United States Court of Appeals
for the
Third Circuit

No. 14-2101

NORTH JERSEY BRAIN & SPINE CENTER,

Appellant,

– against –

AETNA, INC.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
CIVIL ACTION NO. 2:13-05286 (WJM)

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND THE MEDICAL SOCIETY OF NEW JERSEY IN SUPPORT OF PLAINTIFF-APPELLANT AND URGING REVERSAL OF THE DISTRICT COURT JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici*, the American Medical Association ("AMA") and the Medical Society of New Jersey ("MSNJ"), state that they are not-for-profit corporations and no publicly held corporation owns 10% or more of their stock.

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FED. R. APP. P. 29(c)(5) DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 29(c)(5), *amici* the American Medical Association and the Medical Society of New Jersey state that no party or party's counsel authored this brief in whole or in part or contributed money intended to fund the preparation or submission of this brief. *Amici* further state that a portion of the funding for this brief will come from the Litigation Center of the AMA and the State Medical Societies. No other person contributed money intended to fund the preparation or submission of this brief.

IDENTIFICATION AND INTEREST OF AMICI AND SOURCE OF AUTHORITY

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA policy-making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all states, including New Jersey, and in all areas of medical specialization.

The Medical Society of New Jersey ("MSNJ") is a non-profit professional society organized under the laws of the State of New Jersey. MSNJ was founded in 1766 and was the first state society of physicians in the nation. It is the largest

professional association of physicians, residents, and medical students in New Jersey. MSNJ's mission is to promote the betterment of public health and the science and art of medicine, to enlighten public opinion regarding problems of medicine, and to safeguard the rights of the practitioners of medicine.

MSNJ regularly participates in important issues in the judicial, legislative, and regulatory arenas. For more than a decade, MSNJ has led efforts in the State of New Jersey to ensure that physicians are promptly and adequately paid for their services. This includes efforts to reduce the administrative burden of processing insurance claims so that physicians may spend quality time with patients – not chasing payment for their services. Prompt, efficient, and adequate payment for physicians' medical services rendered to patients who have out-of-network insurance benefits ensures that physicians can continue to provide quality medical services to these and other patients.

In particular, MSNJ has advocated for years to require insurance carriers in New Jersey to honor assignments of benefits from patients to their out-of-network physicians. This *amici* brief is part of MSNJ's ongoing effort to ensure that physicians can enforce their assignments, be paid for their services, and keep their focus on providing quality care.

The AMA and the MSNJ join in this Brief on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical

Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The source of authority to file this brief is the consent of all parties.

ISSUE ADDRESSED IN *AMICI* BRIEF

The following brief addresses whether the transfer to a health care provider of a patient's right under an employee welfare benefit plan to payment for covered health services is sufficient to give the provider statutory standing to pursue a claim for benefits under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

STATEMENT OF THE CASE

Plaintiff North Jersey Brain and Spine Center ("NJBSC") is a medical practice specializing in treatment of the brain and spinal cord. PA13, ¶ 1. NJBSC's surgeons operated on three patients who were insured under employee welfare benefit plans administered by Aetna. PA14, ¶ 2. NJBSC obtained assignments from each of these patients, which stated: "I hereby assign to [NJBSC] all payments for medical services rendered to myself or my dependents." PA21-23.

There is no dispute that the surgeries were "medically necessary" and authorized by Aetna in all three cases. PA14, ¶ 2. Nevertheless, Aetna denied or underpaid each of the three claims. *Id.*, ¶ 3. NJBSC appealed the adverse benefits

determinations to Aetna, without success, and subsequently filed this lawsuit pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). PA15, ¶¶ 4-5.

NJBSC attached the three assignments to its Complaint. PA21-23. Aetna filed a motion to dismiss for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6), asserting that the assignments were insufficient to give NJBSC statutory standing to assert ERISA benefits claims because they transferred "merely the right to receive direct payment," and were therefore not "assignment[s] of benefits" under ERISA. Brief in Supp. of Def.'s Mot. to Dismiss 7-8, ECF No. 5. The District Court agreed and dismissed the Complaint, finding that "more than the right to payment is necessary to confer derivative standing under ERISA," and that, instead, "the assignment must include the patient's legal claim to benefits under the plan." PA9. NJBSC sought permission to appeal, which was granted by this Court on April 28, 2014. PA3. *Amici* submit this brief in support of NJBSC's appeal because affirmance of the District Court's ruling would cast doubt on the business practices of physicians throughout this Circuit, contrary to decades of legal precedents that permit physicians to enforce their assignments by bringing ERISA claims in court.

ARGUMENT

Pursuant to their authority to create a body of federal common law to supplement ERISA, every federal Circuit Court that has considered the question has held that a physician with an assignment from her patient may pursue ERISA claims for unpaid benefits. No Circuit Court has ever held that such assignments must explicitly reference the right to bring ERISA claims in court. Several have found such language is unnecessary. Put simply, except for a handful of District Judges in this Circuit, the federal courts have never required any "magic words" to be included in patient assignments because ERISA's policy objectives are best advanced by making it easy for physicians to assert ERISA claims.

In light of this settled federal common law, there is no uniform assignment language that all physicians use. Instead, patient assignments vary widely in their particular wording, reflecting physicians' reasonable expectation that, so long as the assignment transfers the patient's right to insurance benefit payments, it concomitantly transfers standing to enforce that right through ERISA litigation in federal court. This state of affairs is consistent with ERISA's purpose and has served the interests of physicians and their patients for decades. Patients can obtain medical care without being required to pay up front and await payment of their insurance benefits in the future – a financial hardship that would cause many patients *with health insurance* to be unable to afford lifesaving treatments.

Physicians are willing to provide medical care without demanding such up-front payments because they are confident that, if necessary, they can pursue remedies under ERISA for improperly denied insurance benefits.

The District Court's holding below – that patient assignments only transfer ERISA rights if they explicitly include some unspecified magic language – is completely inconsistent with settled federal common law, the purpose of ERISA, and the reasonable expectations of physicians and patients. If the District Court's decision is affirmed, it will harm physicians and patients alike.

Affirming the District Court would harm physicians because it would vitiate the legal rights that they thought they possessed pursuant to standard assignments that reference only the right to payment. The District Court's reasoning would force physicians to pay for legal counsel to assist them in drafting new assignments that satisfy a new standard, even though it is unclear exactly what language that standard requires (*e.g.*, whether the assignment must explicitly provide for the transfer of "ERISA rights," "legal rights," simply "rights," or something else) or where that standard applies (*e.g.*, if this Court affirms the District Court, its decision will be applicable to ERISA claims advanced in Pennsylvania, New Jersey, and Delaware, but that standard will be inapplicable in the other federal circuits that have reached the issue, including the Eleventh, Fifth, and Ninth Circuits). Such a result violates one of the key underlying goals of ERISA:

uniformity. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions . . . which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'") (quoting *Alessi v. Raybestos–Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

Affirming the District Court's holding would also harm patients because many physicians would likely conclude that their ability to assert ERISA benefit claims is simply too uncertain and, as a result, the most prudent response is to refuse to provide medical care to any patient covered by an ERISA plan unless he pays in advance or provides adequate assurances that payment can and will be made later. Indeed, *amicus* MSNJ has already observed just this effect in New Jersey: many out-of-network physicians are considering refusing to treat patients insured by some ERISA plans because, even though these physicians submitted claims to the plans pursuant to assignments, the plans (without asking for or considering the specific assignment language used) have categorically refused to honor *any* assignment and are unwilling to pay the provider directly.

There is no legal or policy reason to set these harms in motion and upset a medical care payment system that is decades in the making. The District Court's decision should be reversed.[1]

I. ENFORCEABLE ASSIGNMENTS ARE KEY TO MAKING HEALTH CARE ACCESSIBLE AND AFFORDABLE FOR PATIENTS.

Under the *status quo* in thousands of medical practices nationwide, when a patient receives care from a physician who accepts health insurance, the patient pays only a small co-insurance payment or nothing at all. In return, the physician receives from the patient a transfer of the patient's interest in the insurance benefits due for those health care services. The physician, based upon the assignment, then submits a claim to the insurer administering the patient's ERISA-governed employee welfare benefit plan. Insurers typically require physicians to submit

[1] Aetna – like most insurers – takes both sides of this issue, depending upon its convenience. When administering claims, Aetna deals with providers directly pursuant to their assignments as indicated on the claim form. *See, e.g.*, PA15 ¶ 4. When providers sue Aetna in state court, Aetna argues that the providers' assignments are sufficient to give the providers ERISA standing so that Aetna can remove the claims to federal court. *See, e.g., Spring E.R., LLC v. Aetna Life Ins. Co.*, 2010 WL 598748, at *3-4 (S.D. Tex. 2010); *Jack Christie, D.C. v. Aetna Health, Inc.*, 2011 U.S. Dist. LEXIS 134428, *12 (S.D. Tex. 2011); *Lone Star Ob/Gyn Assoc. v. Aetna Health Inc.*, 579 F.3d 525, 527 (5th Cir. 2009). But when a provider properly asserts an ERISA benefit claim in *federal* court, and has a real chance of recovering, Aetna does an about-face and argues that an assignment of the right to payment is insufficient for provider standing. Aetna should not be allowed to have it both ways: if an assignment is enough to put the provider in the patient's shoes for claims administration and preemption purposes, it is enough for derivative standing as well.

claims via proprietary claims-submission systems[2] and standardized claim forms, which are often based upon a form approved by the National Uniform Claims Committee ("NUCC") called the "1500 Claim Form."[3] Insurers also require physicians to identify each medical service provided to the patient using a set of nationally-recognized codes (referred to as "Current Procedural Terminology," or "CPT"), which was developed by the AMA to streamline the health insurance claim-submission process.[4]

The 1500 Claim Form includes a check-box indicating whether the provider "accepts assignment" from the patient. *See* 1500 Claim Form, Box 27. The form also includes a space for the patient to sign to indicate that that the patient has assigned to the provider the right to payment from the insurer:

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[2] For example, Aetna has an electronic claims submission system that can only be accessed by health care providers. *See* http://www.aetna.com/health-care-professionals/ claims-payment-reimbursement/electronic-claims.html (last visited July 7, 2014).

[3] The 1500 Claim Form is available at the NUCC's website. *See* http://www.nucc.org/images/stories/PDF/cms_1500_sample.pdf (last visited July 7, 2014); *see also* http://www.nucc.org/index.php?option=com_content&view=article&id=12&Itemid=112 (last visited July 7, 2014). The AMA chairs the NUCC, which includes representatives of health care providers, private insurers, and key government stakeholders. *See* http://www.nucc.org/index.php?option=com_contact&view=category&id=4&Itemid=107 (last visited July 7, 2014).

[4] *See* http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page? (last visited July 7, 2014).

> INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

See 1500 Claim Form, Box 13. Thus, any reasonable provider would understand that similar language is all that is required for a valid, enforceable assignment. Indeed, when the provider has checked Box 27 on the claim form and the patient has signed Box 13 (or the physician indicates that the signature is otherwise on file), insurers generally make payment for the claim directly to the physician. Insurers, including Aetna, make such payments without requesting any evidence of the precise language used in the physician's assignment. If the insurer has questions about a claim, it generally seeks additional information and documentation of the medical services from the physician, not the patient. If the insurer subsequently determines that it has overpaid the claim, the insurer will seek recourse from the physician, not from the patient. If the claim is denied, the physician – not the patient – usually appeals through the insurer's established process, and is required to submit even more documentation.

Thus, industry-wide, claims administration processes are built on the understanding that physicians – not patients – will most often be the ones submitting claims for health-insurance benefits. Rather than requiring patients to pay up front for the cost of medical services, physicians take on both the administrative burden of pursuing insurance claims (sometimes through several

layers of appeals) and the burden of suing the insurance company if a claim is improperly denied. The only reason physicians do so is that they understand – based on ERISA's plain language and nearly three decades of case law interpreting it – that their assignments will be enforceable in court.

Affirming the dismissal of the Plaintiffs' claims on the ground that their assignments were ineffective because they did not include precise, court-prescribed language would cast doubt on the established business practices of physicians nationwide. As numerous courts have observed, if physicians cannot rely on the enforceability of their assignments, they may no longer accept assignments. The alternative is that physicians would be forced to sue their patients instead of the insurance company that owes the benefits – an outcome that would plainly undermine the purpose of ERISA, which was enacted "to promote the interests of employees and their beneficiaries." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). Such lawsuits would also destroy the physician-patient relationship, which is the foundation for all medical care. *See* AMA's Code of Medical Ethics, Opinion 10.01 & Opinion 10.015, available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page (last visited July 7, 2014).

Patients would be forced to pay up front for medical care, and then to pursue the complicated and cumbersome claims process themselves.[5] If additional

[5] Of course, patients who could not afford to pay a provider up front could be

documentation is needed, patients would have to return over and over again to their doctors to obtain details about their treatment. If a claim is denied or underpaid, the patient would have to follow the insurer's appeal procedure, and possibly even sue. Rather than an aggregation of multiple claims brought in a single lawsuit by a physician, the courts could face an explosion in litigation as individual patients throughout the country attempt to obtain their plan benefits. Alternatively, such patients might conclude that litigation is too expensive and time consuming and thus give up, rendering their insurance benefits illusory.

In short, a system of private insurance that makes health care widely available with little up-front cost to patients depends, in substantial measure, on the willingness of physicians to accept assignments of insurance benefits. If the enforceability of those assignments is called into doubt by new rules requiring detailed contracts conveying narrowly-defined rights using specific language prescribed by courts on a case-by-case basis (and varying among the Circuits), physicians' willingness to risk their livelihood on an assignment will quickly evaporate, and, along with it, the very protections ERISA was intended to provide to patients.

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unable to obtain health care at all. For example, it is extremely doubtful that many of NJBSC's patients can pay in advance for the complex brain and spine surgeries NJBSC performs.

II. THE RATIONALE UNIVERSALLY ADOPTED BY THE CIRCUIT COURTS IN UPHOLDING ERISA CLAIMS BROUGHT BY PROVIDERS DEMONSTRATES THAT AN ASSIGNMENT OF THE RIGHT TO PAYMENT IS SUFFICIENT TO GIVE A PHYSICIAN STATUTORY STANDING UNDER ERISA.

Because ERISA does not explicitly address the question of a provider's ability to bring ERISA claims pursuant to an assignment, federal common law controls. *See, e.g.*, *Teamsters Pension Trust Fund of Phila. & Vicinity v. Littlejohn*, 155 F.3d 206, 208–10 (3d Cir. 1998) (when ERISA "does not provide explicit instructions, it is well settled that Congress intended that the federal courts would fill in the gaps by developing, in light of reason, experience, and common sense, a federal common law of rights and obligations imposed by the statute.") (citations omitted); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) ("[W]e have held that courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans'") (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987)); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 228 (1st Cir. 1998) (discussing federal common law of assignments).

Pursuant to this directive, Circuit Courts have consistently held that a physician who receives an assignment from her patient is entitled to pursue ERISA claims. *See, e.g.*, *City of Hope*, 156 F.3d at 228; *Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 330-32 (2d Cir. 2011); *Hermann Hosp. v. MEBA Med. &*

Benefits Plan, 845 F.2d 1286, 1289-90 (5th Cir. 1988); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1277 (6th Cir. 1991); *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991); *Lutheran Med. Ctr., of Omaha, Neb. v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan*, 25 F.3d 616, 619 (8th Cir. 1994); *Misic v. Bldg. Serv. Emp. Health & Welfare Trust*, 789 F.2d 1374, 1378 n.4 (9th Cir. 1986); *Denver Health & Hosp. Auth. v. Beverage Distrib. Co., LLC*, 546 F. App'x 742, 745 (10th Cir. 2013); *Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997).[6]

Contrary to the District Court's decision below, none of these courts has held that an assignment must include certain "magic words," such as an explicit transfer of "ERISA rights" or the "right to sue under ERISA," to give a physician standing under ERISA. *See id.* In fact, several Circuit Court decisions have explicitly upheld derivative provider standing based upon assignments that expressly referred only to the right to payment, like those at issue here. *See Misic*, 789 F.2d at 1376 (provider-assignee had standing where assignments conveyed beneficiaries' "rights of reimbursement" from their health and welfare plan);

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[6] The Court of Appeals for the Fourth Circuit has not squarely addressed *physician* standing-by-assignment, but it found an assignee had standing to sue under ERISA in a case brought by a participant's sole heir. *See Yarde v. Pan Am. Life Ins. Co.*, 67 F.3d 298, 1995 WL 539736, at *5-6 (4th Cir. Sept. 12, 1995). *Amici* have not found a case in which the question of assignee standing has been presented to the Court of Appeals for the District of Columbia Circuit.

Cromwell, 944 F.2d at 1275 (assignment "authorizing '[p]ayment directly to . . . [providers] of any and all sums of money otherwise payable to [patient] under the terms of the home health provisions of said group policy or contract'" held sufficient for standing); *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1351 (11th Cir. 2009) (same for assignment which stated: "I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity"); *Tango Transp. v. Healthcare Fin. Servs. LLC*, 322 F.3d 888, 889 (5th Cir. 2003) (same for assignment which stated: "I hereby assign payment of hospital benefits directly to [provider] herein specified and otherwise payable to me. . . ."); *Kennedy*, 924 F.2d at 699 (same where doctor "agreed to accept as full compensation whatever the insurer would pay").[7] Both the relative lack of attention paid to the specific content of patient-physician assignments and the varied formulations approved by the various Circuits demonstrate that the particular wording of the assignment is not significant.

This settled federal common law reflects two primary considerations – one legal and one policy – both of which shed light on why no "magic words" are required:

[7] Other Circuit Courts have not quoted the assignment language at all in their analysis, suggesting that the specific language is not critical to ERISA standing. *See, e.g.*, *Hermann*, 845 F.2d at 1289-90 (no discussion of assignment language); *Montefiore*, 642 F.3d at 329 (same; finding assignee standing based solely upon provider's selection of check box on claim form).

First, these decisions are based upon black letter law that an assignee occupies the same legal position, and has the same enforcement-related rights, as the assignor. *See, e.g.*, *City of Hope*, 156 F.3d at 228 (discussing federal common law of assignments and explaining, "[i]t is generally understood that the assignee acquires rights similar to those of the assignor, and is put in the same position with reference to those rights as that in which the assignor stood at the time of assignment.") (internal quotation marks omitted); *Misic*, 789 F.2d at 1378 & n.4 (for ERISA benefits claims, "the assignee stands in the shoes of the assignor, and, if the assignment is valid, has standing to assert whatever rights the assignor possessed.") (citing cases); *Yarde*, 1995 WL 539736, at *4 (same); *Hermann*, 845 F.2d at 1290 n.14 (same); *Denver Health*, 546 F. App'x at 745 (same); *Lutheran Med. Ctr.*, 25 F.3d at 619 (agreeing with *Misic* "that assignees stand in the shoes of beneficiaries and thus may sue to collect benefits"). If it is true (and it surely is) that the assignee stands in the assignor's shoes with respect to the transferred interest, then an assignment of the right to payment necessarily includes the right to enforce that entitlement through legal action under ERISA.

Second, these decisions are based on the recognition that, because allowing health care providers to bring ERISA claims furthers ERISA's purpose by facilitating patients' access to medical care, the standards for determining whether a physician may assert ERISA claims should not be particularly demanding or

restrictive. *See, e.g.*, *Hermann*, 845 F.2d at 1289 ("An assignment to a health care provider facilitates rather than hampers the employee's receipt of health benefits."); *City of Hope*, 156 F.3d at 226 (same). Assignments of benefits make it "unnecessary for [] providers to evaluate the solvency of patients" before treating them or for patients to pay up front for care; they also enable ERISA trust funds to negotiate "better coverage and lower rates" directly with physicians. *Misic*, 789 F.2d at 1377; *see also id.* ("Health and welfare benefit trust funds are designed to finance health care. Assignment of trust monies to health care providers results in ***precisely the benefit the trust is designed to provide and the statute is designed to protect.***") (emphasis added). *See also Cagle*, 112 F.3d at 1515 (Because permitting physician-assignees to sue transfers the burden of litigation to the parties who are "better situated and financed to pursue an action for benefits, . . . the interests of ERISA plan participants and beneficiaries are better served by allowing provider-assignees to sue ERISA plans") (internal quotation omitted)); *Montefiore*, 642 F.3d at 329 ("The right to 'health care at no cost' (or at less cost, where a co-payment or co-insurance fee is involved) is made possible only by arrangements to have one's health care provider reimbursed for the balance of the fee for services"). Requiring that certain magic words be included in a patient-physician assignment is inconsistent with this policy objective.

In short, it is beyond dispute – and has been for decades – not only that patients can assign their ERISA benefits to pay for health care, but also that, if they do, they necessarily transfer along with the benefit the right to assert a claim for that benefit under ERISA.

III. THE ONLY CIRCUIT COURT TO ADDRESS EXPLICITLY WHETHER "MAGIC WORDS" ARE REQUIRED HAS EMPHATICALLY HELD THAT THEY ARE NOT.

The settled state of the law on this point was made all the more clear by the Eleventh Circuit in *Connecticut State Dental v. Anthem Health Plans, Inc.*, 591 F.3d 1337 (11th Cir. 2009). In that case, the Eleventh Circuit applied the aforementioned principles of federal common law to reject an insurer's contention that the assignments at issue – which were virtually identical to the ones used by the Appellant here[8] – were "ineffective to create standing because they convey only the right to receive payment of benefits and not the patient's right to file an action under § 502(a)." *Id.* at 1352. Instead, the court held that "[an] assignment of ***the right to payment*** is enough to create standing." *Id.* (emphasis added). *See also Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1294 (11th Cir.2004) ("Healthcare providers may acquire derivative standing . . . by obtaining a written assignment from a 'beneficiary' or 'participant'

[8] The assignment before the Eleventh Circuit said, "I hereby authorize ***payment of the dental benefits*** otherwise payable to me directly to the below named dental entity." 591 F.3d at 1351 (emphasis added).

of his right to payment of benefits under an ERISA-governed plan."); *Cagle*, 112 F.3d at 1515 (finding provider standing based on a beneficiary's assignment of "his right to receive payment of benefits").

The Eleventh Circuit reached this conclusion for precisely the same legal and policy reasons that animated the other Circuit Court decisions. The Court emphasized that "an assignment furthers ERISA's purposes only if the provider can enforce the right to payment," because, if providers cannot sue, "'they will bill the [patient] directly. . . and the [patient] will be required to bring suit against the benefit plan when claims go unpaid.'" *Conn. State Dental*, 591 F.3d at 1352-53 (quoting *Cagle*, 112 F.3d at 1515). Physician-assignee standing, on the other hand, "transfer[s] the burden of bringing suit from plan participants and beneficiaries to 'providers, who are better situated and financed to pursue an action for benefits owed for their services." *Id.* The Court also cited authority for the proposition that "[a]n assignment to receive payment of benefits necessarily incorporates the right to seek payment." *Id.* at 1353 (internal quotation marks omitted).

IV. THIS COURT'S REASONING IN *CARDIONET* STRONGLY SUGGESTS THAT THIS COURT AGREES WITH ITS SISTER CIRCUITS THAT "MAGIC WORDS" ARE NOT REQUIRED.

In its recent decision in *CardioNet, Inc. v. CIGNA Health Corp.*, this Court joined its sister Circuits by expressly holding that "health care providers may obtain standing to sue by assignment from a plan participant." 751 F.3d 165, 2014

WL 1778149, at *9 n.10 (3d Cir. 2014). Although the assignment at issue in that case happened to use more detailed language, the *CardioNet* Court's rationale is inconsistent with the view that any particular words are necessary for an assignment to transfer ERISA standing.

First, this Court relied upon the Eleventh Circuit's decision in *Connecticut State Dental* in holding that because it is black letter law that an assignee of contractual rights receives all of the assignor's rights with respect to the transferred interest – including the right to legal enforcement – a physician with an assignment of the right to be paid insurance benefits was entitled to assert the same ERISA claims, in the same forum, as the patient-assignor. 2014 WL 1778149, at *10. This reasoning is inconsistent with the District Court's view that an assignment of the right to payment does not include the ability to enforce that right under ERISA. Moreover, by citing favorably the Eleventh Circuit's decision, which explicitly upheld the validity of an assignment transferring solely the right to receive payment of benefits, the Third Circuit's decision supports the conclusion that the District Court's contrary holding here was in error.

Second, this Court cited just one decision from this Circuit to support the proposition that "providers [could] assert ***properly assigned*** ERISA claims on behalf of their patients" – *N. Jersey Brain & Spine Ctr. v. St. Peter's Univ. Hosp.*, 2013 WL 5366400, at *3 (D.N.J. Sept. 25, 2013) – which coincidentally involved

the ***same*** medical provider and the ***same assignment form*** at issue in this case. *Id.* (emphasis added). The forms assign to NJBSC "all payments for medical services rendered" to the insured, without explicit reference to ERISA rights. 2013 WL 5366400, at *3 n.3.

Third, the policy rationale that supported the *CardioNet* Court's central holding applies with equal (if not greater) force to this case. The *CardioNet* Court held that an arbitration clause contained in an in-network physician contract did not apply when the physician sued under ERISA pursuant to an assignment from the patient. The Court explained that it had "concerns about the policy implications" of a contrary result because it "trivializes the important public policy interests served by permitting physicians to bring such claims," which include the interest of increasing care:

> "Many providers seek assignments of benefits to avoid billing the beneficiary directly and upsetting his finances and to reduce the risk of non-payment. If their status as assignees does not entitle them to federal standing against the plan, providers would either have to rely on the beneficiary to maintain an ERISA suit, or they would have to sue the beneficiary. Either alternative, indirect and uncertain as they are, would discourage providers from becoming assignees and possibly from helping beneficiaries who were unable to pay them 'upfront.' The providers are better situated and financed to pursue an action for benefits owed for their services."

2014 WL 1778149, at *11 (quoting *Hermann*, 845 F.2d at 1289 n.13).

Affirming the District Court's "magic words" requirement would undermine this public policy interest. Physicians have designed their assignment forms based

on their understanding (formed by decades of jurisprudence) that federal courts would *not* demand precise language before allowing them to assert ERISA claims. Because it is unclear precisely what type of "magic language" the District Court deems necessary, and because affirming the District Court would create a Circuit split making it difficult for physicians (especially those who treat patients from different states) to know exactly what rights they do and do not have, there should be no question that upholding the District Court's reasoning would "discourage" physicians from taking assignments and increase dramatically the likelihood that they will demand payment from patients up front. Moreover, such a Circuit split would fly in the face of Supreme Court precedent requiring that the standards governing ERISA be interpreted uniformly across the country. *See, e.g.*, *Shaw*, 463 U.S. at 90.

V. THERE IS NO LEGAL OR LOGICAL BASIS FOR THE DECISIONS OF A SMALL NUMBER OF DISTRICT JUDGES IN THIS CIRCUIT THAT HAVE FOUND ASSIGNMENTS OF THE RIGHT TO PAYMENT INSUFFICIENT FOR ERISA STANDING.

In dismissing the complaint below, the District Court ignored all of the foregoing.[9] Instead, it relied upon two decisions by District Judge Stanley R. Chesler (which were not subjected to Third Circuit review) holding that an

[9] To be sure, this Court's decision in *CardioNet* was handed down shortly after the District Court's decision below. The overwhelming authority from the other Circuits was available, however.

assignment of the right to payment from an insurance contract, standing alone, is insufficient to give a physician statutory standing. PA9 (citing *Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792, 807 (D.N.J. 2011) (Chesler, J.) and *MHA, LLC v. Aetna Health, Inc.*, 2013 WL 705612, at *3 (D.N.J. Feb. 25, 2013) (Chesler, J.)).[10] This holding, and the assumptions that underlie it, find no support in the law.

First, federal common law relating to ERISA draws no distinction between an assignment of the right to payments mandated by an insurance contract and a "complete assignment of benefits." *Franco*, 818 F. Supp. 2d at 809. As the Eleventh Circuit and other Circuits have made clear, the "benefit" at issue ***is*** the right to be reimbursed (that is, paid) for the health care service the physician provided, and the assignment of that benefit necessarily includes the right to ERISA enforcement. *See* §§ II-IV, *supra*. *See also* 6 Am. Jur. 2d Assignments § 113 ("[A]n assignment ordinarily passes whatever is necessary to make it completely effectual."); *Montefiore*, 642 F.3d at 329 ("the difference between receiving 'health care at no cost' and receiving direct reimbursement of one's costs is largely one of form, rather than of substance").[11] The settled view of the Circuit

[10] The District Court also cited to one of its own prior decisions, which similarly relied on Judge Chesler's analysis. *See Demaria v. Horizon Healthcare Servs., Inc.*, 2012 WL 5472116, at *4 (D.N.J. Nov. 9, 2012) (Martini, J.).

[11] *See also Penn. Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n,* 2014 WL

Courts, and the resulting practice by thousands of physicians across the country, is that particular language or formalities are simply not necessary. *See, e.g.*, 29 Williston on Contracts § 74:3 (4th ed.) ("No words of art are required to constitute an assignment.").[12]

Moreover, the *Franco* and *MHA* decisions demonstrate exactly the problem that would arise if this Court affirmed the decision below. Neither case, at any point, prescribes exactly what assignment language *would* satisfy the heightened standing requirement they impose. If those cases' vague standard became the law in this Circuit, physicians in New Jersey, Pennsylvania, and Delaware would be forced to attempt to craft sufficiently explicit language to create an effective assignment, without any assurance that the language would hold up in subsequent litigation. Dozens of test cases might be necessary before a clear standard emerged – which would, of course, apply only to physicians within this Circuit. Thus, as

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1276585, at *7 (N.D. Ill. Mar. 28, 2014) ("It is clear that IBC does not distribute medical treatment; physicians, chiropractors, and other medical treatment providers do that. Instead, IBC provides an assurance of payment for the treatment, and ultimately actual payment, as well as a mechanism for payment. Those ***payments are the benefits*** that are provided under the relevant plans. The Court concludes that, in the present context, a payment or money for medical services covered in the relevant insurance plans constitutes a 'benefit' under ERISA.") (emphasis added).

[12] In *MHA*, Judge Chesler inappropriately applied New Jersey law to find that an assignment of the right to reimbursement did "not rise to the level of an assignment of rights under ERISA." 2013 WL 705612, at *7. Contrary to Judge Chesler's view, this question is governed by federal common law, not the law of the fifty states. *See, e.g.*, *City of Hope*, 156 F.3d at 228 (citing *Pilot Life*, 481 U.S. at 56).

noted above, an affirmance would create a Circuit split and upend established federal common law, seriously undermining physicians' confidence in their ability to enforce their assignments.

Second, the concern that recognizing a physician's standing to pursue ERISA claims based on an assignment of the right to payment somehow creates the possibility that an insurer might have to pay the same claim twice, *see Franco*, 818 F. Supp. 2d at 811, is a red herring. Under federal common law, a court could reasonably conclude that a patient who has assigned the right to payment to her physician no longer has the right to sue the insurer to collect such payment for *herself*.[13] Such a result would be consistent with legal and policy rationales discussed above and with the assignment itself.

Third, the related concern – that if the assignment preserves the physician's right to balance bill the patient, it does not sufficiently evidence the "intention of parties" to fully transfer the ability to enforce the right to payment from the plan –

[13] Nothing suggests, however, that a patient who assigns the right to payment to a physician has given up her ability to force her insurer to make such payment to the *physician*. For example, if a provider pursued litigation against a patient instead of the patient's insurer, a court could reasonably conclude that the patient is entitled to name her insurer as a third-party defendant, or that the patient is entitled to assert a claim under ERISA to compel the insurer to make payment to the provider. Thus, the hypothetical situation posited by the court in *MHA* is not only unlikely (given providers' understanding that insurers, not patients, are best able to cover the costs of medical care), but easily resolved. *See* 2013 WL 705612 at *8 (suggesting that a provider might balance bill a patient who, because of her assignment to the provider, might lack any legal right to enforce her insurer's obligation to pay).

is inaccurate. As explained above, the policy rationale that contributed to the federal common law rule permitting physicians with assignments to assert ERISA claims is the reality that: (1) physicians are much better positioned to assert those rights than their patients; (2) such a rule furthers the ERISA policy goal of ensuring that patients receive necessary care without being required to pay all costs up front; and (3) insurers – not patients – are the parties financially capable of paying for the up-front cost of even routine medical care, let alone the complex surgical procedures at issue here.

Against this backdrop, and the established federal common law that an assignment includes the right to enforcement, there is simply no plausible reason to conclude in this case (and there was none in *Franco* or *MHA* either) that, by executing a simple assignment of the right to payment, the patient intended to prevent her doctor from pursuing ERISA claims in court – even if the assignment leaves open the possibility that the physician might seek from the patient whatever amounts it could not recover from the insurer. Indeed, precisely because physicians and patients both understand that patients are generally unable to cover the cost of medical services from their own assets, any such assignment strongly suggests that patients intend for their physicians to use every means necessary (including ERISA litigation) to require insurers to cover those costs.

VI. THE DISTRICT COURT FURTHER ERRED BY APPLYING AN IMPROPERLY ONEROUS PLEADING STANDARD.

ERISA permits "a participant or beneficiary" to bring a civil action for benefits against a plan administrator. 29 U.S.C § 1132(a). For purposes of Aetna's motion to dismiss the complaint below, brought under Rule 12(b)(6),[14] the question before the District Court was whether NJBSC had pled allegations making it "plausible" that its assignment gave it derivative standing to sue as a participant or beneficiary. *See* Fed. R. Civ. P. 8; *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). In *Baldwin v. Univ. of Pittsburgh Med. Ctr.*, 636 F.3d 69 (3d. Cir. 2011), this Court explained that this requires an assignee to plead a "colorable claim," *id.* at 75, which is one that is not "wholly insubstantial and frivolous." *Pareja v. Att'y Gen.*, 615 F.3d 180, 186 (3d Cir. 2010).[15]

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[14] The motion was correctly asserted under Rule 12(b)(6), rather than Rule 12(b)(1), because statutory standing is an element of NJBSC's ERISA benefits claim. *See, e.g., Leeson v. Transamerica Disability Income Plan*, 671 F.3d 969, 979 (9th Cir. 2012). The only question is therefore whether NJBSC plausibly stated a claim to benefits under ERISA.

[15] Other Circuits likewise apply the "colorable claim" standard to provider-assignee standing. *See, e.g., Kennedy*, 924 F.2d at 700 (holding that chiropractor had a "colorable claim" to benefits assigned by patient); *Montefiore*, 642 F.3d at 330-32 (provider's claims pursuant to assignment were "colorable claims for benefits pursuant to § 502(a)(1)(B)"); *City of Hope*, 156 F.3d at 227-28 (finding provider had standing based on "a 'colorable claim' that it is an assignee of a beneficiary").

In light of the uniform view of the Circuit Courts that, under federal common law, assignments necessarily also transfer standing to assert ERISA claims, *see* §§ II-IV, *supra*, NJBSC's complaint easily satisfied this pleading requirement by alleging that the physician was entitled to assert its claims pursuant to patient assignments. PA15, ¶ 5. No more is required under Rule 8.

CONCLUSION

For all of the reasons discussed above, this Court should hold that a transfer to a health care provider of a patient's right to payment by an employee welfare benefit plan is an "assignment of benefits" sufficient to give the physician derivative standing to pursue an ERISA claim for benefits under 29 U.S.C. § 1132(a)(1)(B), and the Court should therefore reverse the District Court's order dismissing Plaintiffs' claims.

Dated: July 7, 2014

Respectfully submitted,

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CERTIFICATION OF BAR MEMBERSHIP

I hereby certify that I am a member of the Bar of the United States Court of Appeals for the Third Circuit.

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CERTIFICATION OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

This brief complies with the type–volume limitations of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,831 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) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman font.

Dated: July 7, 2014

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CERTIFICATE OF SERVICE

I hereby certify that all counsel listed below on this Certificate of Service are Filing Users of the Third Circuit's CM/ECF system, and that the foregoing Brief of *Amici Curiae* American Medical Association and the Medical Society of New Jersey in Support of Plaintiff-Appellant and Urging Reversal of the District Court Judgment is being served electronically on them on this 7th day of July, 2014, by Notice of Docket Activity:

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CERTIFICATION OF ELECTRONIC FILING AND VIRUS CHECK

Counsel herby certifies that the electronic copy of this Brief Amici Curiae is identical to the paper copies filed with the Court. A virus check was performed on the PDF electronic file of the brief using Symantec Endpoint virus scan software.

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