14-3993-cv

United States Court of Appeals
for the
Second Circuit

AMERICAN PSYCHIATRIC ASSOCIATION, on behalf of its members and their patients, CONNECTICUT PSYCHIATRIC SOCIETY, INC., on behalf of its members and their patients, CONNECTICUT COUNCIL OF CHILD AND ADOLESCENT PSYCHIATRY, on behalf of its members and their patients, SUSAN SAVULAK, M.D., on behalf of herself and her patients, dba ASSOCIATES IN PSYCHOTHERAPY & PSYCHIATRY, LLC, W.W., THEODORE ZANKER, M.D.,

Plaintiffs-Appellants,

– v. –

ANTHEM HEALTH PLANS, INCORPORATED dba ANTHEM BLUE CROSS & BLUE SHIELD OF CT, WELLPOINT, INC., ANTHEM INSURANCE COMPANIES, INC., dba ANTHEM BLUE CROSS & BLUE SHIELD, WELLPOINT COMPANIES, INC.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

BRIEF FOR AMERICAN MEDICAL ASSOCIATION and CONNECTICUT STATE MEDICAL SOCIETY AS *AMICI CURIAE* SUPPORTING REVERSAL

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CORPORATE DISCLOSURE STATEMENT

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

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INTERESTS OF *AMICI*

All parties have consented to submission of this brief by the American Medical Association (AMA) and the Connecticut State Medical Society (CSMS). The AMA and CSMS appear on their own behalf and as representatives of the AMA Litigation Center, a coalition of the AMA and the medical societies of all fifty states and the District of Columbia, the purpose of which is to represent the interests of the medical profession before the courts.[1] Fed. R. App. P. 29(a).

The 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 Connecticut, and in all areas of medical specialization. Through its Council on Ethical and Judicial Affairs, the AMA maintains and updates

[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).

the Code of Medical Ethics (originally promulgated in 1847) which, among other things, governs the relationship between physician and patient and the physician's duties to the patient. The AMA also issues opinions and reports concerning medical ethics, including the impact of insurance or compensation regimes that create conflicts between physicians' and patients' interests or that impinge on the availability or quality of medical care.

Chartered in 1792, CSMS is a nonprofit physicians' organization with a principal place of business in North Haven, Connecticut. CSMS is a federation of eight component county medical associations with a total membership exceeding six thousand five hundred physicians and physicians in training, as well as a member of the federation of state medical societies represented in the AMA House of Delegates. CSMS' purposes, as stated in its charter and bylaws, include contributing to the diffusion of true science and knowledge of the healing art, uniting and supporting Connecticut's physicians in promoting the health of Connecticut's citizens, protecting and promoting the quality of medicine, and supporting physicians' function as advocates for their patients. CSMS' purposes also include engaging in activities directed toward improving the health and safety of the general public in Connecticut, including advocacy for mental health parity and behavioral health care access.

Amici will address the implications of medical ethics and the physician-patient relationship for the nature of the injury to physicians from Anthem's imposition of restrictions on treatment, and the third party standing of physicians to assert patients' legal rights.

SUMMARY OF ARGUMENT

Physicians, including the psychiatrist-members of the association plaintiffs in this case, have ethical obligations to place the best interests of their patients first, to advocate for appropriate patient care to third parties such as health insurers, and to avoid financial and administrative conditions that compromise their professional judgment about treatment. The relationship between physician and patient is often characterized as "fiduciary." In all respects, as the courts have repeatedly recognized, physicians have a "close relationship" that makes them proper representatives of the patient's legal rights when there are obstacles to the patient's assertion of her own rights. *See, e.g., Pa. Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278 (3d Cir. 2002); *N.Y. State Nat'l Org. for Women v. Terry*, 886 F.2d 1339 (2d Cir. 1989).

Patients receiving mental health treatment are hindered from asserting rights under ERISA because of the stigma associated with mental illness and substance abuse. In addition, the conditions for which they are receiving

treatment may interfere with the patients' awareness or effective assertion of legal rights.

The harm to patients from Anthem's discrimination between mental health care and medical and surgical care is intertwined with concrete injury to the treating physicians. Physicians who remain in Anthem's network are harmed financially (by reduced compensation) and professionally (by impediments to rendering appropriate treatment). And physicians who are forced out of Anthem's network are harmed by the diminished opportunity to render care to Anthem subscribers, many of whom cannot afford out-of-network treatment. Thus, the members of the associations satisfy all of the requirements for third-party standing to pursue their patients' claims as beneficiaries under ERISA. The associations can therefore sue on behalf of their members. *Hunt v. Wash. State Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977).

ARGUMENT

The gist of the operative complaint (JA A12-58) is that the defendants Anthem Health Plans, Inc. (Anthem) and its corporate parent WellPoint, Inc. (WellPoint) have limited the access of subscribers to mental health care and the ability of providers to render appropriate care to their patients by adopting policies to provide less compensation to mental health care

providers than to medical and surgical care providers for comparable services.

The members of the association plaintiffs (the American Psychiatric Association, the Connecticut Psychiatric Society, Inc., the Connecticut Council of Child and Adolescent Psychiatry, Inc.) have an interest in providing appropriate care to their patients and in advocating their patients' rights to appropriate care in accordance with the ethical standards governing the medical profession. *Id.* at A15-16, A21-22, A27, A30-31, A33, A37-38, A39-40 (¶¶ 1-3, 14-16, 36, 43-46, 50, 64-65, 74-77). Thus, the associations' members assert their own injury in fact and a relationship that entitles them to assert the statutory rights of their patients—especially in light of the impediments their patients themselves face. It follows that the association plaintiffs have Article III standing and third party standing; the district court's contrary conclusion (JA A167-172) should be reversed.

I. THE ASSOCIATIONS HAVE ARTICLE III STANDING.

An association has Article III standing to litigate a claim on behalf of its members when "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit."

Hunt, 432 U.S. at 343. The association plaintiffs satisfy all of those requirements.

Anthem's restrictions cause two harms to mental health care providers, either of which constitutes an injury satisfying Article III requirements. *First*, as the district court ruled, for providers who continue to provide high quality care within the Anthem network, Anthem's inadequate payment for services is a direct financial injury. *Second*, Anthem's restrictions may force providers to leave the network or to limit the services they provide to patients who are insured by Anthem, injuring the providers by infringing their ability to render care to existing patients in conformance with their professional obligations. There is no serious disagreement about whether the interest in obtaining adequate compensation for care is germane to the plaintiff associations' purposes, or whether the participation of individual members is required for the injunctive and declaratory relief sought with regard to Count One of the complaint. (Prayer for Relief, JA A55).

A. The Associations' Members Are Injured in Their Own Right By Restrictions on the Provision of Care to Their Patients.

Anthem's unequal treatment of mental health care is a direct attempt to diminish the availability and use of mental health services. Forcing

mental health providers to offer less care to their patients is contrary to ethical standards governing the medical profession. "The patient has a basic right to have available adequate health care." AMA Ethics Op. 10.01(6) (Addendum ("Add.") 10). Ethical standards require physicians to shoulder some, but not all, of the financial burden of assuring care for those who cannot afford it. *Id.* One way to assure care is to help patients obtain insurance coverage for the care they need. "Physicians should advocate for patients in dealing with third parties when appropriate," *id.*, but Anthem's across-the-board policies make such advocacy for patients by providers futile; the policies are *designed* to ration care. (JA A30-31, ¶¶ 43-46). Ethical standards concerning contracts with insurers warn that "physicians should not be subjected to lay interference in professional medical matters" AMA Ethics Op. 8.05 (Add. 2), as Anthem does by requiring mental health providers to withhold care (JA A31, ¶ 46), or to schedule unnecessary and duplicative appointments. (JA A30-31 ¶ 44-45). "Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount." AMA Ethics Op. 10.015 (Add. 12). That ethical standard is inconsistent with insurance requirements that, for example, "discourag[e] psychiatrists from providing an appropriate scope of service where indicated as medically

necessary." (JA A31, ¶ 46). Physicians have an interest in practicing medicine according to the standards of their profession rather than the mandate of an insurance company that discriminates against mental health treatment.

Forcing mental health providers to leave Anthem's network, often with the result that patients can no longer afford to continue treatment, is also contrary to medical ethics standards. Physicians must avoid or seek the removal of contract terms that "undermine their ethical obligation for patient welfare." AMA Ethics Op. 8.0501 (Add. 3). In particular, physicians must avoid "financial incentives or administrative conditions, that are known to compromise professional judgment or integrity." *Id.*; *see also* AMA Ethics Op. 8.053 (Add. 4).

Because Anthem will not negotiate terms with small provider groups (JA A26, ¶ 33), most mental health providers cannot remove ethically unacceptable terms and conditions. Their only choice is to leave Anthem's network (JA A27, ¶ 36), often with the result that patients must discontinue treatment entirely (JA A33-34, ¶ 52), or choose a different provider. (JA A28, 37, ¶¶ 37, 64-65). "The patient has the right to continuity of health care." AMA Ethics Op. 10.01(5) (Add. 10). When established physician-patient relationships are disrupted because continued in-network

participation has become ethically and financially unsustainable, physicians as well as their patients are harmed by a disruption in the physician's fundamental professional obligation to render care to those who need it.

B. The Associations' Members Are Financially Injured in Their Own Right by Restrictions on Compensation for Providing Appropriate Care to Their Patients.

Physicians who remain in-network and accept inadequate compensation for the care they render to Anthem's subscribers are also injured. The district court correctly determined that individual member-physicians have Article III standing based on "the cost of the services provided for which the provider seeks reimbursement." (JA A167 n.6). *See Lion Health Servs., Inc. v. Sebelius*, 635 F.3d 693, 699 (5th Cir. 2011); *Westside Mothers v. Haveman*, 289 F.3d 852, 864 (6th Cir. 2002). A reduction in payment for services (or the loss of an opportunity to earn compensation) is a financial injury. *See Image Carrier Corp. v. Beame*, 567 F.2d 1197, 1201 (2d Cir. 1977).

C. The Interests at Stake are Germane to the Associations' Purposes and Neither the Claims Nor the Relief Requested Require the Participation of Individual Members.

The Third Circuit squarely held, in a case much like this one, that a psychiatric association satisfied associational standing requirements despite the need for "limited individual participation" of association members. *Pa.*

Psychiatric Soc'y, 280 F.3d at 286. The law in this Circuit is an accord. *N.Y. State Nat'l Org. for Women*, 886 F.2d at 1349 (association warranted standing although evidence from some individual members necessary); *see also Hosp. Council of W. Pa. v. City of Pittsburgh*, 949 F.2d 83, 89–90 (3d Cir. 1991) (Alito, J.) ("[A]n association may assert a claim that requires participation by some [association] members"). The complaint seeks declaratory and injunctive relief against general policies adopted at the corporate level, although implemented by Anthem as administrator of individual plans. Thus, "the individual participation of each injured party" is not "indispensable to proper resolution of the cause." *Hunt*, 432 U.S. at 343.[2]

The associations also clearly satisfy the "germaneness" requirement. For example, the APA's vision is "a society that has available, accessible quality psychiatric diagnosis and treatment." Its mission is to: "promote the highest quality care for individuals with mental disorders (including intellectual developmental disorders and substance use disorders) and their

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[2] Anthem did not contest germaneness at all below, and as to the need for member participation, Anthem relied entirely on the district court decision in *N.Y. State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013), *appeal pending*, No. 14-20 (argued Dec. 5. 2014), which is both distinguishable and plainly wrong about the need for individual participation, and which the appellee in that case barely defended on appeal with regard to that issue. *See* ECF No. 39 at 15 (mot. to dismiss); ECF No. 43 at 3 (reply).

families; promote psychiatric education and research; advance and represent the profession of psychiatry; and serve the professional needs of its membership." The APA's values include "advocacy for patients," and "best standards of clinical practice."[3]

II. THE ASSOCIATIONS' MEMBERS HAVE THIRD PARTY STANDING TO ASSERT THE ERISA RIGHTS OF THEIR PATIENTS.

An ERISA plaintiff needs "statutory standing," as well as Article III standing. As Judge Livingston recently explained in *Chabad Lubavitch of Litchfield Cnty., Inc. v. Litchfield Historic Dist. Comm'n*, 768 F.3d 183, 201 (2d Cir. 2014), "statutory standing" is just another way of saying that a plaintiff has a cause of action. The associations can pursue their members' patients' right of action as beneficiaries under ERISA by assignment and under the doctrine of third party standing in light of the close relationship that exists between physician and patient and the obstacles to the patients' assertion of their own rights.[4]

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[3] http://www.psychiatry.org/about-apa--psychiatry/mission-vision-and-values (last visited Feb. 13, 2015).

[4] The flaws in the district court's analysis of the patients' assignments are fully addressed in the appellants' brief (APA Br.) at pp. 37-44.

A. Third Party Standing Doctrine Permits Persons With a Close Relationship to Assert Legal Rights of Another When There Is an Obstacle to the Assertion of those Rights Directly.

Generally, a party "must assert his own legal rights and interests," not those of third parties. *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (citation omitted). Even so, a party *may* assert the legal rights of another, as the physicians belonging to the association plaintiffs seek to do on behalf of their patients, by making "two additional showings": (a) that the litigant has a "'close' relationship' with the person who possesses the right"; and (b) "there is a 'hindrance' to the possessor's ability to protect his own interests." *Id.* at 130 (citations omitted). Both requirements are met. Moreover, Anthem's restrictions at issue in this case violate the rights of patients indirectly, by operating directly on mental health providers and driving them out of Anthem's network, another basis for third party standing. *Id.* (describing cases in which third party standing "when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights.") (citation omitted). This case concerns a statutory entitlement under ERISA rather than a constitutional entitlement, but that makes no difference to the third party standing analysis. *Pa.*

Psychiatric Soc'y, 280 F.3d at 291 (holding that psychiatric association had third party standing to assert statutory rights of members' patients).[5]

The idea that a nominal party other than the holder of the legal right can sue to enforce the right is deeply embedded in our law. In addition to the examples of parties that may sue to enforce third party rights listed in Fed. R. Civ. P. 17(a)(1), rights may be enforced under appropriate circumstances by a next friend.[6] Similarly, the law has long recognized that although a corporation is an entity with legal rights distinct from its shareholders, a shareholder may assert the legal rights of the corporation when the corporation breaches a duty to the shareholders in refusing to assert the right itself.[7] As Justice Jackson explained, "The cause of action

[5] *See Hudson Valley Freedom Theater, Inc. v. Heimbach*, 671 F.2d 702, 706 (2d Cir. 1982) (Friendly, J.) (vocational program can assert statutory rights of participants against racial discrimination); *Nat'l Union of Hosp. & Health Care Emps., RWDSU, AFL-CIO v. Carey*, 557 F.2d 278, 281 (2d Cir. 1977) (applying third party standing analysis to statutory Medicaid claim); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 478 (8th Cir. 2002) (applying *Singleton* analysis to providers' assertion of Medicaid beneficiaries' statutory right); *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 215 (4th Cir. 2002) (applying third party standing analysis to physician's assertion of patients' rights under the ADA).

[6] *See Whitmore v. Arkansas*, 495 U.S. 149 (1990) (habeas corpus); *Bryant v. N.Y. State Educ. Dep't*, 692 F.3d 202 (2d Cir. 2012) (IDEA); *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012) (§ 1983).

[7] *See Dodge v. Woolsey*, 59 U.S. 331 (1855); *Ross v. Bernhard*, 396 U.S. 531, 535-36 (1970) (describing history of equitable action); *Fanchon & Marco v. Paramount Pictures*, 202 F.2d 731 (2d Cir. 1953) (antitrust claim).

which such a plaintiff brings before the court is not his own but the corporation's. It is the real party in interest and he is allowed to act in protection of its interest somewhat as a 'next friend' might do for an individual, because it is disabled from protecting itself." *Koster v. (Am.) Lumbermens Mut. Casualty Co.*, 330 U.S. 518, 522–23 (1947). To be sure, there are differences in the mechanics of actions by trustees, next friends, shareholders, and the third parties here, but in all of these contexts a party is permitted to pursue a cause of action or legal right belonging to another.[8] And in all of these contexts, the legal authority to sue hinges on the nature of the relationship between the third party and the right-holder and the existence of an impediment to the right-holder's own suit.

The district court misinterpreted *dicta* in *Warth v. Seldin*, 422 U.S. 490, 499-501 (1975), as requiring it to determine whether Congress has created an express or implied right of action for the third party before recognizing third party standing. (ECF No. 51 at 14, JA A169). The district court quoted from a recent decision of this Court quoting *Lexmark Int'l, Inc.*

[8] *Connecticut v. Physicians Health Servs. of Conn., Inc.*, 287 F.3d 110 (2d Cir. 2002), does not suggest that ordinary third-party standing principles are inapplicable to ERISA. A *parens patriae* claim is an assertion of the state's *own* sovereign or quasi-sovereign right, not the assertion of a private party's right as a third-party representative. *Pennsylvania v. New Jersey*, 426 U.S. 660, 665 (1976). *See also* APA Br. 36 (explaining that *Connecticut* is based on the implicit exclusion of other state enforcement authority in light of the limited authority expressly conferred).

v. Static Control Components, Inc., 134 S. Ct. 1377, 1387 (2014) with regard to how courts decide if a party has a statutory cause of action, (JA A169) (quoting *Chabad Lubavitch of Litchfield County, Inc.*, 768 F.3d at 201). But such an inquiry is inconsistent with the entire concept of third party standing, which—under limited circumstances—allows a third party (here physicians) to assert a right of action belonging to another (here patients of the physicians). A party that has an implied cause of action has no need of third party standing.[9]

Warth was actually concerned, not with whether Congress had implicitly endowed the third party with a statutory cause of action, but with what it described as a prudential limitation on the jurisdiction of the federal courts to entertain proceedings based on the assertion of third party rights. *Lexmark*, 134 S. Ct. at 1387 n.3 (noting that "[t]he limitations on third-party standing are harder to classify," but "most of our cases have not framed the inquiry" in terms of implied right of action, but in terms of prudential

[9] The district court also referred to *Innovative Health Sys., Inc. v. City of White Plains*, 117 F.3d 37, 47 (2d Cir. 1997), but that was not a third party standing case. The plaintiff alcohol treatment center did not seek to invoke the statutory rights of patients as a third party plaintiff. Rather, it asserted its own statutory right to sue under the ADA as a person "aggrieved" by discrimination against its patients with disabilities. Judge Friendly's opinion in *Hudson Valley Freedom Theater,* expressly examined the difference between *jus tertii* or third party standing (at issue in that case and here) and implied rights of action (examined in *Innovative Health*).

standing limitations on the assertion of third party rights). Congressional intent is also relevant to the prudential standing limitation described in *Warth*, but in that context the question is whether Congress has abrogated the judge-made prudential standing limitation for certain claims, allowing any claim satisfying core Article III standing requirements to proceed. A third party claim that is based on a close relationship and hindrance satisfies the *Warth* prudential standing restriction, so it does not matter whether Congress has abrogated the prudential standing requirement for ERISA.

The prudential standing doctrine is intended to prevent courts from being "called upon to decide abstract questions of wide public significance even though other governmental institutions may be more competent to address the questions and even though judicial intervention may be unnecessary to protect individual rights." *Id.* at 500. That justiciability concern does not exist here; the issues to be adjudicated in this action are no different than they would be if this action were brought by patients rather than associations representing the patients' caregivers. The prudential standing limitations described in *Warth* apply to constitutional and statutory claims alike, *id.* ("the standing question in such cases is whether the *constitutional or statutory provision* on which the claim rests properly can be understood as granting persons in the plaintiff's position a right to

judicial relief.") (emphasis added) and are therefore satisfied as to third party standing in the same way for constitutional and statutory claims—i.e., by showing a close relationship to the party holding the statutory right of action and a hindrance to that party's own assertion of the right.

B. Mental Health Providers Have a Close Relationship With Their Patients.

The Third Circuit concluded that "[p]sychiatrists clearly have the kind of relationship with their patients which lends itself to advancing claims on their behalf. This intimate relationship and the resulting mental health treatment ensures psychiatrists can effectively assert their patients' rights." *Pa. Psychiatric Soc'y*, 280 F.3d at 289. *See Jaffee v. Redmond*, 518 U.S. 1, 12, 15 (1996) (recognizing psychotherapist-patient privilege). Like the Pennsylvania Psychiatric Society in that case, the associations here allege that Anthem "prevent[s] patients from receiving necessary mental health services and psychiatrists from providing them," thus "its member psychiatrists would be well-suited to litigate these claims for both parties, as their interests are clearly aligned. *See Amato v. Wilentz*, 952 F.2d 742, 751 (3d Cir. 1991) (noting doctor-patient relationship provides strong likelihood of effective advocacy by a physician on behalf of his patients)." *Id.* at 289–90.

Advocacy on behalf of patients to obtain resources for needed treatment is among the physician's core ethical responsibilities. While physicians have an ethical duty to "be prudent stewards of health care resources," AMA Ethics Op. 9.0652 (Add. 8), they must also: "advocate for patients in dealing with third parties when appropriate," AMA Ethics Op. 10.01 (Add. 11), and "place patients' welfare above their own self-interest and above obligations to other groups" and "advocate for their patients' welfare." AMA Ethics Op. 10.015 (Add. 12). That includes resisting the influence of market economic forces that may conflict with professional obligations to the patient. "If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit." AMA Ethics Op. 8.03 (Add. 1). Unsurprisingly, many courts (including Connecticut's) in various contexts have explicitly characterized the physician-patient relationship as a fiduciary one.[10]

[10] *E.g.*, *Rosenfield v. Rogin, Nassau, Caplan, Lassman & Hirtle, LLC*, 795 A.2d 572, 580 (Conn. App. 2002) (likening continuous representation by an attorney to continuous treatment by a doctor because "[i]n both situations, the relationship . . . is demarcated by the fiduciary relationship of trust and confidence."); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (1990) (physician may be liable to patient for breach of fiduciary duty); *Nealy v. US Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1991) (allowing claim for breach of fiduciary duty to proceed); *State ex rel. Kitzmiller v. Henning*, 437 S.E.2d

The AMA Council on Ethical and Judicial Affairs—the ethics regulating body of the AMA—stated in a report on managed care, that "The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice." Ethical Issues in Managed Care, 273 JAMA 330, 334 (1995); *see also* AMA Ethics Op. 8.131 (Add. 5-7); Council of Medical Specialty Societies, Ethics Statement (1999) ("The physician's primary, inviolate role is as an active advocate for each patient's care and well-being.").[11] In addition, the interests of patients and physicians are closely aligned; both have a strong interest in adequate compensation for treatment because of the inherent impact of physician compensation on quality of care. *HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co.*, 240 F.3d 982, 1008 (11th Cir. 2001). It is only natural, in light of the confidential relationship and duty of advocacy that physicians serve as representatives of patients' legal rights when there are significant obstacles to the patients' assertion of their own rights.

452, 454 & n.1 (W. Va. 1993) ("all reported cases dealing with this point hold that a fiduciary relationship exists between a physician and a patient.").

[11] Available at http://www.cmss.org/DefaultTwoColumn.aspx?id=79 (last visited Feb. 13, 2015).

C. Stigma and Disability Hinder the Ability of Patients to Protect Their Own Interests in Receiving Appropriate Mental Health Care.

The Third Circuit recognized as a basis for third party standing of psychiatrists to pursue claims on behalf of their patients, that "[t]he stigma associated with receiving mental health services presents a considerable deterrent to litigation." *Pa. Psychiatric Soc'y*, 280 F.3d at 290 (collecting citations). This Court has also recognized the stigma of mental illness as an important reason for protecting the privacy of mental health records. *Matson v. Bd. of Educ.*, 631 F.3d 57, 66 (2d Cir. 2011) (privacy interest based on stigma). The stigma associated with mental health treatment is comparable to that associated with seeking an abortion—which courts have consistently ruled a sufficient "hindrance" to first-party litigation to warrant third party physician standing.

In addition, as the Third Circuit noted, mental illness may directly impair the ability of a patient to protect his or her own legal rights. *Pa. Psychiatric Soc'y*, 280 F.3d at 290.

D. The Operation of the Challenged Practices on Physicians to Indirectly Harm Patients Also Justifies Third Party Standing.

Anthem's unequal treatment of mental health care harms patients by curtailing their access to providers who are driven out of Anthem's network

by inadequate compensation. Thus, "enforcement of a restriction against the litigant [the physician member of the association] prevents a third party [the patient] from entering into a relationship with the litigant (typically a contractual relationship), to which relationship the third party has a legal entitlement." *U.S. Dep't of Labor v. Triplett*, 494 U.S. 715, 720 (1990). The mechanism—inadequate compensation—by which patients are harmed is the same here as the mechanism causing harm to clients of the attorneys who sued in *Caplin & Drysdale, Chtd. v. United States*, 491 U.S. 617, 623-24 (1989), *see Triplett*, 494 U.S. at 720 ("restriction upon the fees a lawyer may charge th[us] deprives the lawyer's prospective client of a due process right to obtain legal representation"), and *id*. (fee restrictions render "claimants unable to obtain legal representation for their black lung claims"). The principle that a third party can challenge restrictions on him or her that are the means of injuring another's legal rights applies to physicians as well as lawyers. *Singleton v. Wulff*, 428 U.S. 106, 117 (1976) (plurality) (physician has standing to challenge effect on restriction of Medicaid funding on patient's right to abortion); *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965) (physician has standing to assert rights of married couple to contraceptive treatment); *Aid for Women v. Foulston*, 441 F.3d 1101, 1111-12 (10th Cir. 2006) (caregivers, including physicians, have

standing to assert privacy rights of their patients in challenge to abuse-reporting statute).

CONCLUSION

The decision below should be reversed.

Dated: February 13, 2015

Respectfully submitted,

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RULE 32(a)(7)(C) CERTIFICATE OF COMPLIANCE

In conformance with Rule 32(a)(7)(C)(i) of the Federal Rules of Appellate Procedure, I certify that:

1. This brief complies with the type-volume limitation of Rule 32(a)(7)(B)(i) of the Federal Rules of Appellate Procedure. This brief contains 4,748 words, excluding the 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 Times New Roman using Microsoft Word 2010.

Dated: February 13, 2015

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CERTIFICATE OF SERVICE

In conformance with Rule 25(d) of the Federal Rules of Appellate Procedure, I certify that on February 13, 2015, I caused the foregoing Brief for American Medical Association and Connecticut State Medical Society as *Amici Curiae* Supporting Reversal 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 foregoing Brief of *Amici Curiae* in conformance with Local Rule 31.1 and Federal Rule of Appellate Procedure 31.

Dated: February 13, 2015

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ADDENDUM

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Opinion 8.03 - Conflicts of Interest: Guidelines

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (II)

Issued July 1986; Updated June 1994

Opinion 8.05 - Contractual Relationships

The contractual relationships that physicians assume when they join or affiliate with group practices or agree to provide services to the patients of an insurance plan are varied.

Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance, and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. (VI)

Issued prior to April 1977; Updated June 1994 and June 1996.

Opinion 8.0501 - Professionalism and Contractual Relations

Physicians are free to enter into a wide range of contractual arrangements. However, physicians should not sign contracts containing provisions that may undermine their ethical obligation to advocate for patient welfare. Therefore, before entering into contractual agreements to provide services that directly or indirectly impact patient care, physicians should negotiate the removal of any terms, such as financial incentives or administrative conditions, that are known to compromise professional judgment or integrity. Particularly, when contractual compensation varies according to performance (see Opinion E-8.054, "Financial Incentive and the Practice of Medicine"), physicians should beware of incentives that may adversely impact patient care. (VI, VIII)

Issued June 2004 based on the report "Professionalism and Contractual Relations," adopted December 2003.

Opinion 8.053 - Restrictions on Disclosure in Health Care Plan Contracts

Despite ethical requirements demanding full disclosure of treatment options regardless of limitations imposed by plan coverage, some health care plans include clauses in their employment contracts that directly inhibit the ability of physicians to keep their patients fully informed. These types of contract clauses erect inappropriate barriers to necessary communications between physicians and patients, labeled "gag clauses" by some observers. Restrictive clauses of this type impact the ability of physicians to provide information to their patients and to act effectively as a patient advocate. They also threaten to undermine individual and public trust in the profession of medicine.

(1) Health care plans have the right to protect proprietary information. However, physicians should oppose any such protection that inhibits them from disclosing relevant information to patients. For this reason, physicians should advocate for the elimination of contract clauses that could prevent them from raising or discussing matters relevant to patients' medical care.

(2) The right of patients to be informed of all pertinent medical information must be reaffirmed by the medical profession, and individual physicians must continue to uphold their ethical obligation to disclose such information.

(3) Physicians, individually or through their representative, should review their contracts carefully to ensure that they are able to fulfill their ethical obligations to patients. (II, III, VI)

Issued June 1998 based on the report "Restrictions on Disclosure in Managed Care Contracts," adopted June 1996; updated June 2002.

Opinion 8.131 Professionalism in Health Care Systems

Containing costs, promoting high quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage under treatment and over treatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations have an ethical responsibility to ensure that practices for financing and organizing the delivery of care:

(a) Are transparent.

(b) Reflect input from key stakeholders, including physicians and patients.

(c) Recognize that over reliance on financial incentives may undermine physician professionalism.

(d) Ensure ethically acceptable incentives that:

(i) Are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data, and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethical guidelines.

(ii) Are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities.

(iii) Are implemented in conjunction with the infrastructure and resources needed to support high value care and physician professionalism.

(iv) Mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(e) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(g) Are routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians have an ethical responsibility to:

(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(i) Advocate for changes in health care payment and delivery models to promote access to high quality care for all patients. (I, II, III, V)

Issued June 2014 based on the report "Professionalism in Health Care Systems,"PDF FIle adopted November 2013.

Opinion 9.0652 - Physician Stewardship of Health Care Resources

Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

(a) base recommendations and decisions on patients' medical needs;

(b) use scientifically grounded evidence to inform professional decisions when available;

(c) help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals;

(d) endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals;

(e) choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient, but require different levels of resources;

(f) be transparent about alternatives, including disclosing when resource constraints play a role in decision making; and

(g) participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession

must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship;

(i) ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending; and

(j) advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship. (I, V, VII, VII, IX)

Issued November 2012 based on the report " Physician Stewardship of Health Care Resources ," adopted June 2012.

Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

(1) The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

(2) The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

(3) The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

(4) The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

(5) The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

(6) The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care.

Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. (I, IV, V, VIII, IX)

Issued June 1992 based on the report "Fundamental Elements of the Patient-Physician Relationship," adopted June 1990 (JAMA. 1990; 262: 3/33); Updated 1993.

Opinion 10.015 - The Patient-Physician Relationship

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.

A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient (or surrogate). In some instances the agreement is implied, such as in emergency care or when physicians provide services at the request of the treating physician. In rare instances, treatment without consent may be provided under court order (see Opinion 2.065, "Court-Initiated Medical Treatments in Criminal Cases"). Nevertheless, the physician's obligations to the patient remain intact.

The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.

Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount. (I, II, VI, VIII)

Issued December 2001 based on the report "The Patient-Physician Relationship," adopted June 2001.