Nos. 18-2784, 18-2790

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

IVAN MITCHELL, et al.,

Plaintiff-Appellants / Cross-Appellees,

v.

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA, et al.,

Defendant-Appellees / Cross-Appellants.

On Appeal from the United States District Court for the District of North Dakota

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANTS / CROSS-APPELLEES

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QUESTIONS PRESENTED

Ivan Mitchell is a former employee of the Towner County Medical Center and a participant in its Health Reimbursement Plan ("Plan"), which was insured and administered by Defendant Blue Cross Blue Shield of North Dakota ("Blue Cross"). Melissa Mitchell, his spouse, is a beneficiary of the Plan. She had a cardiac emergency and was transported from Towner County Medical Center to another facility by air ambulance. Blue Cross denied the Mitchells' claim for full payment of the cost of the air transport but paid a portion of it. After Ivan Mitchell left his employment at the medical center, the Mitchells filed suit against the Plan and Blue Cross under the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, 29 U.S.C. § 1001, et. seq., contesting Blue Cross's decision. Blue Cross asserted that the Mitchells did not have constitutional standing because the air transport provider did not require the Mitchells to pay the remainder of the air ambulance bill and, therefore, they did not suffer an injury sufficient to confer Article III standing. Blue Cross also contended that they lacked statutory standing to sue under ERISA because Ivan Mitchell left his employment at the medical center before they sued. The court rejected Blue Cross's arguments, concluding that the Mitchells met their burden of establishing constitutional and statutory standing, but largely denied their claim on the merits. The Secretary of Labor's brief addresses the following issues:

1. Whether a participant or his beneficiary in an ERISA-covered plan who sues the plan for wrongfully denying his claim for full payment of medical services suffered an "injury in fact" that confers constitutional standing where the medical provider did not require the participant or beneficiary to pay the amount the plan refused to pay.
2. Whether a former employee or his beneficiary in an ERISA-covered plan who has a colorable claim to benefits the plan denied has statutory standing as a plan participant or beneficiary to bring an action under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to challenge the plan's decision.

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

The Secretary of Labor has primary authority to interpret and enforce the provisions of Title I of ERISA to ensure fair and impartial plan administration and compliance with ERISA's requirements and purposes. See 29 U.S.C. §§ 1132, 1135; Donovan v. Cunningham, 716 F.2d 1455, 1462-63 (5th Cir. 1983). The Secretary has an interest upholding the district court's rulings on both questions presented, which this Court has never addressed.

The Secretary files this brief pursuant to Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

I. Facts

Ivan Mitchell was an employee of Towner County Medical Center in Cando, North Dakota. See Pl.'s Opening Br. for J. on the Administrative R. ("Opening Br.") at 6-7.[1] Mr. Mitchell elected coverage for himself and his spouse, Melissa Mitchell, under the Towner County Medical Center – Health Reimbursement Plan ("Plan"), an ERISA-covered health benefit plan administered by Blue Cross. Mitchell v. Blue Cross Blue Shield of N. Dakota, No: 2:15-cv-00086-LLP-ARS, 2018 WL 3463260, at *1 (D.N.D. July 18, 2018). Blue Cross made eligibility and benefit coverage determinations on behalf of the Plan. Id.

On January 15, 2014, Ms. Mitchell was in cardiac distress and sought emergency care at Towner County Medical Center. Mitchell, 2018 WL 3463260, at *1; Opening Br. at 6. Upon examination, her physician determined it medically necessary to transport her to a facility that could provide a higher level of care. Mitchell, 2018 WL 3463260, at *1. Due to the inclement weather and medical urgency, Ms. Mitchell was transported by a "fully staffed multi-million-dollar advanced life support fixed wing aircraft" by Valley Med Flight, Inc. ("VMF"), an out-of-network provider. Id. Blue Cross does not dispute that the transfer by air ambulance was medically necessary. Id. VFM initially billed Ms. Mitchell $33,200

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

for its air ambulance services. Mitchell, 2018 WL 3463260, at *1. Blue Cross paid a total of $6759.98, leaving the Mitchells to cover the remaining $26,440.02. Id.

The Plan covers medically necessary and appropriate ambulance services that are not "excessive in comparison with alternative services." Mitchell, 2018 WL 3463260, at *10. If the ambulance service provider does not participate in Blue Cross's network, the Plan pays 80% of what Blue Cross determines to be the "Allowed Charge." Id. The Plan itself does not explain how Blue Cross determines the Allowed Charge, other than to state that it is reduced by the amount the participant is responsible for in coinsurance payments and annual deductible amounts. Id. at *9, 10. Pursuant to Blue Cross's internal policy, it determined that the Allowable Charge was 150% of the 2013 Medicare rural air ambulance rates. Id. at *10. Blue Cross then paid VMF 80% of that amount after adjusting for the Mitchells' obligations to pay the coinsurance and deductible amounts, which was $6759.98. Id. at *12.

On April 21, 2014, VMF contacted Blue Cross requesting additional payment. Mitchell, 2018 WL 3463260, at *2. Mr. Mitchell also challenged the partial payment. Id. On May 27, 2014, VMF received a letter from Blue Cross stating that the claim was processed correctly. Id. On June 13, 2014, Mr. Mitchell received a letter from Blue Cross stating its final determination that because the claim was processed correctly, Blue Cross would not make additional payment on the claim.

Id.

On July 30, 2015, the Mitchells entered into an agreement with VMF ("July 2015 Agreement") whereby VMF agreed to pay for costs and attorney fees for any suit the Mitchells filed against Blue Cross to seek payment of their benefits. Mitchell, 2018 WL 3463260, at *2. The July 2015 Agreement provides that any recovery of money by the Mitchells from litigation will be disbursed as follows: first, to repay VMF for all costs and attorney fees paid or owed in this matter; second, to satisfy outstanding invoices to VMF; and third, to split the remainder by allotting 70% to VMF and 30% to the Mitchells. Id. The July 2015 Agreement also states that following the lawsuit, VMF will "waive all other claims it has against the [Mitchells] and limit any liability of the [Mitchells] to [VMF] to the amount recovered in [the] lawsuit." Id.

II. Proceedings Below

On September 2, 2015, the Mitchells filed suit against Blue Cross under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), "to enforce [their] rights under the terms of the plan." Mitchell, 2018 WL 3463260, at *2.

The Mitchells and Blue Cross filed cross-motions for summary judgment, in which the Mitchells argued that their cost-sharing obligations should be limited to their coinsurance liability and that Blue Cross must pay the remainder of the claim. Mitchell, 2018 WL 3463260, at *1. Blue Cross's motion defended the merits of its

decision and challenged the Mitchells' Article III standing, arguing that they did not suffer any injury in fact because the July 2015 Agreement relieved them from any requirement to pay VMF's fees out of their own pockets. Id.; Def. Opp'n. to Pl. Mot. Summ. J. ("Def. Opp'n.") at 22-23. Blue Cross also argued that the Mitchells lacked statutory standing because Ivan Mitchell is a former employee and no longer participates in the plan. See Def. Opp'n. at 29-30.

The district court held that the Mitchells had constitutional standing because they suffered a concrete injury when Blue Cross deprived them of benefits allegedly owed under the Plan – full payment of VMF's bill – regardless of VMF's decision not to pursue its legal rights to collect the remaining balance on the bill from the Mitchells through balance billing. Mitchell, 2018 WL 3463260, at *6. Because the Mitchells showed that they have a "colorable claim to benefits which the employer promised to provide," the court found that they had established statutory standing. Id. at *8. On the merits, the court affirmed Blue Cross's denial of the claim for full reimbursement of VMF. Id. at *15-16.

SUMMARY OF THE ARGUMENT

1. A denial of a participant's or beneficiary's right to have a benefits claim determined in accordance with plan terms is an injury sufficient to establish constitutional standing. The Mitchells suffered an injury in fact when Blue Cross denied benefits they contend were promised by the Plan by failing to fully reimburse

their medical service provider. Under Spokeo v. Robbins, 136 S. Ct. 1540 (2016), when considering whether an injury is sufficiently "concrete" for Article III purposes, a court examines analogous harms in "history and the judgment of Congress." Here, the Mitchells allege a breach of the terms of their employee health plan and a deprivation of promised benefits payable to their service provider. A breach of a promise in a plan is analogous to a breach of contract, and courts have always considered breaches of contractual promises to constitute Article III injuries. Moreover, Congress designed ERISA causes of actions to protect contractually-defined plan benefits. Based on Congressional intent and historical analogy to breaches of contract, the Mitchells' injury constitute concrete "injuries in fact" under Article III.

Four circuit courts of appeal agree that a denial of a benefits claim in alleged violation of plan terms, by itself, constitutes a sufficient Article III injury. The Fifth, Sixth, Ninth, and Eleventh Circuits all reached the same conclusion in analogous contexts. No circuits disagree.

Blue Cross attempts to distinguish this case based on the Mitchells' agreement to pay their provider the proceeds of this litigation in exchange for the provider releasing the Mitchells from any further financial obligation to pay for services rendered. Whether the Mitchells assigned the proceeds of this litigation (but not their underlying claim) to another party is irrelevant to their injury in fact: Blue Cross's

denial of promised benefits. The four circuits all rejected similar arguments because the relevant injury is the plan's failure to pay for covered services at the promised rate. That injury is not eliminated if the provider decides not to balance bill the patient for the amount the plan did not pay. The district court's ruling should be affirmed.

2. The Mitchells have a colorable claim for benefits under their Plan, which gives them statutory standing to bring an action under ERISA section 502(a)(1)(B). ERISA section 502(a)(1)(B) empowers a plan "participant" or "beneficiary" to sue "to recover benefits due him under the terms of the plan, to enforce his rights under the terms of the plan or to clarify his rights to future benefits under the plan." 29 U.S.C. § 1132(a)(1)(B). The Supreme Court in LaRue v. DeWolff, Boberg & Assocs., Inc., 552 U.S. 248 (2008), stated that an ERISA "participant," as defined by 29 U.S.C. § 1002(7), "may include a former employee with a colorable claim for benefits." Id. at 256 n.6 (citing Harzewski v. Guidant Corp., 489 F.3d 799 (7th Cir. 2007)). As a former employee and his beneficiary, the Mitchells need only show that they have a "colorable claim for benefits." Because the Mitchells made a colorable argument that Blue Cross interpreted the Plan terms to deprive them of rights promised to them under the Plan, they established statutory standing to bring an action under ERISA section 502(a)(1)(B).

ARGUMENT

I. The Mitchells Have Constitutional Standing To Dispute Blue Cross's Denial Of Benefits

The Supreme Court recently restated the requirements for Article III standing. Spokeo, 136 S. Ct. at 1540. "[T]he 'irreducible constitutional minimum' of standing consists of three elements . . . . [T]he plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision." Id. at 1547. "To establish injury in fact, a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" Spokeo, 136 S. Ct. at 1548 (quoting Lujan v. Defs. of Wildlife, 504 U.S. 555, 560 (1992)).

In Spokeo, the Supreme Court "confirmed . . . that intangible injuries [to a legally protected right] can nevertheless be concrete" for constitutional standing purposes. 136 S. Ct. at 1549. I"I]n determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." Id. First, "it is instructive to consider whether an alleged intangible harm has a close relationship to a harm that has traditionally been regarded as providing a basis for a lawsuit." Id. Second, "because Congress is well positioned to identify intangible harms that meet minimum Article III requirements, its judgment is also instructive and important." Id. Spokeo's analysis specifically addressed "intangible

injuries" caused by statutory violations in contrast to violations of private rights, including contractual rights. 136 S. Ct. at 1549 ("Congress' role in identifying and elevating intangible harms does not mean that a plaintiff automatically satisfies the injury-in-fact requirement whenever a statute grants a person a statutory right and purports to authorize that person to sue to vindicate that right."); see also id. at 1550 (Thomas, J., concurring) ("Common-law courts more readily entertained suits from private plaintiffs who alleged a violation of their own rights, in contrast to private plaintiffs who asserted claims vindicating public rights.").

Here, Blue Cross argues that the Mitchells did not suffer an Article III "injury" because the agreement between the provider and the Mitchells extinguishes their liability. See Principal and Responding Br. of Appellee ("Appellee Br.") 46-47. According to Blue Cross, under the July 2015 Agreement, the Mitchells will never pay VMF from their own funds; therefore, it argues, the Mitchells cannot suffer out-of-pocket losses and cannot establish an injury sufficient for Article III standing. See id. at 42. Blue Cross is wrong, and four circuits have rejected similar arguments.

A. Four Circuits Agree That Participants Have Article III Standing To Challenge Benefits Denials Even If They Are Not Billed

Recently, the Sixth Circuit addressed the same constitutional standing question where the insurer argued that the participant did not suffer an injury because he was not billed for medical services and did not allege any out-of-pocket loss. Springer, 900 F.3d at 287 (holding that a participant need not suffer financial loss to establish

constitutional standing because his concrete injury "stemmed from traditional principles of contract law that did not depend on financial harm"). Similar to this case, the plaintiff in Springer had purchased a health plan that said it would pay all transportation costs. Id. Upon receiving a bill for services rendered, the plan only paid ten percent of the bill. Id. Therefore, the participant "suffered an injury within the meaning of Article III because he was denied health benefits he was allegedly owed under the plan." Id.

In Springer, the Sixth Circuit followed the reasoning of three other circuit court decisions which held that a healthcare provider – to whom the plan participant assigned his benefit claim – has standing to challenge the insurer's denial of a benefit due to the participant even though the provider had not billed the participant. See N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare, 781 F.3d 182 (5th Cir. 2015); Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz., Inc., 770 F.3d 1282 (9th Cir. 2014); HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co., 240 F.3d 982 (11th Cir. 2001).

The Fifth Circuit addressed the specific question presented in this appeal in North Cypress. The insurer there argued that the healthcare provider had not suffered a concrete injury sufficient for Article III standing because the provider never billed the participants for the amounts the insurer did not pay and the provider "never intended to do so." N. Cypress, 781 F.3d at 192. The Fifth Circuit found that

as the participant's assignee, the provider had standing based on the participant's injury. Id. "It is well established that a healthcare provider, though not a statutorily designed ERISA beneficiary, may obtain standing to sue derivatively to enforce an ERISA plan beneficiary's claim." Id. at 191 (internal citations omitted). This holding follows the well-established principle that a provider, as an assignee, has constitutional standing to assert a section 502(a)(1)(B) claim based on the constitutional injury suffered by the plan participant, the assignor. See Sprint Commc'ns Co., L.P. v. APCC Servs., Inc., 554 U.S. 269, 290 (2008); Peterson v. UnitedHealth Grp. Inc., No. 17-1744, 2019 WL 190929, at *4 (8th Cir. Jan. 15, 2019) (a healthcare provider had standing to sue under section 502(a)(1)(B) based on an assignment from a plan beneficiary); Brown v. BlueCross BlueShield of Tenn., Inc., 827 F.3d 543, 546 (6th Cir. 2016). "[I]t is black-letter law that an assignee has the same injury as its assignor for purposes of Article III." Spinedex, 770 F.3d at 1291 (9th Cir. 2014).

The Fifth Circuit rejected the insurer's argument because its assignor, the participant, "suffers a concrete injury if money that she is allegedly owed contractually is not paid, regardless of whether she has directed the money be paid to a third party for her convenience." N. Cypress, 781 F.3d at 192. "From a different angle, failure to pay also denies the [participant] the benefit of her bargain. In purchasing her [ERISA-covered] plan she agreed to pay for coverage at out-of-

network providers like North Cypress, and [the insurer] is failing to uphold the bargain by paying for covered services." Id.

The other circuit courts that have addressed this issue uniformly concluded that the violation of the patient's right to benefits as promised by the plan, including promised payment to providers, suffices as a constitutional injury. The Eleventh Circuit noted that the basis for the assignee-assignor relationship was to permit an adjudication of benefits without the provider first billing the patient, and based on this rationale, the constitutional injury should not turn on the existence of a bill but rather the patient and provider's "recovery of benefits under the group insurance plan." HCA, 240 F.3d at 991. The Ninth Circuit also reached a similar result in Spinedex, 770 F.3d at 1291, where the provider-assignee had Article III standing even though it had not sought payment of any shortfall from its patient-assignors before filing suit against the plan. Spinedex, 770 F.3d at 1289, relied on HCA Health Services to reach its decision, and noted that "[w]e are aware of no circuit court that has accepted defendants' argument" against Article III standing for the provider-assignee. Id. (citing HCA, 240 F.3d 982, as "directly on point"). No circuit court has disagreed with these rulings.

As discussed in these cases, whether a provider decided to seek payment for services from a plan participant or whether the participant actually paid is irrelevant to the injury that the participant suffers from the deprivation of benefits owed under

the plan. See Springer, 900 F.3d at 288 (finding that a plan participant suffers a concrete injury sufficient for Article III standing when alleging a specific contractual right owed to him and his beneficiary); HCA, 240 F.3d at 991. The Fifth Circuit in North Cypress, for example, agreed with a district court decision, Biomed Pharm., Inc. v. Oxford Health Plans (N.Y.), Inc., No. 10-CIV. 7427, 2011 WL 803097 (S.D.N.Y. Feb. 18, 2011), which held that an agreement between a provider and a patient to waive payment for services does not extinguish a patient's standing to bring suit under plan terms. N. Cypress, 781 F.3d at 193. In Biomed, the service provider granted the participant a financial hardship waiver. 2011 WL 803097, at *2. The plan argued that because the patient had no obligation to pay the provider after the waiver, the provider could not show an injury in fact for its claim for benefits as the patient's assignee. Id. at *4. Rejecting this argument, the court ruled that, although the plan was "free to challenge" its contractual obligation to pay under the plan terms, the waiver had "nothing to do with standing." Id. As the court explained, this argument confused a "possible" defense to the contractual claim "under the [p]lan with the requirements of standing." Id. In short, the plan "failed to fulfill its contractual obligations to the [p]atient; this is all that is required to demonstrate Article III standing." Id. The reasoning from these cases apply directly to the afacts here; even if the Mitchells are not required to pay the remaining balance, they still have constitutional standing to ensure the Plan satisfies its contractual obligations.

B. The Four Circuits' Analysis Comports With *Spokeo*

Blue Cross argues that because the causes of action under section "constitute a comprehensive and exclusive enforcement scheme for ERISA," a claim under section 502(a)(1)(B) is an ERISA benefits claim and should not be construed as a breach of contract claim. See Appellant Br. 52-54. As previously discussed, however, the Supreme Court's rationale in Spokeo for finding that intangible injuries can be concrete for constitutional standing purposes examines long-standing common law principles and Congressional intent. Both are considered in determining a plaintiff has constitutional standing to redress a statutory violation. Consistent with this framework, the four circuits held that the constitutional "injury" is the participant's loss of a right to benefits under an ERISA plan, and that injury is analogous to the Article III injury caused by common law contractual breaches. Contrary to Blue Cross's arguments, the approach in Spokeo to characterize the relevant injury under Article III for statutory claims based on common law principles and Congressional intent fully supports the four circuits' characterization of the "injury" for section 502(a)(1)(B) as a contractual breach. See Spokeo, 136 S. Ct. at 1549, 1551.

First, this analogy to injury caused by contractual breaches also comports with the Congressional intent underlying ERISA's protections. See N. Cypress, 781 F.3d at 193-94; Springer, 900 F.3d at 292 (Thapar, J., concurring) (clarifying that where a plaintiff seeks to vindicate private rights that he held pursuant to the terms of his

ERISA plan, such claims are historically analyzed under a breach-of-contract analysis and are valid even when no real loss is proved). The Congressional intent underlying ERISA is to "'protect contractually defined benefits.'" U.S. Airways, Inc., 569 U.S. at 100 (quoting Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148 (1985)). ERISA section 502(a)(1)(B) specifically empowers a participant or beneficiary "to bring a civil action . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). "Congress's creation of this cause of action has given patients a right to enforce the insurance coverage they contracted for. They were given a right to recompense for an actual injury and have standing to pursue alleged breaches of this statutory duty." N. Cypress, 781 F.3d at 194. Similarly, in discussing equitable remedies under ERISA, the Supreme Court recognized in CIGNA v. Amara, 563 U.S. 421, 444 (2011), that "actual harm . . . might also come from the loss of a right protected by ERISA or its trust-law antecedents." The loss of the right here is the right enforceable pursuant to the terms of the plan, which is directly analogous to loss of contractual rights in a breach.

Second, settled common law precedent recognizes constitutional standing to sue in analogous circumstances when plaintiffs claim a breach of contract even if some or all of the benefits accrue to another party. United Steel, Paper & Forestry,

Rubber, Manufacturing, Energy, Allied Industrial & Service Workers International Union, AFL–CIO/CLC v. Cookson America, Inc., 710 F.3d 470 (2d Cir. 2013), stated that "'[i]t is axiomatic that a party to an agreement has standing to sue a counter-party who breaches that agreement, even where some or all of the benefits of that contract accrue to a third party.'" Id. at 475 (citation omitted). Similarly, in Kuhns v. Scottrade, Inc., 868 F.3d 711, 716 (8th Cir. 2017), the Eighth Circuit recognized that "'a party to a breached contract has a judicially cognizable interest for standing purposes, regardless of the merits of the breach alleged.'" (quoting Carlsen v. GameStop, Inc., 833 F.3d 903, 908 (8th Cir. 2016)). See also Katz v. Pershing, LLC, 672 F.3d 64, 72 (1st Cir. 2012); DiCarlo v. St. Mary Hosp., 530 F.3d 255, 263 (3d Cir. 2008).

Accordingly, the promises in ERISA plans, and the breach of those promises, are analogous to contractual breaches, cognizable injuries for Article III purposes. See, e.g., Johnson v. Allsteel, Inc., 259 F.3d 885, 888 (7th Cir. 2001) (applying the principle to an ERISA plan violation). Moreover, the Mitchells' loss of a contractual right to benefits is by no means abstract, but was a concrete failure to make the promised payment to a provider for services rendered, which constitutes an injury for purposes of Article III standing. See Springer, 900 F.3d at 288. As stated in the Fifth, Sixth, Ninth, and Eleventh Circuit decisions, the characterization of the relevant injury as the participant's loss of a contractual right to benefits is consistent

with long-standing common law principles and Congressional intent underlying ERISA's protections, the same two sources of authority recognized by Spokeo for determining "concrete" injuries.

C. The July 2015 Agreement Does Not Distinguish This Case From The Other Circuit Decisions

1. The Agreement Did Not Assign The Mitchells' Right to Sue

Blue Cross attempts to distinguish this case based on its factually incorrect assertion that the Mitchells' assignment of *proceeds* of the litigation to VMF was actually an assignment of their right to sue. See Appellee Br. 46. Throughout their brief, Blue Cross suggests the assignment of proceeds establishes that the Mitchells no longer have a claim for benefits due to them under the Plan or ERISA. See id. at 46-47. This assertion is wrong.

The July 2015 Agreement between the Mitchells and VMF did not assign their benefit claim to VMF. Rather, it assigned any proceeds of this litigation to VMF in exchange for a waiver of any claims that VMF has against the Mitchells. See Mitchell, 2018 WL 3463260, at *5-6. This case is distinguishable from Sprint Communications where payphone operators who were individually owed a small amount of money by long-distance carriers assigned their *claims* to aggregators "lock, stock, and barrel." 554 U.S. at 286. In Sprint Communications, the aggregators, in exchange for a fee, agreed to pursue the payphone operators' claims against the carriers and to remit the proceeds of the suits to the payphone operators.

See id. The July 2015 Agreement, on the other hand, did not give VMF the right to pursue the Mitchells' benefit claim; it only required the Mitchells to remit to VMF the amounts won by the Mitchells through a settlement or judgment of the benefit claim *they* pursued. See Mitchell, 2018 WL 3463260, at *2, *6. The benefits won by this suit are still due to the Mitchells, and it is irrelevant for this suit whether the Mitchells later transfer the benefits obtained to reimburse VMF *after* the suit. See supra Section IA.

Thus, this case is indistinguishable from other circuit decisions where courts allow providers to sue on behalf of participants as assignees, and the participants' benefits all rebound to the provider by contract, and not to the participants. The Mitchells asserted their own claim against Blue Cross and a denial of promised benefits is sufficient to establish a concrete injury for Article III standing. An Article III "case or controversy" over the benefits due to the Mitchells still exists. See Spokeo, 136 S. Ct. at 1540.

2. The Agreement Did Not Eliminate The Mitchells' Personal Stake In The Outcome Of This Case

Blue Cross also argues that the Mitchells do not assert a form of redressable injury under section 502(a)(1)(B) because the only form of relief available to the Mitchells in this action is reimbursement of payments they made to VMF. See Appellee Br. 49-50. Blue Cross argues that no monetary judgment would compensate the Mitchells for an expense they incurred, because they have paid

nothing and are not obligated to pay anything; therefore, they do not have a personal stake in the outcome of this case.

But the Mitchells do not seek reimbursement of their own out-of-pocket losses through this ERISA action. The Mitchells' ERISA claim and constitutional injury is that Blue Cross unreasonably denied coverage of payment of medical services rendered to them. Thus, through judicial review of Blue Cross's decision, the Mitchells seek to enforce their rights under the Plan terms to reimburse medical services provided to them, not just any out-of-pocket liability, which falls squarely within ERISA section 502(a)(1)(B). See 29 U.S.C. § 1132(a)(1)(B) ("a civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of the plan [or] to enforce his rights under the terms of the plan"). The July 2015 Agreement determines the allocation of the proceeds of this litigation; it do not alter the basis of the Mitchells' ERISA claim and the controversy in this case. Therefore, though Blue Cross argues that the lack of financial impact on the Mitchells removes any personal stake they have in this case, the Mitchells' financial situation after litigation is not determinative of whether they have a personal stake in the judicial review of Blue Cross's denial of their benefits. The Mitchells retain a financial stake in this litigation because they received coverage for medical services provided that is left unpaid. Their choice to direct any benefits from that coverage to their provider by contract does not obviate the indisputable fact that the Mitchells

have a colorable right to those benefits and a right to direct those benefits in any way they want.

By asserting that they were denied benefits promised under the Plan, the Mitchells suffered an injury in fact that satisfies the requirements for Article III standing. The district court's conclusion that the Mitchells established constitutional standing regardless of a provider's decision not to pursue payment comports with the Fifth, Sixth, Ninth, and Eleventh Circuit decisions and is well-grounded in long-standing precedent and Congressional intent. A contrary result in this case will create an unnecessary circuit split and deny a participant the only recourse for judicial review of a plan's denial of a benefit. Therefore, this Court should affirm the district court's conclusion that the Mitchells established constitutional standing.

II. The Mitchells Have "Statutory Standing" To Bring An Action Under ERISA Section 502(a)(1)(B)

Blue Cross mistakenly argues that the Mitchells lack statutory standing to bring an action under ERISA section 502(a)(1)(B) because Ivan Mitchell is no longer employed by the Plan's sponsor. See Appellee Br. 55-56. Blue Cross asserts that because Mr. Mitchell left his employment with Towner Medical Center, neither he nor his beneficiary, can be eligible for benefits under the Plan. See id.; Def. Opp'n. at 29. Additionally, Blue Cross argues that because the Mitchells do not assert any claim for benefits due to them under the Plan and because they will never make any more payments to VMF, the Mitchells no longer have a "colorable claim to a benefit

from the Plan at any time during the pendency of this action" to establish statutory standing under ERISA section 502(a)(1)(B). See Appellee Br. 32-33, 55-56. Blue Cross's arguments are meritless.

A. As a former employee, Mr. Mitchell meets the statutory definition of "participant" under ERISA to recover benefits under the Plan

ERISA is designed to promote the interests of plan participants and their beneficiaries, and to protect contractually-defined benefits. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113-14 (1989). To this end, ERISA section 502(a)(1)(B) empowers a plan participant or beneficiary to sue "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan or to clarify his rights to future benefits under the plan." 29 U.S.C. § 1132(a)(1)(B). ERISA defines the term "participant" as "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 which covers employees of such employer . . . or *whose beneficiaries may be eligible to receive any such benefit*." 29 U.S.C. § 1002(7) (emphasis added). The term "beneficiary" is defined as "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. at § 1002(7) (emphasis added).

The Supreme Court in Firestone construed the term "participant" to include "former employees who have a reasonable expectation of returning to covered employment or who have a colorable claim to vested benefits." 489 U.S. at 117. To

establish that a claimant "may become eligible" for benefits, he or she "must have a colorable claim that (1) he [or she] will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future." Id. at 117-18. Interpreting the requirement for "vested benefits," the Seventh Circuit in Harzewski noted that the Firestone Court "glossed 'benefit' in section 1002(7) as 'vested benefit,' which has caused the lower courts a good deal of angst." 489 F.3d at 806. "But in context," the Seventh Circuit continued, "it is apparent that all the [Supreme] Court meant was that the former employee . . . had to show that had it not been for the trustees' breach of their fiduciary duty he would have been entitled to greater benefits than he received." Id.

The Supreme Court clarified the requirements for "vested benefits" in LaRue, stating that a Plan "participant," as defined by 29 U.S.C. § 1002(7), "may include a former employee with a colorable claim for benefits." 552 U.S. at 256 n.6 (citing Harzewski, 489 F.3d at 799). The Ninth Circuit in Poore v. Simpson Paper Co., 566 F.3d 922 (9th Cir. 2009), relied on two Supreme Court case decided between Firestone and LaRue to support the understanding that "LaRue remedied the 'angst' noted by the Seventh Circuit by loosening the requirement that the claimed benefits be 'vested,' at least insofar as vested means permanently fixed and unalterable." 566 F.3d at 926. The first case, Curtis-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995), allowed former employees of a health plan to sue under ERISA section 502,

where the former employees claimed that their plan did not contain an amendment procedure as required by ERISA. The second case, Inter-Modal Rail Emps. Ass'n. v. Atchison, Topeka & Santa Fe Ry., 520 U.S. 510, 514-15 (1997), held that the protections of ERISA section 510, 29 U.S.C. § 1140, extend to those with non-vested rights. In both cases, the Supreme Court extended protections to participants without vested rights because Congress did not limit its protections to those with vested benefits. Thus, the Ninth Circuit explained that "[l]ikewise, as is the situation here, if Congress intended to limit the right to sue under § 1132 to vested right-holders, it would have said so instead of granting it to 'participant[s]' (a defined term which includes both vested and non-vested persons)." Poore, 566 F.3d at 926.

Four circuits have uniformly held that a former employee has statutory standing to sue as a "participant" under ERISA section 502(a). See Vaughn v. Bay Envtl. Mgmt., Inc., 567 F.3d 1021, 1030 (9th Cir. 2009); Evans v. Akers, 534 F.3d 65, 67 (1st Cir. 2008); In re Mut. Funds Inv. Litig. 529 F.3d 207, 216 (4th Cir. 2008); Graden v. Conexant Sys. Inc., 496 F.3d 291, 294 (3d Cir. 2007). No circuit has ruled otherwise. While many of these cases concern statutory standing for ERISA fiduciary breach claims under section 502(a)(2), they interpret the same defined term in ERISA, "participant," that is used in both section 502(a)(1)(B) and section 502(a)(2). Moreover, these cases rely on Firestone, which interpreted "participant" in parallel provisions, section 502(a)(1) and 502(c)(1)(B). Their reasoning, therefore,

applies equally to the Mitchells' section 502(a)(1)(B) claim.

B. The Mitchells have a colorable claim to benefits to establish statutory standing under ERISA section 502(a)(1)(B)

As a former employee or his beneficiary, the Mitchells only need to show that they have a "colorable claim to benefits which the employer promised to provide pursuant to the employer relationship" to sue under ERISA section 502(a)(1)(B). Panaras v. Liquid Carbonic Indus. Corp., 74 F.3d 786, 791 (7th Cir. 1996). The fact that Mr. Mitchell's employment ended does not deprive the Mitchells of their statutory right to recover promised benefits because "when determining participant standing under ERISA, the relevant inquiry is whether the plaintiff alleges that his benefit payment was deficient on the day it was paid under the terms of the plan and the statute. If so, he states a claim for benefits, which, if colorable, makes him a participant with standing to sue." Graden, 496 F.3d at 303 (emphasis added); accord Vaughn, 567 F.3d at 1030; Evans, 534 F.3d at 76; In re Mut. Funds Inv. Litig., 529 F.3d at 216. The right to sue turns on the date of payment and any purported underpayment, not on the participant's employment status.

Blue Cross also argues that the agreement to direct proceeds of this suit to VMF eliminates the Mitchells' statutory standing to sue because they no longer sue for benefits "due" to them under ERISA. See Appellee Br. 55-56. Nothing in ERISA suggests that the benefits for participants cannot be directed or assigned to third parties, such as medical providers. In fact, numerous cases, including from this

Court, all agree that ERISA claims and benefits can be assigned to medical providers for reimbursement of covered medical services without affecting the participants' statutory standing. See, e.g., Grasso Enters., LLC v. Express Scripts, Inc., 809 F.3d 1033, 1040 (8th Cir. 2016).

The right to sue also does not turn on how any benefits obtained by a suit should be directed. "The standard for a colorable claim is low. A colorable claim is one that [is] non-frivolous but 'need not have a likelihood of success on the merits.'" Mitchell, 2018 WL 3463260, at *8 (internal citations omitted). The Mitchells have consistently argued that Blue Cross denied healthcare benefits promised to them under the terms of the Plan. See id. The district court correctly concluded that the Mitchells made a non-frivolous and "colorable" claim that Blue Cross unreasonably interpreted Plan terms to deprive them of their rights. In fact, the district court agreed with the Mitchells on one of their claims for benefits. See id. at *13. Thus, this Court should affirm the district court's conclusion the Mitchells established statutory standing to bring an action under ERISA Section 502(a)(1)(B).

CONCLUSION

The Secretary respectfully requests that this Court affirm the District Court's ruling on constitutional standing and statutory standing.

DATED: January 17, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 32(a)

1. This brief complies with the type-volume limitations of Fed. R. App. P. 32(g)(1) because this brief contains 6469 words excluding the parts of the brief exempted by the Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in 14-point, Times New Roman font.

DATED: January 17, 2019

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CERTIFICATE OF SERVICE

I hereby certify that on January 17, 2019, I electronically filed the foregoing Brief of the Secretary, United States Department of Labor, as Amicus Curiae, in Support of Plaintiffs-Appellants / Cross-Appellees, with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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