No. 17-4181

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JASON SPRINGER,
Plaintiff-Appellant,

v.

CLEVELAND CLINIC EMPLOYEE HEALTH PLAN TOTAL CARE,
Defendant-Appellee.

On Appeal from the United States District Court
for the Northern District of Ohio

BRIEF OF THE SECRETARY OF LABOR, AS AMICUS CURIAE IN SUPPORT OF APPELLANT

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QUESTION PRESENTED

Plaintiff Jason Springer, a participant in the defendant Cleveland Clinic Employee Health Plan Total Care (the "Plan"), filed suit under the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, 29 U.S.C. § 1001, et. seq., contesting the Plan's denial of his claim for full payment of the cost of air-ambulance transportation for his son who suffers from serious health conditions. The Plan moved to dismiss the participant's claim for lack of subject matter jurisdiction. The court granted the motion, holding that because the air-ambulance service had not billed the participant for its services, the participant failed to allege facts sufficient to demonstrate an "injury in fact" and, therefore, lacked constitutional standing under Article III. The Secretary of Labor's brief addresses the following issue:

Whether a participant in an ERISA-covered plan who sues the plan for wrongfully denying his claim for payment of medical services suffered an "injury in fact" when the plan refused to fully reimburse his medical provider.

STATEMENT OF IDENTITY, INTEREST AND AUTHORITY TO FILE

The Secretary of Labor has primary authority to interpret and enforce the provisions of Title I of ERISA to effectuate its protective purposes. See 29 U.S.C. §§ 1132, 1135; Donovan v. Cunningham, 716 F.2d 1455, 1462-63 (5th Cir. 1983). The district court's decision bars the plaintiff from exercising his statutory right to

have his benefits claim determined in accordance with the plan terms by a federal court. If allowed to stand, the decision's reasoning improperly frustrates Congress's express intent to provide plan participants "ready access to the Federal courts," 29 U.S.C. § 1001(b), "to 'protect contractually defined benefits.'" U.S. Airways, Inc. v. McCutchen, 569 U.S. 88, 100-101 (2013) (citation omitted). The Secretary has a compelling interest in ensuring that the district court's ruling, which requires a participant's healthcare provider to bill the participant before the participant can challenge his plan's decision not to cover the provider's services, does not erroneously impose a constitutional barrier for plan participants with routine claim disputes.

The Secretary also has a compelling interest in ensuring courts adopt a uniform national rule that participants have standing to sue for unpaid benefits without receiving a direct bill for medical care, and that the relevant injury is the plan's failure to pay for the services at the plan's promised rate, not the participant's receipt of a bill. Cf. Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404, 409 (9th Cir. 1995) (urging uniformity in conferring standing for ERISA claims). The district court's decision to deny a participant constitutional standing because his provider did not directly bill him conflicts in principle with rulings by the Fifth, Ninth, and Eleventh Circuits and would impose severe consequences for ERISA participants by unraveling well-established billing practices.

The Secretary does not address the merits of the benefits claim. Standing "in no way depends on the merits of the plaintiff's contention that particular conduct is illegal." Smith v. SEC, 129 F.3d 356, 363 (6th Cir. 1997) (en banc) (quoting Warth v. Seldin, 422 U.S. 490, 500 (1975)). The Secretary files this brief pursuant to Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

Plaintiff Jason Springer, a physician, formerly lived with his family in Utah. Springer v. Cleveland Clinic Emp. Health Plan Total Care, No. 1:15-CV-00020, 2017 WL 4837478, at *1 (N.D. Ohio Oct. 26, 2017).[1] In the spring of 2010, Dr. Springer accepted a position with the Cleveland Clinic (the "Clinic") in Ohio. Id. He was to begin his employment on July 1, 2010. Id. He enrolled himself, his wife, and his son, J.S., in the Plan established for the Clinic's employees and their dependents. Id. The Plan's benefits are self-funded by the Clinic and are not covered by an insurance policy. Id. at *3. The Plan is administered by Antares Management Solutions, Inc. ("Antares"), a third-party plan administrator ("TPA") that makes eligibility and benefit coverage determinations for the Plan. Id. at *2, *3. Under the Plan's terms, "as long as you have enrolled in the health plan within 31 days of your start date, your coverage is effective on the first day you actively

[1] The Secretary's factual statements are based on the district court's factual statements and the parties' undisputed characterization of the evidentiary record.

start to work." Id. The Springer family became participants in the Plan on July 1, 2010. Id.

J.S. was born on May 4, 2009, with multiple congenital abnormalities, the most serious of which were omphalocele (external protrusion of the intestine and other abdominal organs from the navel), left intra-abdominal fluid collection near the left kidney, and amniotic band syndrome (no stomach muscles). See Pl.'s Opening Br. for J. on the Administrative R. ("Opening Br.") 4. These conditions and ensuing severe complications required around-the-clock healthcare and left J.S. dependent on a mechanical ventilator to breathe. Id.

When Dr. Springer accepted his position, he arranged to have J.S., then 14 months old, transported to a waiting hospital bed at the Clinic by Angel Jet Services, LLC ("Angel Jet"), an air ambulance service selected by Dr. Springer. Springer, 2017 WL 4837478, at *1; Opening Br. 5. J.S.'s primary care physician signed a Medical Letter of Necessity explaining the need for such transportation services. Springer, 2017 WL 4837478, at *1. Among other things, J.S. required a critical-care neonatal flight nurse and paramedic during transport. Opening Br. 5. In the case of an emergency, the Plan covers all air-transportation costs to get to an emergency room. Springer, 2017 WL 4837478, at *6. Absent an emergency, the Plan will pay 100% of those costs only if the Plan pre-certifies coverage, i.e., pre-approves coverage. Id.

Angel Jet sought coverage information from Antares before the flight. Springer, 2017 WL 4837478, at *3. Antares was unable to verify the family's enrollment when J.S. was scheduled for transport by Angel Jet's air ambulance to the Clinic on July 7, 2010, because the service occurred during the enrollment-processing period. Id. The Plan provides that claims for medical services rendered during the enrollment-processing period "may be denied" initially but the "claims will be adjusted on the backend when the TPA processes your benefit selections data." See Opening Br. 3. Dr. Springer relied upon that plan language in later asserting his claim that the Plan must fully pay for Angel Jet's services despite the lack of pre-certification. Springer, 2017 WL 4837478, at *6 ("[T]he record does not reflect an attempt [by Angel Air] to obtain precertification for the air ambulance services prior to the date of the flight.").

Shortly after J.S. arrived at the Clinic on July 7, 2010, Angel Jet submitted a bill directly to Antares for $340,100 for its services. Springer, 2017 WL 4837478, at *1. On August 31, 2010, an Antares representative informed Angel Jet that the claim was approved. Id. However, on September 2, 2010, Antares denied the claim because it found that Angel Jet did not establish that an emergency existed and that the Plan did not pre-certify coverage as required in non-emergencies. Id.

Normally, the Plan provides its air-ambulance benefit through a different airline with which the Plan has an ongoing relationship. Springer, 2017 WL

4837478, at *1; see also Def.'s Resp. Br. for J. on the Administrative R. ("Resp. Br."), 7 (calling the airline a "preferred provider"). Based on this relationship, the Plan offers members a steep discount on air ambulance services. Springer, 2017 WL 4837478, at *1. While the Plan denied Angel Jet's $340,100 claim, it nevertheless issued Angel Jet a check for $34,451.75 (approximately 10% of the billed charges) on January 27, 2011. Id. at *1, *6. According to the Plan, this payment is the amount the Plan's preferred provider of air transport services would have charged for transporting J.S. Id. at *1. The Plan asserts in litigation that this payment was "not required due to lack of preauthorization, [but] had been paid out of fairness." See Resp. Br. 7. Angel Jet sued for benefits under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), for the remainder of the $340,100 bill, asserting that Dr. Springer assigned his claim to benefits to Angel Jet. Angel Jet Servs., LLC v. Cleveland Clinic Emp. Health Plan Total Care, 34 F. Supp. 3d 780, 781-82 (N.D. Ohio 2014) (Angel Jet "challenges the decision of the Plan Administrator and seeks full payment under the Plan."). The court dismissed the suit, because it found that Dr. Springer had not assigned his benefits claim to Angel Jet. Id. at 783.

Dr. Springer then made his own claim for benefits under the Plan, requesting that the Plan pay Angel Jet 100% of the billed charges. Springer, 2017 WL 4837478, at *1. Antares denied the claim, finding that Dr. Springer failed to

establish that an emergency existed and that the Plan did not pre-certify coverage as required in non-emergencies. Id. Dr. Springer filed suit under ERISA section 502(a)(1)(B) against the Plan, challenging the denial of the full amount of the billed charges. Id. at *1. The Plan then moved to dismiss the case, contending that Dr. Springer did not have constitutional standing. Id. at *2. The district court agreed and dismissed the case because Dr. Springer failed to show a "concrete injury" under Article III. Id. at *5. The district court first found the record "entirely silent on any charges from Angel Jet to [Dr. Springer]. [Dr. Springer] does not point the Court to any evidence in the administrative record demonstrating that [he] is liable for the balance of the Angel Jet claim nor has [he] alleged that Angel Jet has sought reimbursement from him." Id. at *5. In his reply brief, Dr. Springer indicated that Angel Jet "has not sought reimbursement." Id.

The district court concluded that Dr. Springer did not suffer a concrete injury sufficient for Article III standing because Dr. Springer "received air ambulance service[,] [the] Defendant Plan paid what they determined was covered under the Plan[,] [and] Angel Jet accepted that payment and has not sought reimbursement from [Dr. Springer]." Springer, 2017 WL 4837478, at *6. The district court also dismissed the case on alternative grounds by reaching the merits of the benefits claim and affirming the Plan's denial of benefits. Id.

SUMMARY OF THE ARGUMENT

The district court erred in holding that a participant's right to have his benefits claim determined in accordance with the plan terms is insufficient to establish constitutional standing. Here, the plaintiff seeks to vindicate his right to challenge the plan's denial of his benefits and to have his benefits claim determined according to the terms of the Plan in federal court. His claim that the Plan denied him benefits in violation of Plan terms confers a concrete, personal stake in this case and, therefore, constitutes an injury-in-fact to support Article III standing.

This Court has not previously addressed whether a participant who sues a plan for wrongfully denying his claim for payment of medical services suffers an "injury in fact" if the provider of those services did not first bill the patient for any charges. Three circuit courts, however, have ruled that a denial of a benefits claim in alleged violation of plan terms, by itself, constitutes a sufficient Article III injury even though the provider did not first bill the patient. The Fifth, Ninth, and Eleventh Circuits reached this conclusion in an analogous context where medical providers sued an ERISA plan, its administrator or insurer, as a participant's assignee. These courts held that the assignee providers had constitutional standing to sue the ERISA plan, its administrator or insurer, for unpaid benefits under ERISA without first charging or "balance billing" patients for any unpaid medical services. The Eleventh Circuit ruled that the relevant injury is the plan's failure to

pay for covered services at the promised rate, not whether the provider had billed the patient. HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co., 240 F.3d 982 (11th Cir. 2001) (overruled on other grounds by Doyle v. Liberty Life Ins. Co., 542 F.3d 1352 (11th Cir. 2008)). The Fifth and Ninth Circuits reached the same conclusion in North Cypress Medical Center Operating Co. v. CIGNA Healthcare, 781 F.3d 182 (5th Cir. 2015), and Spinedex Physical Therapy USA, Inc. v. UnitedHealthcare of Arizona, Inc., 770 F.3d 1282 (9th Cir. 2014). The logic of these decisions requires the same conclusion where, as here, a participant (rather than a provider-assignee) sues the plan.

The courts agree that the relevant injury is the plan's alleged failure to pay for the medical services at the promised rate, not the participant's receipt of a bill for services. Accordingly, the Plan's alleged failure to pay the claim here in accordance with the plan terms is itself sufficient to establish the plaintiff's injury in fact required to establish Article III standing to sue for unpaid benefits without first receiving a direct bill for services. Moreover, not only would affirmance of the district court's erroneous ruling conflict in principle with the rulings of other circuits, it would limit ERISA participants' ability to challenge a benefits denial by requiring participants to first pay the medical bill or otherwise subject themselves to a provider's bill collection efforts. Imposing such a requirement undermines widely-used billing practices endorsed uniformly by the courts. Generally,

providers may postpone billing patients until the provider or patient exhausts any rights to review the plan's denial of benefits, including filing suit in federal court.

ARGUMENT

Plaintiff Has Article III Standing To Challenge The Adjudication Of His Benefits Claim

Federal courts have an independent duty to examine constitutional standing to determine whether they have jurisdiction. Ruhrgas AG v. Marathon Oil Co., 526 U.S. 574, 583 (1999). This threshold determination, however, is independent from the merits of the claims. Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1277 (6th Cir. 1991). "When considering whether a plaintiff has Article III standing, a federal court must assume arguendo the merits of his or her legal claim." North Cypress, 781 F.3d at 191 (citation and brackets omitted). Without regard to the merits of Plaintiff's claim, he has an injury-in-fact that satisfies Article III, and a decision to the contrary would disrupt established nationwide billing practices.

A. *Plaintiff's "Injury-in-Fact" Satisfies Constitutional Requirements*

The Supreme Court recently articulated the standing requirements a plaintiff must meet to establish a "case or controversy" within federal court jurisdiction under Article III in Spokeo, Inc. v. Robins, 136 S. Ct. 1540 (2016). "[T]he 'irreducible constitutional minimum' of standing consists of three elements . . . the plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the

challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." Id. at 1547. "To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" Id. at 1548 (quoting Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992)). When considering "injury in fact" for claims based on the "invasion of a legally protected interest," the Supreme Court in Spokeo "confirmed . . . that intangible injuries can nevertheless be concrete" for constitutional standing purposes. Id. at 1549. Spokeo then stated that "[i]n determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." Id. First, "it is instructive to consider whether an alleged intangible harm has a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit in English or American courts." Id. Second, "because Congress is well positioned to identify intangible harms that meet minimum Article III requirements, its judgment is also instructive and important." Id.

Spokeo's analysis addressed "intangible injuries" caused by statutory violations in contrast to violations of private rights such as contractual rights. 136 S. Ct. at 1549 ("Congress' role in identifying and elevating intangible harms does not mean that a plaintiff automatically satisfies the injury-in-fact requirement

whenever a statute grants a person a statutory right and purports to authorize that person to sue to vindicate that right."); see also Spokeo, 136 S. Ct. at 1550 (Thomas, J., concurring) ("Common-law courts more readily entertained suits from private plaintiffs who alleged a violation of their own rights, in contrast to private plaintiffs who asserted claims vindicating public rights.").

Before Spokeo, the Fifth Circuit addressed the specific question presented in this appeal in North Cypress: whether a participant suffers an "injury in fact" when the plan fails to fully reimburse his provider as promised by the plan and the provider did not first bill the participant for the medical services. 781 F.3d at 192. Regardless of whether the claim denial is viewed as a violation of an ERISA statutory right to enforce the plan terms or a violation of a contractual right to recover promised plan benefits, the Fifth Circuit's decision and reasoning are fully consistent with Spokeo's focus on "harm that has traditionally been regarded as providing a basis for a lawsuit in English or American courts," and Congressional intent. 136 S. Ct. at 1549; see 29 U.S.C. § 1132(a)(1)(B).

In North Cypress, participants assigned their benefit claims to the treating hospital, which challenged the determination by Cigna, the insurer, of the amounts due under the terms of the plan. 781 F.3d at 190. Cigna argued that the provider had no concrete injury sufficient for Article III standing because it had never billed the participants for the amounts the insurer did not pay and "never intended to do

so." Id. at 192. The Fifth Circuit first found that the provider, as assignee, must rely on the participant's injury for its standing. Id. This principle is well-established. The provider, as assignee, has constitutional standing to assert a section 502(a)(1)(B) claim based on the constitutional injury suffered by the plan participant, the assignor. See Sprint Commc'ns Co., L.P. v. APCC Servs., Inc., 554 U.S. 269, 290 (2008). "[I]t is black-letter law that an assignee has the same injury as its assignor for purposes of Article III." Spinedex, 770 F.3d at 1291. As the Third Circuit stated:

> It is a basic principle of assignment law that an assignee's rights derive from the assignor. That is, "an assignee of a contract occupies the same legal position under a contract as did the original contracting party, he or she can acquire through the assignment no more and no fewer rights than the assignor had, and cannot recover under the assignment any more than the assignor could recover."

CardioNet, Inc. v. Cigna Health Corp., 751 F.3d 165, 178 (3d Cir. 2014) (quoting 6A C.J.S. Assignments § 110).

Examining the patient-participant's injury, the Fifth Circuit rejected Cigna's argument and concluded that "a patient suffers a concrete injury if money that she is allegedly owed contractually is not paid, regardless of whether she has directed the money be paid to a third party for her convenience. The patient in this circumstance is being denied use of funds rightfully hers." North Cypress, 781 F.3d at 192. "From a different angle, failure to pay also denies the patient the benefit of her bargain. In purchasing her Cigna plan she agreed to pay for

coverage at out-of-network providers like North Cypress, and Cigna is failing to uphold the bargain by paying for covered services." Id.[2]

The Eleventh Circuit reached the same conclusion in similar circumstances. HCA, 240 F.3d at 991. The Eleventh Circuit noted that the purpose of the assignment was to permit an adjudication of benefit claims without first billing the patient. Id. Based on that rationale, the constitutional injury should not turn on the existence of a bill but rather the patient and provider's "recovery of benefits under the group insurance plan." Id. The Fifth Circuit also observed that the Ninth Circuit in Spinedex, 770 F.3d at 1288-91, "addressed the issue of standing in this situation head-on" and rejected the same argument that "there was no injury in fact to patients because they were not billed for the amount allegedly due from the insurance plans." North Cypress, 781 F.3d at 192 n.35. While Spinedex was less

[2] The Fifth Circuit also agreed with a district court decision, Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc., No. 10-CV-7427, 2011 WL 803097 (S.D.N.Y. Feb. 18, 2011). North Cypress, 781 F.3d at 193. In that decision, the service provider Biomed granted the participant a financial hardship waiver for three consecutive years based upon his inability to pay. Biomed, 2011 WL 803097, at *2. The defendant plan argued that because the patient had no obligation to pay Biomed after the waiver, Biomed could not show an injury in fact for its claim for benefits as the patient's assignee. Id. at *4. Rejecting this argument, the court ruled that although the plan was "free to challenge" its contractual obligation to pay under the plan terms, the waiver had "nothing to do with standing." Id. As the court explained, this argument confused a "possible" defense to the contractual claim "under the Plan with the requirements of standing." Id. In short, the plan "failed to fulfill its contractual obligations to the Patient; this is all that is required to demonstrate Article III standing." Id.

explicit in its opinion, the Ninth Circuit clearly relied on HCA to reach its decision, and noted that "[w]e are aware of no circuit court that has accepted defendants' argument" against Article III standing for the provider-assignee. 770 F.3d at 1289 (citing HCA, 240 F.3d 982, as "directly on point").[3] In short, three Circuits rejected the defendant-insurers' similar arguments and concluded that the violation of the participant-patient's right to benefits as promised by the benefits plan, including promised payment to providers, suffices as a constitutional injury. No circuit court has disagreed with these rulings.

As North Cypress recognized, this conclusion is fully consistent with long-standing case law and Congressional intent, the same touchstones later recognized by Spokeo for determining whether an intangible injury is "concrete." 781 F.3d at 193-94. First, settled precedent recognizes constitutional standing to sue for a breach of contract, which is akin to a breach of plan terms that promised benefits, even if some or all of the benefits accrue to another party. In North Cypress, the Fifth Circuit relied on United Steel, Paper & Forestry, Rubber, Manufacturing, Energy, Allied Industrial & Service Workers International Union, AFL-CIO/CLC v. Cookson America, Inc., 710 F.3d 470, 474-75 (2d Cir. 2013), which stated that

[3] While Spinedex reached the same result, the Ninth Circuit's decision focused primarily on the specific facts that arise in the assignment context, the details of which are not relevant here. 770 F.3d at 1291 (ruling that the provider-assignee had Article III standing even though it had not sought payment of any shortfall from its patient-assignors before filing suit against the plan).

"'[i]t is axiomatic that a party to an agreement has standing to sue a counter-party who breaches that agreement, even where some or all of the benefits of that contract accrue to a third party.'" Id. at 475 (citation omitted); see also Katz v. Pershing, LLC, 672 F.3d 64, 72 (1st Cir. 2012) (by "alleg[ing] the existence of a contract, express or implied, and a concomitant breach of that contract, [the plaintiff's] complaint adequately show[ed] an injury to her rights" for purposes of standing, even though she was not a party to the contracts in question and could not survive a motion to dismiss under Rule 12(b)(6)). Similarly, this Court recognized a violation of a contractual right as sufficient "injury-in-fact." See Linton by Arnold v. Comm'r of Health and Env't, State of Tenn., 973 F.2d 1311, 1317 (6th Cir. 1992). As the Eleventh Circuit recognized, "the breach of a contract has long been held to be among the types of injuries that confer standing to sue." E.A. Renfroe & Co., Inc. v. Moran, 249 F. App'x 88, 91 (11th Cir. Aug. 24, 2007) (unpublished). As an example of this long-standing principle, the Eleventh Circuit cited, id., the Supreme Court's decision in Tennessee Electric Power Co. v. Tennessee Valley Authority, 306 U.S. 118, 137-38 (1939), which held that "standing is available where 'the right invaded is a legal right, — one of property, one arising out of [a] contract, one protected against tortious invasion, or one founded on a statute which confers a privilege[.]'" Accord Kuhns v. Scottrade, Inc., 868 F.3d 711, 716 (8th Cir. 2017) ("'a party to a breached contract has a

judicially cognizable interest for standing purposes, regardless of the merits of the breach alleged.'") (quoting Carlsen v. GameStop, Inc., 833 F.3d 903, 908 (8th Cir. 2016)); L-3 Commc'ns Corp. v. Serco, Inc., 673 F. App'x 284, 289 (4th Cir. 2016) (unpublished); In re Thorpe Insulation Co., 677 F.3d 869, 887 (9th Cir. 2012); Katz, 672 F.3d at 72; Castro Convertible Corp. v. Castro, 596 F.2d 123, 124 n.3 (5th Cir. 1979); see also Spokeo, 136 S.Ct. at 1551 (Thomas, J., concurring) (discussing long-standing principles). Consistent with North Cypress, the Seventh Circuit applied these principles in finding constitutional standing for a suit alleging an ERISA violation because the violation deprived plan participants the benefit of their contractual bargain as promised in the plan. See Johnson v. Allsteel, Inc., 259 F.3d 885, 887-88 (7th Cir. 2001).

Second, North Cypress' definition of the relevant injury as the participant's loss of a contractual right to benefits is consistent with the Congressional intent underlying ERISA's protections. "ERISA's principal function [is] to 'protect contractually defined benefits.'" McCutchen, 569 U.S. at 100-01 (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)); see also M & G Polymers USA, LLC v. Tackett, 135 S. Ct. 926, 933 (2015) (interpreting plan terms in accordance with contract law principles). ERISA section 502(a)(1)(B) specifically empowers a participant or beneficiary "to bring a civil action . . . (B) 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. § 1132(a)(1)(B). Absent ERISA's protections, claim denials that violate plan terms are likely treated as state contractual claims. See Turner v. Fallon Cmty. Health Plan, Inc., 127 F.3d 196, 199 (1st Cir. 1997) ("Absent [ERISA] preemption, a health benefits plan like Fallon's could certainly be treated as a contract enforceable under state law"). "Congress's creation of this cause of action has given patients a right to enforce the insurance coverage they contracted for. They were given a right to recompense for an actual injury and have standing to pursue alleged breaches of this statutory duty." North Cypress, 781 F.3d at 194. In discussing equitable remedies under ERISA, the Supreme Court recognized in CIGNA v. Amara, 563 U.S. 421, 444 (2011), that "actual harm . . . might also come from the loss of a right protected by ERISA or its trust-law antecedents." The loss of a contractual right to benefits protected by ERISA is by no means abstract, but rather an actual financial loss of a promised payment to a provider for services rendered.

Whether or not a participant is directly billed for the costs is irrelevant to the injury. Nonetheless, even though the breach of a contractual right itself is the injury, as the Second Circuit has noted, in circumstances where it is unclear whether the provider "can seek full reimbursement directly from patients . . . patients are likely to be held liable for the services they receive — indeed, it does

not take a stretch of the imagination to expect that a patient who receives medical care will be required to pay for it." Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 330 (2d Cir. 2011). Here, it requires no imagination to expect Dr. Springer will ultimately be compelled to pay some, if not all of, the cost of the provider's services rendered on his behalf. By receiving the services, Dr. Springer clearly incurred the charges, even though Angel Air directly billed the plan responsible for the participant's medical benefits and not the participant. Springer, 2017 WL 4837478, at *1-*2. The Plan accepted and processed the bill as part of a valid claim: the administrator accepted the "billed" charge for Angel Jet's services as totaling $340,100, and the Plan paid about 10% of that billed charge. Id. at *1-*2. The participant alleges the Plan promised to pay the full amount, and the participant now seeks payment for the rest. The defendant's alleged failure to abide by the Plan's contractual obligation is a sufficiently concrete violation of a contractual right and thus "injury in fact."

B. *Affirmance Would Disrupt Established Billing Practices*

Providers, as assignees of participants, have Article III standing to sue without first billing the participants for services rendered in the Fifth, Ninth, and Eleventh Circuits. A contrary result in this case will not only create a split in principle with three circuits, but also undermine this well-established and

beneficial practice that allows providers to avoid billing patients before the insurers' coverage is finally determined.

In cases not addressing constitutional standing, many circuit decisions confirm that the provider can seek, as the participant's assignee, an adjudication of a patient's claim in district court under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), even before the provider bills the participant. E.g., CardioNet, Inc., 751 F.3d at 178-79; Misic v. Bldg. Serv. Emps. Health and Welfare Tr., 789 F.2d 1374, 1377 (9th Cir. 1986) (approving the use of assignments because they "eliminat[e] the necessity for beneficiaries to pay potentially large medical bills and await compensation from the plan"); Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997) ("If provider-assignees cannot sue the ERISA plan for payment, they will bill the participant or beneficiary directly for the insured medical bills, and the participant or beneficiary will be required to bring suit against the benefit plan when claims go unpaid."); see also Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698, 700 (7th Cir. 1991) (treating the failure to bill participant as a question of merits, not jurisdiction).[4] As the Fifth Circuit stated:

[4] Without directly addressing whether providers can sue as assignees without first billing the participant, other courts, including this Court, uniformly endorse the general principle that providers can assert claims under ERISA section 502(a)(1)(B) as the participant's assignee. See Brown v. BlueCross BlueShield of Tenn., Inc., 827 F.3d 543, 546 (6th Cir. 2016) ("there is now a broad consensus that 'when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA § 502(a)'")

> 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."

Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286, 1289 n.13 (5th Cir. 1988), abrogated on other grounds by Access Mediquip, L.C.C. v. UnitedHealthcare Ins. Co., 698 F.3d 229 (5th Cir. 2012).

None of these cases question the providers' ability to sue as assignees before billing patients for their services. The established rationale for assignments in ERISA benefits law is to avoid circumstances where patients seeking medical care from providers must be billed or be subject to collection before the provider, as the patient's assignee, can file a claim with the plan and in federal court to determine coverage. The same rationale applies when the participant sues the plan in court.[5]

(quoting North Jersey Brain & Spine Ctr. v. Aetna, Inc., 801 F.3d 369, 377 (3d Cir. 2015)); I.V. Servs. of Am., Inc. v. Trs. of Am. Consulting Eng'rs Council Ins. Tr. Fund, 136 F.3d 114, 117 (2d Cir. 1998); Lutheran Med. Ctr. of Omaha, Neb. v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan, 25 F.3d 616, 618-19 (8th Cir. 1994) (abrogated on other grounds by Martin v. Ark. Blue Cross & Blue Shield, 299 F.3d 966 (8th Cir. 2002)); I.V. Servs. of Am. v. Inn Dev. & Mgmt., 182 F.3d 51, 54 n.3 (1st Cir. 1999).

[5] In many circumstances, the patient either does not provide an assignment or is barred from making an assignment because of the plan's anti-assignment clause.

Because the participant has the same rights to sue as the provider-assignee, e.g., CardioNet, 751 F.3d at 178-79, the participant should also be able to file for judicial review without any prior billing from provider to patient. Either way, both providers and patients benefit from a determination of the plan's coverage amounts before a final bill is issued.[6] Providers benefit because they can postpone billing participants directly until after the participants sue for judicial review to avoid "upsetting [the participants'] finances and to reduce the risk of non-payment." Hermann Hosp., 845 F.2d at 1289 n.13. Providers can also avoid premature collection costs and wait until the claims denial is upheld in court. Reversing the district court will support this well-established practice and ensures uniformity in the treatment of assignments and related billing practices for ERISA plans. Cf.

E.g., Riverview Health Inst. LLC v. Med. Mut. of Ohio, 601 F.3d 505, 520 (6th Cir. 2010).

[6] Some employee benefit plans may require a provider to submit evidence of the amount it charged the participant before deciding how much to pay the provider. E.g., Krauss v. Oxford Health Plans, Inc., 517 F.3d 614, 619-20 (2d Cir. 2008). Other plans may permit an out-of-network provider to directly bill the plan. E.g., Kennedy, 924 F.2d at 701. During the claims adjudication process, a plan administrator may also request documentation or evidence of the amount of services rendered. See, e.g., 29 C.F.R. § 2560.503-1(g)(1)(iii) (regulation that governs claims processing in ERISA plans issued pursuant to 29 U.S.C. § 1133). Neither the regulation that governs claims procedures nor ERISA itself, however, require a participant to receive a bill for payment before filing a claim. A plan sponsor's or plan administrator's decision to require a submission of a bill is a matter of plan design or claims administration, but not a question of constitutional dimensions.

North Jersey Brain & Spine Ctr. v. Aetna, Inc., 801 F.3d 369, 374 (3d Cir. 2015) (noting "the public interest in uniform interpretation of ERISA" with respect to the treatment of assignments).

C. *The District Court's Opinion Misreads Precedent And Is Inconsistent With The Claims Regulation*

The district court's conclusion that a direct bill from the provider to the participant is necessary for constitutional standing conflicts in principle with three circuit decisions. The district court did not address those three decisions or provide a basis for this Court to create a circuit split. Instead, the district court relied on Soehnlen v. Fleet Owners Insurance Fund, 844 F.3d 576, 582-83 (6th Cir. 2016), but this decision is easily distinguishable. In Soehnlen, the plaintiffs "allege[d] that by failing to comply with the ACA provisions enjoining annual and life-time limitations on benefits, Defendants violated their ERISA rights." 844 F.3d at 580. The plaintiffs also alleged that other participants may suffer harm from non-compliance but never argued how the individual plaintiffs themselves suffered any harm from non-compliance. Id. at 582. For example, the plaintiffs did not assert that they personally exercised any right under the plan that would be impeded by the non-compliant provisions. Id. (noting allegations that "certain members of their class suffer from conditions that have previously required medical expenses in excess of the benefit caps imposed by the Plan" but the absence of allegations of harm to named plaintiffs). Instead, the plaintiffs' reliance

on a bare allegation that the plan was non-compliant failed to establish an "injury-in-fact." Id. Here, unlike Soehnlen, the plaintiff identifies the denial of his individual claim for benefits under the plan as the injury; the plaintiff has thus shown, unlike in Soehlen, that a "specific right owed to [him] was infringed." Id. at 585.

Finally, the district court's point that no injury exists because Angel Jet accepted the Plan's partial payment of the billed charge is legally and factually erroneous. Under the Secretary's claims regulation, which governs claims processing in ERISA plans, see 29 U.S.C. § 1133, a participant (or a provider-assignee) can challenge an underpayment; accepting a partial payment does not preclude a participant or his assignee from claiming that the plan promised more. See 29 C.F.R. § 2560.503-1(m)(4)(1) (defining an "adverse benefit determination" as "[a] denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit . . .") (emphasis added). Moreover, as a factual matter, Angel Jet challenged the payment amount as a purported assignee, clearly indicating that it was not satisfied with payment of about 10% of its bill. See Angel Jet Servs., LLC, 34 F. Supp. 3d at 781-82.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests that this Court reverse the district court's ruling that the plaintiff lacked standing to challenge the Plan's benefits decision.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(d) and 32(a)(7)(B)-(C), I certify that this amicus contains 6,193 words.

Dated: January 19, 2018 /s/ Marcia E. Bove

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CERTIFICATE OF SERVICE

I hereby certify that on this day, January 19, 2018, I electronically filed the foregoing Brief of The Secretary, United States Department of Labor, as Amicus Curiae, in Support of Plaintiff-Appellant, with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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