14-3455

United States Court of Appeals
For the Second Circuit

HENRY L. ROJAS, M.D., MITCHELL K. ROSEN, M.D., H&L ROJAS, M.D., P.C., DBA ROJAS AND ROSEN M.D.,

Plaintiffs-Counter-Defendants-Appellants

v.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendants-Counter-Claimants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK
(THE HONORABLE KENNETH M. KARAS, DISTRICT JUDGE)

BRIEF OF *AMICI CURIAE*

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CORPORATE DISCLOSURE STATEMENT

In conformance with Federal Rules of Appellate Procedure Rule 26.1, *amicus curiae*, the American Medical Association ("AMA"), states that it is a not-for-profit corporation and that no publicly-held corporation owns 10% or more of its stock.

CORPORATE DISCLOSURE STATEMENT

In conformance with Federal Rules of Appellate Procedure Rule 26.1, *amicus curiae*, the Medical Society of the State of New York ("MSSNY"), states that it is a not-for-profit corporation and that no publicly-held corporation owns 10% or more of its stock.

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INTERESTS OF *AMICI*

All parties have consented to submission of this brief. The *amici* appear on their own behalf and as representatives of the AMA Litigation Center. The Litigation Center is a coalition of the AMA and the medical societies of all fifty states and the District of Columbia. It represents the interests of the medical profession. Fed. R. App. P. 29(a).[1]

The AMA and MSSNY represent the interests of physicians, residents, and medical students. AMA physicians serve patients throughout the United States. MSSNY physicians serve patients in the State of New York. The *amici* strive to promote the science and art of medicine and the betterment of public health. When appropriate, the AMA and MSSNY submit *amicus* briefs to support physicians' rights to pursue legal remedies provided for under ERISA.

In that regard, the AMA recently submitted an *amicus* brief to the Seventh Circuit in support of the district court's decision in

[1] No party or party's counsel authored this brief in whole or in part or contributed money intended to fund preparation or submission of this brief. No person, other than *amici*, their members, or their counsel contributed money intended to fund preparation or submission of this brief. Fed. R. App. P. 29(c)(5).

Pennsylvania Chiropractic Association v. *Blue Cross Blue Shield Association,* 2014 WL 1276585 (N.D. Ill., Mar. 29, 2014). In that case, the district court had found that an insurer violated ERISA by retroactively denying previously approved claims and demanding corresponding repayments from in-network providers without abiding by any of the due process protections required by ERISA. The district court held that the insurer was not free to ignore ERISA because the underlying plans had "unambiguously" designated in-network providers to "be paid directly by IBC [the insurer] when they provide covered services to participants." *Id.* at *10. The district court found such providers satisfied the statutory definition of "beneficiary" under 29 U.S.C. § 1002(8), which defines a "beneficiary" as "a person designated . . . by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *Id.* at *10. The AMA filed an *amicus* brief in that case because it recognized that if the appellant–insurer was to succeed in overturning the district court's decision, insurers who make retroactive denials of in-network benefits payments would be immune from ERISA. In its opinion here, the Panel criticized the district court's holding in *Pennsylvania Chiropractic*. The Panel

believed that the district court misunderstood the terms "benefit" and "beneficiary." *Rojas* v. *Cigna Health and Life Ins. Co.,* Docket No. 14-3455, Slip Op. at 10 n.7 (2d Cir., July 15, 2015). But the Panel's contrary analysis would mean that the insurer in *Pennsylvania Chiropractic* could flout ERISA with impunity. Its contrary analysis also threatens the ability of providers to bring ***any*** ERISA claims, not just the anti-retaliation claims advanced by Appellants.

As a result, *Amici* have a significant interest in this case.

SUMMARY OF ARGUMENT

The Panel was confronted with a narrow issue: whether an in-network provider can assert a claim under the anti-retaliation provision of ERISA to avoid termination of an in-network contract. The anti-retaliation provision is enforceable only by a "participant, beneficiary, or fiduciary." 29 U.S.C. § 1140. To invoke this provision, Appellants asserted (among other things) that because they were in-network providers they had a right to benefit payments, and therefore satisfied ERISA's definition of "beneficiary," as a "person designated . . . by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

To resolve this issue, the Panel could have focused on whether the underlying plan documents in fact "designated" the providers—as opposed to the insureds—as persons entitled to receive the payment of benefits. Instead, the Panel held that ERISA's use of the term "benefit" refers to the patient's actual health care or the right to "receive coverage from the healthcare plan," and that plan payments to which Appellants alleged they were entitled did not satisfy this definition. Slip Op. at 9. This is contrary to the plain meaning of ERISA, and decisions by this Court and other Circuit Courts. It also contravenes the reasoning behind the rule that providers may bring a claim under § 1132(a) when they obtain an assignment of the right to payment from their patients.

A rehearing by this Panel or *en banc* review is necessary.

ARGUMENT

I. The Panel's Holding is Contrary to ERISA.

Title 29 U.S.C. § 1002(8) broadly defines a person as an ERISA "beneficiary" if the person is (or may become) entitled to a "benefit" under the plan. The statute does not define an ERISA "beneficiary" as someone who is considered to be a beneficiary *by* the plan. Nor does it

state that an ERISA "beneficiary" is limited to persons "covered" by the plan. In that respect, a "beneficiary" is not limited to individuals or family members. *Peterson* v. *Am. Life & Health Ins. Co.*, 48 F.3d 404, 409 (9th Cir. 1995). In fact, ERISA's definition of "person" includes business entities and organizations. 29 U.S.C. § 1002(9).

Appellants contend that they satisfy the statutory definition of an ERISA "beneficiary" because they were entitled to payments from the plan and that these payments constituted ERISA "benefits." The Panel rejected this argument. But it did not do so based on whether the plans in fact designated the providers to receive anything—benefits or otherwise. Instead, it held that in a welfare benefit plan the ERISA "benefit" is the right to a "good" such as "medical, surgical, or hospital care rather than the right to payment for medical services rendered." Slip Op at 9 (citation omitted). It also held that an ERISA "beneficiary" includes only a person who is entitled to obtain "medical services and supplies covered under their health care policy." *Id.* at 11. These holdings are contrary to the plain language of the statute. We explain.

ERISA regulates both welfare benefit plans and pension benefit plans. 29 U.S.C. §§ 1003(a), 1002(3). Although it does not define the

term "benefit," ERISA uses that term in the same manner when discussing both types of plans. Several ERISA provisions demonstrate that when Congress used the term "benefit" it meant a plan's monetary payment. Conversely, no provision of ERISA suggests that Congress intended the term to include only goods like medical care. Nor is there any provision of ERISA that suggests that an ERISA "beneficiary" is limited to persons "covered" by the plan.

Although the Panel relied on the fact that ERISA defines a welfare benefit plan as a plan that provides "medical, surgical, or hospital care," Slip Op. at 9 (citing *Kosasinski* v. *Cigna Healthplan of CT, Inc.*, 163 F.3d 148, 149 n.1 (2d Cir. 1998)), the definition suggests that care provided by a doctor is different than the medical, surgical, or hospital "benefits" that a plan provides. *See* 29 U.S.C. § 1002(1)(A). That is because the definition refers to "medical, surgical, or hospital care ***or*** benefits. . . .") (emphasis added).

The definition also incorporates "any benefit described in [Title 29] section 186(c)." 29 U.S.C. § 1002(1)(B). Section 186(c) contains a list of nine "benefits"—each of which is accurately categorized as rights to payment, rather than as "bargained-for goods." The list includes

benefits such as "payment . . . of any money or other thing of value in satisfaction of a judgment"; "defraying [the] costs of apprenticeship or other training programs"; and "money or other thing of value paid by any employer to a pooled or individual trust fund . . . for the purpose of . . . scholarships." 29 U.S.C. § 186(c).

There are other provisions of ERISA that also equate an ERISA "benefit" with a monetary payment. For example, ERISA allows for a civil action "to recover benefits" due under a health insurance plan. 29 U.S.C. § 1132(a)(1)(B). This phrase has only one reasonable interpretation—to "recover" the costs relating to the health care services that were provided to a Covered Person. The phrase would not make sense if benefits solely related to medical care, which cannot be "recovered."

Confirming this understanding, ERISA discusses "calculating" and making benefits "payments." 29 U.S.C. 1002(2)(A) and (B). It defines a "normal retirement benefit" as the money owed "without regard to (A) medical benefits, and (B) disability benefit. . . ." This further demonstrates that "retirement," "medical," and "disability" benefits are references to cash payments. § 1002(m)(22); *see also* § 1002(33)(v)

(reference to retaining an employee's account "for the payment of benefits"). In line with this statutory language, other Circuits that have analyzed the meaning of the term "benefit" under ERISA have concluded that a benefit means monetary payment, not medical care.

The First Circuit rejected a patient's argument that her claim against an insurance company for taking too long to approve payment for follow-up cancer treatment did not involve a "benefit." *Hotz* v. *Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 59 (1st Cir. 2002). The plaintiff argued that "benefit" meant coverage under her policy "and not the benefit provided by the insurance company to the employee (*i.e.,* payment for medical services)." *Id.* at 59. The First Circuit rejected that argument based on its recognition that "numerous past ERISA suits brought to secure payment for medical services from third-party providers under ERISA plans"—including decisions from this Court—were decided on the notion that a "benefit" is a "payment." *Id. See also, e.g.*, *Kennedy* v. *Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701 (7th Cir. 1991) (provider satisfied ERISA definition of beneficiary because it was entitled to "direct payment" from plans); *Danca* v. *Private Health Care Systems, Inc.*, 185 F.3d 1, n. 6 (1st Cir. 1999) ("We therefore conclude

that [health care] 'benefits' in this context, as in the pension context, are the monetary payments for medical services, ***not the services themselves***.") (emphasis added); *see also Pascack Valley Hospital, Inc.* v. *Local 464 A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 395-96 (3d Cir. 2004) ("The Plan is a reimbursement plan only; it reimburses participants and beneficiaries for out-out-of-pocket medical expenses but does not itself provide medical care."); *Pennsylvania Chiropractic*, 2014 WL 1276585, at *7 ("IBC does not distribute 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."). Indeed, even insurers have argued successfully that ERISA governs provider disputes based on this understanding of "benefits." *E.g., Univ. of Wisconsin Hosp. & Clinics Auth.* v. *Aetna Life Ins. Co.*, 2015 WL 1065559, at *3 (W.D. Wis., Mar. 11, 2015); *Melamed* v. *Blue Cross of California*, 2011 WL 3585980 (C.D. Cal., Aug. 16, 2011), *aff'd,* 557 F. App'x 659 (9th Cir. 2014).

The Panel's analysis not only conflicts with the reasoning of these courts, it attributes to welfare "benefits" a meaning different from

pension "benefits." As the Supreme Court has explained, "[u]nder the normal rule of statutory interpretation, identical words used in different parts of the same statute are generally presumed to have the same meaning." *IBP, Inc.* v. *Alvarez*, 546 U.S. 21, 33-34 (2005). The "benefit" provided under a pension plan is the payment of money by the employer. The plan is obligated to make such a payment if the employee works for an amount of time specified by the plan. If the employee designates her husband as being entitled to payment, he becomes an ERISA "beneficiary." *See, e.g.*, *O'Connell* v. *Kenney*, 2003 WL 22991732, at *2 (D. Conn., Dec. 15, 2003). Under the Panel's interpretation of the terms "benefit" and "beneficiary," however, the husband has no ERISA rights because an ERISA "beneficiary" must personally do the things that trigger the benefit. Because he did not work for the company, the payment to which he is entitled cannot be deemed to be an ERISA "benefit" and he cannot be an ERISA "beneficiary."

The Panel's analysis suggests that ERISA's use of the terms "benefit" and "beneficiary" mean different things in the pension plan context than they do in the welfare plan context and that longstanding ERISA

jurisprudence with respect to the ability of beneficiaries to bring ERISA claims for pension benefits has been reasoned incorrectly.

II. The Panel's Holding Is Inconsistent with Settled Law Concerning Patient Assignments.

As the Panel acknowledged, because Appellants obtained assignments from their patient that conveyed all medical benefits otherwise "payable to [me] for services rendered,"[2] they were entitled to bring a claim for benefits under § 1132(a)(1)(B). Slip Op. at 12. This is consistent with settled law that a patient assignment is sufficient to give a provider the ability to assert a claim under ERISA. *See, e.g.*, *I.V. Servs. of Am., Inc.* v. *Trustees of Am. Consulting Engineers Council Ins. Trust Fund*, 136 F.3d 114, 117 n.2 (2d Cir. 1998).

If the "benefit" provided by an employer-sponsored welfare plan is the right to obtain covered medical care, however, assignments do not function as intended and have little utility. That is because under this definition, assignments would then give providers the right to obtain covered healthcare for themselves, not payment for the care they provide. Yet this Court and others have consistently treated the obligation of the plan to make payments as the ERISA benefit itself. In

[2] Here too, "benefits" are equated to payments.

I.V. Services., for instance, this Court allowed a provider to sue under ERISA to "seek reimbursement from [the insurer] for medical expenses incurred." *Id.* at 116. The ERISA benefit that the provider pursued there was *payment* for medical services.

More recently, in *Montefiore Medical Center* v. *Teamsters Local 272*, 642 F.3d 321, 330-32 (2d Cir. 2011), this Court recognized the validity of patient assignments received by in-network providers. Akin to the Panel's holding here, the hospital in *Montefiore* argued that these assignments were a "nullity" because when the patients saw in-network providers the "benefit" was "health care at no cost" (a good)—not reimbursement (a payment). The *Montefiore* Court rejected that argument. It observed that "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." *Id.* at 329. The Court recognized that the right to receive health care is possible only because the benefit to which the patient is entitled is—not health care services themselves—but payment for those services. Thus, the animating principle in *Montefiore* was that ERISA benefits are payments, not goods; a proposition at odds with the Panel's definition of benefits.

Other Circuits have similarly equated plan payments to providers with ERISA "benefits" by upholding the rule that provider-assignees may enforce payment rights under § 1132(a)(1)(B):

- *CardioNet, Inc.* v. *Cigna Health Corp.*, 751 F.3d 165, 176 & n.10 (3d Cir. 2014) ("Through the derivative claims, the Providers seek reimbursement for the cost of the OCT services provided to the five Participants. . . . We adopt the majority position that health care providers may obtain standing to sue by assignment from a plan participant.");

- *N. Cypress Med. Ctr. Operating Co.* v. *Cigna Healthcare*, 781 F.3d 182, 195 (5th Cir. 2015) ("***[A]ny patient's injury is caused by Cigna's refusal to pay North Cypress*** as directed, and a favorable decision awarding North Cypress damages is likely to redress the injury. . . . In short, North Cypress also has statutory standing under ERISA for the benefit claims at issue because of assignments from plan beneficiaries.") (emphasis added);

- *Decatur Mem'l Hosp.* v. *Connecticut Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993) ("An assignee of benefits under an ERISA plan becomes a statutory 'beneficiary' and thus may use 29 U.S.C. § 1132(a)(1)(B) to collect. . . ."); *Neuma, Inc.* v. *AMP, Inc.*, 259 F.3d 864, 878 (7th Cir. 2001) (a corporation that purchased rights to a member's life insurance benefits could "be considered a 'beneficiary'");

- *Misic* v. *Bldg. Serv. Employees Health & Welfare Trust*, 789 F.2d 1374, 1377 (9th Cir. 1986) ("the general goal" of ERISA would not be served "by prohibiting the type of assignments involved in this case—assignment to the person who provided the beneficiary with the health care of the ***beneficiaries' right to reimbursement for the cost of that care***") (emphasis added);

- *Conn. 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") (emphasis added).

Each of these holdings is predicated on the understanding that the "benefit" is the payment—not the right to receive medical care or "covered" medical care.

III. This Court Could Resolve This Case on Narrower Grounds.

The Court could have resolved the question before it without weighing in on the meaning of an ERISA "benefit." The Cigna plan at issue stated that "'[a]ll Medical Benefits are payable to [the patient]," ***not*** the provider. Cigna reserved only "the option" to pay providers directly. Slip Op. at 3. The Court held that this means that the plan did not give Appellants a "guarantee of direct payment." *Id.* at 11. Thus, the Court could have held that Appellants' entitlement to benefits was too attenuated to satisfy the statutory requirement that they be "designated" by the plan as being "entitled" to benefits.[3] *See Dallas County Hosp. Dist.* v. *Associates' Health and Welfare Plan*, 293 F.3d

[3] In contrast, the plans at issue in *Pennsylvania Chiropractic* "state[d] unambiguously that participating providers are to be paid directly by IBC when they provide covered services to participants." 2014 WL 1276585, at *10. In other words, the plan provisions operated as built-in assignments.

282, 289 (5th Cir. 2002) (holding that the provider was not an ERISA beneficiary because it had made "no showing" that it had been designated as such by the Plan document). With such a finding, the Court could then have held that the assignments the providers obtained limited their claim to one for benefits under 29 U.S.C. § 1132, rather than ancillary claims otherwise available under ERISA, such as under 29 U.S.C. § 1140.

CONCLUSION

The Panel's decision suggests that when Congress gave "beneficiaries" the right to enforce ERISA it sought to narrowly define that term to include exclusively individuals "covered" by the plan. But ERISA does not say that. Instead, it broadly defines an ERISA "beneficiary" as anyone entitled to a plan "benefit." And it repeatedly uses the term "benefit" to refer to monetary payments made by the plan.

The Panel determined that "Congress did not intend to include doctors in the category of 'beneficiaries.'" Slip Op. at 9. Yet there is nothing in the text of ERISA to demonstrate that intent. Moreover, the Panel's analysis threatens the ability of providers ***ever*** to assert ***any***

ERISA claim, even if the provider is designated by the plan and an insured as entitled to benefit payments, and even if the provider seeks to challenge a benefit denial inconsistent with plan terms. That conclusion is contrary to virtually every other Circuit Court decision addressing providers' rights to bring claims under ERISA.

The AMA and MSSNY support Appellants' request that this Panel, or this Court sitting *en banc*, reconsider these aspects of the Panel's decision.

Dated: July 29, 2015

Respectfully submitted,

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CERTIFICATE OF WORD COUNT

I certify that:

1. This brief complies with the type-volume limitation of Rule 32(a)(7)(B)(ii) of the Federal Rules of Appellate Procedure. I am relying on the word count of the word-processing system (Microsoft Word) used to prepare this brief, which indicates that 3,229 words appear in the brief, excluding parts of the brief exempted by Rule 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Rule 32(a)(5) of the Federal Rules of Appellate Procedure and the type style requirements of Rule 32(a)(6). This brief was prepared in 14 point Century Schoolbook font (a proportionally-spaced typeface) using Microsoft Word 2010.

Dated: July 29, 2015

/s/ D. Brian Hufford
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CERTIFICATE OF SERVICE

In conformance with Rule 25(d) of the Federal Rules of Appellate Procedure, I certify that on July 29, 2015, I caused the foregoing Brief of *Amici Curiae* to be filed electronically with the Clerk of the Court of the United States Court of Appeals for the Second Circuit by using the Court's Case Management/Electronic Case Filing (CM/ECF) system, which will send notification of this filing to all registered counsel of record.

I further certify that I will submit paper copies of the Brief in conformance with Local Rules 31.1 and the Federal Rules of Appellate Procedure.

Dated: July 29, 2015

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