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

Case No. 17-22886-CIV-WILLIAMS/TORRES

STEPHEN A. MARINO, JR.,

Plaintiff,

v.

BLUE CROSS & BLUE SHIELD OF FLORIDA, INC., d/b/a/ FLORIDA BLUE,

Defendant.
_____/

**REPORT AND RECOMMENDATION ON DEFENDANT'S MOTION TO DISMISS**

This matter is before the Court on Defendant's Motion to Dismiss the Amended Complaint ("Defendant's Motion" or the "Motion"), filed on January 4, 2018. [D.E. 17]. Plaintiff filed its Response on February 21, 2018 [D.E. 24], and Defendant's Reply followed on March 9. [D.E. 26]. Upon review of the Motion, the Response and Reply, and all relevant authorities, we hereby **RECOMMEND** that Defendant's Motion be **DENIED**.

## *I. BACKGROUND*

On June 20, 2017, Plaintiff filed a one-count complaint in Florida state court. [D.E. 1-2 at 2]. According to Plaintiff, Defendant provided health insurance coverage to Marino and his family under a group policy secured through Plaintiff's employment as a lawyer (the "Plan"). *Id.*, ¶ 4. Plaintiff claimed that he incurred medical expenses in connection with treatment provided to his son for conditions

covered by the insurance policy, and that Defendant refused to provide reimbursement for those costs. *Id.*, ¶¶ 8-10. The complaint asserted a single claim for breach of contract against Defendant, which included the allegation that Defendant violated Fla. Stat. § 627.6686 in failing to provide payment for the medical treatment at issue. *Id.*, ¶¶ 10, 14.

On July 31, 2017, Defendant removed the case to federal court, asserting jurisdiction pursuant to 28 U.S.C. § 1331 and arguing that the Employment Retirement Income Security Act of 1974 ("ERISA") preempted Plaintiff's claim in its entirety. [D.E. 1, ¶ 7-9]. Defendant supported removal with an affidavit from Annette Norman, a consultant in Florida Blue's legal affairs department, who stated that the plan at issue is governed by ERISA. [D.E. 1-3, ¶ 6]. Plaintiff does not dispute this fact.

Defendant then moved to dismiss the complaint based on the alleged ERISA preemption. [D.E. 4]. This Court granted Defendant's motion, dismissing the complaint without prejudice and noting that Plaintiff should be given the chance to amend the pleading in order to pursue the claim under ERISA. [D.E. 12 at 6].

On December 21, 2017, Plaintiff filed the Amended Complaint. [D.E. 16]. Plaintiff again claims that he incurred medical expenses in connection with medically necessary treatment provided to his son for conditions covered under the insurance policy, and that Defendant refused to provide reimbursement for those costs. *Id.*, ¶¶ 8-16. The Amended Complaint asserts a single count for recovery of benefits pursuant to 29 U.S.C. § 1132(a)(1)(B), *id.*, ¶ 19-23, which includes

allegations that Plaintiff has "exhausted all administrative remedies and any further administrative review would be futile," *id.*, ¶ 17, and that "[a]ll conditions precedent to bringing this action have been met, been waived or otherwise occurred." *Id.*, ¶ 18. Plaintiff also alleges that the insurance policy upon which this lawsuit is based "is not in Plaintiff's possession but, upon information and belief, is in [Defendant's] possession, and will be filed with the Court upon receipt of same from [Defendant]." *Id.*, ¶ 6.

In connection with these allegations, Plaintiff claims that he had "been damaged, which damages will continue to accrue as a result of [Defendant's] continuing breaches through the date of trial." *Id.*, ¶ 23. Plaintiff requests judgment against Defendant "for past due benefits, together with pre- and post-judgment interest, attorney's fees and court costs, and such other relief as the Court deems just and equitable." *Id.* On January 4, 2018, Defendant moved to dismiss the Amended Complaint. [D.E. 17].

In the pending Motion to Dismiss, Defendant argues that Plaintiff again did not state a claim for relief, this time under section 1132(a)(1)(B) of ERISA. Defendant posits that Plaintiff failed to adequately plead that he has exhausted his administrative remedies under the Plan, failed to identify any Plan terms that entitle Plaintiff to relief, and failed to seek appropriate relief under the statute. [D.E. 17]. We shall address each issue in turn.

## *II. LEGAL STANDARD*

The purpose of a motion under Federal Rule of Civil Procedure 12(b)(6) is to test the facial sufficiency of a complaint. *In re Managed Care Litig.*, 595 F. Supp. 2d 1349, 1352 (S.D. Fla. 2009). The rule permits dismissal of a complaint when it fails to state a claim upon which relief can be granted. Fed. R. Civ. P. 12(b)(6). It should be read alongside Rule 8, which requires "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). The purpose of this requirement "is to give the defendant fair notice of what the claim is and the grounds upon which it rests." *Davis v. Coca-Cola Bottling Co. Consol.*, 516 F.3d 955, 974 (11th Cir. 2008) (quotation omitted). The Supreme Court has held that "[w]hile a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, a plaintiff's obligation to provide the 'grounds' of his 'entitlement to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (internal citations omitted). "Factual allegations must be enough to raise a right to relief above the speculative level." *Id.*

To survive a motion to dismiss, a complaint "must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quotations and citations omitted). "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." *Id.* When considering a motion brought under Rule 12(b), a

court must accept all of the plaintiff's allegations as true. *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984).

## *III. ANALYSIS*

### *A. Exhaustion of Administrative Remedies Under ERISA*

It is understood that plaintiffs in ERISA cases must normally exhaust available administrative remedies before filing suit in federal court. *Counts v. Am. Gen. Life & Accident Ins. Co.*, 111 F.3d 105, 108 (11th Cir. 1997). This exhaustion requirement applies to both breach of contract claims and to actions premised on alleged statutory violations. *Springer v. Wal-Mart Assocs.' Grp. Health Plan*, 908 F.2d 897, 899 (11th Cir. 1990) (internal citations omitted). However, district courts have discretion to excuse the exhaustion requirement when resort to administrative remedies would be futile or the remedy inadequate, *Springer*, 908 F.2d at 899, or where meaningful access to the administrative review process has been denied. *Perrino v. So. Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000). But a plaintiff must make a "clear and positive" showing of futility before the Court can excuse the exhaustion requirement. *Bickley v. Caremark Rx, Inc.*, 461 F.3d 1325, 1330 (11th Cir. 2006). Simply pleading that "all conditions precedent have been satisfied" or that all "such conditions have been waived or excused" is not sufficient to excuse exhaustion. *Variety Children's Hosp. v. Century Medical Health Plan, Inc.*, 57 F.3d 1040, 1042 n. 2 (11th Cir. 1995).

Relying on these principles, Defendant first argues that the Amended Complaint should be dismissed because Plaintiff fails to adequately allege that he

has exhausted his administrative remedies under the Plan. [D.E. 17 at 4]. Specifically, Defendant argues that Plaintiff "failed to allege any facts whatsoever detailing what action Plaintiff took under the Plan's administrative appeals process or the outcome of any such action." *Id.* at 5.

Defendant relies upon *Variety Children's Hosp.*[1], *Byrd*[2], and *Sanctuary Surgical Centre, Inc.*[3] in support of its argument. In *Variety Children's Hosp.*, a district court found that the hospital failed to properly plead the exhaustion requirement of ERISA where plaintiff alleged that "[a]t all times material hereto, the [p]laintiff performed all obligations imposed on her by the contract of insurance in effect or, in the alternative, such conditions have been waived or excused," 942 F. Supp. at 568, but failed to allege any facts whatsoever relating to administrative remedies. In *Byrd*, the Eleventh Circuit upheld the district court's determination that the plaintiff failed to properly plead exhaustion because the plaintiff "did not allege anything about whether she pursued any available relief under the claims procedures terms of [the] employee benefits plan." 961 F.2d at 160-61. And in *Sanctuary Surgical Centre, Inc.*, the Court held that this provider did not properly plead the exhaustion requirement of ERISA even though it alleged that they had "filed internal appeals" where they also failed to allege that the appeals process was followed to its conclusion. 2011 WL 2134534, at *3.

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[1] *Variety Children's Hosp. v. Blue Cross/Blue Shield of Florida*, 942 F. Supp. 562 (S.D. Fla. 1996).
[2] *Byrd v. MacPapers, Inc.*, 961 F.2d 157 (11th Cir. 1992).
[3] *Sanctuary Surgical Centre, Inc. v. United Healthcare, Inc.*, 2011 WL 2134534 (S.D. Fla. May 27, 2011).

In contrast, however, we find that the allegations set forth in this complaint are readily distinguishable from those cases. The complaints in *Variety Children's Hosp.* and *Byrd* failed to address any claims procedures at all related to administrative remedies, *see Variety Children's Hosp.*, 942 F. Supp. at 568; *Byrd*, 961 F.2d at 160-61, and the complaint in *Sanctuary Surgical Centre, Inc.* although it addressed claims procedures, failed to allege that the plaintiff followed the appeals process to its conclusion or was otherwise prevented from doing so. *See Sanctuary Surgical Centre*, 2011 WL 2134534, at *3.

This Amended Complaint is not plagued by either deficiency. *See* [D.E. 16, ¶ 17] ("Plaintiff has exhausted all administrative remedies and any further administrative review would be futile."). By alleging that Plaintiff "has exhausted all administrative remedies," *id.*, the Amended Complaint clearly addresses that Plaintiff pursued *and* exhausted claims procedures. *Id.* Additionally, in support of the alternative allegation of futility, Plaintiff alleges that Defendant failed to respond to Plaintiff's timely submitted claim for over ninety (90) days; that despite intervention of a claims consultant, Defendant again failed to meaningfully respond or make payment; and that Defendant almost entirely ignored or otherwise declined Plaintiff's claims. *Id.*, ¶¶ 14-16; *see Sanctuary Surgical Centre*, 2011 WL 2134534, at *9 ("To properly plead futility, plaintiffs must allege why exhausting their administrative remedies would be futile and provide sufficient detail to make their claim of futility plausible.").

Support for this can be found in the cases cited by Plaintiff mirror the

allegations in the Amended Complaint and support the position that Plaintiff where those complaints satisfied the requirements for pleading exhaustion under ERISA. *See Chiropractic Wellness Ctr., Inc. v. Aetna, Inc.*, 2015 WL 144243, at *5 (M.D. Fla. Jan. 12, 2015) (finding that plaintiffs properly pleaded the exhaustion requirement of ERISA by alleging that the exhaustion requirement was deemed fulfilled by operation of the law or, in the alternative, that the requirement was excused due to futility); *Ruiz v. Motorola Solutions, Inc.*, No. 13-62666, 2014 WL 11706425, at *2 (S.D. Fla. July 21, 2014) (finding that the plaintiff properly pleaded exhaustion by alleging that he had "exhausted all levels of the administrative remedies and appeals in compliance with the Plan prior to the filing of the within lawsuit" [D.E. 38, ¶ 12]); *O'Toole v. Ford Motor Co.*, 2014 WL 2532451, at *4 (M.D. Fla. Mar. 6 2014) (finding plaintiff's allegation that he had "exhausted his administrative remedies by submissions to the [Plan] Administrator, to no avail" was sufficient because plaintiff was not required to plead specificity for the condition precedent of exhaustion of administrative remedies); *Markwart v. United Parcel Service*, 2013 WL 3864347, at *5 (M.D. Fla. July 24, 2013) (finding plaintiff's allegation that "she administratively exhausted her claim" was sufficient to survive a motion to dismiss).

We find that Plaintiff has the better side of the argument in this round of dismissal motions. Accordingly, we find that Plaintiff's allegations are sufficient for pleading purposes and the motion to dismiss the Amended Complaint should be denied. *See also Mercek v. Northwest Airlines Corp.*, 2007 WL 4557153, at *2 (S.D.

Fla. Dec. 20, 2007) (finding plaintiff's allegations that "[a]ll administrative remedies have been exhausted, or, in the alternative, such exhaustion is either not required, has been waived or is futile" were sufficient to survive a motion to dismiss).

***B. Plan Terms***

Defendant's next argument is that the Amended Complaint should be dismissed because Plaintiff has not pleaded sufficient facts about the Plan's provisions to make the ERISA claim plausible and to put Defendant on notice as to which provisions of the Plan it allegedly breached. [D.E. 17 at 7-8].

Defendant cites several inapposite cases in support of its argument that failure to specify an allegedly breached plan term is grounds for dismissal. *See, e.g.*, *Sanctuary Surgical Ctr., Inc. v. United Health Grp., Inc.*, 2013 WL 149356, at *1 (S.D. Fla. Jan. 14, 2013) (granting defendant's motion to dismiss because plaintiffs failed to identify a specific plan term that conferred the benefit in question in an action involving "at least 300 different health insurance plans governing 996 derivative ERISA benefit claims asserted on behalf of approximately 500 different patients"); *In re Managed Care Litig.*, 2009 WL 742678, at *3 (S.D. Fla. Mar. 20, 2009) (granting defendants' motion to dismiss in an action by six health care providers and an additional 1,019 unnamed plaintiffs because plaintiffs' allegation that the relevant insurance plans were "group health insurance policies constitut[ing] employee welfare plans as defined by [ERISA]" failed to put defendants on notice of the intended benefits or the proper beneficiaries under each plan).

Again, we find that the allegations set forth in these cases are readily distinguishable from ours. Here, Plaintiff alleges that Defendant provided health insurance coverage to Plaintiff and his son, [D.E. 16, ¶ 6], that Plaintiff is member number H2625904003, *id.*, that Plaintiff and his son were insured at all times material to the action, *id.*, ¶ 7, that Plaintiff began receiving treatment for developmental delays diagnosed by his primary care physician, *id.*, ¶ 8, that Plaintiff's son was then diagnosed with autism and began receiving additional treatment, *id.* ¶ 9-10, that the treatment provided to Plaintiff's son is medically necessary and covered by the policy, *id.*, ¶ 12, that Plaintiff has expended roughly four thousand dollars per month for these treatments, *id.*, ¶ 11, that Defendant has failed to meaningfully respond to Plaintiff or reimburse Plaintiff for these costs, *id.*, ¶ 16, and that Plaintiff requests judgment against Defendant for past due benefits. *Id.* at 3.

Unlike the cases cited by Defendant, which involve hundreds or thousands of plaintiffs and allege the existence of several unidentifiable plans, this case involves only one plaintiff and only one particular plan, and the Amended Complaint sufficiently identifies the plan at issue. The factual content of the Amended Complaint describes the benefits covered by the Plan, the beneficiaries under the Plan, the services provided under the Plan, the source of financing of the Plan, the procedure for receiving benefits under the Plan, and the alleged breach of the Plan. So through an objective review of the Amended Complaint, Defendant cannot persuasively claim that the allegations failed to put Defendant on notice of the

grounds upon which the claim rests, *see Davis*, 516 F.3d at 974, or that Plaintiff failed to state a plausible claim for relief. *Iqbal*, 556 U.S. at 678. Accordingly, we find that these allegations are sufficient to survive the motion to dismiss.

***C. Relief***

Defendant finally argues that the Amended Complaint fails to state a claim because it seeks an inappropriate remedy; namely legal relief in the form of damages. [D.E. 17 at 8].

Section 502(1)(a)(B) provides that "[a] civil action may be brought by a participant or beneficiary . . . 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.A. § 1132(a)(1)(B). Furthermore, the Eleventh Circuit has treated actions to recover benefits under section 502(a)(1)(b) as equitable in nature. *Hunt v. Hawthorne Assocs., Inc.*, 119 F.3d 888, 907 (11th Cir. 1997). Based on this Defendant interprets the Amended Complaint as seeking relief that goes beyond what section 1132 may provide.

On this score Defendant is making more of Plaintiff's allegations than necessary. Here, Plaintiff plainly alleges that he has been "damaged, which damages will continue to accrue as a result of [Defendant's] continuing breaches through the date of trial." [D.E. 16, ¶ 23]. Plaintiff also requests judgment against Defendant "for past due benefits, together with pre- and post-judgment interest, attorney's fees and court costs, and such other relief as the Court deems just and equitable." *Id.* at 3-4. To the extent the Amended Complaint is unclear, we

construe Plaintiff's allegations to mean that Plaintiff requests recovery of all benefits due under the Plan at the time a judgment is rendered. We also note that, in an action pursuant to 29 U.S.C. § 1132(a)(1)(B), "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C.A. § 1132(g)(1). Accordingly, we find no deficiency in Plaintiff's request for relief. And even if there was such a deficiency, dismissal is not required. The allegations in the Amended Complaint are sufficient to withstand Defendant's Motion to Dismiss.

## *III. CONCLUSION*

For the foregoing reasons, the Court **RECOMMENDS** that the Motion to Dismiss be **DENIED**. [D.E. 17]. Pursuant to Local Magistrate Rule 4(b) and Fed. R. Civ. P. 73, the parties have fourteen (14) days from service of this Report and Recommendation within which to file written objections, if any, with the District Judge. Failure to timely file objections shall bar the parties from *de novo* determination by the District Judge of any factual or legal issue covered in the Report *and* shall bar the parties from challenging on appeal the District Judge's Order based on any unobjected-to factual or legal conclusions included in the Report. 28 U.S.C. § 636(b)(1); 11th Cir. Rule 3-1; *see, e.g., Patton v. Rowell*, 2017 WL 443634 (11th Cir. Feb. 2, 2017); *Colley v. Comm'r of Social Sec.*, 2016 WL 7321208 (11th Cir. Dec. 16, 2016).

**DONE AND SUBMITTED** in Chambers at Miami, Florida this 2nd day of April, 2018.

/s/ *Edwin G. Torres*
United States Magistrate Judge