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,

Plaintiffs,

Case No.: 2:10-cv-00720-JS-ARL
Electronically Filed

vs.

THE PRUDENTIAL INSURANCE
COMPANY OF AMERICA
a for- profit corporation,

Defendant
_____/

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS PURSUANT TO 12(b)(1) and 12(b)(6).

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Plaintiffs, Carol DaCosta, Wayne Cooper, M.D., Dana DiCocco and Melanie Green, individually and on behalf of those similarly situated respectfully submit this Memorandum of Law in Opposition to Defendant's Motion to Dismiss Plaintiffs' Class Action Complaint, with prejudice.

STATEMENT OF FACTS

This is an action brought against Prudential Insurance Company of America for breaching their fiduciary duty to Plaintiffs by violating multiple mandatory procedures set forth in The Employee Retirement Income Security Act of 1974 ("ERISA"). Prudential failed to provide participants a "full and fair review" of long-term disability claims and adverse benefit determinations during voluntary appeals, as required by ERISA and The United States Department of Labor. Prudential implemented a secretive company-wide policy amending their voluntary review process in violation of ERISA solely for the purpose of cutting costs and increasing profitability. Prudential then failed to notify any of its plan participants or administrators of this new voluntary appeals policy change in further violation of ERISA's rules and regulations.

Prior to January 1, 2005, Prudential had a three-step appeals process in the event a long- term disability claim had been terminated or denied, under which a claimant was afforded two mandatory level appeals and one voluntary appeal. Prudential provided an ERISA Statement to its beneficiaries and their employers setting out the claims and appellate procedures.[1] The claims at each of the three appellate levels were entitled to a "full and fair review" as required under ERISA. Specifically, Prudential complied with

[1] *See* Compl. Ex. "A" at 3. stating "Upon receipt of a third appeal (voluntary), the claim will be directed to Prudential's Appeals Committee by a member of the Prudential Senior Claims Management Team. This committee will be composed of three members of the Senior Claims Management Team who have not been involved in any previous appeals.

ERISA's requirements that all three levels of appellate review were to be reviewed by individuals that were not involved in the claim decision at any prior level.

Prudential modified their appeals process, effective January 1, 2005, offering only one mandatory appeal and one voluntary appeal. Prudential laid out the procedures in detail for their new appeals process in an "Appeals Procedures Division Memorandum."[2] These procedures were in compliance with 29 C.F.R.§2560.503-1.

However, on November 18, 2005 at 12:10 a.m. Drew DeChristopher, Manager of Disability Claims, circulated an internal email[3] to Prudential employees setting out the details of a new policy for voluntary appeals that stated as follows:

> Our operation is **shifting its approach to the handling of volunteer appeal levels,** this refers to the second or third appeal, whichever is deemed voluntary...**For the voluntary appeal,** the appeal can be handled by the **same individual** who handled the prior mandatory appeals. There are **no requirements** that Prudential consult with a different medical consultant if the claim was previously based on the medical. **A de novo standard does not apply.**
>
> Beginning with any voluntary appeals received 11/14/05 or later, I would ask you to begin to **manage your own 2nd appeals**...**There are no hard and fast rules for what steps to take on such an appeal.** You are expected to exercise good judgment based on the circumstances of the claim. If the claim review can be perfected further by taking action, you should take such appropriate action. **If no action is warranted, that is ok too....**

[2] *See* Compl. Ex. "B" at 9. Specifically, the second appeal (voluntary appeal) would receive a full and independent review of the claim file. No deference could be given to either the initial denial or the denial on appeal. The decision on second (voluntary) appeal will be authorized by a member of Prudential's Management Team that was not previously involved in an adverse decision on the claim.
[3] *See* Compl. Ex. "C."

> **Hopefully this change will reduce case load burden a bit since there will be files you will receive/self assign as new pendings that you will not need to learn from scratch**. Desired behavior is to ensure that the 1st review is the strongest review possible… as it could be the last review Prudential is afforded. If that behavior occurs, **the burden of 2nd appeal reviews should be further lessened.**

Prudential unilaterally, and without notice to any of its participants, determined that they no longer had to comply with ERISA standards when handling voluntary appeals on or after November 14, 2005. No documents were ever provided to participants establishing Prudential's new claims handling procedures, as required by federal law. The new procedures were never added to Prudential's Summary Plan Description (SPD) nor were they disclosed in Prudential's Summary of Material Modifications of Claims Procedures (SMM) drafted in 2005 and again in 2006. In fact **these new appeal procedures were never provided to participants or their employers even when specifically requested in writing.** Prudential claims that the denial letter sent to the claimants which included a sentence stating: "please forward your appeal request to me at the above address", was sufficient notice informing the claimant that should they decide to file a voluntary appeal, that appeal would be reviewed and determined by the same individual who denied their first appeal. Defendant's position has no merit.

The failure to disclose the new voluntary appeal procedures to plan participants is a violation of 29 C.F.R §2560.503-1(c)(3)(iv), 29 C.F.R §2560.503-1(j)(4) and (5)(i). As Prudential failed to provide Plaintiffs with sufficient information relating to the voluntary level of appeal; Plaintiffs were deprived of a meaningful opportunity to make an

informed decision about whether to submit a benefit dispute to the voluntary level of appeal. Specifically 29 C.F.R.§2560.503-1(c)(3)(iv) states in pertinent part:

> To the extent that a plan offers **voluntary levels of appeal**...the claims procedures provide that: **The plan provides 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...the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as financial or personal interests in the result or any past or present relationship with any party to the review process.**

The United States Department of Labor promulgated specific ERISA claims guidelines for an administrator to follow in order to provide a full and fair review. Specific guidelines for voluntary appeals are set out in the Department of Labor's Compliance Assistance Manual, under Frequently Asked Questions, stating in pertinent part:

> **E-1** While regulation limits a plan's claim procedure to a maximum of two mandatory appeal levels, the regulation does permit plans to offer voluntary additional levels of appeal...providing certain conditions are met. **The conditions of the regulation focus on ensuring that the claimant elects the additional appeal voluntarily. Specifically, the regulation provides that, in the case of such voluntary levels of appeal, the plan's claim procedure must provide...the claimant with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including the specific information delineated in the regulation.**

Prudential failed to notify their plan participants or administrators that after November 14, 2005, the voluntary appeals review process would no longer be complying with ERISA which in turn meant that claimants would no longer be receiving a full and fair review of their voluntary appeals. Prudential failed to provide participants with "sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process" as required by 29 C.F.R. §2560.503-1(c)(3)(iv) and the Department of Labor. At no time did Prudential provide information regarding the "process for selecting the decision maker, and the circumstances, if any, that 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" as required by 29 C.F.R. §2560.503-1(c)(3)(iv).

Prudential never informed its participants that the same person that denied their first mandatory appeal was going to be the same individual that would review and determine the outcome of their voluntary appeal. Plaintiffs requested specifically, in writing, procedures for voluntary appeals to no avail. The class claimants never had any idea as to how their voluntary appeal would be handled. ERISA requires that Prudential disclose these procedures upon request. Prudential failed to do so. As a result, claimants were completely unaware that their voluntary appeals were going to be "rubber stamped" by the same person who had just denied their first appeal.

STANDARD OF REVIEW

Rule 12(b)(6) of the Federal Rules of Civil Procedure provides for dismissal of a complaint that fails to state a claim upon which relief may be granted. "In ruling on a motion to dismiss for failure to state a claim upon which relief may be granted, the court

is required to accept the material facts alleged in the complaint as true." *Fishbein v. Miranda,* 670 F. Supp. 2d 264, (S.D.N.Y. 2009) (citing; *Frasier v. Gen Elec. Co.,* 930 F.2d 1004, 1007 (2d Cir. 1991)). The court is also required to read the complaint generously, drawing all reasonable inferences from its allegations in favor of the plaintiff. *California Motor Transp Co. v. Trucking Unlimited,* 404 U.S. 508, 515 (1972). "The court must not dismiss a complaint unless it appears beyond a doubt, even when the complaint is liberally construed, that the plaintiff can prove no set of facts that would entitle him to relief." *Frommert v. Conkright,* 433 F.3d 254, 262 (2d Cir. 2006) (citing *Jaghory v. N.Y. State Dep't of Educ.,*131 F.3d 326, 329 (2d Cir. 1997)).

At this early stage of the litigation, the Court is not called upon to determine the merits of the Plaintiffs' case, but simply is called upon to test the sufficiency of the Plaintiffs' complaint. A motion to dismiss pursuant to Rule 12(b)(6) requires the Court to construe the complaint in the light most favorable to the plaintiff. *Bloch v. Ribar,* 156 F.3d 673, 677 (6th Cir. 1998); and determine whether "it appears beyond a doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson,* 355 U.S. 41, 45-46 (1957). The court must liberally construe the complaint in favor of the party opposing the motion and may dismiss the case only where no set of facts could be proved consistent with the allegations which would entitle the plaintiff to recover. *Hishon v. Spalding,* 467 U.S. 69, 73 (1984).

In deciding a motion to dismiss the question is "not whether the plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Shuer v. Rhodes,* 416 U.S. 232, 236 (1974).

Plaintiffs have clearly stated a claim upon which relief can be granted. Therefore, Defendant's motion to dismiss Plaintiffs' Complaint with prejudice should be denied.

ARGUMENT

I. PRUDENTIAL FAILED TO PROVIDE REASONABLE NOTICE THAT PLAINTIFFS' VOLUNTARY APPEAL WOULD NOT BE AFFORDED A "FULL AND FAIR REVIEW" AS REQUIRED BY ERISA.

Prudential argues that ERISA's rules and regulations only apply to mandatory appeals and voluntary appeals are not governed by ERISA. This premise is completely false. There is no case law in any circuit that states or implies that the full and fair review standards required by 29 U.S.C.§ 1133(2) and 29 C.F.R. 2560.503-1(b)(1) do not apply to voluntary appeals. In fact, the opposite is true. Prudential claims that since the appeals are "voluntary" they can do as they please. The internal email sent by Drew De Christopher to Prudential employees states, **"there are no hard and fast rules for what steps to take on such an appeal."** [4] Prudential's argument that ERISA allows an administrator to conduct an appellate review with no hard and fast rules and without providing a full and fair review is contrary to the entire intent behind ERISA.[5]

29 U.S.C.§ 1133(2) mandates that every ERISA plan "afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the appropriate named fiduciary of the decision denying the claim." *Ward v. Life Ins. Co. of North America,* 2009 WL 2740202 *6 (M.D.N.C. 2009). In *Ward v. LINA,* the Court held that **a voluntary appeal is governed by ERISA and must be afforded a full and fair review.** In *Ward,* Plaintiff appealed the initial denial of benefits.

[4] *See* Compl. Ex. "C."

[5] "One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Fort Halifax Packing Co. v. Coyne,*482 U.S. 1 (1987).

The appeal was denied. Plaintiff then chose to submit a second, voluntary appeal. The Defendant, LINA, argued that since Plaintiff was only questioning the treatment of his second, voluntary appeal, and the filing of a voluntary appeal is not required by ERISA prior to the filing of a lawsuit, the admitted procedural error "does not undermine LINA's first and second determinations that the Plaintiff was not disabled." The court did not agree. *Id.* at*5.

According to the court in *Ward,* ERISA requires employee benefit plans that deny disability benefits to "set forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." *Id.*at*6. *See.* 29 U.S.C. § 1133. The accompanying regulations further require the plan to describe "any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(iii). Once an appeal is filed, the plan administrator must provide a full and fair review, as provided by the statute and regulations. *See* § 2560.503-1(j). These rules are "designed both to allow the claimant to address the determinative issues on appeal and to ensure meaningful review of the denial." *Love v. Nat'l City Corp. Welfare Benefits Plan,* 574 F.3d 392 (7th Cir. 2009).

Here, the letter denying Plaintiff's second (voluntary) appeal clearly, and admittedly, contains egregious errors and is deficient in providing a basis for denial of the appeal. It is not clear in any way that Plaintiff's appeal received a meaningful and reasoned consideration. While it is true that Plaintiff's second appeal was "voluntary" under ERISA, it does not necessarily follow that the plan administrator could ignore the appeal or not afford it a full and fair review.

Ward at *6. (emphasis added)

The Court held that Defendant failed to provide a full and fair review of Plaintiffs (voluntary) appeal of the denial of disability benefits. *Ward* at *6.

II. PRUDENTIAL FAILED TO COMPLY WITH ERISA REGULATIONS WITH RESPECT TO VOLUNTARY APPEALS

ERISA does not require a Plan to offer a voluntary appeal. However, if the Plan chooses to offer the option of submitting a voluntary appeal, it must comply with ERISA's rules and regulations with respect to reviewing voluntary appeals. According to the Court in *Cook v. The New York Times Co. Long-Term Disability Plan,* [2004 WL 203111 (S.D.N.Y 2004)], **the administrator of an employer's long-term disability plan was required to comply with ERISA's notification requirements and requirement of full and fair review of determination on a former employee's third (voluntary) appeal from denial of benefits, regardless of the fact that it was the employee's third (voluntary) appeal.** According to the Court in *Cook,*

> **It could be argued that ERISA's regulations should not apply to decisions on review after the first appeal. Defendant however, does not raise this argument, and even if it did, it would not be persuasive.** First, by its language, **ERISA's regulations apply equally to all "notifications of benefit determination on review and do not distinguish among levels of appeal.** [*Cook* at *16 (citing 29 C.F.R.§ 2560.503-1(j))]. **Second, the requirement of a full and fair review on the first go-around should apply no less simply because an administrator grants an additional level of appeal: a second appeal that does nothing to cure the procedural deficiencies of the first will not constitute substantial compliance merely by virtue of its existence. Because the notice of denial on plaintiff's second appeal again failed to provide the required information, the denial of**

> **the third (voluntary) appeal equally violates ERISA.** [*Id* at*16.]

Prudential failed to conduct their voluntary appeals in compliance with 29 C.F.R. 2560.503-1(c)(3) as they did not provide Plaintiffs with sufficient information relating to the voluntary level of appeal to enable them to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. Additionally, the Summary of Material Modifications of Claims Procedures[6] (SMM) was disbursed to participants and their employers on or about August 1, 2006. The SMM fails to advise claimants of the manner in which voluntary appeals are to be conducted. Paragraph one of the SMM states:

> **The following describes the current claims procedures followed by Prudential when processing Group Short Term and Long Term Disability claims. It clarifies when a claim is considered to have been filed, and restates our current process for determining benefits and for the processing of appeals of adverse claim determinations. It is a Summary of Material Modifications (SMM) which is required to be disclosed to participants by federal law, and which explains the changes to the Summary Plan Description (SPD) of the Plan.**

Nowhere in the SMM does it indicate that the procedures for processing a voluntary appeal have changed. Nowhere does it state that if a voluntary appeal is submitted, it will not be afforded a full and fair review. Federal law requires that Prudential notify its beneficiaries of changes in claim filing procedures. 29 C.F.R.2560.503-1. That is the purpose behind the requirement of distributing an SMM. It is clear that this information was not provided in the SMM or anywhere else due to the

[6] See Summary of Material Modifications of Claims Procedures dated August 1, 2006 attached to Plaintiffs' Complaint.

fact that Prudential's modifications to the voluntary appeal process were in violation of ERISA's rules and regulations.

Furthermore, ERISA's implementing regulations require that disability denials which rely on "an internal rule, guideline, protocol, or other similar criterion" must set forth the specific criterion relied upon, or state that a copy will be "provided free of charge to the claimant upon request." 29 C.F.R. §2560.503-1(g)(v)(A). Prudential violated this provision by failing to set forth the internal guidelines and protocols for their voluntary appeals.

III. ARTICLE III STANDING

Plaintiffs have filed a cause of action alleging violations of several rights ERISA bestows upon plan participants that are wholly procedural in character. Specifically, Prudential is alleged to have violated 29 C.F.R. §2560.503-1(c)(3)(iv)[7]; § 2560.503-1(g)(1)(iv) & (v)(A)[8]; §2560.503-1(h)(3)(ii) & (v); and §2560.503-1(j)(4) & (5)(i).

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[7] "The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section-- To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that: The plan provides 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, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that 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." 29 C.F.R. §2560.503-1(c)(3)(iv).

[8] "Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant-- (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review; (v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits, (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the

29 U.S.C. § 1132(a)(3) empowers a plan participant or beneficiary to bring a civil suit "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3). 29 U.S.C. § 1132(a)(1)(b) empowers a plan participant or beneficiary to bring suit "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).

The aforementioned rights that Plaintiffs allege to have been violated are designed to safeguard a plan participant's concrete and particularized right to a full and fair determination of a claim by a plan administrator. These violations are ongoing and represent the Defendant's *modus operandi*. The Defendant continues to violate the terms of ERISA, purportedly secure in its belief that despite acting in contravention of federal law, affecting untold numbers of beneficiaries, it can claim *it is no big deal*. It is axiomatic that the deprivation of a remedy is the deprivation of the right it is intended to vindicate.

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adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request." §2560.503-1(g)(iv) & (v)(A).

A) STANDING, GENERALLY:

"There are three Article III standing requirements: (1) the plaintiff must have suffered an injury-in-fact; (2) there must be a causal connection between the injury and the conduct at issue; and (3) the injury must be likely to be redressed by a favorable decision." *Kendall v. Employees Retirement Plan of Avon Products*, 561 F. 3d 112, 118 (2d Cir. 2009) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992)). "In a class action, once standing is established for a named plaintiff, standing is established for the entire class." *Id.* "[O]nly one of the named Plaintiffs is required to establish standing in order to seek relief on behalf of the entire class." *Central States Southwest & Southwest Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 504 F. 3d 229, 241 (2d Cir. 2007).[9] *See* 1 ALBA CONTE & HERBERT B. NEWBERG, NEWBERG ON CLASS ACTIONS § 2:6 n. 3 (4th ed. 2002) ("To establish Article III standing in a class action, it is not required that each named plaintiff must have a claim against each named defendant. Rather, for every named defendant there must be at least one named plaintiff who can assert a claim directly against that defendant, and at that point standing is satisfied and only then will the inquiry shift to a class action analysis").

> To seek injunctive relief, a plaintiff must show that he is under threat of suffering "injury in fact" that is concrete and particularized; the threat must be actual and imminent, not conjectural or hypothetical; it must be fairly traceable to the challenged action of the defendant; and it must be likely that a favorable judicial decision will prevent or redress the injury. This requirement assures that there is a real need to exercise the power of judicial review in order to protect the interests of the complaining party[.]

[9] Hereinafter referred to as "Central States II."

Summers v. Earth Island Institute, 129 S. Ct. 1142, 1149 (2009) (internal citation and quotation omitted).

Prudential's emphasis on its "substantial compliance", in addition to being factually incorrect, is also misplaced in an argument contesting standing.

> Although *standing in no way depends on the merits of the plaintiff's contention that particular conduct is illegal*, it often turns on the nature and source of the claim asserted. *The actual or threatened injury required by Art. III may exist solely by virtue of statutes creating legal rights, the invasion of which creates standing* .... Moreover, the source of the plaintiff's claim to relief assumes critical importance with respect to the prudential rules of standing that, apart from Art. III's minimum requirements, serve to limit the role of the courts in resolving public disputes. *Essentially, the standing question in such cases 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.*

Warth v. Seldin, 422 U.S. 490, 500-501 (1975) (internal citations & quotation omitted) (emphasis added). 29 U.S.C. § 1132(a)(3) specifically endows the Plaintiffs, as plan participants, to sue to enjoin violations of ERISA, which is precisely the relief sought by Plaintiffs in this case.

B) CLAIMS TO AVAIL PROCEDURAL RIGHTS ARE SPECIAL:

The courts of the Second Circuit have "recognized that a plan participant may have Article III standing to obtain injunctive relief related to ERISA's disclosure and fiduciary duty requirements without a showing of individual harm to the participant." *Central States Southwest & Southwest Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 433 F. 3d 181, 199 (2d Cir. 2005)[10]. *"[T]he disclosure requirements and fiduciary duties contained in ERISA create in [the plan participant] certain rights, including the rights to receive particular information and to have [the plan*

[10] Hereinafter referred to as "Central States I."

administrator] act in a fiduciary capacity. Thus, [the plan participant] need not demonstrate actual harm in order to have standing to seek injunctive relief requiring that [the plan administrator] satisfy its statutorily-created disclosure or fiduciary responsibilities." Horvath v. Keystone Health Plan East, Inc., 333 F. 3d 450, 456 (3d Cir. 2003) (emphasis added). *See also Financial Inst. Retirement Fund,* 964 F.2d 142, 149 (2d Cir. 1992) (noting that "ERISA's goal of deterring fiduciary misdeeds" supports a "broad view of participant standing under ERISA," and holding that a violation of § 404 satisfies the injury requirement of Article III); *Gillis v. Hoechst Celanese Corp.,* 4 F.3d 1137, 1148 (3d Cir. 1993) (finding "ERISA does not require that harm be shown before a plan participant is entitled to an injunction ordering the plan administrator to comply with ERISA's reporting and disclosure requirements"); *RJG Cab, Inc. v. Hodel,* 797 F.2d 111, 118 (3d Cir. 1986) (quoting *Warth,* 422 U.S. at 499-500. ("[t]he actual or threatened injury required by Art. III may exist solely by virtue of statutes creating legal rights, the invasion of which creates standing."); *see also Larson v. Northrop Corp.,* 21 F.3d 1164, 1171 (D.C. Cir. 1994) (holding plaintiff need not demonstrate actual harm in order to file suit for alleged breach of fiduciary duty under ERISA § 404).

At present, Plaintiffs seek only injunctive relief, not disgorgement or restitution, thereby abating the necessity to demonstrate actual harm as a requisite to conferring standing.

> In the specific context of ERISA causes of action, the Second Circuit has recently expressly drawn a distinction between constitutional standing to bring a claim for injunctive relief and constitutional standing to bring a claim for the remedy of disgorgement or restitution. As to the former remedy, the Second Circuit held that *standing to bring an ERISA claim for injunctive relief is to be*

> *viewed broadly, and a plaintiff need not demonstrate actual harm to have standing to seek such relief.*

Faber v. Metropolitan Life Ins. Co., 2009 WL 3415369 (S.D.N.Y. 2009) (emphasis added). *See Central States I*, 433 F. 3d at 199-200. Prudential's argument that Plaintiffs' failure to contend that the results of Prudential's intentionally reckless appeal process would have differed had Prudential complied is unavailing. Plaintiffs' allegations of Prudential's violations of statutory procedural rights, meant to ensure the vitality of the claim process, need not make the standard showing of redressability and immediacy to find standing.

> There is this much truth to the assertion that "procedural rights" are special: *The person who has been accorded a procedural right to protect his concrete interests can assert that right without meeting all the normal standards for redressability and immediacy*. Thus, under our case law, one living adjacent to the site for proposed construction of a federally licensed dam has standing to challenge the licensing agency's failure to prepare an environmental impact statement, *even though he cannot establish with any certainty that the statement will cause the license to be withheld or altered*, and even though the dam will not be completed for many years.

Lujan v. Defenders of Wildlife, 504 U.S. 555, 573(1992) (emphasis added).

Had Prudential complied with its statutory obligations under ERISA, the Plaintiffs could have had a meaningful opportunity to assess their chances, develop the administrative record through a course of fair dealing, and avoided the complete waste of precious time and scarce resources pursuing what turned out to be a fixed appeal process. Had the Plaintiffs actually known that Prudential had no intention of submitting their

claim to minds not jaded by the conclusions of the prior claim determination, they could have filed their suit months earlier. Prudential not only robbed Plaintiffs of the opportunity to have a fiduciary honestly appraise their claim, but also held their claims in abeyance with the promise of another chance to have their fiduciary validate their pain.

IV. THE SUBSTANTIAL COMPLIANCE DOCTRINE HAS NOT BEEN ADOPTED BY THE SECOND CIRCUIT

Substantial compliance is a doctrine that forgives technical noncompliance for purposes of review of a plan administrator's discretionary decision. We are faced here with the very different question of whether substantial compliance can block or delay a plaintiff's access to the federal courts. The proposition that substantial compliance can prevent overturning a decision is akin to harmless error analysis, establishing merely that a decision need not be carried out with absolute procedural perfection so long as the regulatory purpose is fulfilled. On the other hand, adopting the proposition that substantial compliance can delay accrual of the right to sue would permit plan administrators to indefinitely tie up claimants, who are often in immediate need of benefits, with ongoing requests for information. Such a result would render the plain language of Section 2560.503 -1(h)(1) a nullity. *Nichols v. Prudential Ins. Co. of America*, 406 F. 3d 98, 107 (2d Cir. 2005) (noting that the plain language of the prior version of 29 C.F.R. § 2560.503-1(h) precluded judicial creation of substantial compliance doctrine as it would render applicable provision a nullity). *See Aitkins v. Park Place Entertainment Corp.*, 2008 WL 820040, *19 (E.D.N.Y. 2008) ("As a threshold matter, it is unclear whether the Second Circuit has--as defendants claim--"adopted" the substantial compliance standard."); *Mohamed v. Sanofi-Aventis Pharmaceuticals*, 2009 WL 4975260, *16 (S.D.N.Y. 2009) ("The Court notes that it

appears to remain an open question in the Second Circuit whether substantial compliance with ERISA's procedural obligations will suffice."). As conceded by Defendant in its Memorandum of Law in support of their Motion to Dismiss, the Second Circuit has not yet adopted the "substantial compliance" doctrine, citing *Towner v. Cigna Life Ins. Co of New York,* 419 F.Supp 2d 172, 179-180 (D. Conn. 2006).

V. PRUDENTIAL HAS NOT SUBSTANTIALLY COMPLIED WITH ERISA

According to the Court in *Cook*, "the substantial compliance framework leaves the question of how tightly administrators must comply with ERISA's regulations within the discretion of the courts. A holding that a violation has occurred may seem difficult to square with this flexible framework, especially where a good deal of specific information has been provided to the claimant over the course of the appeals process." 2004 WL 203111 at *17. The *Cook* case, however, demonstrates the pitfalls of too lax an approach to the regulatory guidelines. "The defendant could likely have prevented this lengthy process, which was surely expensive and time-consuming for both parties, had it simply provided the plaintiff with the relevant criteria it was relying upon early in the process, or with access to her file at a time when it would have given her a meaningful opportunity to address any deficiencies." *Id* at *17. ERISA's procedural regulations "go [ ] to the core of the purpose of ERISA's notice requirements," *Dawes v. First UNUM Life Ins. Co.* 1992 WL 350778,* 5, and must be enforced such that they retain their effectiveness. *Richardson v. Central States Southeast and Southwest Areas Pension Fund,* 645 F.2d 660, 665 (8th Cir. 1981) ("The statute and the regulations were intended to help claimants process their claims efficiently and fairly; they were not intended to be used by [a plan administrator] as a smoke screen to shield itself from legitimate claims.");

Marlot v. Alliant Techsystems, Inc., 146 F.3d 617, 620 (8th Cir. 1998) "We will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the fact plan interpretations devised for purposes of litigation." *Marlot* at 620. The Court in *Cook* held that the defendant's failure to provide Cook with the required information as to the criteria it relied upon and the rights attendant upon appeal renders its determination so procedurally flawed as to be arbitrary and capricious. *Cook* at *17.

Substantial compliance means that the beneficiary was "supplied with a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Halpin v.W.W. Grainger, Inc.* 962 F.2d 685, 690 (7th Cir. 1992). In the case at hand, Prudential did not substantially comply with ERISA with regards to the voluntary appeals review process. Prudential never advised the claimants that the same person would be reviewing the first and second appeal and making the final decision to deny the claim. The claimants specifically requested, in writing, the appeals claim procedures, and they were never produced. There is no question that the class claimants did not have a sufficiently clear understanding of the voluntary appeals process.

Prudential argues in their Motion to Dismiss that the Department of Labor 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]." However, intentionally hiding the new voluntary appeal procedures from participants and then failing to provide participants with the procedures for their voluntary appeal even after requested in writing is hardly a "**good faith effort.**"

Prudential claims that Plaintiffs "do not allege that they ever indicated to Prudential that they thought the SMM and the denial letter descriptions were inadequate or misleading; and they do not allege that Prudential would have refused to provide even greater details upon request." Plaintiffs could not possibly notify Prudential that the SMM and denial letter descriptions were inadequate or misleading when there was never **any** information regarding the new voluntary appeals process provided in **any** document to the participants. Plaintiffs had no idea that there were any new procedures for voluntary review because nobody ever informed them.

VI. PLAINTIFFS ARE ENTITLED TO RELIEF UNDER ERISA §§ 502(a)(3) and 502(a)(1)(B)

Prudential argues that Plaintiffs cannot have a claim under ERISA § 502(a)(3) and § 502(a)(1)(B) simultaneously. However, the Second Circuit disagrees with Prudential's position. In *Devlin v. Empire Blue Cross and Blue Shield,* 274 F.3d 76, 89 (2nd Cir. 2001), the Second Circuit disagreed with Defendant's contention that "there is no private action for breach of fiduciary duty under ERISA when another remedy is available under 29 U.S.C.§ 1132." *Id* at 89. The Court stated that "the Supreme Court in *Varity Corp. v. Howe,* [516 U.S. at 515, 1065 (1996)] did not eliminate the possibility of a plaintiff successfully asserting a claim under both §502(a)(1)(b), to enforce the terms of a plan, and §502(a)(3) for breach of fiduciary duty; instead the Court indicated that equitable relief under § 502(a)(3) would 'normally' not be appropriate. Ultimately, we believe that the determination of **'appropriate equitable relief' rests with the district court should plaintiffs succeed in both claims."** *Devlin* at 89. **The Court in *Devlin* held that "*Varity Corp.* did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available; instead, the district court's remedy is limited to**

such equitable relief as is considered appropriate." *Id.* at 90. Furthermore, in *Frommert v. Conkright,* 433 F.3d 254 (2d Cir. 2006) the court disagreed with the district court's conclusion that all of the relief sought by the plaintiffs in their claim for breach of fiduciary duties can be adequately addressed by the relief available under §502(a)(1)(B). Thus, the Court in *Frommert* directed the district court that if the plaintiffs prevail on their claim, it must determine what 'appropriate equitable relief' is necessary." *Frommert* at 272.

VII. PLAINTFFS' COMPLAINT CORRECTLY PLEADS A CASE FOR INJUNCTIVE RELIEF.

Prudential also argues "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" (citing *Krauss v. Oxford Health Plans, Inc.* 517 F.3d 614, 630 (2d Cir. 2008)). Prudential completely misses the point here. Plaintiffs are seeking injunctive relief which would require Prudential not only to advise its participants of the changes in the voluntary appeals procedures, but also to re-evaluate each appeal which was not afforded a full and fair review. Requiring Prudential to provide participants with information about its new policies for voluntary appeals, which have been in effect for the last five years, but which have never been revealed to its participants, would not be futile. Furthermore, requiring Prudential to re-evaluate all voluntary appeals into which Prudential allowed Plaintiffs to enter blindly, under the misrepresentation that they would receive a full and fair review, would also not be an exercise in futility.

It is not uncommon in the disability insurance industry for a long-term disability insurance carrier to be ordered to re-evaluate disability claims due to wrongful claims handling procedures. [11][12]

CONCLUSION

For reasons stated above, Defendant's motion to dismiss pursuant to Rule 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure should be denied as a matter of law.

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[11] *See* Stipulation and Waiver; In The Matter of the Licenses and Licensing Rights of Life Insurance Company of North America, CASE NO: UPA 2008-0004; http//www. Insurance.ca.gov/0400-news/0100-press-releases/0080-2009/release146-09.cfm. wherein the Insurance Commissioner of the State of California came to an agreement with LINA in which LINA would stop all practices in violation of the Insurance Code and the California Code of Regulations by: updating and clarifying its policies and procedures; creating new policies and procedures that adhered to the code; reviewing all of California residents closed denied claims between January 1, 2005 through December 31, 2007; and paying a penalty of $600,000.

[12] *See* First Unum Life Insurance Company Regulatory Settlement Agreement; http//www.unum.com/settlementagreement/ where UNUM and the Superintendant of Insurance of the State of New York, the Commissioner of the Tennessee Department of Commerce and Insurance, the Commissioner of the Massachusetts Division of Insurance and the Superintendent of the State of Maine Bureau of Insurance (collectively with Lead Regulator, the "Lead Regulators") and the United States Department of Labor entered in an agreement wherein UNUM would provide an effective Claim Reassessment Process for an identified class of claimants who seek review of the earlier decision using an experienced claim unit formed by UNUM solely for the purpose to (i) perform a de novo review of the claims using past and current information that is relevant to the claim decision and (ii) apply the improved claim handling procedures…in order that this Claim Reassessment Process constitute a fair way in which to remedy deficiencies that may have affected earlier claim decisions…Unum also paid a $15,000,000 fine.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 18th day of June, 2010 a true and correct copy of the above and foregoing document has been electronically filed with the Clerk of the Court on this 18th day of June, 2010 by using the CM/ECF system which will send notice of electronic mail to:

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