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Third Circuit Resolves District Court Conflict On ERISA Standing-By-Assignment, But Questions Remain

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When enacting ERISA, Congress conferred direct standing on a very limited set of potential litigants: participants (the actual employee members of the group that sponsors a healthcare plan), beneficiaries (those whom the employee may designate as being eligible for benefits under his plan, such as his spouse or children), and fiduciaries (most commonly the insurance companies and benefit management firms with responsibility for and discretionary authority over the plan itself). For decades, however, medical providers – particularly out-of-network medical providers having no independent contractual relationship with an insurance company – have filed ERISA enforcement actions against carriers on the argument that they have derivative standing as their patients' "assignee of benefits."

What exactly does it mean for a provider to have a "valid" assignment of benefits? For years trial courts within the District of New Jersey hotly debated the issue, as one camp of judges endorsed a narrow approach while another camp endorsed a broad approach.

The Third Circuit, like many courts, was at first reluctant to endorse this standing-by-assignment theory. In fact, when it first addressed the issue in 1985, the Court expressed "serious doubts" whether a plan participant or beneficiary could ever assign his or her right to bring an ERISA enforcement action in Federal court. *Northeast Dept. ILGWU Health & Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3d Cir. 1985). Nearly thirty years later, however, the Third Circuit officially adopted the opposite position and held, definitively, that providers may assert derivative standing as assignees under ERISA. *CardioNet, Inc. v. Cigna Health Corp.*, 751 F.3d 165 (3d Cir. 2014). This holding came as little surprise to healthcare attorneys, as virtually all Circuit Courts and most Third Circuit District Courts who decided the issue in the interim reached the same conclusion.

But as legal and medical communities awaited final clarification from the Third Circuit as to whether providers may exercise derivative ERISA standing at all, the standing-by-assignment debate became more nuanced. As more and more Federal Courts of Appeals endorsed derivative provider standing by assignment, and with the Third Circuit's eventual endorsement of that theory effectively a foregone conclusion, the focus of the debate became not *whether* a provider may have standing to prosecute an enforcement action, but *what kind* of assignment of benefits was sufficient to confer that standing. *CardioNet* itself recognized that not any "assignment" will do, and that only "valid" assignments suffice to confer derivative standing.

What exactly does it mean for a provider to have a "valid" assignment of benefits? For years trial courts within the District of New Jersey hotly debated the issue, as one camp of judges endorsed a narrow approach while another camp endorsed a broad approach. Judges subscribing to the narrow approach held that, as with any other contractual assignment, a valid, standing-conferring assignment of benefits under ERISA must contain clear and unequivocal language indicating that the patient fully and irrevocably assigns all benefits under his health insurance plan to his provider; that the assignment is effective without further action on the patient's part; that the patient loses all control over the assigned res; and that the provider assumes full risk of the assignment.

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Judges adopting this approach routinely concluded that assignments of benefits limited to a provider's right to receive payment directly from an insurance company, and/or which preserved the patient's responsibility for the provider's charges, were not valid assignments under general contract law and therefore did not confer derivative standing upon the provider to bring an ERISA enforcement action.

Conversely, other judges held that an assignment of benefits need not be so specifically defined in order to confer derivative standing under ERISA to prosecute an enforcement action to recover benefits. Relying on more equitable considerations such as a provider being better situated to justify treatments or procedures to an insurance company, these courts held that even a limited assignment of benefits which speaks only to the right to receive payment necessarily encompasses the right to bring an ERISA enforcement action to recover that payment, and hence confers derivative standing on the provider.

This schism persisted at the district court level for several years. The practical – and, for legal purists, detrimental – effect of these conflicting schools of thought was that the threshold issue of the "sufficiency" of an assignment of benefits would be decided not by clear legal principles but by which judge the litigants drew.

The Third Circuit endeavored to resolve the issue in September 2015, when it issued opinions in the consolidated appeals of *North Jersey Brain & Spine Center v. Aetna, Inc.* and *American Chiropractic Association v. Cigna Corporation*, both of which involved assignments of benefits which authorized insurance payments directly to the provider, but did not directly speak to an assignment of a patient's legal claim to standing. In its published *Aetna* Opinion, the Third Circuit concluded that, "as a matter of federal common law, when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment" under ERISA's civil enforcement provision. Relying on the same practical and equitable considerations raised by like-minded courts (e.g., a provider being better situated and financed to pursue legal action for benefits owed for their services), the Third Circuit reasoned that a provider's right to receive insurance benefits from his patient's carrier would be hollow without enforcement capabilities. The Third Circuit drew the same conclusion in its unpublished *Cigna* opinion.

While the Third Circuit's pronouncements may be superficially appealing in their simplicity, they open the door to several other questions and pose practical problems of their own. Consider the scenario of an out-of-network provider who takes an assignment of benefits from his patient limited to the right to receive insurance payments for services rendered. Suppose the patient's insurance company pays only a small portion of the provider's charges and the provider, as is his right, bills the patient for the balance. Suppose further that the patient, to avoid collection efforts by the provider, pays the bill but intends to dispute the covered portion of the claim with his insurance company, contending that the insurance company should have paid a greater portion. Does the patient have standing to bring an ERISA action to recover additional benefits from his insurance company? After all, according to the Third Circuit, the patient is deemed to have "assigned" that right (notwithstanding his assignment of benefits' silence on the subject) to his provider – the same provider who has now been paid in full and who therefore has no financial incentive to pursue an enforcement action on the patient's behalf. Who "owns" the right to challenge the insurance company in such a case? If, presumably, it is the provider, can legal standing be "unassigned" in such a scenario? And if so, how are courts to reconcile such a conclusion with general contract law, under which an assignment of a contractual right is supposed to be irrevocable?

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Because neither *Aetna* nor *Cigna* presented such a factual scenario, the Third Circuit declined to address it as part of its holding. It did opine in *Aetna's* dictum, however, that a Court faced with such facts should determine "whether an implied term of the assignment is that a provider must make a reasonable effort to collect from the insurer before attempting to collect from the patient." No doubt in future cases some judges will answer this question in the affirmative and some in the negative. And for those judges who ultimately do answer in the affirmative, "reasonableness" is obviously in the eye of the beholder. Where will courts draw the line as far as what constitutes a "reasonable" effort to collect from an insurance carrier? Is simply submitting a bill and having it rejected reasonable enough? Must the provider exhaust the patient's internal appeal rights in order to meet the threshold level of reasonableness? Must he pursue external arbitration or utilization review? The Third Circuit did not say, nor did it provide any guidance, thereby opening the door for District Courts to create yet another schism on yet another issue.

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