The ERISA Edit: Ninth and Eleventh Circuits Issue Mixed Decisions on Assignments of ERISA Claims

Employee Benefits Alert
01.18.2024

Ninth Circuit Finds Assignment of Benefits to Surgery Center "Clearly and Necessarily" Included the Right to Sue for Non-Payment

On January 10, 2024, the U.S. Court of Appeals for the Ninth Circuit determined that a district court erred in dismissing an ERISA action brought by South Coast Specialty Surgery Center, Inc. (South Coast), an ambulatory surgery center, against Blue Cross of California, d/b/a Anthem Blue Cross (Anthem), as insurer and claims administrator, for Anthem's alleged failure to fully reimburse the costs of medical services provided to South Coast's patients. The district court had reasoned that South Coast's "Assignment of Benefits" form conveyed only "the right to receive direct payment from Anthem" and not the right to sue for nonpayment of plan benefits, and that South Coast lacked independent authority to sue under ERISA. The Ninth Circuit reversed and remanded, holding that the patients' assignments of rights to South Coast were valid and included the right to sue. *South Coast Specialty Surgery Ctr., Inc. v. Blue Cross of California*, No. 22-55717, __F.4th__, 2024 WL 105317 (9th Cir. Jan. 10, 2024).

The dispute arose after Anthem instituted a new "pre-payment review" process that, according to South Coast, significantly reduced coverage of South Coast's services to patients – resulting in a potential shortfall exceeding $5.4 million. Previously, Anthem had processed and paid hundreds of claims submitted by South Coast on behalf of its patients without dispute. By instituting the new process, Anthem allegedly ignored ERISA plan documents; improperly required "full medical records" to evaluate the "appropriateness," "accuracy," and "correctness" of submitted claims; and rejected South Coast's claims for payment "without proper reference to the terms and conditions of the controlling ERISA plan." South Coast sued Anthem under section 502(a) of ERISA, 29 U.S.C. § 1132(a)(1)(B), for "fail[ing] to follow [p]lan terms and conditions with respect to the processing and payment of [submitted] claims."

Section 502(a) of ERISA permits a plan participant or beneficiary to bring suit to recover benefits due to them. South Coast asserted that although it could not bring a direct enforcement action under § 502(a) because it was not a plan participant or beneficiary, it could still enforce ERISA's protections because its patients had assigned to South Coast their rights to sue for non-payment of plan benefits.

The Ninth Circuit agreed. The court noted that "under ERISA's clear terms, South Coast lacks direct authority to enforce its protections" because healthcare providers are not plan participants or beneficiaries. The court held, and the parties did not dispute, however, that ERISA beneficiaries may assign their rights to reimbursement under a health plan to a healthcare provider and that assignees may bring derivative actions to enforce these rights. Thus, the true question before the court was whether the language in South Coast's "Assignment of Benefits" form created a valid assignment. The form stated:

> I hereby authorize my Insurance Company to pay by check made payable and mailed directly to: [South Coast] for the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the South Coast Specialty Surgery Center will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current

> manner, any charges not covered by the insurance payment. If it is necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fees incurred by the outpatient medical center in the collection of the outstanding fees.
>
> Actual Plan Benefits cannot be determined until the claim is received by your insurance company and is based upon their determination of medical necessity. The information received from the above stated is not a guarantee of payment.

The court applied traditional principles of contract law and relied on the "intent of the parties" to determine "what rights and remedies pass with a given assignment." It stated that the "explicit presence [of the word *assignment*] in the title of a document certainly helps . . . to divine whether the parties intend that the form operate as a valid assignment." And it observed that South Coast's form used wording that "track[ed] text" the court had previously concluded "conveys a valid assignment."

Having found the assignment itself valid, the court then held that the scope of the assignment "clearly and necessarily" included the associated right to sue for non-payment. Although South Coast's form did not expressly state that it could sue insurers on its patients' behalf, the court concluded that a contrary conclusion would "make[] neither textual nor practical sense" as Anthem could deny reimbursement, which could then force South Coast to file individual collection actions against hundreds of patients, who in turn could then "pay South Coast; refuse to pay; or seek coverage from Anthem, likely resulting in potential individual actions against the insurer." Such an outcome would "stymie" the purpose of ERISA, which was meant to "protect . . . the interests of participants in employee benefit plans."

The court cautioned that not "*all* assignments of the right to benefits—regardless of who made the assignment and who received it—necessarily confer the right to sue under ERISA" and expressly limited its decision to "whether section 502(a) of ERISA permits a healthcare provider to bring a derivative suit, seeking the payment of benefits, when it has been given a valid assignment to do so."

In a Pair of Decisions, Eleventh Circuit Finds Assignments to Dermatologist Invalid

The Ninth Circuit's decision in the South Coast case came on the heels of pair of appeals before the Eleventh Circuit that also raised questions regarding the assignment of ERISA claims. In those cases, a dermatologist, W.A. Griffin, asserted that her patients assigned to her the right to bring ERISA claims on their behalf. In both cases, the Eleventh Circuit held that Dr. Griffin, whom the district court characterized as "a frequent *pro se* filer," lacked standing under ERISA.

The first appeal involved § 502(c)(1)(B) of ERISA, which provides that an administrator of an ERISA-governed health plan who fails to comply with a request for information that the administrator is required to furnish to a plan participant "may in the court's discretion be personally liable" to the participant "in an amount of up to $100 a day from the date of such failure or refusal." Invoking § 502(c)(1)(B) and asserting that she had been assigned the right to bring claims on her patient's behalf, Dr. Griffin sued Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP) seeking to recover statutory penalties for BCBSHP's alleged failure to timely comply with her requests for plan documents. The district court dismissed Dr. Griffin's complaint and the Eleventh Circuit affirmed. *Griffin v. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.* , No. 23-11414, 2023 WL 8743387 (11th Cir. Dec. 19, 2023). The court noted that to have standing to bring an ERISA claim, under ERISA § 502(a)(1) the plaintiff must be either a participant or beneficiary of an ERISA plan, although a healthcare provider may obtain derivative standing for payment of medical benefits through a written assignment from the participant or beneficiary. According to the court, however, an assignment of rights does not necessarily encompass the right to pursue non-payment claims (*i.e.*, those for statutory penalties), as opposed to payment claims (*i.e.*, to recover benefits provided by an ERISA plan). The court therefore examined the pertinent language of the written agreement between Dr. Griffin and her patient, which stated that the patient assigned to Dr. Griffin her "rights and benefits." According to the court, this language was not "sufficiently explicit" to give Dr. Griffin the right to seek statutory penalties under ERISA.

In the second case, *Griffin v. AT&T Services, Inc*., No. 23-11408, 2023 WL 8852925 (11th Cir. Dec. 21, 2023), Dr. Griffin had brought claims for breach of fiduciary duty against AT&T Services, Inc., again based on a patient's assignment of rights. But because the plan at issue contained an express anti-assignment provision, the district court concluded that the plan participant was "prohibited from assigning her rights and benefits to Griffin" and it dismissed the case. On appeal, the Eleventh Circuit observed that "[a]lthough assignments are generally recognized, an 'unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable.'" Thus, "[i]f there is an unambiguous anti-assignment provision, the healthcare provider will lack derivative standing and cannot maintain the ERISA action." The district court had, in fact, found the anti-assignment provision to be unambiguous, and Dr. Griffin did not challenge that finding on appeal. Because Dr. Griffin abandoned that issue before the Eleventh Circuit, the court was "compelled to affirm."

Comment Period Extended for No Surprises Act IDR Operations Proposed Rule

On January 17, 2024, the Departments of Health and Human Services, Labor, and the Treasury (collectively, the Departments) and the Office of Personnel Management (OPM) issued a notice reopening the period for submitting comments on the proposed rule, "Federal Independent Dispute Resolution (IDR) Operations." That rulemaking, published on November 3, 2023, proposed requirements related to the IDR process established under the No Surprises Act (NSA), including new requirements for disclosing information along with the initial payment or notice of denial of payment for certain items and services subject to the surprise billing protections in the NSA and when initiating the IDR process and the provision of certain Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) with paper or electronic remittances. Additionally, the proposed rule would define bundled payment arrangements and would amend certain requirements related to the open negotiation period, initiation of the IDR process, eligibility determinations, batched disputes, extensions due to extenuating circumstances, selection of the certified IDR entity, and the collection of administrative fees and certified IDR entity fees. Lastly, the proposed rule would require plans and issuers to register in the IDR portal. The comment period for that proposed rule, which closed on January 2, 2024, is being reopened to allow interested parties to submit comments on how that proposal is impacted by the final rule on IDR fees, "Federal Independent Dispute Resolution Process Administrative Fee and Certified IDR Entity Fee Ranges," issued on December 21, 2023. The new comment deadline is 14 days after publication of the extension notice in the Federal Register, which is scheduled to take place January 22, 2023, so the new comment deadline is expected to be February 5, 2024.
