No. 12-2308

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

TRI3 ENTERPRISES, LLC,
Plaintiff-Appellant,

v.

AETNA, Inc.,
Defendant-Appellee.

On Appeal from the United States District Court
for the District of New Jersey

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE SUPPORTING PLAINTIFF-APPELLANT

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QUESTION PRESENTED

Whether Aetna's demand for restitution of previously-paid benefits from a medical device supplier, because Aetna later determined those benefits to be not covered by the plan, is subject to review under ERISA and its accompanying claims regulation.

THE SECRETARY'S INTEREST

The Secretary of Labor ("Secretary") has primary regulatory and enforcement authority for Title I of ERISA. Pursuant to that authority and to ERISA section 503, 29 U.S.C. § 1133, the Secretary issued regulations that govern claims procedures applicable to benefit claims under the Act. Plaintiff Tri3 Enterprises ("Tri3"), a healthcare provider of medical equipment, allegedly obtained a valid assignment of participants' benefit claims and, as assignee of those claims and as the patients' authorized representative, was entitled to challenge Aetna's decision to reverse the award of benefits and demand reimbursement from Tri3 in an administrative claims process that complied with the Department of Labor ("Department")'s regulations. If, as Tri3 alleges, Aetna failed to comply with those regulations, the district court erred by dismissing Tri3's complaint.

The Secretary's interests include promoting uniformity of law, protecting beneficiaries, enforcing fiduciary standards, and ensuring the financial stability of employee benefit plan assets. Secretary of Labor v. Fitzsimmons, 805 F.2d 682,

692-93 (7th Cir. 1986) (en banc). Strict enforcement of the claims regulation is necessary to protect claimants who need the healthcare coverage that is provided under their plans. The district court's opinion permits insurers to make healthcare providers and plan participants assume liability for uncompensated care, while simultaneously denying them the full and fair claims process that ERISA and the Secretary's regulations require. The Secretary thus has a strong interest in reversing the district court's opinion to ensure that plans are operated in compliance with the regulatory requirements.[1]

STATEMENT OF FACTS

Tri3 is a provider of medical equipment to, among others, participants and beneficiaries in ERISA health care plans insured by the defendant Aetna. Tri3 Enterprises, LLC v. Aetna Inc., No. 11–3921, 2012 WL 1416530, at *1 (D. N.J. April 24, 2012). After providing equipment to participants and beneficiaries, Tri3 obtains assignments from the participants and beneficiaries for any of their ERISA claims. Tri3 Enterprises, 2012 WL 1416530, at *1. Tri3 is also allegedly the "authorized representative" of the beneficiaries or participants. Complaint [Doc. 1] ("Compl.") ¶¶ 11, 70, at A34, A52-53. As an out-of-network provider, Tri3 can also bill the patients for any unpaid benefits. Plaintiff's Reply Memorandum of

[1] The Secretary, however, does not express a view on the merits of the coverage dispute or on Aetna's fraud allegations. As explained below, at pp. 28-29, ERISA does not bar state law fraud claims if coverage is not proper under the plan.

Law in Support of Motion to File Supplemental Authority in Opposition to Defendants' Motion to Dismiss and to Apply Judicial Estoppel to Preclude Arguments Asserted by Defendants (filed 1/10/2012) [Doc. 44], at 7 ("Plaintiff's Reply Memorandum"); see Compl. ¶ 11, at A34.

As relevant to this case, Aetna paid Tri3 for its provision of two types of devices to participants and beneficiaries in numerous ERISA healthcare plans: the Game Ready and NanoTherm devices. Compl. ¶ 14, at A36; ¶ 18, at A38. These are "pneumatic compressors (non-segmental home model)" that "reduce[] pain, muscle spasms, tissue damage, and swelling." Compl. ¶¶ 16, 18, at A37-A38.

Aetna maintains a Special Investigations Unit ("SIU") to detect and investigate incorrect or fraudulent insurance claims through post-payment audits. Tri3 Enterprises, 2012 WL 1416530, at *1. As part of such an investigation, Aetna questioned Tri3's use of a billing code for the Game Ready and NanoTherm devices and determined that these devices are not covered by the ERISA plans. Id. at *2. Tri3 provided evidence showing that these devices were properly coded as non-segmented pneumatic compressors, which had been previously determined to be covered under the plan. Compl. ¶ 15 at A36-A37. Aetna rejected this evidence and concluded that, regardless of the billing code provided and its prior authorization of payment, no pneumatic compressors are covered under the plan and that the two devices at issue are, in any event, excluded from coverage because

Aetna considers them to be experimental and/or investigational. Compl. ¶¶ 15, 18, 20 at A36-A39; Plaintiff's Memorandum of Law in Opposition to Defendants' Motion for Failure to State a Claim (filed 9/19/2011) [Doc. 29], at 19. As a result, Aetna demanded restitution from Tri3 for the "overpayments." Tri3 Enterprises, 2012 WL 1416530, at *2. Aetna allegedly refused to treat its decision as a claims denial and refused to provide the procedural protections accorded under ERISA and its regulations to such decisions. E.g., Compl. ¶¶ 26-27, at A41-A42; ¶ 31, at A43.

Tri3, acting solely as an assignee of the beneficiaries and participants, sued Aetna pursuant to ERISA section 502(a)(1)(B) and for injunctive relief under section 502(a)(3). Compl. ¶¶ 59, 68, 76 and ¶ B, at A51-54. According to Tri3, Aetna's demands for restitution of previously paid benefits were "revised benefit determinations." See, e.g., id. ¶ 31, at A43. Tri3 further alleges that Aetna failed to provide either Tri3 or its patients a "full and fair review" of the denied claims pursuant to 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1. Id. ¶ 71, at A53. Tri3 asks the court to order Aetna to permit it to challenge the adverse benefits decisions in accordance with the claims procedures required by the ERISA claims regulation. Compl. ¶¶ C, D, E at A54. In the alternative, Tri3 also asks the court to deem the review process to be administratively exhausted, declare the claim

improperly denied, and enjoin recoupment of any paid benefits. Id. ¶¶ 75-76, at A53-A54.

Aetna moved to dismiss the claims, arguing that "the actions complained of arise in the context of fraud prevention and recovery" that other circuits have held may be pursued under state law without triggering ERISA preemption. Tri3 Enterprises, 2012 WL 1416530, at *4-*5 (citing Geller v. County Line Auto Sales, Inc., 86 F.3d 18 (2d Cir. 1996), and Trustees of the AFTRA Health Fund v. Biondi, 303 F.3d 765 (7th Cir. 2002)). Tri3 responded that its action is solely a dispute over whether the ERISA plans cover the disputed devices. Id. at *4.

The district court granted the motion to dismiss. First, it "rejected Tri3's argument that this is nothing more than a coverage dispute," finding instead that "[i]t is clear from the complaint that the central issue of the dispute is Aetna's allegation that Tri3 had misrepresented to Aetna the nature of the medical device that had been supplied to Insureds." Id. at *8. Second, the court found the precedents "holding that an insurer may bring claims for fraud and misrepresentation outside the context of ERISA to be persuasive and relevant to the instant dispute" even though, here, Tri3 brought its ERISA action in federal court before any state law action by Aetna was filed. Id. The court thus concluded: "the basis upon which an insurer seeks recovery in such circumstances derive [sic] from state law. . . . [e]ven though reference to the relevant plans may

be required to establish the context of any alleged misrepresentation." Id. at *9 (citations omitted).

SUMMARY OF ARGUMENT

The district court erred in viewing the complaint through the prism of preemption and Aetna's hypothetical state law claims of fraud. Properly analyzed under the Rule 12(b)(6) standard of review, the complaint adequately pleads ERISA claims to enforce plan terms. It also plausibly alleges that Aetna violated ERISA's procedural requirements for processing benefit claims. Accordingly, the complaint should survive a motion to dismiss.

ARGUMENT

TRI3'S CLAIM THAT AETNA'S DEMAND FOR REIMBURSEMENT BASED ON A RETROACTIVE DENIAL OF BENEFITS ON GROUNDS THAT THEY WERE NOT COVERED BY THE PARTICIPANTS' PLANS STATES AN ERISA CAUSE OF ACTION THAT THE DISTRICT COURT SHOULD NOT HAVE DISMISSED

A. The Complaint States ERISA Claims for Benefits and Injunctive Relief

Tri3 plainly pleads two federal claims based on ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and Section 502(a)(3), 29 U.S.C. § 1132(a)(3). Compl. ¶¶ 59, 70, at A51-A53. The complaint alleges that "Aetna 'denied claims' in a manner inconsistent with or unauthorized by the terms of the Plans" and seeks declaratory and injunctive relief to require Aetna to comply with the plan terms and ERISA when determining the claimant's entitlement to

previously-granted benefits. Tri3 Enterprises, 2012 WL 1416530, at *2; see Compl. ¶¶ B-E, at A54 (requesting the enforcement of procedural rights when determining the disputed plan benefits); 29 C.F.R. § 2560.503-1(a) (requiring plans to provide participants and beneficiaries certain minimum procedural rights when determining entitlement to plan benefits).

These claims are cognizable ERISA causes of action. Under section 502(a), "[r]elief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53 (1987); see also Franchise Tax Bd. of State of Cal. v. Construction Laborers, 463 U.S. 1, 10 & n.9, 27-28 & n.31 (1983) (noting that section 502(a) provides a declaratory judgment action to determine the meaning and enforceability of plan documents). More specifically, section 502(a)(1)(B) allows the participant or beneficiary "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). Section 502(a)(3) permits the participant or beneficiary "to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3).

As alleged, Tri3's claims simply seek to enforce plan terms, including the provision of benefits covered under the plan, and the statutory guarantee of procedural rights with respect to the determination of plan benefits. This request to

interpret and enforce plan terms subject to procedural safeguards is at the heart of ERISA's protections. 29 U.S.C. § 1001(a) ("that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [ERISA] plans"); Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 273 (3d Cir. 2001) ("[A] claim alleging that an [insurer] declined to approve certain requested medical services or treatment on the ground that they were not covered under the plan would manifestly be one regarding the proper administration of benefits"). Indeed, this Court has held: "'where 'plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) of ERISA is appropriate.'" Wirth v. Aetna U.S. Healthcare, 469 F.3d 305, 308-09 (3d Cir. 2006) (quoting Levine v. United Healthcare Corp., 402 F.3d 156, 163 (3d Cir. 2005)); see also Arana v. Ochsner, 338 F.3d 433, 438 (5th Cir. 2003) (en banc). That holding squarely applies to this case.

Accordingly, the complaint properly alleges federal ERISA claims to remedy the improper denial of benefits or rights promised by the employee benefit plans. Under the "well-pleaded complaint" rule, if the plaintiff, as a "master of the claim," properly pleads a cause of action arising under federal law in his complaint, there is federal subject-matter jurisdiction over the complaint. See Rivet v. Regions Bank of Louisiana, 522 U.S. 470, 475 (1998); Caterpillar Inc. v. Williams,

482 U.S. 386, 392 (1987) ("[t]he [well-pleaded complaint] rule makes the plaintiff the master of the claim"). There is no need to look beyond the complaint to any anticipated defenses. Rivet, 522 U.S. at 475.[2]

This Court has recognized federal jurisdiction over similar ERISA claims by assignees – including health provider assignees – of participant claims seeking enforcement or interpretation of ERISA plan terms. See United Steelworkers of America, AFL-CIO-CLC v. Rohm and Haas Co., 522 F.3d 324, 327, 334-35 (3d Cir. 2008) (union claim); Hahnemann Univ. Hosp. v. All Shore, Inc., 514 F.3d 300, 307-08 & n.5 (3d Cir. 2008) (healthcare provider claim); Pennsylvania Psychiatric Soc. v. Green Spring Health Services, Inc., 280 F.3d 278, 281 n.2 (3rd Cir. 2002) (same); see generally Connecticut State Dental Ass'n v. Anthem Health Plans, Inc., 591 F.3d 1337, 1347 (11th Cir. 2009) ("it is well-established in this and most other circuits that a healthcare provider may acquire derivative standing to sue under ERISA by obtaining a written assignment from a 'participant' or 'beneficiary' of his right to payment of medical benefits. . . . Claims for benefits by

[2] ERISA Section 502(a) identifies the substantive rights and provides the cause of action, and thus the jurisdictional basis, for Tri3's claims. The plaintiff's claims therefore cannot be characterized merely as a defense to Aetna's anticipated state law claims; nor does the plaintiff rely on the Declaratory Judgment Act for federal court jurisdiction. Compare Tri3 Enterprises, 2012 WL 1416530, at *8 (treating plaintiff's claim as merely a defense against Aetna's allegations of fraud); cf. Exxon Corp. v. Hunt, 683 F.2d 69, 73 (3d Cir. 1982) (describing the limited exception to the well-pleaded complaint rule for declaratory actions anticipating federal defenses to state law claim).

healthcare providers pursuant to an assignment are thus within the scope of § 502(a)").

Similarly, here, Tri3, acting on behalf of ERISA participants as an assignee, has properly invoked the district court's jurisdiction under section 502(e)(1) of ERISA to decide whether Aetna's retroactive denials and reimbursement demands are subject to ERISA's claims procedures. Section 502(e)(1), 29 U.S.C. § 1132(e)(1) provides, in relevant part: "Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, . . . State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraph[] (1)(B) . . . of subsection (a) of this section." Nothing in Aetna's arguments in response to the complaint that Tri3 improperly or even fraudulently billed and received payment for non-covered devices divests the court of that jurisdiction, or prevents the court either from remanding for exhaustion of the ERISA claims process or, alternatively, deciding on the merits the plan coverage issue at the heart of this dispute. There is thus no doubt that the complaint properly

invokes federal question jurisdiction by raising a question arising out of federal law and should not have been dismissed for failure to state an ERISA claim.[3]

B. ERISA's Claim Review and Appeal Process Applies to the Dispute Between Tri3 and Aetna

ERISA requires each plan to guarantee "full and fair review" of denied benefit claims and to ensure that beneficiaries and participants receive "adequate notice" of each plan's claim review process. 29 U.S.C. § 1133. ERISA section 503 delegates to the Secretary of Labor the regulatory authority to define these plan requirements. Id. Pursuant to this authority, the Secretary has issued extensive regulations governing procedures for processing claims. See 29 C.F.R. § 2560.503-1. Consistent with the statutory provision, the regulations require ERISA plans to provide specific procedures when the fiduciary renders an "adverse benefit determination." 29 C.F.R. § 2560.503-1(g)-(h). For example, the plan must provide an appeals procedure whenever it makes an "adverse benefit determination." Id. An "adverse benefit determination" means:

> any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit . . . including, with respect to group health plans, a denial, reduction, or

[3] "[T]he basis for petitioners' assertion that they had a federal right . . . governed wholly by federal law cannot be said to be so insubstantial, implausible, foreclosed by prior decisions of this Court, or otherwise completely devoid of merit as not to involve a federal controversy . . . whatever may be the ultimate resolution of the federal issues on the merits." Oneida Indian Nation of N. Y. State v. Oneida County, New York, 414 U.S. 661, 666-67 (1974). Here, however, the federal controversy is certainly substantial.

> termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

29 C.F.R. § 2560.503-1(m)(4). Application of this term to "any" "reduction" or "termination," and the reference to " any utilization review" with respect to group health plans, makes plain that the claims regulations apply to post-payment, or retroactive, denials of health benefits.[4]

After receiving Aetna's reimbursement demand for overpayments related to services and devices not covered under the participants' plans, Tri3 seeks an injunction and other relief pursuant to ERISA sections 502(a)(1)(B) and 502(a)(3) as an assignee of the ERISA participants. As stated earlier, section 502(a)(1)(B) gives participants (or assignees of participants) a cause of action "to enforce[their] rights under the terms of the plan," and section 502(a)(3) gives them the right to "enjoin" any act that violates ERISA or the terms of a plan, or "enforce any

[4] Aetna argued below that the claims regulations do not apply to allegations of fraud, "post-payment audits or the recovery of overpayments from providers." Brief in Reply and Further Support of Defendants' Motion to Dismiss for Failure to State a Claim [Doc. 32] (filed 10/7/2011), at 8 ("Aetna's Reply"). Aetna's citation to Midgett v. Washington Group Int'l Long Term Disability Plan, 561 F.3d 887, 894 (8th Cir. 2009), is inapposite. The passage cited discusses only the distinction between an initial adverse benefits determination and its appeal; it does not discuss the applicability of the "adverse benefits determination" definition to the situation at issue here.

provisions of this subchapter or the terms of the plan." 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3).

Because Tri3's complaint was dismissed on a Rule 12(b)(6) motion, the only issue on appeal is whether Tri3 plausibly alleged that Aetna's retroactive determination of lack of coverage violated ERISA's claims procedure requirements. See Tri3 Enterprises, 2012 WL 1416530, at *4; see also Brief in Support of Defendants' Motion to Dismiss for Failure to State a Claim, at 4 [Doc. 26-1] (filed 8/15/2011) ("this matter must be dismissed because all of Plaintiff's claims rest upon the erroneous legal theory that ERISA requirements for claim submissions specifically apply"). Tri3's proposed injunction would send the non-coverage determination back to Aetna and require Aetna to follow the ERISA claims procedure before making a final determination of non-coverage. See Syed v. Hercules Inc., 214 F.3d 155, 162 (3d Cir. 2000) ("the remedy for a violation of § 503 is to remand to the plan administrator so the claimant gets the benefit of a full and fair review"); Grossmuller v. Int'l Union, United Auto., Aerospace and Agr. Implement Workers of Am., 715 F.2d 853, 858-59 (3d Cir. 1983) (same).

Alternatively, this Court could direct the district court to decide the merits of the coverage dispute rather than send it back to Aetna. In addition to seeking a remand to the administrator, Tri3 also asked the court to deem the administrative process exhausted, resolve the coverage dispute, and directly enjoin Aetna from

recovering benefits paid if the benefits are actually covered by the plan. Compl. ¶¶ 74-76, at A53-A54; see 29 C.F.R. § 2560.503-1(l).

In either event, resolution of the issue before this Court turns on whether Aetna's retroactive determination to deny coverage for Tri3 devices constitutes an "adverse benefit determination" under 29 C.F.R. § 2560.503-1, which triggers the application of ERISA section 503 and its claims procedures. Included within this issue is whether that decision implicated a participant or beneficiary's "claim for benefits." If the answers are "yes," then ERISA's requirements apply to Aetna's decision to reverse its prior grant of benefits and to seek reimbursement. Preliminarily, however, it is necessary to establish that Tri3's claims are, in essence, claims of the participants who used Tri3's medical devices and who assigned to Tri3 the right to seek payments for coverage and to bring claims for any wrongfully denied benefits.

As set forth below, Tri3's assignment gave it the right to invoke the ERISA claims process, and that process applies to Aetna's retroactive benefits denial. Therefore, the case was erroneously dismissed.

1. Tri3 has the right as an assignee to bring ERISA benefit claims

The relationship between the beneficiary, its provider, and the insurer often turns on the provider's status as an "out-of-network" versus an "in-network" provider. In-network providers enter into contracts with health insurance

companies, such as Aetna, and agree to provide services to the insureds at a reduced rate in exchange for getting access to the insurer's patient base. Ordinarily, the insured beneficiary or participant is only required to pay an in-network provider the applicable co-payment or co-insurance under his plan and nothing more. On the other hand, out-of-network providers do not have a contractual arrangement for payment with the insurer. Accordingly, they typically require the insureds to provide assignments of benefits and afterwards submit claims directly to the insurer on the patients' behalf. Such providers may then be entitled to bill the patient for any amount exceeding what the plan will pay under the terms of its coverage. See generally Staten Island Chiropractic Associates, PLLC v. Aetna, Inc., No. 09–CV–2276, 2012 WL 832252, at *1 (E.D.N.Y. Mar. 12, 2012). In this case, Tri3 is an out-of-network provider that accepted an assignment of benefits from patients and has the right to bill patients for any costs the plan does not cover and to sue them for nonpayment. Compl. ¶ 11, at A34; Plaintiff's Reply Memorandum, at 7.

It is well established that assignee medical providers may challenge benefit denials through the claims process. See Advanced Rehabilitation, LLC v. UnitedHealthgroup, Inc., No. 11–4269, 2012 WL 4354782, at *1-*2 (3d Cir. September 25, 2012); Hahnemann University Hosp., 514 F.3d at 307-08 & n.5; accord Baptist Memorial Hospital--DeSoto Inc. v. Crain Automotive Inc., 392 F.

App'x 288, 291-93 (5th Cir. Aug. 19, 2010); Univ. Hospitals of Cleveland v. South Lorain Merchants Ass'n, 441 F.3d 430, 431, 434 (6th Cir. 2006). "As assignee, [the hospital] stands in the shoes of [the patient-participant] and may pursue only whatever rights [the patient-participant] enjoyed under the terms of the plan." Memorial Hosp. System v. Northbrook Life Ins. Co., 904 F.2d 236, 250 (5th Cir. 1990); accord Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997).

It is also the Department's longstanding position that assignee medical providers are entitled to challenge benefit denials through the claims process as authorized representatives in appropriate cases. In "FAQs About The Benefit Claims Procedure Regulation," the Department has stated that:

> Q-A8: Do the requirements applicable to group health plans apply to contractual disputes between health care providers (e.g., physicians, hospitals) and insurers or managed care organizations (e.g., HMOs)?
>
> A: No, provided that the contractual dispute will have no effect on a claimant's right to benefits under a plan. The regulation applies only to claims for benefits.
>
> [However] …. where a claimant may request payments for medical services from a plan, but the medical provider will continue to have recourse against the claimant for amounts unpaid by the plan, the request, whether made by the claimant or by the medical provider (e.g., in the case of an assignment of benefits by the claimant) would constitute a claim for benefits by the claimant.

http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html. The Secretary's interpretation of her own regulations, as here, is entitled to substantial deference. E.g., Martin v. Occupational Safety & Health Review Comm'n, 499 U.S. 144, 150-

51 (1991). The Secretary's views as expressed in these FAQs are entitled to deference. E.g., Black & Decker Disability Plan v. Nord, 538 U.S. 822, 833-34 (2003).[5]

2. Tri3's challenge concerns a "claim for benefits"

a. The FAQ section quoted above sets out three conditions for determining if there is a "claim for benefits" for which ERISA section 503 and claims regulation would apply: (1) whether the claim was made by the claimant or a medical provider with an assignment; (2) whether there is a request to a plan for medical service coverage; and (3) whether the provider will have recourse against the claimant for unpaid amounts. See Pennsylvania Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n, No. 09-C-5619, 2012 WL 4866494, at *6-*7 (N.D. Ill. Oct. 12, 2012).

All three conditions are satisfied here. First, the complaint makes clear that the medical provider is acting as an assignee and an authorized representative in disputing the coverage of the devices under the plan. Compl. ¶ 11, at A34. As an

[5] This Court has generally deferred to the Department's views on ERISA issues. E.g., In re U.S. Healthcare, Inc., 193 F.3d 151, 163 (3d Cir. 1999) (agreeing with the Secretary's amicus brief); Gruber v. Hubbard Bert Karle Weber, Inc., 159 F.3d 780, 787-88 (3d Cir. 1998) ("'[t]he Department of Labor's construction of ERISA is entitled to a substantial measure of deference"') (citation omitted) (citing Department's advisory letters). Other circuits have specifically deferred to the Secretary's views with respect to the claims procedure. E.g., Eastman Kodak Co. v. STWB, Inc., 452 F.3d 215, 222 (2d Cir. 2006) (relying on the Secretary's amicus brief to interpret the Secretary's claims regulations).

out-of-network provider, Tri3 obtained the assignment at the time of the medical services it provided, enabling it to be paid directly by the plan. Compl. ¶ 11, at A34, ¶ 14, at A36; Plaintiff's Reply Memorandum, at 7. The assignment also gave it the right to assert the participant's rights in an ERISA action. Compl. ¶ 11, at A34.

Second, Tri3 clearly alleges that the dispute is over plan coverage and the proper interpretation of the plan terms. Tri3 identifies conversations with Aetna's representatives, which confirm the dispute was over plan coverage. See Compl. ¶ 16, at A37; id. ¶ 18, at A38; id. ¶ 25, at A40. For example, Aetna's representative allegedly "stated that all pneumatic compression devices [including the devices in question] were not Covered Services under the terms and conditions of Aetna's Plans and thus were not eligible for payment." Compl. ¶ 16, at A37.

Third, Tri3 continues to have recourse against the claimant for amounts unpaid by the plan. Compl. ¶ 11, at A34 ("I [the participant] hereby guarantee payment to Tri3 of any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment thereunder.") (quoting participant's assignment to Tri3).

It is, accordingly, critical to this case that Tri3 is acting on an assignment of rights from the patient-participants, but retaining recourse against them should it be required to reimburse the insurer if the insurer determines sometime after payment

that the services were not covered under an ERISA plan. Unlike in-network providers, out-of-network providers, such as Tri3, do not have contracts with the insurer and their rights derive from the participants' assigned ERISA rights to plan benefits. See Hahnemann, 514 F.3d at 307-08 & n.5. Here, unlike in-network contractual disputes, which typically affect only how much the insurer owes the provider without affecting the patient's financial obligations, the grant or denial of the assigned claim has a direct effect on the plan participants or beneficiaries because the out-of-network provider has recourse against them for any healthcare costs not covered by those assigned ERISA plan benefits.

b. Tri3's case directly turns on questions of plan interpretation. E.g., Compl. ¶ 18, at A38 (alleging that Aetna had said that "Aetna doesn't cover the [Game Ready® Vasopneumatic Compression Device] regardless of the code billed."); see Aetna's Reply, at 11 ("Aetna explained to [Tri3] that the device should have been billed under a different code and that the type of device that was actually dispensed was not covered under the terms of the plans at issue"). As alleged, Aetna's demand for restitution is ultimately premised on its view that the medical devices were not covered by the plans, and Tri3 asserts the beneficiary or participant's right to have the benefits issue adjudicated in the claims process. Id.

Accordingly, contrary to the district court's decision, the dispute here does not merely concern the commercial relationship between a medical provider and an

insurer. Rather, the dispute concerns an assignee medical provider who is asserting the participants' rights under the ERISA plan as an ERISA party against the insurer, their ERISA fiduciary. See Memorial Hosp. System, 904 F.2d at 250. Those rights, as asserted by Tri3, include the right to challenge Aetna's interpretation of the plan and to obtain a "full and fair" review of the benefits denial. 29 U.S.C. § 1133; see Hahnemann, 514 F.3d at 307-08 & n.5; Tanzillo v. Local Union 617, Intern. Broth. of Teamsters, Chauffeurs, Warehousemen and Helpers, 769 F.2d 140, 144 & n.5 (3d Cir. 1985).

Moreover, as the Department has stated, even if Aetna views this challenge as completely without merit, the claimant, or his assignee, still has the right to exhaust the claims procedures. See "FAQs About The Benefit Claims Procedure Regulation," C-12, available at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html ("The fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule."); 65 Fed. Reg. 70246, 70255 n.37 (Nov. 21, 2000) ("the Department notes that all such claims for benefits are covered by this regulation, regardless of the reason or reasons a plan may have for denying the claim. . . . [A] claim for a health care service, even a health care service that is specifically excluded by the plan's governing documents, would be covered by the regulation") (preamble to the final claims regulations).

3. Aetna's denial of coverage is an "adverse benefits determination"

Aetna's denial of coverage for the Tri3 devices constitutes an "adverse benefits determination," thus triggering ERISA's and the claim regulations' administrative and judicial appeal procedure. The regulations define "adverse benefits determination" broadly as "a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit." 29 C.F.R. § 2560.503-1(m)(4). Aetna demanded restitution after it determined that the devices were not covered and thus it had made overpayments of benefits. E.g., Compl. ¶ 16, at A37; see also Tri3 Enterprises, 2012 WL 1416530, at *2. Here, Aetna first granted full benefits, which it now seeks to reverse. Whatever the merits of the latter decision, Aetna's reversal in its coverage determination and its overpayment demand constitute an "adverse benefits determination" because Aetna's actions effectively makes (because of Tri3's recourse right) the participants ultimately responsible for the reimbursement.

It bears emphasis that the claims procedure applies to all denials of benefits, whether made initially or after further review, and whether the benefit was initially granted or denied on other grounds. Where an insurer, for example, gives a new basis for a benefits denial on administrative appeal, such a new decision is subject to the claims procedure as if the appellate decision were an "initial denial." E.g., Gagliano v. Reliance Standard Life Ins. Co., 547 F.3d 230, 236 (4th Cir. 2008);

Martin v. Hartford Life and Acc. Ins. Co., 478 F. App'x 695, 698 (2d Cir. Apr. 19, 2012). Analogously, Aetna's new benefits denial decision is subject to the claims procedure in the same way as an "initial denial." This Court's decisions in Miller v. American Airlines, Inc., 632 F.3d 837 (3d Cir. 2011) and Foley v. Int'l Brotherhood of Elec. Workers Local Union 98 Pension Fund, 271 F.3d 551 (3d Cir. 2001), are instructive. In Miller, the Court considered its prior decisions involving instances where plan trustees had changed their minds and revoked previously granted benefits. Id. at 848 (citing Foley). While these decisions concerned whether a reversal of a benefits decision "is a significant factor to be weighed on arbitrary and capricious review," Miller, 271 F.3d at 848, they applied ERISA's procedures and standards of review to the subsequent denial. Id. at 844-45; Foley, 271 F.3d at 555.

Similarly, in Miller v. Fortis Benefits Ins. Co., 475 F.3d 516, 521-22 (3rd Cir. 2007), this Court noted that a plan's incorrect calculation and payment of benefits after originally granting the benefits at the proper percentage of salary was an alleged "underpayment" of benefits, and, therefore, an "adverse benefits determination" as defined by the claims regulation. See also Hahnemann University Hosp., 514 F.3d at 303-304 (claims regulation applied to payment dispute arising months after initial determination of coverage). The claims regulation and the Department's FAQs contemplate these situations by recognizing

disputes that are subsequent to the initial claims decision (i.e., a grant or denial) to be "adverse benefits determinations." See 29 C.F.R. § 2560.503-1(m)(4) (defining "adverse benefits determination" as "a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit"); "FAQs About The Benefit Claims Procedure Regulation," C-12, available at http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (noting that payments of less than 100% of claims are considered adverse benefits determinations). Likewise, in cases where the plan seeks reimbursement for already paid benefits it determines to have been wrongly paid, the dispute is rightly characterized as a dispute over benefits due under the plan, and, therefore, the reimbursement demand is an "adverse benefits determination." See, e.g., Wirth, 469 F.3d at 309 (recognizing that benefits are not fully recovered for the beneficiary when the plan seeks reimbursement because they are "under something of a cloud") (quoting Arana, 338 F.3d at 438). The precondition for invoking the claims process is therefore met in these circumstances.

Accordingly, the district court erred in concluding that ERISA did not apply to Aetna's reversal of its coverage decision.

C. The District Court Erred in Adopting Aetna's View of the Dispute

Instead of protecting the claimant's right to dispute a fiduciary-administrator's plan interpretation through the claims procedure, the district court

improperly deferred to Aetna's characterization of Tri3's claims and its plan interpretation as "fraudulent" or without merit. As required on a motion to dismiss, the court failed to accept as true Tri3's allegations and failed to draw all reasonable inferences in favor of Tri3. See DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 445 (3d Cir. 2003); compare Tri3 Enterprises, 2012 WL 1416530, at *4, *8 (finding that "[i]t is clear from the complaint that the central issue of the dispute is Aetna's allegation that Tri3 had misrepresented to Aetna the nature of the medical device") (emphasis added). As alleged and previously discussed, however, the dispute turns on the parties' disagreement over plan coverage.

A coverage dispute is a clear ERISA issue. This is true whether the claimant is seeking to rectify a wrongful denial of promised benefits or the plan fiduciary is seeking to rectify a wrongful grant of benefits not promised under the plan. E.g., Aetna Health Inc. v. Davila, 542 U.S. 200, 213-214 (2004) (finding section 502 "relates to" preemption for claimants who "br[ought] suit only to rectify a wrongful denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA"); see also id. ("[Fiduciaries'] potential liability . . . in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans."); Pilot Life, 481 U.S. at 47-48, 56-57 (finding section 514 express preemption for state law claims related to the processing of claims).

Aetna and the district court relied on two inapposite appellate cases from different circuits in which the insurer alleged fraud in state court actions against a claimant for misrepresenting facts that permitted a grant of benefits. In those cases, the disputes centered on whether the participants had defrauded the plans by making misrepresentations about employment and marital status, and the defendants unsuccessfully argued that ERISA preempted such ordinary state law claims. See Geller, 86 F.3d at 20 (the beneficiary was never an employee); Biondi, 303 F.3d at 770 (the claimant failed to notify Trustee that he had divorced a previously covered beneficiary).

These preemption cases presented no issue of plan interpretation (the plans clearly covered only employees or married spouses) and the participants did not seek relief based on an asserted violation of the right to a full and fair claims process. Thus, the more recent Biondi decision summarized both cases as holding that state law fraud claims against participants or beneficiaries that *do not require plan interpretation* are not preempted by ERISA. 303 F.3d at 780. Neither decision addressed the issue presented by this case: a participant's right, through an assignee, to bring an ERISA suit to resolve a question of plan interpretation through the claims process and in federal court. In contrast to Geller and Biondi, disputes over plan interpretation arising from plans' attempts to recover paid benefits have been analyzed under ERISA. See D & H Therapy Associates, LLC

v. Boston Mut. Life Ins. Co., 640 F.3d 27, 32-34 (1st Cir. 2011) (reviewing under ERISA a participant's challenge to a plan interpretation adopted by an administrator exercising the plan's right to recover paid benefits); Herman v. Central States, Southeast and Southwest Areas Pension Fund, 423 F.3d 684, 694-95 (7th Cir. 2005) (same); Jordal v. Simmons, 926 F.2d 223, 225-26 (2d Cir. 1991) (noting that whereas the plan may grant a "'right to recover . . . any benefit payment made in error,' the determination of whether a payment has been made in error still turns on an interpretation of eligibility under a specific plan," and, therefore, is reviewed under ERISA).

In any event, there is no reverse preemption under ERISA. Assuming, therefore, that Aetna can pursue an action against Tri3 for reimbursement on a common law fraud or wrongful payment theory without the action being preempted by ERISA, when an unresolved issue of plan interpretation lies at the heart of the dispute, it does not follow that Tri3's ERISA action fails to establish subject-matter jurisdiction or requires dismissal in anticipation of Aetna's hypothetical state-law cause of action. The district court was wrong to hold otherwise.

D. ERISA's Purposes Favor Reversal

Under the district court's view, the initial payment of benefits would presumably be subject to the claims procedure but Aetna's subsequent denial would

not. As a result, the plan participant would be subject to liability for benefits that the participant had received in reliance on the plan's earlier determination, without any means for challenging the plan's revised determination. Such a result is wholly inconsistent with the Secretary's claims regulation and the statutory requirement for full and fair review of adverse benefit decisions. Insurers cannot retroactively deprive plan participants of valuable benefits and leave them fully liable for expensive medical treatment, without even providing a means of challenging the benefit denial or its legitimacy under the plan's terms.

Moreover, such a result perversely incentivizes retroactive denials by insulating such decisions from ERISA and its claims regulations. Cf. Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 974 (9th Cir. 2006) ("[A]n administrator that adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review, contravenes the purpose of ERISA."); Juliano v. Health Maint. Org. of N. J., Inc., 221 F.3d 279, 287 (2d Cir. 2000) (same). From an ERISA perspective, there is nothing wrong, and much to commend, in post-award investigations of potential fraud or mistaken overpayments. But if a plan permits the type of retroactive review of claims that Aetna, through its SIU, undertook in this case, ERISA does not countenance the short-circuiting of the procedural protections, including federal court review, afforded to participants when reviewing a benefit denial, whenever such review

takes place. E.g., D & H Therapy Associates, 640 F.3d at 32-34; Jordal, 926 F.2d at 225-26.

The crux of the question at issue here is not whether the plaintiff or the defendant is correct in their views of the plan terms, but whether Aetna must comply with the procedures mandated by ERISA section 503 and its accompanying regulations in rendering a determination based on a plan interpretation that is adverse to the plan participants and beneficiaries. Under the statute and regulations, the beneficiary or participant is entitled to a claims procedure that "afford[s] a reasonable opportunity . . . for a full and fair review by the appropriate named fiduciary of [a] decision denying [a] claim," 29 U.S.C. § 1133, and can then appeal the denial in federal or state court. See 29 U.S.C. §§ 1132(a)(1)(B), (e); 29 CFR § 2560.503-1(g)(1)(iv), (l) (noting that if the "the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim," the beneficiary is entitled to seek remedies in court). If the claims regulation process Tri3 has sought to pursue yields a definitive plan interpretation and Aetna prevails, Aetna can pursue a state law claim against Tri3 for fraud based on the interpretation of plan non-coverage established in that process. See Biondi, 303 F.3d at 770, 782; Geller, 86 F.3d at 20 (permitting state law fraud actions where there were undisputed plan terms); cf. Altria Group v. Good, 555 U.S. 70, 79-80 (2008) (recognizing that the duty not to commit fraud is

an independent legal duty). Alternatively, if its plan provides for reimbursement actions, see Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 362-64 (2006), Aetna could pursue an equitable claim under ERISA section 502(a)(3) for reimbursement of any overpayments. See Louisiana Health Service & Indem. Co. v. Rapides Healthcare System, 461 F.3d 529, 536 (5th Cir. 2006) (citing Bombardier Aerospace Emp. Wel. Benef. Plan v. Ferrer, Poirot and Wansbrough, 354 F.3d 348, 356-58 (5th Cir. 2003)). In either event, Tri3 is entitled to insist upon its assigned right to challenge the allegedly wrongful decision to deny benefits through a process that complies with the claims regulation.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests the Court reverse the district court's order dismissing the case, and remand the case for further proceedings.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32A

I hereby certify that this brief complies with Federal Rule of Appellate Procedure 32(a)(7)(B). It has a total of 6,998 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6). It has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman font size 14.

Dated: November 30, 2012

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CERTIFICATE OF SERVICE

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IDENTICAL COMPLIANCE OF BRIEF

I certify that the text of the E-Brief and the text of the hard copies are identical.

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CERTIFICATION OF VIRUS CHECK

I certify that a virus check was performed on the PDF file of the brief using

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