IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

CASE NOS. 14-2322, 14-3174, and 15-1274

PENNSYLVANIA CHIROPRACTIC ASSOCIATION, et al.,

Plaintiffs/Appellees,

v.

INDEPENDENCE HOSPITAL INDEMNITY PLAN, INC.,

Defendant/Appellant.

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND ILLINOIS STATE MEDICAL SOCIETY IN SUPPORT OF APPELLEES SUPPORTING AFFIRMANCE

On Appeal from the United States District Court
Northern District of Illinois, Eastern Division
Case No. 1:09-CV-05619-MFK

BARNES & THORNBURG LLP

*BRIAN E. CASEY, ESQ.
IN Bar No.: 24939-71
ALICE J. SPRINGER, ESQ.
IN Bar No.: 25105-64
100 N. Michigan St., Ste. 600
South Bend, IN 46601
Tel: (574) 233-1171

MARK E. RUST, ESQ.
IL ARDC No. 06201820
One N. Wacker Drive,
Suite 4400
Chicago, IL 60606-2833
Tel: (312) 357-1313

Counsel for American Medical Association and Illinois State Medical Society

DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1(a) and Circuit Rule 26.1, *Amici* disclose the following information:

1. The full name of every *amicus* that the attorney represents in the case: American Medical Association and Illinois State Medical Society.

2. The names of all law firms whose partners or associates have appeared for the party in the case or are expected to appear: Barnes & Thornburg LLP.

3. If the party is a corporation:

   i) Identify all its parent corporations, if any: None.

   ii) List any publicly traded company that owns 10% or more of the party's stock: None.

/s/ Brian E. Casey
BARNES & THORNBURG LLP
700 1st Source Bank Center
100 N. Michigan
South Bend, IN 46601
574.233.1171

Attorneys for American Medical Association and Illinois State Medical Society

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/s/ Alice J. Springer
BARNES & THORNBURG LLP
700 1st Source Bank Center
100 N. Michigan
South Bend, IN 46601
574.233.1171

Attorneys for American Medical Association and Illinois State Medical Society

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/s/ Mark E. Rust
BARNES & THORNBURG LLP
One N. Wacker Drive, Suite 4400
Chicago, IL 60606-2833
312.357.1313

Attorneys for American Medical Association and Illinois State Medical Society

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INTEREST OF AMICI CURIAE[1]

The American Medical Association ("AMA") and the Illinois State Medical Society ("ISMS") submit this brief as *amici curiae* in support of Appellees. Like the chiropractors here, the AMA and ISMS's members often must litigate the types of claims disputed here.

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all United States physicians, residents, and medical students are represented in the AMA's policy making process. The AMA promotes the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area, in every state, including both Illinois and Pennsylvania, and throughout the Seventh Circuit. The AMA has taken a leadership role on behalf of its members nationwide to establish equitable procedures and relationships with the nation's health

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[1] Counsel certifies that all parties consented to the filing of this brief. No party's counsel authored this brief in any part. No counsel, party, or other person, other than *amici*, their members, or their counsel, contributed monetarily to this brief's preparation or submission. *See* Fed.R.App.P. 29.

insurers and third-party administrators regarding issues affecting the economic aspects of health care and the practice of medicine. The AMA has taken a leading role in systematizing the claims process to address and alleviate disputes like those here.

ISMS is a professional association representing over 9,000 physicians, residents, and medical students in Illinois. Founded in 1840, ISMS is the leading advocate in Illinois for the medical profession and represents the overwhelming majority of Illinois physicians as they practice the science and art of medicine. Its physician members represent every medical specialty in every practice setting. ISMS's mission is to advocate for patients and promote the physician/patient relationship, the ethical practice of medicine, and the betterment of the public health.

The AMA and ISMS also represent the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and private, voluntary, nonprofit medical societies of each state, plus the District of Columbia. It represents the viewpoint of organized medicine in the courts in accordance with the AMA's policies and objectives.

STATEMENT OF ISSUE

Whether the procedural requirements in the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* ("ERISA") apply to healthcare providers' challenges to a third-party payer's retroactive denial of health plan benefits when the ERISA-regulated plan states that providers should receive direct payment of plan benefits and the providers obtained assignments of plan benefits from their patients.

STATEMENT OF THE CASE

Twenty years ago, in analogous circumstances, this Court rhetorically asked, "Why should we leave physicians holding the bag?" *Central States, Southeast & Southwest Areas Health & Welfare Fund v. Pathology Laboratories of Arkansas, P.A.*, 71 F.3d 1251, 1255 (7th Cir. 1995).[2] Not much has changed since then. "This case is yet another act in the all-too-familiar drama involving patients, their health care providers, and their health care benefit plans." *Montefiore*

[2] There, as here, "[t]he real conflict [was] between [Independence] and its participants; one or the other should pay [the providers'] bill, but [Independence] wants to achieve a state in which neither has paid." *Id.* Back then, the Court "allowed [the provider] to keep its payment, and properly so." *Id.* The same result should apply here.

Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 324 (2d Cir. 2011). The decades-long dispute continues between medical providers and the third-party administrators ("TPAs") or insurers (collectively, "third-party payers") of ERISA-regulated health plans over whether providers should be paid for their services, and how providers can assert their right to receive payment. Unsurprisingly, the position Independence Hospital Indemnity Plan ("Independence") takes would result in providers, here chiropractors, but often other medical professionals, performing necessary medical services and then being left "holding the bag."

Medical professionals (or plan participants) and third-party payers or the plans they administer frequently skirmish over what claims plaintiffs can assert and where. Medical professionals, plan participants, and other beneficiaries have tried litigating in state court, asserting contract, tort, or state statutory claims, which all allow for extracontractual damages, more in-depth discovery, and jury trials. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (prohibiting extracontractual remedies).

Third-party payers, or the plans they administer, typically prefer

federal court litigation under ERISA because of, *inter alia*, its more limited, contractual remedies, circumscribed discovery, and lack of jury trials. 29 U.S.C. §1132(a). Therefore, payers have argued vociferously, and with substantial success, that claims seeking benefits which derive from benefit plans and require interpretation of plan terms can only be ERISA §502(a)(1)(B) claims. *See Schoedinger v. United Healthcare of the Midwest, Inc.*, 557 F.3d 872 (8th Cir. 2009); *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1346-47 (11th Cir. 2009) ("*CSDA*"). These payers frequently cite *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), in which the Court explained ERISA's purpose and its preemptive scope.

The *Davila* Court explained that "Congress enacted ERISA to protect the interests of plan participants and beneficiaries by "setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Id.* at 208 (quoting 29 U.S.C. §1001(b)). ERISA's purpose is "to provide a uniform regulatory regime over employee benefit plans." *Id.* To ensure that "plan regulation" is "exclusively a federal concern," ERISA includes "expansive pre-emption provisions,"

id. (citing 29 U.S.C. §1144), and an "integrated enforcement mechanism," ERISA §502(a), 29 U.S.C. §1132(a), with such "extraordinary pre-emptive power" that it can convert state-law claims into ERISA wrongful denial of benefits claims which are removable to federal court. *Id.* at 208-09; *Franciscan Skemp Healthcare, Inc. v. Central States Joint Bd. Health & Welfare Trust Fund*, 538 F.3d 594, 596-97 (7th Cir. 2008).

Section 502(a)'s "comprehensive civil enforcement scheme" includes and excludes certain remedies in a "careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Davila*, 542 U.S. at 208 (quotation omitted).

Other claims that do not rely on plan interpretation certainly remain for a provider against a TPA/insurer arising from the care a provider renders. *See, e.g.*, *Franciscan Skemp*, 538 F.3d at 597-99; *see infra* at 29-31. However, claims seeking benefits under a plan which "derive[] entirely from the particular rights and obligations established by the benefit plans," *Davila*, 542 U.S. at 213, are properly ERISA claims.

Ironically, Plaintiffs Pennsylvania Chiropractic Association ("PCA") and the individual chiropractors, have taken the TPA/insurers at their word, asserting ERISA §502(a) claims for wrongful denial of benefits arising from Independence's improper "recoupment" of benefits previously paid to Plaintiffs for services Plaintiffs provided to Independence's plan members. RSA76-77. These recoupment decisions often arise from the payer's "medical necessity determination" or "eligibility determination," or other coverage determination. RSA88-89.

Plaintiffs demonstrated that Independence failed to comply with ERISA's notice and appeal requirements, including ERISA's claims-processing regulations. 29 C.F.R. §2560.503-1(g), (h), (j). Independence did not "identify the provision(s) of the given insured's plan that [Independence] relied on in making its determination nor does it even provide the reason for the recoupment." RSA87. It did not "inform the provider that she has a right to appeal [Independence's] determination, let alone describe what the appeal process would entail and what it requires the provider to do." *Id.* Effectively, therefore, Independence did not "provide providers facing recoupment information about a review of an adverse benefit determination, including the outcome of

the review and the evidence that [Independence] considered in reaching its decision." RSA87-88. Even Independence admitted it "does not take ERISA into account when adopting, implementing or observing its policies and procedures relating to recoupment." RSA90.

Plaintiffs asserted claims as "beneficiaries" under ERISA-regulated plans because they are both: (1) "designated by a participant" to receive benefits through the assignments of benefits participants execute; and (2) designated "by the terms of an employee benefit plan" because the plans provide for direct payment to Plaintiffs as in-network providers. 29 U.S.C. §1002(8). RSA92-93. Plaintiffs demonstrated that, under the operative plans, as in-network providers, they were entitled to be paid, and were paid, directly by Independence for providing covered services to plan participants. RSA98-99 ("The Carrier is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this Plan."); RSA99 ("there's a claim payment that goes to the provider.").

Plaintiffs also showed that Independence's "recoupment" of previously paid claims for services Plaintiffs provided constituted

"adverse benefit determinations" under ERISA because they were "a denial, reduction, termination of … or a failure to provide or make payment (in whole or in part)" based on "a participant's or beneficiary's eligibility to participate in a plan," or "the application of utilization review," or because a service "is determined to be experimental or investigational or not medically necessary or appropriate." 29 C.F.R. §2560.503-1(m)(4) (defining "adverse benefit determination"). Specifically, most recoupments "involved non-covered services," even after Independence advised Plaintiffs that "the services were covered or were given reasonable assurance that this was so." RSA105-06.

The district court concluded that Independence violated ERISA in several ways. RSA110. Independence failed to give Plaintiffs adequate notice of the adverse benefit determinations because Independence "[did] not identify the basis for [its] conclusion that it has overpaid or paid in error," thus ignoring its notice obligations. RSA109. It "[did] not inform providers that they have a right to appeal [its] determination, let alone describe what the appeal process would entail and what it requires the provider to do if he wishes to appeal." *Id.* It also "[did] not offer providers any chance to appeal an adverse benefit

determination when it is based on an eligibility determination …, or a medical necessity determination, the last of which is a relatively common occurrence." *Id.* And it did not "inform a provider of the decision that it has reached on review of an earlier adverse determination." RSA110. These failures, among others, "preclude[d] full and fair review" under ERISA and made it "virtually impossible" to determine whether Independence satisfied other "full and fair review" obligations. *Id.*

The district court's conclusion should be affirmed.

SUMMARY OF ARGUMENT

ERISA's "comprehensive legislative scheme," *Davila*, 542 U.S. at 208, provides procedures for: (1) notifying a claimant who has been denied benefit payments under an ERISA-regulated plan, along with the basis and reasoning for such denial, 29 C.F.R. §2560.503-1(g); and (2) allowing that claimant to have a "full and fair review" of that adverse benefit determination, first internally and ultimately to federal court. *Id.*, §2560.503-1(h), (j); ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B); ERISA §503, 29 U.S.C. §1133. These provisions give the plan participant or beneficiary statutory notice and appeal rights if a

third-party payer makes an adverse benefit determination regarding a claim.

Third-party payers should not be able to circumvent ERISA's notice and appeal requirements by paying a provider's claim initially under those requirements and then recouping that payment later when, according to the payer, those requirements do not apply. Presumably, Independence does not contend that it can ignore ERISA's procedures when claims are first paid. Allowing those procedures to be ignored when those payments are "recouped" then goes beyond exalting form over substance. It functionally eviscerates ERISA by imposing procedural requirements on only one of two paths to the same outcome, *i.e.*, the provider does not get paid for its services.

Interpreting ERISA's statutory language and enabling regulations, the district court correctly determined that Plaintiffs were ERISA "beneficiaries," both as assignees and under the governing plans. Either way, since retroactive denials of claims and recoupments are functionally identical to an "adverse benefit determination," ERISA entitled Plaintiffs to notice of the reasons for those denials and the right to a "full and fair review" of those denials. *See* 29 U.S.C. §1133; 29

C.F.R. 2560.503-1. Independence's failure to comply with ERISA constitutes an abuse of discretion and an appropriate basis for relief under ERISA §502(a).

These issues take on heightened importance as providers face increased pressure to join networks. Payers give consumers discounted rates for joining their network, so increasingly they do so. Practically, providers must follow suit to obtain patients and avoid payers' substantial disincentives for non-network providers (including not paying for out-of-network care, thus requiring providers to seek payment entirely from patients which drives up administrative costs).[3] As payer concentration grows in many markets, the asymmetry between payer and provider also increases. *See* AMA, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS 4 (2014) ("the majority of health insurance markets in the United States are highly concentrated. Coupled with a growing body of evidence on their anti-competitive behavior, this strongly suggests that health insurers are exercising market power in many parts of the country and in turn

[3] *See* Reed Abelson, *Health Insurance Shoppers Look to Limited Networks to Save Money*, NEW YORK TIMES (April 13, 2015), http://www.nytimes.com/2015/04/14/business/health-insurance-shoppers-look-to-limited-networks-to-save-money.html.

causing competitive harm to consumers and providers of care."); *id.* at 15 (Philadelphia market is highly concentrated, and Independence has the largest share (57%) of the market).

The passage of the Patient Protection and Affordable Care Act ("PPACA") also highlights these issues. The PPACA incorporates ERISA's claims procedure into its internal appeals process for group health plans. 42 U.S.C. §300gg-19(a)(2)(A) (incorporating 29 C.F.R. §2560.503-1). One reason for adopting ERISA's claims procedure for the benefit plans the PPACA regulates is to reduce the impediments to Americans receiving the health care to which they are entitled under their plans. Congress' intent when enacting the PPACA is thwarted if providing medical care to patients is impeded by a third-party payer's systematic scheme to nominally provide benefits under the PPACA and ERISA and then take them away later (without following the PPACA and ERISA's regulations).

Under Independence's view, providers and patients lack recourse to ERISA's notice and appeal procedural requirements when a TPA/insurer makes an adverse benefit determination retroactively or seeks recoupment of a previously paid claim. This would again leave

providers (like physicians and, here, chiropractors) improperly "holding the bag." *Pathology Laboratories,* 71 F.3d at 1255.

ARGUMENT

I. Courts Recognize Multiple Ways For Providers To Receive Payment For Their Services

Multiple parties and processes are involved when a provider requests payment from third-party payers. Because "confusion is all too common in ERISA land," *Larson v. United Healthcare Ins. Co.*, 723 F.3d 905, 912 (7th Cir. 2013) (citation omitted), it is important to understand the typical claims payment process, the parties involved in that process, and various potential challenges when claims are denied to provide context for the issues this case raises.

A. The Parties

Four parties are normally involved in an ERISA dispute: 1) the plan; 2) the TPA/insurer (third-party payer); 3) the provider; and 4) the participant or beneficiary. ERISA-regulated plans are governed by plan documents that explain the scope of benefits, the procedure for filing claims, and how to appeal adverse benefit determinations. The heart of ERISA deals with interpreting and enforcing a plan's terms. There are

two types of plans: 1) insured plans, where an employer purchases an insurance policy that covers its employees; and 2) self-funded plans, where the employer bears the risk of paying employees' medical claims. Regardless of plan type, the plan dictates who can receive benefits, the scope of coverage, and the benefits due under the plan.

Plans typically have a claims administrator. For self-funded plans, the employer (plan sponsor) usually hires a TPA, often an insurer that also sells insurance to insured plans, to process claims and perform other administrative services. For insured plans, the insurer both processes claims and pays benefits. Regardless of which plan type, however, the TPA/insurer generally interfaces on the plan's behalf with both plan participants and providers, particularly regarding claims payment, and are commonly referred to as third-party payers. To the participant or provider, it is often difficult to determine whether a third-party payer is a TPA or an insurer for a particular plan. An insurance company, like Independence, administers claims on behalf of multiple unrelated plans and is responsible for reviewing those plans and determining what benefits claims should be paid under a particular plan.

A provider provides services to patients. "In-network" providers have contracts (provider agreements) with third-party payers under which they agree to accept discounted payments in return for patients. The plan often pays less than retail for "in-network" providers.[4] "Out-of-network" providers have no contract with a particular payer and thus are not obligated to accept a negotiated discount. Rather, the third-party payer will examine the plan and determine what portion of the retail charge will be paid. The larger the reductions the payer makes to the provider's retail charge, the more the patient will likely pay. *See* White Paper at 3.

Finally, ERISA defines plan participants and beneficiaries. A participant is "any employee or former employee of an employer … who is or may become eligible to receive a benefit of any type from an employee benefit plan." 29 U.S.C. §1002(7). A "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *Id.*, §1002(8). Therefore, under ERISA's text, both the participant and the

[4] *See* The AMA Practice Management Center, *Standardization of the Claims Process: Administrative Simplification White Paper*, (June 22, 2009), www.ama-assn.org ("White Paper").

plan identify who is a beneficiary.

B. The Payment Process

Amici have long supported greater transparency in the claims payment process. As healthcare costs continue increasing, *amici*, providers, and patients recognize the need to obtain proper information from third-party payers about plan coverage so patients and providers can make informed decisions about treatment options. Receiving a timely and accurate coverage determination assists in patient scheduling, billing, and communicating the patient's financial responsibility. *See* White Paper at 1, 7.

Because providers and patients need to know exactly what services a plan covers, providers typically seek pre-certification or authorization before providing services. Third-party payers verify for providers the patient's coverage under a plan and eligibility for the services being rendered, and both provider and patient rely on that information when determining treatment.

After receiving preliminary certification of coverage and providing

the appropriate services[5], a provider typically submits a payment claim to the patient's third-party payer (acting for the plan). The third-party payer reviews the claim, comparing it to the plan's benefit level, medical necessity description, and covered and non-covered service descriptions to confirm coverage. Next, the payer determines whether the provider is "in-network" or "out-of-network" to determine the percentage of the retail charge the plan will pay. It may also use "payment rules" to adjust payment. Once this process is completed, the final payment is determined. *Id.* at 3-4.

Then, an Explanation of Benefits (EOB) is sent to the provider and patient. The plan must explain its rationale for any partial payment, delay, or denial of a claim in the EOB. *See* 29 U.S.C. §1133(a). Upon receiving an EOB, a participant or beneficiary can appeal an adverse benefit determination, where she is statutorily entitled to a full and fair review of that determination. 29 U.S.C. § 1133(b). When the provider receives the EOB, it generally also receives the payment for the services the plan will cover. That should be the end of the claims payment process.

[5] In cases of medical necessity, a coverage determination occurs after the claim is submitted.

Here, the process continued thereafter. Independence initially approved claims and actually remitted payments for them. Months later, without issuing another EOB or notice adequately explaining its actions or allowing a full and fair review of those actions, Independence simply asserted it was "recouping" inadvertent payments for claims it mistakenly believed were covered by a plan, often by underpaying other valid claims regarding other patients covered by other plans. These "recoupments" are another attempt to leave providers "holding the bag."

C. Disputes Regarding Payment For Medical Care

If a provider provides services for a plan participant patient, and the third-party payer refuses to pay for those services, the provider potentially has several claims under federal law, typically ERISA, and under state contract or tort law, depending on the circumstances, to dispute that denial. These paths to relief should be alternative or complementary. *CSDA*, 591 F.3d at 1347 ("[A] provider that has received an assignment of benefits and has a[n independent] state law claim . . . holds *two separate claims*." (emphasis added)); *Franciscan Skemp*, 538 F.3d at 598 (describing potential ERISA claim as assignee and state law promissory estoppel claim).

The too-frequent reality is that whichever avenue the provider takes, the third-party payer asserts that the claim is improper and, like a game of three-card monte, the provider's relief, if any, only exists through some other claim under another legal regime. Third-party payers, like Independence, create the impression that no claim is viable under any legal regime.

In reality, courts recognize multiple different legal theories that permit a provider to challenge the denial of a claim for payment for services rendered. While each does not fit all situations, contrary to the posture of many third-party payers, ample precedent demonstrates that providers can assert each claim legitimately under appropriate circumstances.

a. Federal ERISA Claims

Third-party payers often assert that ERISA provides relief (often the only relief) in cases where a claim for plan benefits should have been paid. *Pilot Life*, 481 U.S. at 52 ("the civil enforcement provisions of ERISA §502(a) [are] the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits."). When providers or plan participants assert state-law

claims, third-party payers often argue that ERISA preempts such claims and is the only appropriate relief. *Davila*, 542 U.S. at 209; *CSDA*, 591 F.3d at 1352 (arguing that ERISA preempted state-law claims).

Third-party payers typically assert that ERISA §502(a)(1)(B) completely preempts any state-law claim that "'protect[s] contractually defined benefits,'" *Larson*, 723 F.3d at 911 (quoting *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)) and "derives entirely from the particular rights and obligations established by the benefit plans." *Davila*, 542 U.S. at 213. Section 502(a)(1)(B)'s complete preemption even allows for removal to federal court of state-law claims that should be characterized as denial of benefits claims. *Davila*, 542 U.S. at 209.

Davila established a two-prong test that determines when a state-law claim is completely preempted by ERISA §502(a)(1)(B): (1) if the ERISA plaintiff "at some point in time, could have brought his claim under ERISA §502(a)(1)(B); and (2) if "there is no other [non-ERISA] independent legal duty that is implicated by a defendant's actions." *Davila*, 542 U.S. at 210.

In *Davila*, the Court concluded that ERISA completely preempted

plaintiffs' claims because: (1) they only related to "denial of coverage promised under the terms of the ERISA-regulated employee benefit plans" and could have been asserted under §502(a)(1)(B), and (2) they only sought to "rectify a wrongful denial of benefits promised under [an] ERISA-regulated plan[], and [did] not attempt to remedy any violation of a legal duty independent of ERISA." *Id.* at 211, 214.

In an obvious reversal of the third-party payer's typical position, Independence asserts that ERISA does *not* regulate this dispute and implies that Plaintiffs should have filed contract claims in state court. *See* Independence Br. at 1. Independence is incorrect. There are at least two well-accepted mechanisms under which an ERISA claim can be asserted appropriately, and the district court correctly concluded that Plaintiffs asserted both properly.

i. Derivative Standing As An Assignee

Courts agree that providers can assert ERISA claims derivatively, as an assignee of a plan participant's right to benefits. *Neuma, Inc. v. AMP, Inc.*, 259 F.3d 864, 878 (7th Cir. 2001); *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991). Such assignments justify an insurer's removal to federal court based on §502(a)(1)(B)'s

preemptive force. *Kennedy*, 924 F.2d at 699 ("[Kennedy] filed suit in state court as assignee of Myers' claim against the insurer; CIGNA removed it to federal court, as it could because the claim necessarily rests on [ERISA].").

Since third-party payers can remove a provider's state-law claim under an assignment of benefits via §502(a)(1)(B)'s complete preemption, the assignee provider's §502(a)(1)(B) claim filed in federal court is equally cognizable. *Id.* at 700 ("§1132(a)(1)(B) supplies jurisdiction when a provider of medical services sues as assignee of a participant."). *Cardionet, Inc. v. CIGNA Health Corp.*, 751 F.3d 165, 176 n.10 (3d Cir. 2014) (adopting "majority position that health care providers may obtain standing to sue by assignment from a plan participant.").

As assignee, the provider has "standing to assert whatever rights the assignor[s] possessed." *Misic v. Bldg. Serv. Emp. Health & Welfare Trust*, 789 F.2d 1374, 1378 n.4 (9th Cir. 1986). This necessarily includes the right to payment and the right to assert a claim, if necessary, to seek payment. *CSDA*, 591 F.3d at 1352 ("an assignment furthers ERISA's purposes only if the provider can enforce the right to

payment."); *id.* at 1353 ("An assignment to receive payment of benefits necessarily incorporates the right to seek payment.") (internal quotes omitted); *Demaria v. Horizon Healthcare Serv., Inc.*, 2015 U.S. Dist. LEXIS 70176, *20 (D.N.J. June 1, 2015) (assignment "creates a derivative right to sue for payment under … ERISA").

"[I]mportant public policy interests [are] served by permitting providers to bring such claims on behalf of plan participants." *Cardionet*, 751 F.3d at 179.

> 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 "up-front." The providers are better situated and financed to pursue an action for benefits owed for their services.

Id. (quotation omitted).

Allowing providers to accept assignments from plan participants and bill (and be paid by) third-party payers directly streamlines the claims submission and payment process. A third-party payer's repeated acceptance of such assignments over time, as here, even constitutes a

waiver of any potential anti-assignment provisions in an employee benefit plan. *Premier Health Ctr. v. UnitedHealth Group*, 2012 WL 1135608, *9 (D.N.J. Apr. 4, 2012) ("an anti-assignment clause may be waived by a written instrument, a course of dealing, or even passive conduct, *i.e.*, taking no action to invalidate the assignment vis-à-vis the assignee"); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F.Supp.2d 901, 922-24 (M.D. Tenn. 2013).

Third-party payers undoubtedly also accept assignments because they reduce their administrative burden. Indeed, the AMA chairs the National Uniform Claim Committee ("NUCC") (which includes representatives from America's Health Insurance Plans and Blue Cross Blue Shield Association), which developed the 1500 Claim Form as the "single paper claim form for use by all third-party payers."[6] That form, which Plaintiffs submitted repeatedly on behalf of their patients, *see* Supp.161-73, includes Box 13 where the patient can indicate she has assigned to the provider the right to payment, saying: "I authorize payment of medical benefits to the undersigned physician or supplier

[6] *See* http://www.nucc.org/index.php?option=com_content&view=article&id=196&Itemid =112 (explanation of NUCC); http://www.nucc.org/images/stories/PDF/1500_claim_form_2012_02.pdf (Form 1500).

for services described below." Providers have long understood that checking Box 13 on Form 1500 demonstrated that the provider was the patient's assignee for receiving payment, and if necessary, enforcing the right to do so.

The fact that Independence's licensor, BCBSA, actively participated in creating the standardized document which provides for assignment of "payment of medical benefits" makes Independence's anti-assignment argument now ring especially hollow. *Demaria*, 2015 U.S. Dist. LEXIS 70176, *20-21 ("Horizon's making a decision based on a Form 1500 should be read as a waiver of any anti-assignment clause, at least as far as suit for payment on the particular claim goes. The same can be said of the right to sue under ERISA.").

ii. Direct Standing As A Plan Beneficiary

The district court's conclusion that the operative plan language permitted Plaintiffs to assert a §502(a)(1)(B) claim directly also is firmly grounded in ERISA and caselaw. RSA98-99. Under ERISA, a plan "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. §1002(8). As an assignee, a provider is a

beneficiary that a participant designates. A provider can also be designated a beneficiary "by the terms of an employee benefit plan." *Id.* As a beneficiary, a provider's claim falls within ERISA's claims procedure. 29 C.F.R. §2560.503-1(a) (defining "participants and beneficiaries" as "claimants" for purposes of claims procedure).

Precedent supports including providers directly within the definition of an ERISA beneficiary. *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Neurobehavioral Associates, P.A.*, 53 F.3d 172, 173 (7th Cir. 1995); ("A medical care provider who receives benefits from the fund at the behest of a participant is a beneficiary."); *Kennedy*, 924 F.2d at 701 ("[t]he possibility of direct payment is enough to establish subject matter jurisdiction."); *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 6 (1st Cir. 1999) ("benefits" include "the monetary payments for medical services").

The Supreme Court repeatedly admonishes that an ERISA plan's terms govern and should be followed. *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (ERISA scheme "is built around reliance on the face of written plan documents") (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995)). In fact, ERISA requires a plan

administrator to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [Title I] and [Title IV] of [ERISA]." 29 U.S.C. §1104(a)(1)(D). As a beneficiary designated by the relevant plans, the provider can bring a civil action 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"; and to "obtain other appropriate equitable relief." 29 U.S.C. §§1132(a)(1)(B), (a)(3)(A), (B).

iii. Third-Party Payers Are Appropriate Defendants In A §502(a)(1)(B) Action

Under either approach, a third-party payer, like Independence, is an appropriate defendant for Plaintiffs' §502(a)(1)(B) claim. Indeed, "[w]hen an employee-benefits plan is implemented by insurance and the insurance company decides contractual eligibility and benefits questions and pays the claims, an action against the insurer for benefits due 'is precisely the civil action authorized by §1132(a)(1)(B).'" *Larson*, 723 at 913 (internal citations omitted). "Neither the statute nor caselaw directs that §1132(a)(1)(B) should insulate an entity from liability merely for being a TPA." *LifeCare Mgmt. Servs. LLC v. Ins. Mgmt.*

Adm'rs, 703 F.3d 835, 845 (5th Cir. 2013).

iv. ERISA Recoupment Actions

The fact that ERISA already provides third-party payers with a ERISA §502(a)(3) claim to recoup alleged overpayments reinforces the view that ERISA governs this dispute. *McCutchen*, 133 S. Ct. at 1548-50 (discussing ERISA §502(a)(3) reimbursement claim); *Neurobehavioral Assoc.,* 53 F.3d at 173. Since ERISA provides payers with the statutory basis to recoup overpayments, Independence's practice of unilaterally recouping alleged overpayments without invoking ERISA, or its requirements, is all the more inappropriate. Independence's continuing relationship with providers should not be a means to circumvent ERISA's procedural requirements. Doing so runs afoul of ERISA's purpose and intent.

b. State Law Claims

Amici have often advocated, however, that certain state-law claims are still proper and that ERISA preemption does not preclude provider claims that affect plans "in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 (1983). Sometimes, a provider can assert state-law claims against a third-party payer or plan in

addition to, or instead of, an ERISA claim. *CSDA*, 591 F.3d at 1347 ("[A] provider that has received an assignment of benefits and has a[n independent] state law claim . . . holds two separate claims."). These claims typically arise from an in-network provider's dispute with a payer regarding the parties' provider agreement or representations made apart from a benefit plan.

This court, and others, distinguish between ERISA §502(a)(1)(B) denial of benefits claims and state-law contract claims construing provider agreements which "do[] not require interpreting or applying the Plan, nor does it relate to the Plan in any significant way." *Kolbe & Kolbe Health & Welfare Benefit Plan v. Medical College of Wisc., Inc.*, 657 F.3d 496, 504 (7th Cir. 2011); *Borrero v. United Healthcare of New York*, 610 F.3d 1296, 1302 (11th Cir. 2010); *Blue Cross of Cal. v. Anesthesia Care Assoc. Med. Group, Inc.*, 187 F.3d 1045, 1050 (9th Cir. 1999). The Fifth Circuit explained one often-used dividing line:

> A claim that implicates the rate of payment as set out in the Provider Agreement, rather than the right to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA. … [A]ny determination of benefits under the terms of a plan – *i.e.*, what is 'medically necessary' or a 'Covered Service" – does fall within ERISA, [but the provider's] claims are entirely separate from coverage and arise out of the independent legal duty

contained in the contract …

Lone Star OB/GYN Associates v. Aetna Health Inc., 579 F.3d 525, 530-31 (5th Cir. 2009).

Beyond contract claims, providers can assert promissory estoppel or misrepresentation claims against the third-party payer when the payer misrepresents a patient's coverage to the provider. *Franciscan Skemp*, 538 F.3d at 597 (promissory estoppel and common law fraud claims "arise not from the plan or its terms, but from [] alleged oral representations."); *Access Mediquip L.L.C. v. United Health Care Ins. Co.*, 662 F.3d 376, 386-87 (5th Cir. 2011), *aff'd en banc*, 698 F.3d 229 (5th Cir. 2012); *Connecticut General Life Ins. Co. v. Grand Avenue Surgical Ctr., Ltd.*, 2014 WL 151755, *6 (N.D. Ill. Jan. 14, 2014).

Providers, therefore, potentially have multiple claims to assert when a third-party payer refuses to pay for the care a provider gives a patient entitled to benefits under a plan. Here, Plaintiffs asserted claims alleging that Independence wrongfully retroactively denied their claims for benefits under various ERISA-regulated plans by unilaterally "recouping" payments it previously made under those plans' terms. Claims that require construing ERISA plans to determine the propriety

of benefit denials under those plans are the epitome of ERISA claims, not state law claims.

II. The District Court Correctly Concluded That Independence Violated ERISA's Notice And Appeal Requirements.

The district court properly concluded that Independence violated ERISA's notice and appeal requirements. RSA109-10. The court found that Plaintiffs were not provided notice of the basis for Independence's recoupment decisions and could not meaningfully appeal. RSA88. Independence did not "explain how [it] had determined that the provider owed it the amount indicated, or provide the insurance plans (or relevant language from the plans) of the patients who had allegedly received the non-capitated services inappropriately from the provider." RSA86. Plaintiffs also were informed that they lost multiple "appeals" without having the appeal process explained or the basis for those decisions. *Id.*

Independence's actions justify the court's conclusion that Independence violated ERISA. The court's decision follows directly from ERISA's text, the operative plans, binding precedent, common sense, and sound policy.

A. The Court's Decision Follows ERISA's Language

The court's decision flows logically from ERISA's statutory text. Plaintiffs are ERISA "beneficiaries," because: (1) they were "designated by a participant"; and (2) they were "designated . . . by the terms of an employee benefit plan." 29 U.S.C. § 1002(8). As assignees, *see* Supp.161-74, RSA99-102, Plaintiffs were designated by plan participants to receive plan benefits. *Danca*, 185 F.3d at 6 ("benefits" include "the monetary payments for medical services"). They were also "designated . . . by the terms of [a] plan" to receive benefits directly. *See* RSA98-99 ("The Carrier is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this Plan.").

As beneficiaries, they are properly "claimants" under ERISA's claims procedures. 29 C.F.R. §2560.503-1 (defining claimants as participants or beneficiaries). Independence's unilateral "recoupments" of previously paid claims are "adverse benefit determinations" because they are "a denial, reduction, ... or a failure to provide or make payment (in whole or in part)." *Id.*, §2560.503-1(m)(4). Those denials,

Independence conceded, are often based upon its determination of a plan participant's "eligibility to participate in a plan," or its "application of utilization review," or because a service was deemed "not medically necessary or appropriate." *Id.*; RSA105-06.

As beneficiaries who received adverse benefit determinations, ERISA's claims procedures require that Plaintiffs receive notice and a right to appeal. 29 C.F.R. §2560.503-1(g), (h), (j). The district court properly concluded that Independence failed to comport with these requirements when recouping funds from Plaintiffs. RSA87-88, 90. Independence even admitted it simply "does not take ERISA into account when adopting, implementing or observing its policies and procedures relating to recoupment." RSA90.

Plaintiffs, therefore, filed appropriate ERISA §502(a)(1)(B) claims to vindicate and clarify their rights under the operative plans. The district court properly concluded that Independence violated ERISA.

B. The Court's Decision Follows The Operative Plans

Under the operative plans, Independence was "authorized" "to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided

under this Plan." RSA98-99. Independence confirmed at trial that "a claim payment [] goes to the provider" for in-network services. RSA99. Thus, the district court properly concluded that the plans themselves designated Plaintiffs as beneficiaries.

Adhering to the plans' language, the district court properly followed one of ERISA's principal requirements – to follow plan documents. 29 U.S.C. §1104(a)(1)(D); *McCutchen*, 133 S. Ct. at 1548 (ERISA's enforcement mechanism "is built around reliance on the face of written plan documents") (quotation omitted).

C. The Court's Decision Follows Precedent

The district court's thorough analysis also follows logically from precedent. This Court has acknowledged that, whether as assignees or direct beneficiaries, Plaintiffs have standing to assert their claims in federal court. *Neurobehavioral Assoc.*, 53 F.3d at 173 ("A medical care provider who receives benefits from the fund at the behest of a participant is a beneficiary."); *Kennedy*, 924 F.2d at 699; *Trustmark Life Ins. Co. v. Univ. of Chi. Hosps.*, 207 F.3d 876, 880 (7th Cir. 2000).

As such, ERISA §502(a) is the "exclusive vehicle" for asserting their claims that Independence improperly processed their benefit

claims under the operative plans. *Pilot Life*, 481 U.S. at 52 ("civil enforcement provisions of ERISA §502(a) [are] the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits."); *Davila*, 542 U.S. at 213 (claims which "derive[] entirely from the particular rights and obligations established by the benefit plans" are ERISA §502(a) claims); *Lone Star,* 579 F.3d at 530-31 ([A]ny determination of benefits under the terms of a plan – *i.e.*, what is 'medically necessary' or a 'Covered Service' – does fall within ERISA").

D. The Court's Decision Follows Common Sense

The district court's decision also comports with common sense. Independence's recoupments are "adverse benefit determinations" or denials of benefits according to plan terms. Had Independence made these determinations when it initially processed Plaintiffs' claims, the procedural requirements (including notice and appeal rights) in ERISA's claims regulations would have governed those decisions, and they would have been subject to a §502(a)(1)(B) claim. Independence would have to ignore decades of caselaw to argue otherwise. It defies common sense that payers could circumvent these front-end procedural

safeguards by simply paying claims initially and then reversing them days, or years, later.

Independence's position essentially guts ERISA's claims processing regulations and its "full and fair review" obligations. What payer would follow those regulations when it can simply pay a claim initially and then "recoup" that payment later without adhering to ERISA's notice and review procedures? The intent of Congress and the Department of Labor, in enacting 29 U.S.C. §1133 and 29 C.F.R. §2560.503-1, cannot be circumvented so easily.

Amici have worked steadfastly for decades to streamline the claims payment process and increase its transparency and predictability. Adopting Independence's position would upend those efforts and infuse the marketplace with unnecessary, and costly, uncertainty and complexity.

E. The Court's Decision Is Consistent With Public Policy

Finally, the district court's position comports with public policy. The PPACA expressly adopted ERISA's claims regulation and broadened its applicability. *See* 75 Fed.Reg. 43330, 43332 (July 23, 2010) (adverse benefit determinations are broader under PPACA than

ERISA). A PPACA "adverse benefit determination" also includes any "denial, reduction, termination, or failure to provide or make a payment" based on, *inter alia*, "imposition of a … network exclusion, or other limitation on otherwise covered benefits" and rescissions of coverage. *Id.*

The PPACA would be hollowed out if third-party payers could pay claims under the PPACA/ERISA claims processing regulations and then summarily reverse those decisions and recoup those payments without following those same regulations.

Finally, Independence's recoupments raise concerns about third-party payers' activities and status under ERISA. Independence can offset a provider's prior claim for services provided to Patient A (a participant in Plan #1) in Year 1 against "proper" claims for services provided to Patient B (a participant in Plan #2) in Year 2. Independence thus avoids paying admittedly proper benefits under Plan #2. This also is clearly an ERISA fiduciary action, contrary to many third-party payers' characterization that they perform ministerial activities and the plans retain ultimate discretionary authority. *Klosterman v. Western Gen. Mgmt.*, 32 F.3d 1119, 1124-1125 (7th Cir.

1994). Plan #1 cannot simply repay itself for an alleged prior overpayment with funds from Plan #2. Only because the third-party payer exerts discretionary authority over both plans' assets and apparently commingles them is such "recoupment" possible. When exercising that authority, Independence, and other third-party payers, should not escape ERISA's purview.

CONCLUSION

Amici respectfully request that this Court affirm the district court.

Respectfully submitted,

By: /s/ Brian E. Casey
Brian E. Casey
Alice J. Springer
BARNES & THORNBURG LLP
700 1st Source Bank Center
100 N. Michigan
South Bend, IN 46601
574.233.1171

Mark E. Rust
BARNES & THORNBURG LLP
One N. Wacker Drive, Suite 4400
Chicago, IL 60606-2833
312.357.1313

Attorneys for American Medical Association and Illinois State Medical Society

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 7,000 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2003 with 14 point Century font.

/s/ Brian E. Casey

CERTIFICATE OF SERVICE

I hereby certify that on June 5, 2015, I electronically filed a copy of the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh 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.

/s/ Brian E. Casey
Brian E. Casey

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