

NO. 12-20695

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

NORTH CYPRESS MEDICAL CENTER OPERATING CO., LIMITED,
NORTH CYPRESS MEDICAL CENTER OPERATING CO., GP, L.L.C.,
Plaintiffs-Appellants Cross-Appellees

v.

CIGNA HEALTHCARE; CONNECTICUT GENERAL LIFE
INSURANCE COMPANY; CIGNA HEALTHCARE OF TEXAS,
INCORPORATED,
Defendants-Appellees Cross-Appellants

Appeal from the United States District Court
for the Southern District of Texas, Houston
Case No. 4:09-CV-2556

BRIEF OF THOMAS E. PEREZ, SECRETARY OF LABOR, AS AMICUS
CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANTS AND
REQUESTING REVERSAL

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STATEMENT OF THE ISSUE

Plaintiffs North Cypress Medical Center and its operating company (collectively "North Cypress") own a hospital in Houston, Texas, which provided out-of-network medical care to participants in numerous ERISA-covered healthcare plans that CIGNA Healthcare and its affiliates (collectively "CIGNA") administer. North Cypress alleges that CIGNA routinely reimbursed it for only \$100 per claim regardless of the value of the medical services or terms of the plan, which required larger payments. Plan participants assigned their claims to North Cypress and North Cypress sued CIGNA under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), seeking to compel CIGNA to provide the full amount of benefits to which it claims participants are entitled under the terms of their plans. The Secretary of Labor's brief addresses the following issue:

Whether the district court erred in ruling that North Cypress lacked Article III standing to pursue its claims for benefits under ERISA on the grounds that it had not billed its patient-participants for the amounts that CIGNA had refused to pay and that plan participants, therefore, had not suffered an "injury in fact" when CIGNA refused to fully reimburse North Cypress.¹

¹ The Secretary expresses no views on any of the other issues in the case.

STATEMENT OF IDENTITY, INTEREST AND AUTHORITY TO FILE

The Secretary of Labor ("Secretary") has primary regulatory and enforcement authority for Title I of ERISA. See 29 U.S.C. §§ 1134, 1135. Pursuant to that authority and to ERISA section 503, 29 U.S.C. § 1133, which expressly delegates to the Secretary rulemaking authority with respect to the "full and fair review" of benefit claims that the statute mandates, the Secretary issued a regulation that governs claims procedures applicable to such claims. See 29 C.F.R. § 2560.503-1(1).

After North Cypress, as assignee, sued CIGNA for medical benefits, the district court granted CIGNA summary judgment on Article III standing grounds because the hospital had not pursued its patient-assignors for the unpaid medical bills. The Secretary has a strong interest in ensuring that medical care providers are not barred from pursuing claims for health benefits under ERISA plans merely because they have not billed their patients directly, and has filed a similar brief to this effect in Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc., No. 12-17604, which is currently pending in the Ninth Circuit. See <http://www.dol.gov/sol/media/briefs/spindex%28A%29-06-05-2013.pdf>.

The Secretary files this brief as amicus curiae under Federal Rule of Appellate Procedure 29(a).

STATEMENT OF THE CASE

This case arose from a dispute between North Cypress and CIGNA concerning the hospital's status as an out-of-network provider for numerous ERISA-covered healthcare plans administered after its negotiations with CIGNA to become an in-network provider collapsed over a dispute about contractual reimbursement rates. Docket 318; 2012 WL 8019265, at *1.² Although North Cypress later joined CIGNA's network, during the relevant period, North Cypress was an out-of-network provider for thousands of participants and beneficiaries in ERISA-covered plans that CIGNA administered. Appellants' Br. at 6-7. North Cypress obtained assignments from its patients, which state, in relevant part:

I HEREBY IRREVOCABLY ASSIGN AND TRANSFER TO THE HOSPITAL AND/OR HOSPITAL-BASED PHYSICIANS ALL RIGHT, TITLE AND INTEREST IN ALL BENEFITS PAYABLE FOR THE HEALTHCARE RENDERED WHICH ARE PROVIDED IN ANY AND ALL INSURANCE POLICIES AND HEALTH BENEFIT PLANS FROM WHICH I AM ENTITLED TO RECOVER. I

² Much of the evidence relevant to this appeal is under seal in the district court and unavailable to the Secretary or the public. Where the pleadings and exhibits are unavailable, the Secretary cites to the parties' respective appellate briefs, the district court decisions, and Second Amended Complaint.

UNDERSTAND THAT ANY PAYMENT RECEIVED FROM THESE POLICIES AND/OR PLANS WILL BE APPLIED TO THE AMOUNT THAT I HAVE AGREED TO PAY FOR SERVICES RENDERED DURING THE ADMISSION

Id. at 7.

From the date it opened on January 4, 2007, North Cypress has had a "prompt pay" discount program for out-of network patients under which it agreed to accept a discounted fee calculated by using 125% of the Medicare rate if the patient agreed to and paid the discounted fee within 120 days (the amount of time it usually took a payor to adjudicate a claim). Docket 110; Second Amended Complaint ("SAC") ¶ 23. On January 3, 2007, the day before it opened, North Cypress notified CIGNA in writing of its "prompt pay" discount program for its patients. Id. In addition, agents for CIGNA allegedly negotiated and signed similar agreements, referred to as "discount agreements" with North Cypress, which give CIGNA a discounted price in exchange for an agreement to promptly pay submitted invoices. Appellants' Br. at 21.

Although for nearly two years CIGNA paid benefits directly to North Cypress based on its billed charges or at the reduced rates set forth in its "discount agreements," in November 2008, after negotiations for North Cypress to become an in-network provider broke down, CIGNA allegedly

began to pay North Cypress approximately \$100 per claim regardless of the actual value of the medical services the hospital provided. Appellants' Br. at 5, 9, 13-15, 27. Thus, North Cypress claims that CIGNA paid only approximately \$7 million for over \$80 million of billed charges for medically necessary care it involving over 10,000 claims between November 18, 2008 and August 1, 2012, it. Appellants' Br. at 6.

CIGNA also adopted a policy of directing all claims submitted by North Cypress to CIGNA's Special Investigation Unit ("SIU") as potential fraud claims. Appellants' Br. at 9. Consequently, CIGNA manually processed each North Cypress claim, a practice which caused substantial delays for even small payments CIGNA made to North Cypress. Id. at 14. Further, according to North Cypress, CIGNA referred emergency care claims for fraud review and paid only \$100 on each of these claims even though North Cypress did not apply its "prompt pay" discount program to these claims. Id. at 4. The hospital also alleged that its patients paid additional premiums for out-of-network coverage. Id. at 4-6, 10, 29-30.

On the basis of this conduct, North Cypress sued CIGNA for additional benefits under ERISA, as well as for fiduciary breach, failure to provide a full and fair review of the benefit claims at issue and to abide by the claims procedure regulation, and for penalties for failure to provide

requested documents. SAC ¶¶ 57-84. North Cypress also sued for violations of the Texas Insurance Code, for breach of contract, based on the "discount agreements" with CIGNA agents, and for violations of the Racketeer Influenced and Corrupt Organizations Act ("RICO"), based on an alleged conspiracy to extort North Cypress into accepting unfavorable in-network agreements. SAC ¶¶ 79, 85-90.

As relevant here, although CIGNA agrees that the plans allow participants and beneficiaries to receive medical services from out-of-network providers like North Cypress, it notes that, in order to discourage the use of out-of-network services, and thereby control costs for the plan sponsors, the plans impose a much higher percentage of the costs for these services on the participants. Docket 318; 2012 WL 8019265, at *3-4. Without such financial disincentives, CIGNA argues, more participants and beneficiaries would go out-of-network and drive up the costs of providing benefits. Id. Thus, by charging most patients the same rate they would pay for in-network services under its "prompt pay" program (125% of Medicare rates, rather than between 400% and 600% of Medicare rates, as North Cypress typically seeks to charge CIGNA), CIGNA claims that North Cypress was trying to undermine this disincentive and "entice" participants out-of-network. Id., at *4. Moreover, according to CIGNA, North Cypress's

requests for reimbursement of more than what it charges the patients were fraudulent because the plans do not cover amounts that medical service providers decline to charge plan participants, and the plans generally require plan participants and beneficiaries to pay 40% of their out-of-network costs. CIGNA thus not only defended its payments to North Cypress, it also attempted to recoup, by counter-suit, millions of dollars in alleged overpayments to North Cypress that predated its new payment practices. Id. at *3.

The district court did not resolve the parties' competing theories concerning what benefits were owed under the plans. Instead, on June 25, 2012, it granted CIGNA summary judgment on the grounds that North Cypress lacked Article III standing to pursue its ERISA claims. Docket 318; 2012 WL 8019265, at *10-11. Without addressing the allegation that CIGNA improperly paid only \$100 per claim, it reasoned that the evidence showed that "when patients participated in the prompt payment discount program, they were in fact not required to pay anything more than the discounted amount" and therefore "suffered no out-of pocket loss, no injury, as a result of Defendants' alleged underpayments to Plaintiffs." Id., at *10 (citations omitted). The district court also rejected North Cypress' argument that plan participants suffered an injury in fact "because of a threat to the

efficacy of the plan or because Defendants failed to fulfill their contractual obligations," concluding that these allegations were not sufficiently "concrete and particular" to confer standing. Id.³

Shortly thereafter, on July 25, 2012, the court dismissed CIGNA's counterclaims as untimely. Docket 326. Then on August 10, 2012, the court granted summary judgment to CIGNA on North Cypress's state-law breach of contract claim based on the court's deference to CIGNA's interpretation of plan terms incorporated by reference into the "discount agreements." Docket No. 331 at 7. Finally, on September 27, 2012, the court issued an order denying North Cypress' motion to set aside the court's August 10, 2012 ruling, and granting CIGNA's motion to unseal the court's June 25, 2012 and August 10, 2012 Orders. Docket No. 347.

³ The court had earlier issued a decision concluding that North Cypress had standing to assert its ERISA claims, Docket No. 100, 782 F. Supp. 2d 294, 303 (2011). However, in its June 25, 2012 decision, the court stated that its earlier decision was appropriate on a motion to dismiss, but did not preclude it from concluding after development of the record that the participants did not, in fact, suffer any constitutional injury based on CIGNA's failure to pay additional amounts to North Cypress. Docket No. 318; 2012 WL 8019265, at *10. In this same 2011 decision, the court also dismissed North Cypress's claim under state insurance law, concluding that this claim was preempted by ERISA. Docket No. 100, 782 F. Supp. 2d at 315. The court also issued a decision on November 3, 2011, dismissing with prejudice North Cypress's RICO claims. Docket No. 214.

SUMMARY OF THE ARGUMENT

The district court erred in dismissing North Cypress's benefit claims for lack of Article III standing. As assignee of plan participants whose medical benefit claims allegedly were denied in part, North Cypress has constitutional standing to sue for denied benefits under ERISA. Regardless of whether North Cypress is likely to sue participants directly for their services, these participants are injured in the requisite sense not only because they retain an unextinguished debt, but more fundamentally because ERISA plan participants have the statutory right to have their promised benefits paid in accordance with their plans' terms and the Secretary's claim regulation. North Cypress, in turn, is also clearly injured because it has provided unreimbursed medical care. Moreover, North Cypress contends that CIGNA adopted a policy of routinely refusing to pay any amount over \$100 per claim, regardless of the actual cost of the services, thus violating ERISA's "full and fair" review provision and the Secretary's claims regulation. Given that this Court and others have long recognized the rights of medical provider assignees to sue for ERISA benefits, CIGNA's insistence that providers like North Cypress sue or threaten to sue plan participants before demanding that CIGNA pay the providers directly for

covered services, defies common sense and undermines ERISA's protective purposes.

The district court's narrow focus on North Cypress' failure to sue its patients and whether they suffered out-of-pocket losses ignores their status as ERISA plan participants who are statutorily entitled to have their health care benefits provided in accordance with their plans' terms and the Secretary's claim regulation and discourages providers from providing care to participants and their beneficiaries without first demanding payment. While the Secretary does not express a view on the merits of the parties' dispute regarding the reimbursement rates appropriate under the plans, North Cypress has standing to assert and is entitled to judicial resolution of these claims for benefits.

ARGUMENT

NORTH CYPRESS HAS STANDING AS AN ASSIGNEE OF PLAN PARTICIPANTS TO SUE FOR ADDITIONAL PLAN BENEFITS REGARDLESS OF WHETHER IT INTENDS TO BILL PARTICIPANTS FOR THE REMAINING COST OF THE MEDICAL SERVICES PROVIDED

ERISA is designed to promote the interests of plan participants and their beneficiaries, and to protect contractually-defined benefits. 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 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). Moreover, to provide "adequate notice" of any claims denial, as well as "full and fair review" of such denials, ERISA section 503 requires that plan fiduciaries comply with the Secretary's claims regulation, 29 C.F.R. §2560.503-1, which imposes specific requirements governing such matters as the timing and content of benefit denials. Plan fiduciaries also are prohibited from imposing procedures that unduly inhibit claims processing. Id. § 2560.503-1(b)(3).

Article III of the United States Constitution requires a party invoking federal court jurisdiction to show an "injury in fact," a causal relationship between the injury and the challenged conduct, and likelihood of redressibility. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992). "Injury in fact" exists when there is "an invasion of a legally protected interest," that is "concrete and particularized," as well as "actual or imminent, not conjectural or hypothetical." Lujan, 504 U.S. at 560; see Glanton v. AdvancePCS, Inc., 465 F.3d 1123, 1125 (9th Cir. 2006).

Injury in fact is not limited to monetary loss. See Sierra Club v. Morton, 405 U.S. 727, 738 (1972) (stating that Article III standing may be based on monetary, psychological, and even aesthetic injury); Sabine River

Auth. v. U.S. Dep't of Interior, 951 F.2d 669, 674 (5th Cir. 1992) (same);
Save Our Wetlands, Inc. v. Sands, 711 F.2d 634, 640 (5th Cir. 1983) (same).

There is an injury in fact when a plaintiff personally and individually suffers an invasion of a legally protected interest. Lujan, 504 U.S. at 560.

The district court erred in ruling that the individual participants suffered no cognizable injuries, and therefore lacked Article III standing to assert their benefit claims merely because their provider, North Cypress, failed to prove that it had or was likely to sue them for the remaining balance on the medical bills their plans' insurer, CIGNA, refused to pay. When Congress gave statutory standing to participants to sue for benefits due to them "under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B), and the right to a "full and fair" review of their benefit claims, 29 U.S.C. § 1133, it gave the plan participants and their assignees all the personal stake in this dispute necessary to render a judicial resolution. Thus, in alleging that the plan participants and beneficiaries whose claims have been assigned to North Cypress have been denied contractually promised benefits, and their claims have not received the kind of "full and fair" review required under the claims regulation, North Cypress has met all justiciability requirements for a "case or controversy" and presents the court with a factual context that is "concrete

and particularized," not "conjectural or hypothetical." Lujan, 504 U.S. at 560.

As an initial matter, under ERISA section 503 and the Secretary's claims regulation, 29 C.F.R. § 2560.503-1, the claims of individual participants must be given "full and fair" review in accordance with the terms of their plans, not simply denied or paid at a set rate of \$100 per claim regardless of the applicable plan terms or individual circumstances of the claims. Moreover, while it seems clear that North Cypress' practice was not to seek additional payments from patients who met its prompt pay requirements, the evidence also shows that North Cypress explicitly informed its patients in the written assignments that they retained ultimate responsibility for paying their medical bills. Appellants' Br. at 7, 20. North Cypress also charged some patients additional amounts because they failed to pay within the time frames of the "prompt pay" program, and it is undisputed that the hospital did not offer this program to its emergency room patients, among others. Id. at 4; SAC ¶ 23. Accordingly, the evidence shows that participants were left with an unextinguished debt to North Cypress; that debt is a direct injury in fact sufficient to preclude summary judgment based on a lack of Article III standing. See James v. City of Dallas, Tex., 254 F.3d 551, 564 (5th Cir. 2001) (the "continued threat of

collection actions . . . based on the unpaid debt also suffices to demonstrate the likelihood of real and immediate future injury" for Article III purposes).

Furthermore, although ERISA expressly authorizes only participants or beneficiaries to sue for such payments, the Fifth Circuit has long recognized that medical provider assignees have derivative standing to sue for these benefits. See, e.g., Tango Transp. v. Healthcare Fin. Servs. LLC, 322 F.3d 888, 891-92 (5th Cir. 2003) (collecting cases).⁴ "[G]ranting derivative standing to the assignees . . . helps plan participants and beneficiaries by encouraging providers to accept participants who are unable to pay up front" (id. at 894) and furthers Congress' goal of enhancing employees' medical benefit coverage because "providers are better situated and financed to pursue an action for benefits owed for their services."

⁴ Accord Mistic v. Bldg Serv. Emps Health & Welfare Trust, 789 F.2d 1374, 1377 (9th Cir. 1986) (noting that assignment would facilitate receipt of health care benefits by making "it unnecessary for [] providers to evaluate the solvency of patients before commencing medical treatment" and sparing participants the burden of paying potentially large medical bills while waiting for reimbursement from their plans); Davidowitz v. Delta Dental Plan, Inc., 946 F.2d 1476, 1477 (9th Cir. 1991); I.V. Servs. of Am., Inc. v. Trs. of the Am. Consulting Eng'rs Council Ins. Tr. Fund, 136 F.3d 114, 117 n. 2 (2d Cir. 1998); Yarde v. Pan Am. Life Ins. Co., 67 F.3d 298, 1995 WL 539736 at *5 (4th Cir. 1995); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1277-78 (6th Cir. 1991); Lutheran Med. Ctr. of Omaha, NE v. Contractors, Laborers, Teamsters & Eng'rs Health & Welfare Plan, 25 F.3d 616, 619-20 (8th Cir. 1994); Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997).

Hermann Hosp. v. MEBA Medical & Benefits Plan, 845 F.2d 1286, 1289 n.13 (5th Cir.1988). The relevant injury is caused by the asserted failure to pay for covered benefits at the plan's rate. 29 U.S.C. § 1132(a)(1)(B) (authorizing a participant or beneficiary to sue to "enforce his rights under the terms of the plans").

Consistent with these well settled principles, the only circuit to have addressed the issue of constitutional standing in a factually analogous case, the Eleventh Circuit, correctly concluded that medical provider assignees have ERISA standing to sue for unpaid benefits under an ERISA plan without first pursuing or "balance billing" their patients for the unpaid benefits. HCA Health Servs. of Ga., Inc. v. Emps Health Ins. Co., 240 F.3d 982, 991 (11th Cir. 2001). In reaching this conclusion, the court first explained that the Eleventh Circuit (like the Fifth) has long recognized the rights of provider assignees to assert derivative standing and sue for benefits under an ERISA plan, id. (citing Cagle v. Bruner, 112 F.3d 1510, 1515 (11th Cir. 1997)); cf. Sprint Comm'ns, Co. L.P., v. APCC Servs., 554 U.S. 269, 287-88 (2008) (holding that "an assignee can sue based on his assignor's injuries," and standing for assignees for collection exists even though the relief will not run to the party bringing suits as when "[t]rustees bring suit to benefit their trusts").

Moreover, the Eleventh Circuit reasoned that because the "provider-assignees can sue ... an assignment will transfer the burden of bringing suit from plan participants... to providers, [who] are better situated and financed to pursue an action for benefits owed for their services." HCA, 240 F.3d at 991 (quoting Cagle, 112 F.3d at 1515). This, the court reasoned, furthers the remedial purposes of ERISA by allowing medical providers to obtain reimbursement for their services without having to "balance bill" plan participants whose claims should be covered under their employer provided medical plans, see HCA, 240 F.3d at 991 n.19, precisely what CIGNA claims is necessary here.

The Eleventh Circuit's ruling is consistent with Supreme Court precedent holding that the "injury required by Article III may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing.'" Lujan, 504 U.S. at 578 (quoting Warth v. Seldin, 422 U.S. 490, 500 (1975)); see also Cole v. Gen. Motors Corp., 484 F.3d 717, 723 (5th Cir. 2007) (loss of the benefit of the bargain may constitute an injury in fact). Under these decisions and others like them, the invasion of plaintiffs' statutory right to have their benefit claims determined in accordance with their plan terms and the minimum procedures mandated by section 503 and § 2560.503-1, and to have their covered benefits paid, gave them a concrete,

personal stake this case and, therefore the "injury in fact" required for Article III standing. See, e.g., Int'l Union of Operating Eng'rs v. Ward, 563 F.3d 276, 286 (7th Cir. 2009) (plaintiffs can assert a violation of their "right to faithful performance by [fiduciaries] of the general and specific fiduciary obligations enumerated in" the statute); Branson School Dist. RE-82 v. Romer, 161 F.3d 619, 631 (10th Cir. 1998) (alleged violation of a right to fiduciary performance is sufficient for constitutional standing purposes). This is particularly the case where, as here, the participants have allegedly paid additional premiums for out-of-network coverage. Appellants' Br. at 4-6, 10, 29-30.

The Supreme Court's decision in Havens Realty Corp. v. Coleman, 455 U.S. 363 (1982), best illustrates this principle that plaintiffs can base Article III standing on the invasion of statutorily protected rights. There, the Court considered whether "testers" who pose as renters or real estate buyers for the purpose of collecting evidence of "unlawful steering practices" had Article III standing when they were falsely told that particular housing was unavailable. Id. at 373. The Court explained that section 804(d) of the Fair Housing Act (FHA) "conferred on all 'persons' a legal right to truthful information about available housing." Id. Because an Article III injury can exist "solely" by virtue of "'statutes creating legal

rights," and the "tester" has "suffered an injury in precisely the form the statute was intended to guard against," id., the Court held that a tester who "alleged injury to her statutorily created right to truthful housing information" had Article III standing, even if the tester never intended to rent or purchase the real estate. Id. at 374.

Like the text of the FHA, the text of sections 502(a)(1)(B) and 503 is clear; those provisions give plan participants an interest in the benefits promised under their employee benefits plans along with the right to have their benefit claims determined under plan procedures that comply with the minimum procedures mandated by section 503 and its accompanying claims regulation, 29 C.F.R. § 2560.503-1. Congress has identified the injury it seeks to vindicate, i.e., improper denial of benefits, 29 U.S.C. § 1132, and related the injury to the class of persons entitled to bring suit, i.e., participants and beneficiaries, id. § 1132(a)(1)(B). The statutory text is "unambiguous" that a plan participant or beneficiary may sue to obtain benefits due under the plan (or indeed to obtain clarification that benefits are or will be due) and that should be the beginning and end of the inquiry. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 53 (1987) (under section 502(a)(1)(B), "[r]elief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a

plan administrator's improper refusal to pay benefits"). And, as we have discussed, the Fifth Circuit and others have correctly recognized that assignee medical providers may likewise bring suit under ERISA, see La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys., 461 F.3d 529, 535 (5th Cir. 2006), a result supported, if not mandated, by the Supreme Court's decision in Sprint, 554 U.S. at 287-88 (recognizing that assignees for collection had standing to sue even though no relief would flow to them).

Indeed, in this case, unlike Sprint, the health providers decidedly have been economically harmed by the decisions they are challenging. Contrary to the district court's conclusion, the injury to the providers and the participants was neither "conjectural" nor "hypothetical." Docket 318; 2012 WL 8019265, at * 11 (citation omitted). The participant whose assignee received a smaller payment for covered medical services than the plan promised was injured because he received less than the full "benefits due under the plan." And the assignee stepping into the participant's shoes was even more obviously injured because the plan denied full payment for services provided. Moreover, by its conduct, CIGNA may have increased the risk for the participants and beneficiaries that North Cypress would deny them care in the future.

In finding North Cypress's injury speculative, the district court cited Friends of the Earth, Inc. v. Laidlaw Env'tl. Servs. (TOC), Inc., 528 U.S. 167, 183-84 (2000). There, the Supreme Court found that the plaintiff had Article III standing to sue to prevent the defendant from repeatedly discharging toxic mercury into a river after concluding that "affiants' conditional statements – that they would use the nearby [river] for recreation if defendant were not discharging pollutants into the river "were not speculative because it was undisputed that the "unlawful conduct ... was occurring" when plaintiff sued. Id. at 183-84. This finding turned on the reasonableness of plaintiffs' fear that defendant's conduct would interfere with their recreational activities. Id. at 184. Here, CIGNA's targeting of all North Cypress claims for fraud investigations, even emergency care that was not covered by the "prompt pay" discount, and its reimbursement of claims at a seemingly arbitrary rate of \$100 was still ongoing when North Cypress sued, North Cypress reasonably believed that CIGNA's conduct violated ERISA, and it has been injured as a result of CIGNA's failure to comply with the plans' terms and the claims regulation. Thus, North Cypress's injuries were not at all speculative and for this reason Friends of the Earth and the other cases cited by the district court are distinguishable. See Owen v. Regence Bluecross Blueshield of Utah, 388 F. Supp. 2d 1318, 1328-29

(D. Utah 2005) (plaintiff lacked standing under ERISA where she was not covered by policy at issue, had no definite intention to buy it, and could identify no "legally-protected interest"); Harley v. Minn. Mining & Mfg. Co., 284 F.3d 901, 907-08 (8th Cir. 2002) (participants in a defined benefit plan lacked standing to recover \$20 million in plan investment losses where the defined benefit plan's actuarial value exceeded its accrued liabilities, the plan sponsor had contributed over \$683 million more than plan's minimum funding requirements after the losses were incurred, and the court believed no participant had or would receive anything less than their full benefits).⁵

Moreover, there appears to be at least a dispute about whether CIGNA unduly inhibited the processing of North Cypress's claims in order to gain leverage in its "in-network" dispute by unjustifiably delaying payment by referring all claims by North Cypress to be reviewed for fraud and paying all claims at the seemingly arbitrary rate of \$100, contrary to § 2560.503-1(b)(3) (barring plan fiduciaries from imposing procedures that unduly inhibit claims processing). On this basis alone, this Court should recognize North Cypress's standing to sue to deter CIGNA from committing

⁵ The Secretary also believes that Harley was wrongly decided because the plan participants in that case clearly suffered an injury in the precise "form the statute was intended to guard against," Havens Realty, 455 U.S. at 373, when the fiduciaries of the plan squandered \$20 million in plan assets and put their retirement at greater risk.

future violations of section 503 and the Secretary's implementing regulation. Friends of Earth, 528 U.S. at 184 (recognizing standing pursuant to a citizen suit provision of Clean Water Act, even though the penalties are paid to government, because penalties would both encourage defendant to discontinue current violations and deter it from committing future ones).

The district court's narrow focus on whether North Cypress sued its patients, causing them an out-of-pocket financial loss side-steps North Cypress's allegation that CIGNA violated its duties under section 503 and the Secretary's implementing claims regulation, and undermines ERISA's purpose to protect promised benefits by discouraging providers from caring for participants and beneficiaries in CIGNA administered plans without first demanding money.

CONCLUSION

For the foregoing reasons, the Secretary respectfully requests that the district court's decision be reversed.

Respectfully submitted,

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Pursuant to Rules 32(a)(7)(B) and (C), Fed. R. App. P., I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains 4,817 words.

I certify that the digital version and hard copies of the Secretary's Brief are identical. I further certify that a virus scan was performed on the Brief using McAfee, and that no viruses were detected.

Dated: October 30th, 2013

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ECF CERTIFICATION

I certify that (i) the required privacy redactions have been made pursuant to Fifth Circuit Rule 25.2.13; (ii) this electronic submission is an exact copy of the paper document pursuant to Rule 25.2.1; (iii) this document has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses; and (iv) the original paper document was signed by the attorney of record and will be maintained for a period of three years after mandate or order closing the case issues, in compliance with Fifth Circuit Rule 25.2.9.

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CERTIFICATE OF SERVICE

The undersigned certifies that on this 30th day of October, 2013, a copy of the attached Amicus Brief of Secretary of Labor was electronically transmitted to the United States Court of Appeals for the Fifth Circuit using the Court's ECF Filing System and was served on the following parties via (i) electronic notice pursuant to the Court's ECF Filing System, or (ii) United States First Class Mail, postage paid to the persons who did not receive electronic notice pursuant to the Court's ECF Filing System:

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