in favor of the complaining party." *Kendall v. Employees Ret. Plan of Avon Prods.*, 561 F.3d 112, 118 (2d Cir. 2009). At the same time, the "party invoking federal jurisdiction bears the burden of establishing" that constitutional standing exists. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992).

Finally, this Court may consider any documents incorporated into the Complaint by reference. *See Chambers*, 282 F.3d at 153 n.2 (explaining that courts may consider any "materials 'referred to in the plaintiff's complaint and … central to [its] claim'" (quoting *Collins v. Morgan Stanley Dean Witter*, 224 F.3d 496, 498-99 (5th Cir. 2000)).

## ARGUMENT

### I. PRUDENTIAL HAS MET ITS OBLIGATION TO PROVIDE "FULL AND FAIR REVIEW" OF ADVERSE BENEFIT DETERMINATIONS AND PLAINTIFFS' CLAIMS ARE MERITLESS AS A MATTER OF LAW

The gravamen of the Complaint is that Prudential failed to provide plaintiffs with the same procedural protections for both mandatory and voluntary second-level appeals. (*See* Compl. ¶¶ 87-90, 93-97.) Plaintiffs' allegations fail as a matter of law. Contrary to the Complaint's contention, plaintiffs are not entitled to the same procedures at every stage of a plan's internal-appeal process. Rather, as the text, structure, and purpose of ERISA and the Secretary's regulations make clear, only at the mandatory appeal stage are plaintiffs entitled to "a reasonable opportunity … for a full and fair review by the appropriate named fiduciary of the decision denying the claim," with a review by individuals not involved in the initial benefit determination who will not afford deference to that determination. 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(3)(ii)-(v). And that is what plaintiffs and the proposed class *undisputedly* received. Accordingly, the Complaint's allegations based on the asserted deprivation of the same procedures during the voluntary appeals in both Count I and Count II should be dismissed pursuant to Rule 12(b)(6).

#### A. ERISA Mandates Procedural Requirements for Mandatory Appeals Only.

ERISA requires that a plan "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim," 29 U.S.C. § 1133(2), and provides a right to subsequent

judicial review of the claim administrator's decision, 29 U.S.C. § 1132(a). The Secretary of the U.S. Department of Labor ("Secretary") has promulgated regulations to "establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations." *See* 29 C.F.R. § 2560.503-1(b) (as revised Nov. 21, 2000). As relevant here, the regulations require a claim administrator to afford "a reasonable opportunity to appeal an adverse benefit determination ... under which there will be a full and fair review of the claim and adverse benefit determination," *id.* at § 2560.503-1(h)(1).

As the text of the regulations makes clear, a plan participant is entitled to a "full and fair review" of an "adverse benefit determination." *Id.* at § 2560.503-1(h)(1). The regulations define an "adverse benefit determination" as "a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit ...." *Id.* at § 2560-503-1(m)(4). The definition refers to the initial benefit denial, not the mandatory appeal decision affirming the initial denial. *See Midgett v. Wash. Group Int'l Long Term Disability Plan*, 561 F.3d 887, 894 (8th Cir. 2009) (holding that the "'adverse benefit determination' referred to throughout § 2560.503-1(h) is the plan administrator's initial denial of a claim for benefits."); *Price v. Xerox Corp.*, 445 F.3d 1054, 1056 (8th Cir. 2006 )(the regulation's language "indicates that only the initial denial of benefits is an 'adverse benefit determination"); *compare* 29 C.F.R. § 2560.503-1(f) (claim administrator must notify a claimant of an "adverse benefit determination" within 90 days) with § 2560.503-1(i)(1)(i), (3)(i) (requiring separate notification of a "benefit determination on review" within 45 or 60 days). *See Midgett*, 561 F.3d at 895 (noting that the regulations' reference to determinations "on review" in other provisions "differentiates the initial 'adverse benefit determination'" from "later internal appeals of it").

The Secretary's regulations elaborate that a plan's claims procedures "will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless" the procedures "[p]rovide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual," *id.* at § 2560.503-1(h)(3)(ii). Any health care professional retained to assist with the review similarly must be independent of individuals involved in the initial benefit determination. *Id.* at § 2560.503-1(h)(3)(iii)-(v).

The regulations distinguish between mandatory and voluntary appeals. An appeal is "mandatory" if a claimant has an obligation to exhaust the appeal before filing a benefit claim in federal court. 29 C.F.R. § 2560.503-1(c)(2) (a plan may not require "a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under [ERISA 502(a)]"). By contrast, an appeal is "voluntary" if the claim administrator agrees to waive its exhaustion defense if the claimant decides not to file the appeal; a claimant who does not wish to use a voluntary appeal may simply skip it. *Id.* at § 2560.503-1(c)(3)(i), (ii), (iii), (d). *See generally* Dep't of Labor, Compliance Assistance: Group Health and Disability Plans: Benefit Claims Procedure Regulation (29 C.F.R. § 2560.503-1), at 17-23 (distinguishing between mandatory appeals, which it calls "Benefit Appeals," and voluntary appeals, which it refers to as "Postappeal Level Reviews"), *available at* http://www.dol.gov/ebsa/pdf/CAGHDP.pdf (hereinafter "Compliance Assistance publication" or "publication").

Imposing multiple mandatory appeals could "hamper and frustrate claimants," because claimants are obligated to exhaust them before proceeding to court, *see* Dep't of Labor Final

Regulation, 65 Fed. Reg. 70246, 70253 (Nov. 21, 2000). By contrast, there is no reason to "preclude a plan from offering, or a claimant from agreeing to utilize, additional *voluntary* administrative appeals processes," *id.* (emphasis added). Thus, the regulations do not specify a particular process for voluntary appeals and, instead, contemplate a flexible approach that does not require application of the mandatory appeal procedures. This common-sense interpretation is consistent with the Supreme Court's recent recognition that "ERISA law was already complicated enough without adding 'special procedural or evidentiary rules' to the mix." *See Conkright,* slip op. at 5.

Given the difference between these types of appeals, the Secretary's regulations limit a claim administrator to two mandatory appeals, *id.* at § 2560.503-1(c)(2), but allow the administrator to offer an unlimited number of voluntary appeals, *id.* at § 2560.503-1(c)(3). Moreover, although the mandatory appeal stage—which is the first level of appeal chronologically, *see id.* at § 2560.503-1(c)(3)(iii)[5]—is bound by the "full and fair review" restrictions described above, the regulations nowhere demand that a voluntary appeal be structured in any particular manner. Indeed, there is *no* obligation to provide voluntary appeals at all. Rather than mandating voluntary appeals and their structure, the regulations mandate disclosure, calling on a plan that "offers voluntary levels of appeal … [to] provide[] to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal." *Id.* at § 2560.503-1(c)(3)(iv). The regulations clarify that if requested, a claim administrator should provide information regarding "the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that

[5] ERISA and the Secretary's regulations do not *require* two mandatory appeals—the Secretary's regulations merely *limit* them to two, *see id.* at § 2560.503-1(c)(2)—and Prudential currently provides for only one mandatory appeal, *see* Compl. ¶ 57.

may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process." *Id.*

### B. Prudential Has Complied with the Regulations With Respect to Its Mandatory Appeals.

#### 1. ERISA Does Not Require the Same Process for Voluntary and Mandatory Appeals.

Plaintiffs concede that Prudential *does* satisfy the review requirements for the first, mandatory appeal, *see supra* at 3. That is, as required by the regulations, Prudential ensures, among other things, that the individuals who review a claim at the mandatory-appeal stage, and any physicians consulted during that stage, did not in any way participate in the initial denial; and Prudential instructs its mandatory-appeal reviewers to accord no deference to the initial denial. *See* 29 C.F.R. § 2560.503-1(h). Plaintiffs nonetheless allege that Prudential must *also* afford the same procedures to any subsequent voluntary appeals. This argument is irreconcilable with the text, structure, and purposes of ERISA and the applicable regulations.

Both ERISA and the Secretary's regulations are clear in rejecting plaintiffs' position.[6] *See supra* at I.A.; *see Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 540 (5th Cir. 2007). Decisions reached during the mandatory appeals are not themselves "adverse benefit determinations," *see supra* at I.A., and therefore Prudential has no obligation to review those mandatory appeal decisions, upon submission of a voluntary appeal, in accordance with § 2560.503-1(h). Accordingly, Prudential has provided Plaintiffs with what ERISA requires—a review of their adverse benefit determinations in accordance with § 2560.503-1(h) through its mandatory appeals. *See Eastman Kodak Co. v. Coyne*, 452 F.3d 215,

[6] Statutory interpretation must begin with the text of the provision on which a claim is based. *Raila v. United States*, 355 F.3d 118, 120 (2d Cir. 2004). And "where the statutory language provides a clear answer, it ends there as well." *Id.* (quoting *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999)). These principles apply to the interpretation of administrative regulations as well. *See Resnik v. Swartz*, 303 F.3d 147, 152 (2d Cir. 2002).

219 (2d Cir. 2006) (observing that the Secretary's regulations require "a full and fair review of the ***initial*** determination" (emphasis added)); *Midgett*, 561 F.3d at 894 (same); *Price*, 445 F.3d at 1056; *see also* 65 Fed. Reg. 70246, 70252 (noting that the Secretary's proposal, which was ultimately adopted in revisions to 29 C.F.R. § 2560.503-1, "required that the review be conducted by an appropriate named fiduciary who is neither the party who made the ***initial*** adverse determination, nor the subordinate of such party; that the review not afford deference to the *initial* adverse benefit determination; and that .... [any] health care professional ... be 'independent' of any health care professional consulted in making the ***initial*** adverse benefit determination." (emphasis added)).

Plaintiffs' reading is at odds not only with the text and structure of ERISA and the Secretary's regulations, but also with their purpose. "The end goal of judicial intervention in ERISA is not to correct problems at every level of plan administration, but to encourage resolution of the dispute at the administrator's level before judicial review." *Wade*, 493 F.3d at 540. Yet if plaintiffs' position were accepted, it would have the effect of discouraging plans from offering voluntary appeals—and thus diminish the likelihood that disputes will be resolved without recourse to federal courts, contrary to ERISA's purpose of "promot[ing] efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation." *Conkright,* slip op. at 9. As the regulations make clear, a plan is not *obligated* to provide voluntary appeals. *See supra* at I.A. And if plans are not permitted to adopt streamlined voluntary-appeal provisions (such as permitting the individuals most familiar with the case file to make that voluntary-appeal assessment), they may very well not adopt voluntary-appeals at all.[7]

[7] Indeed, under plaintiffs' interpretation, a claim administrator could not even invite claimants to give a telephone call to the individual who decided a mandatory appeal, to discuss concerns; such an invitation, and any other form of

Forcing plans and claim administrators to make an all-or-nothing choice cannot be squared with ERISA's careful balancing of regulation and flexibility. *Cf. Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). Because employers are not required "to establish benefit plans in the first place", the Supreme Court has recognized that "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." *Conkright*, slip op. at 9. Thus, Congress enacted ERISA "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Conkright*, slip op. at 9 citing *Varity Corp.*, 516 U.S. at 497; *see also* 65 Fed. Reg. at 70246 (noting that, in revising the claim administration regulations, "the Department [of Labor] has attempted to reconcile the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered").

### 2. The Secretary's Informal Guidance Does Not Mandate a Review Under § 2560.503-1(h) for Voluntary Appeals.

Lacking any grounding in the text, structure, or purposes of ERISA and the Secretary's regulations, the Complaint relies heavily on an informal Compliance Assistance publication that is available at the Department of Labor's website, *see supra* at I.A., and that is designed to "answer[] frequently asked questions about the application of the [Secretary's] regulation," *see* Compliance Assistance publication at p. 1; (*see also* Compl. ¶ 69 (quoting Compliance Assistance publication)). The plaintiffs' reliance on this publication is misplaced because the document does not support their position—it undermines it.

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voluntary "dispute resolution," would count as a voluntary appeal, 29 C.F.R. § 2560.503-1(c)(3), and in plaintiffs' view, such appeals must be treated just like mandatory appeals, or they must not be provided at all.

As relevant,[8] the publication has sections discussing the basic requirement that claim procedures be "reasonable," Compliance Assistance publication at 7-9, and organizes regulations into these main sections: "Initial Benefit Determinations," *id.* at 9-17; mandatory appeals, which the publication describes as "Benefit Appeals" or "the review of adverse benefit determinations," *id.* at 17-22; and, finally, voluntary appeals, which the publication labels as "Postappeal Level Reviews," *id.* at 22-23. The Compliance Assistance publication makes clear that the procedural protections that plaintiffs are seeking apply *only* to the mandatory appeals—to the "review of adverse benefit determinations"—and not to the voluntary appeals, or "postappeal level reviews." It does so by explaining, in the section dealing with mandatory appeals, that those appeals must comply with § 2560.503-1(h), *see id.* at 17-18, but do not repeat those same procedures in the voluntary appeal section, *see id.* at 22.

Nonetheless, the Complaint misleadingly quotes the following passage from the Compliance Assistance publication, and implies that the passage is intended to refer *both* to mandatory and voluntary appeals:

> Q-D3: If a group health plan provides for two levels of review, rather than one, following an adverse benefit determination, what standards, if any, govern the second level of review?
>
> A: Where a plan provides for two levels of review on appeal, it is the view of the Department that the second level of review is subject to the same standards that apply to the first level of review. For example, the second level reviewer may not afford deference to the decision at the first level of review, and the reviewer must not be the same person who made the first level review decision on

[8] The Court need not limit itself to reviewing the portions of the Compliance Assistance publication that plaintiffs have quoted (out of context) in their Complaint. The document is incorporated by reference into the Complaint, and thus the Court may consider the entire document at the motion to dismiss stage. *See supra* at 7. The Court may also take judicial notice of the full document. *B.T. Produce Co. v. Robert A. Johnson Sales, Inc.*, 354 F. Supp. 2d 284, 285 n.2 (S.D.N.Y. 2004) ("Courts have frequently taken judicial notice of official government reports as being capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." (citation and internal quotation marks omitted)).

> the claim or a subordinate of that person. (See §§ 2560.503-1(c)(2) and 2560.503-1(h)(3)(ii).)

Compliance Assistance publication at 18; (*see also* Compl. ¶ 56.)[9] Even a cursory review of the publication, however, reveals that this discussion appears within the mandatory-appeal section of the publication, and that the "two levels of review" under discussion are the two levels of mandatory appeal that the regulations allow a plan to impose. *See* Compliance Assistance publication at 17-18; see also § 2560.503-1(c)(2) (addressing exhaustion of mandatory appeal before filing an action under ERISA § 502(a)). As the *separate* section dealing with voluntary appeals explains, instead, voluntary appeals are permitted to be handled in a flexible manner, including alternative dispute resolution or arbitration:

> Q-E1: Under what circumstances may a plan afford claimants the ability to appeal their benefit claim beyond the review level required by the regulation?
>
> A: While the regulation limits a plan's claims procedure to a maximum of two mandatory appeal levels, the regulation does permit plans to offer voluntary additional levels of appeal, including arbitration or any other form of alternative dispute resolution, provided that . . . the claimant elects the additional appeal voluntarily. The conditions of the regulation focus on ensuring that the claimant elects the additional appeal voluntarily.

Compliance Assistance publication at 22 (emphasis added). Accordingly, although the Complaint places heavy reliance on the Secretary's informal guidance, that guidance actually undermines plaintiffs' claims.[10]

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[9] The sections of the regulations cited in this excerpt of the Compliance Assistance publication apply to group health plans, but they are also made applicable to disability plans pursuant to 29 C.F.R. § 2560.503-1(d), (h)(4).

[10] In any event, to the extent the Compliance Assistance publication could possibly be read as supporting plaintiffs' position, such a reading would be inconsistent with the regulation's text, structure, and purpose, *see supra* at I.A.-B.1., and would need to be ignored. *AFSCME v. Am. Int'l Group, Inc.*, 462 F.3d 121, 126 (2d Cir. 2006).

For the reasons explained above, because neither ERISA nor the regulations require Prudential to provide a § 2560.503-1(h) review to voluntary appeals after a mandatory appeal decision, plaintiffs have failed to state a claim.

## II. THE CLAIM THAT PRUDENTIAL FAILED TO PROVIDE REQUESTED INFORMATION MUST BE DISMISSED FOR LACK OF CONSTITUTIONAL STANDING AND IS ALSO MERITLESS AS A MATTER OF LAW

In addition to alleging that Prudential failed to provide them and all proposed class members a "full and fair review" at the voluntary-appeal stage, *see supra* at Part I, plaintiffs contend, in both Counts I and II, that Prudential failed to disclose sufficient information about the structure of its streamlined voluntary-appeal process. (*See* Compl. ¶¶ 12, 19, 30, 40, 42, 61, 62, 63, 65, 70, 95, 96.) These claims must be dismissed pursuant to Rule 12(b)(1) for lack of standing under Article III of the U.S. Constitution. But even if plaintiffs had established the requirements for Article III standing, their information-disclosure claim would nonetheless be properly dismissed pursuant to Rule 12(b)(6). As the Complaint and its attached exhibits reveal, Prudential has substantially complied with the requirement to provide requested information about its claim procedures.

### A. Plaintiffs Lack Standing To Complain that They Received Insufficient Information about the Structure of Prudential's Voluntary-Appeal Process.

Article III of the U.S. Constitution limits the federal judicial power to "Cases" or "Controversies," and the Supreme Court has explained that standing "is an essential and unchanging part of the case-or-controversy requirement," *Lujan*, 504 U.S. at 560. "Three elements make up the 'irreducible constitutional minimum of standing.'" *Central States Southeast and Southwest Areas Health and Welfare Fund v.Merck-Medco Managed Care, L.L.C.*, 433 F.3d 181, 198 (2d Cir. 2005); *see also Kendall*, 561 F.3d at 118) (dismissing ERISA claims for lack of standing). First, "the plaintiff[s] must have suffered an injury in fact"—an

invasion of a legally protected interest which is (a) "concrete and particularized", and (b) "actual or imminent, not conjectural or hypothetical." *Id.* Second, "there must be a causal connection between the injury and the conduct complained of—the injury has to be fairly traceable to the challenged action of the defendant …." *Id.* And third, "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Id.* [11]

Plaintiffs allege they were injured in fact when Prudential failed to provide them with sufficient information about its voluntary-appeal process. Yet "deprivation of a procedural right without some concrete interest that is affected by the deprivation—a procedural right *in vacuo*—is insufficient to create Article III standing." *Summers v. Earth Island Institute*, 129 S. Ct. 1142, 1151 (2009). In recognition of this limitation on standing, plaintiffs appear to be suggesting that the alleged deprivation of information has affected two "concrete interests"—an interest in not submitting to the voluntary appeal process, and an interest in ultimately prevailing on their benefit claims. (Compl., ¶¶ 65, 95, 96.) These allegations do not suffice for standing purposes. Even accepting plaintiffs' assertions as adequately alleging an injury in fact, plaintiffs cannot meet the remaining two elements of Article III standing on their theory of injury.

*First*, there is no causal connection between the alleged denial of information and the alleged injuries. The first alleged injury—submission to the voluntary-appeal process—was not *caused* by Prudential's alleged failure to disclose needed information. That is so because plaintiffs do not allege they were hesitant to use the voluntary-appeal process, or that they would have declined to use the voluntary-appeal process had Prudential provided them with more information. And there is plainly no "causal connection" between the failure to receive information and the second alleged injury: denial of plaintiffs' claims on the merits. Plaintiffs

[11] As *Kendall* confirmed, a plaintiff must demonstrate that she has standing herself, even if she purports to bring the lawsuit on behalf of the plan pursuant to ERISA § 503(a)(3). *See Kendall*, 561 F.3d at 118 ("A plan participant suing under ERISA must establish both statutory standing and constitutional standing ….").

make no effort to explain how Prudential's decision to deny their claims—which was the product not only of the voluntary appeal process that plaintiffs disparage, but also of a thorough initial examination and determination, as well as an undisputedly full and fair first-level appeal—could have been *caused* by any failure to provide information. As noted *supra* at I.A., the purpose of providing information about voluntary-appeal procedures is to enable a participant to decide whether to pursue a voluntary appeal; it has no effect on the review of the appeal, and thus Prudential's review and decision on the voluntary appeals would have been the same regardless of whether it provided the requested information to plaintiffs.

*Second*, there is no showing of redressability at all. Plaintiffs do not explain how more information would aid them now: they, and every member of the proposed class, have already chosen to submit to the voluntary-appeal process, after having "exhaust[ed] … all administrative remedies" provided to them," (Compl. ¶ 54). Granting them an order requiring Prudential to provide information about its voluntary appeals would not redress either of the alleged harms. It could not possibly redress the allegedly misinformed decisions to exhaust the voluntary appeals; and it would have no effect on the fact that plaintiffs' benefits claims were denied on the merits.

**B. Prudential Has Substantially Complied with the Regulations.**

Even if plaintiffs had established constitutional standing, their claim would be properly dismissed under Rule 12(b)(6), because plaintiffs are not entitled to relief in light of Prudential's "substantial compliance" with the regulations. *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 635 (10th Cir. 2003) (noting a plan could be in "substantial compliance" when technical violations are inconsequential and "in the context of an ongoing good faith exchange of information between the administrator and the claimant"); *LaFleur v. Louisiana Health Serv. & Indemnity Co.*, 563 F.3d 148, 154 (5th Cir. 2009); *see also Towner v. Cigna Life Ins. Co. of New York*, 419 F. Supp. 2d 172, 179-80 (D. Conn. 2006) (explaining that although the Second Circuit

has not yet adopted the "substantial compliance" doctrine, "it has been applied by several district courts within the Circuit," and collecting cases).

The DOL regulations do not compel claim administrators to inundate participants with unsolicited information; rather, they require only good faith efforts to respond to participants "request[s]," 29 C.F.R. § 2560.503-1(c)(3)(iv); *see Gilbertson,* 328 F.3d at 634-36 (observing that ERISA's procedural provisions aim to create a meaningful dialogue and that, as long as that dialogue took place, there is substantial compliance); *see also Wade*, 493 F.3d at 540 (citing *Gilbertson*, 328 F.3d at 634-36). Plaintiffs do not allege that they ever indicated to Prudential that they thought the SMM and denial letter descriptions were inadequate or misleading; and they do not allege that Prudential would have refused to provide even greater details upon request. These facts establish substantial compliance as a matter of law.

## III. COUNT I SHOULD BE DISMISSED BECAUSE THERE IS NO BASIS FOR THE INJUNCTIVE AND MONETARY RELIEF THAT PLAINTIFFS SEEK

Several of plaintiffs' remedial requests would have to be rejected as a matter of law *even if* plaintiffs had stated a valid claim.

*First*, the allegations and relief plaintiffs seek in Count I duplicates that in Count II. For example, plaintiffs are seeking the same injunctive relief—an injunction ordering Prudential to "re-evaluate all of the denied, terminated or suspended claims," (Compl. p. 24)—under ERISA § 502(a)(1)(B) in Count II. In the Second Circuit, courts will dismiss a § 502(a)(3) claim when, as here, "adequate relief is available under [ERISA § 502(a)(1)(B)]." *Frommert v. Conkright*, 433 F.3d 254, 270 (2d Cir. 2006), *rev'd on other grounds,* 559 U.S.__, No. 08-810, slip op. (U.S. Apr. 21, 2010); *see also Varity Corp.*, 516 U.S. at 515. Count I must be dismissed for this reason alone.

*Second*, plaintiffs' prayer for damages is not cognizable under either Count I or Count II. Plaintiffs cannot obtain damages under ERISA § 502(a)(3) because monetary damages do not constitute "appropriate equitable relief" under that provision, *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993); *Kendall*, 561 F.3d at 119; *Coan v. Kaufman*, 457 F.3d 250, 262 (2d Cir. 2006). And they cannot possibly obtain damages under ERISA § 502(a)(1)(B), because they do not here challenge the merits of Prudential's claim denials; plaintiffs are merely seeking to have Prudential re-evaluate their claims, which may well result in affirmances of the initial denials.

*Third*, with respect to plaintiffs' claim based on an alleged failure to provide sufficient information (raised in both Counts I and II), there is no basis for injunctive relief. When injunctive relief would be "futile"—as it would be here, given that compelling Prudential to provide further information about the voluntary-appeal procedures that plaintiffs have already exhausted would not address any cognizable injury—a plaintiff is "not entitled to relief for breach of fiduciary duty." *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 630 (2d Cir. 2008); *see also id.* (administrative remand would be futile "now that the relevant information has been finally disclosed").

## CONCLUSION

For the foregoing reasons, the Complaint should be dismissed in its entirety and with prejudice.

Dated: New York, New York
May 5, 2010

Respectfully submitted:

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

| | |
|---|---|
| CAROL DaCOSTA, WAYNE COOPER, M.D., DANA DiCOCCO and MELANIE GREEN, individually and on behalf of all others similarly situated,<br><br>*Plaintiffs*,<br><br>-against-<br><br>THE PRUDENTIAL INSURANCE COMPANY OF AMERICA,<br><br>*Defendant*. | 10-cv-00720 (JS) (ARL)<br><br>Electronically Filed |

**CERTIFICATE OF SERVICE**

I, Shiva Eftekhari, certify that on the 5th day of May, 2010, I caused to be served true and accurate copies of the attached Corrected Memorandum of Law in Support of Defendant's Motion to Dismiss by electronic mail and Federal Express on:

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May 5, 2010