No. 19-15192

IN THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

CALIFORNIA SPINE AND NEUROSURGERY INSTITUTE,

Plaintiff-Appellant,

vs.

BLUE CROSS OF CALIFORNIA,

Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
CASE NO. 4:18-cv-04777-PJH
HONORABLE PHYLLIS J. HAMILTON

BRIEF OF UNITED POLICYHOLDERS AS AMICUS CURIAE SUPPORTING PLAINTIFF-APPELLANT

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CORPORATE DISCLOSURE STATEMENT

United Policyholders is a non-profit, tax-exempt organization incorporated in California. United Policyholders has no parent corporation and no publicly held company has greater than 10% ownership in it.

STATEMENT REGARDING PARTY SUPPORTED,CONSENT TO FILE, AND AUTHORSHIP AND FUNDING OF THIS BRIEF

This brief from amicus curiae United Policyholders is in support of Plaintiff-Appellant California Spine and Neurosurgery Institute and seeks reversal of the decision below. All parties have consented to the filing of this brief.

Pursuant to Circuit Rule 29(a), counsel for United Policyholders hereby certifies that no counsel for the parties to this case authored this brief in whole or in part, no party to this case or counsel to a party to this case contributed money that was intended to fund preparing or submitting this brief, no person other than United Policyholders contributed money that was intended to fund preparing or submitting the brief.

IDENTITY AND INTEREST OF AMICUS CURIAE

United Policyholders (UP) is a non-profit 501(c)(3) organization whose mission is to be a trustworthy and useful information source, as well as an effective voice for consumers of all types of insurance nationwide. UP speaks for a diverse range of policyholders and has filed more than 400 amicus briefs in state and federal courts, including in the United States Supreme Court. UP seeks to present

its "unique information or perspective," *Ryan v. Commodity Futures Trading Commission,* 125 F.3d 1062, 1063 (7th Cir.1997), with regard to the issues in this case, and thereby fulfill the "classic role of amicus curiae by assisting in a case of general public interest, supplementing efforts of counsel, and drawing the court's attention to law that escaped consideration." *Miller-Wohl Co. v. Comm'r of Labor & Indus.*, 694 F.2d 203, 204 (9th Cir. 1982).

UP's interest is to present the Court with the unique perspective of health insurance policyholders in a national context to assist in evaluating the interpretive and policy issues in this case. This case raises an issue of significant importance to healthcare consumers: whether an insurance company acting as an administrator and thus a fiduciary under a healthcare plan covered by the Employee Retirement Income and Security Act 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*., is permitted to wait until it is sued to inform a medical provider who has been assigned a claim for benefits by the plan participant that the plan prohibits assignments, and to defend its denial on that basis.

As discussed below, doctors and other medical providers must be able to rely on assignments without being surprised by an assertion, long after treatment is provided and the claims process has been exhausted, that they are not entitled to make a claim in court for repayment from the insurance company. UP views the district court's ruling allowing such gamesmanship as effectively insulating

insurance companies and plans from meeting their promises to pay for medically necessary treatment, to the detriment of both medical providers and, ultimately, to their patients, healthcare policyholders.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Plaintiff California Spine and Neurosurgery Institute dba San Jose Neurospine ("SJN") is a California corporation that specializes in sophisticated spinal surgery. Excerpts of Record ("ER") 124. On January 19, 2017, SJN provided surgery services to a patient, referred to in this litigation under the pseudonym "HR." ER 124-25. This patient was covered under an ERISA healthcare plan ("Plan") administered by Defendant Blue Cross of California dba Anthem Blue Cross ("Blue Cross"). *Id.* As is its custom, SJN obtained from HR a signed agreement assigning HR's rights and benefits under the Plan to SJN. ER 126, 136. According to the complaint, SJN asserts that it was also its practice before performing surgery to call the Blue Cross number listed on the patient's insurance card in order to verify the patient's coverage and the percentage of out-of-network charges that would be paid. *Id.* at 126-27.

Despite presumably following this practice in this case, Blue Cross never told SJN that HR's Plan precluded assignments. ER 128. Instead, it allowed SJN to submit a claim for benefits to reimburse it for the costs of the surgery, but it only paid only $2,095.34 of the $93,000.00 in billed charges for HR's spinal surgery.

ER 125. In so doing, Blue Cross sent SJN an explanation of benefits that stated, without further explanation, that $88,906.62 was "non-covered" because it exceeded the maximum allowable amount. *Id.* SJN submitted its claim on a Claim Form 1500, a standard form used by medical providers to submit benefit claims to insurers, which clearly informed Blue Cross that SJN was acting pursuant to an assignment. ER 138, 30, 103.

SJN appealed this underpayment of benefits and, after receiving no response from Blue Cross, filed suit. ER 129. Only then, after the administrative record had closed and the time limits for HR to assert a claim had likely run, did Blue Cross assert that the Plan contained an "anti-assignment" provision that it claimed rendered the assignment void and precluded SJN from bringing a claim for benefits. *Id.* at 114-22. The district court granted Blue Cross's motion to dismiss the case on the basis of the newly asserted anti-assignment provision, concluding that Blue Cross did not waive reliance on the provision and could not be equitably estopped from enforcing it. ER 10.

This tactic is not allowed under ERISA, as the Ninth Circuit has recognized in two published decisions: *Harlick v. Blue Shield of California*, 686 F.3d 699, 719 (9th Cir. 2012), and *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014). The unpublished decisions on which Blue Cross relies cannot and do not overrule this clear and controlling precedent.

Whether denominated a basis for denial or a defense to suit, allowing an insurer to reserve the assertion of an anti-assignment provision until a suit for benefits has been filed would undermine the core protective purposes of ERISA. As *Harlick* and *Spinedex* recognize, ERISA requires that plan fiduciaries decide benefit claims under a full and fair process that informs plan participants and beneficiaries of the basis for any denial and that does not impede participants and beneficiaries from asserting and perfecting their claims for plan benefits. Because Blue Cross never informed either the plan participant or SJN, as the assignee, that it was denying or declining to decide the appeal of the benefit claim because of an anti-assignment clause, and through this failure impeded HR from pursuing the claim for benefits, the district court should have precluded Blue Cross from relying on the anti-assignment provision in this litigation.

Ultimately, if the district court's decision were to be affirmed, it is likely that many medical providers would be forced to demand prepayment from their patients who are covered under ERISA plans. Because many patients would be unable to come up with the required cash to pay for surgery or other expensive medical procedures, they would have to forego such procedures despite being participants in insured medical plans that promise to cover medically necessary treatment. This, in turn, could cause at least some medical providers to go out of business. In other words, such a ruling is likely to harm both medical providers

and their patients who have health insurance through ERISA-covered plans. These adverse consequences are not consistent with the protective purposes of ERISA and are wholly avoided if existing precedent is applied as it ought to be to prevent insurance companies from lying in wait before asserting plan anti-assignment provisions.

ARGUMENT

I. UNDER ERISA, AN INSURANCE COMPANY MAY NOT WAIT UNTIL A MEDICAL PROVIDER THAT IT KNOWS OR SHOULD KNOW HAS BEEN ASSIGNED A CLAIM FOR BENEFITS HAS FILED SUIT TO RAISE AN ANTI-ASSIGMENT PROVISION

ERISA is a remedial statute designed to "protect . . . the interests of participants in employee benefit plans and their beneficiaries" by setting forth "standards of conduct, responsibility, and obligation for fiduciaries of plans." 29 U.S.C. § 1001(b). *See also Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140 n.8 (1985) (ERISA was enacted to "establish judicially enforceable standards to ensure honest, faithful, and competent management of pension and welfare funds"). It aims to ensure that plan participants and beneficiaries are paid the benefits they are promised, *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996), and to this end, ERISA makes those who decide benefit claims plan fiduciaries subject to strict standards of care and loyalty. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 111 (2008).

ERISA provides that a plan participant or beneficiary may bring a civil action to recover plan benefits. 29 U.S.C. § 1132(a)(1)(B). Consistent with the statute's protective purposes, ERISA expressly forbids assignment or alienation of pension benefits so that retirees and their spouses are ensured retirement income, 29 U.S.C. § 1056(d), but does not prohibit assignments of other kinds of employee benefits, such as healthcare benefits. Given this silence on the assignability of healthcare benefits and claims for those benefits, the Ninth Circuit has long recognized that healthcare providers, such as SJN, may sue to recover plan benefits if they have a valid and enforceable assignment from a plan participant or beneficiary for whom they provided services. *Misic v. Bldg. Serv. Emps. Health & Welfare Tr.*, 789 F.2d 1374, 1377 (9th Cir. 1986) (per curiam). Indeed, *Misic* correctly recognized that ERISA's purposes are undermined by prohibiting such assignments to medical providers. *Id.* at 1377. Conversely, such an assignment "to health care providers results in precisely the benefit the trust is designed to provide and the statute is designed to protect" and "also protects beneficiaries by making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment, and by eliminating the necessity for beneficiaries to pay potentially large medical bills and await compensation from the plan." *Id.*

Moreover, ERISA and its Claims Regulation require that benefit claims be decided under a fair claims procedure that fully alerts claimants to the information necessary to perfect their claims, including any Plan provision relevant to the claim. *See* 29 U.S.C. § 1133; 29 C.F.R. § 2560.503–1(g).

A. This Court's decisions in Harlick and Spinedex establish that an administrator may not wait until a suit is filed to assert an anti-assignment clause

For precisely these reasons, this Court has recognized that a claims administrator that knows that a benefit claim has been assigned cannot wait until a suit is filed to raise an anti-assignment provision. In *Harlick*, this Court expressly held that "a plan administrator may not fail to give a reason for a benefits denial during the administrative process and then raise that reason for the first time when the denial is challenged in federal court, unless the plan beneficiary has waived any objection to the reason being advanced for the first time during the judicial proceeding." 686 F.3d at 719. *Harlick* pointed out that the statute itself requires that an administrator who denies a claim must explain the "specific reasons for such denial" and provide a "full and fair review" of the denial, *id.* (quoting 29 U.S.C. § 1133), requirements underscored by the Claims Regulation, which further specifies that the claimant be given "information about the denial, including the 'specific plan provisions' on which it is based and 'any additional material or information necessary for the claimant to perfect the claim.'" *Harlick*, 686 F.3d at

719 (quoting 29 C.F.R. § 2560.503–1(g)). Given this, *Harlick* concluded that "ERISA and its implementing regulations are undermined where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary." 686 F.3d at 719 (internal quotation marks and citations omitted).

If there were any doubt whether this Court meant for the ruling in *Harlick* to apply where a plan administrator fails to assert an anti-assignment clause during the claims process, the Court eliminated it just two years later in *Spinedex*. There, the Court addressed whether an anti-assignment provision in one of the healthcare plans at issue in that case prevented a healthcare provider from derivatively asserting claims on behalf of the patients.

The Court in *Spinedex* recognized that it had previously held that "anti-assignment clauses in ERISA plans are valid and enforceable." 770 F.3d at 1296 (citing *Davidowitz v. Delta Dental Plan of Cal., Inc.,* 946 F.2d 1476, 1481 (9th Cir.1991)). Nevertheless, the Court also pointed out that, under *Harlick*, "an administrator may not hold in reserve a known or reasonably knowable reason for denying a claim, and give that reason for the first time when the claimant challenges a benefits denial in court." *Spinedex*, 770 F.3d at 1296. In this regard, *Spinedex* cited with approval the Fifth Circuit's decision in *Hermann Hospital v. MEBA Medical & Benefits Plan,* in which that court rejected a plan's argument that

"there was never a reason to assert the non-assignment clause until [the provider] formally claimed an assignment in its lawsuit," and held, to the contrary, that the plan was "estopped to assert the anti-assignment clause ... because of its protracted failure to assert the clause when [the provider] requested payment pursuant to a clear and unambiguous assignment." *Spinedex*, 770 F.3d at 1297 (citing *Hermann*, 959 F.2d 569, 574-75 (5th Cir.1992), *overruled on other grounds, Access Mediquip, LLC v. UnitedHealthcare Ins. Co.,* 698 F.3d 229 (5th Cir. 2012) (en banc)).

The Court in *Spinedex* ultimately distinguished *Hermann* because it found "no evidence that United was aware, or should have been aware, during the administrative process that Spinedex was acting as its patients' assignee." 770 F.3d at 1297. Nevertheless, in making this determination, the Court clearly held that, under *Harlick*, where an administrator is or should be aware that a provider is acting pursuant to an assignment, it would not be permitted to assert an anti-assignment clause for the first time in federal court if it did not do so during the claims process. *Id.* at 1296.

B. Brand Tarzana and Eden Surgical are not to the contrary

The Ninth Circuit's unpublished decisions in *Brand Tarzana v. International Longshore and Warehouse Union-Pacific Maritime Association Welfare Plan*, 706 Fed. Appx. 442 (9th Cir. 2017), and *Eden Surgical Center v. Cognizant*

Technology Solutions Corp., 720 Fed. Appx. 862 (9th Cir. 2018), do not undermine this conclusion. In *Brand Tarzana*, although the Court stated that the Plan did not need to raise the anti-assignment provision during the claim administration process in that case because the provision "was a litigation defense, not a substantive basis for claim denial," it also concluded that "the Plan did not waive the provision through its course of dealing" with the medical provider during the administrative process. 706 Fed. Appx. at 444. This was because, in that case, "[t]here was no evidence that the Plan or its vendors took action inconsistent with the anti-assignment provision, or that they were aware, or should have been aware that Brand was acting as an assignee." *Id.* at 444-45 (citing *Spinedex*, 770 F.3d at 1297).

Likewise, in *Eden Surgical*, the Court concluded that, unlike in *Harlick*, the administrator did not raise a reason for denial in federal court that it had failed to raise during the administrative process. 720 Fed. Appx. at 863. Instead, benefits were not payable in that case "because the beneficiary's deductible had not been met," a fact that "the district court properly noted." *Id.*

In other words, in both *Brand Tarzana* and *Eden Surgical*, the Ninth Circuit affirmed grants of summary judgment based on the particular facts of those cases, and not because the Court concluded that anti-assignment clauses provide a basis

to dismiss on the pleadings without regard to the conduct of an insurer during the administrative process.

C. A rule allowing a plan administrator to delay asserting an anti-assignment clause until a suit has been filed cannot be squared with ERISA, the Claims Regulation or with the protective policies the statue is designed to serve

ERISA Section 503 specifically governs the claims process. 29 U.S.C. § 1133. It requires plans to follow the Claims Regulation and to provide written notice of any benefits denial, "setting forth the specific reason for the denial," and to provide "a reasonable opportunity to any participant whose claim has been denied for a full and fair review by an appropriate named fiduciary of the decision denying the claim." *Id.* The Claims Regulation puts meat on the bones of this statutory provision by requiring, among other things, that benefit claims be decided under procedures that, among other things, "do not contain any provision, and are not administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits." 29 C.F.R. § 2560.503-1(b)(3). Any adverse benefit determination must provide the claimant with a written notification that informs the claimant of the "specific reason or reasons for the adverse determination," "the specific plan provisions on which the determination is based," and include a "description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." *Id.* § 2560.503-1(g)(i),(ii), (iii). Moreover, it requires

"a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there shall be a full and fair review of the claim and the adverse benefit determination." *Id.* § 2560.503-1(h)(1).

These statutory and regulatory provisions, and the goals they serve, would be directly undermined by allowing a plan administrator to lie in wait during the administrative process, knowing full well that the participant has assigned his or her claim to a medical provider, and then first assert an anti-assignment provision in court after the administrative process has been exhausted. Here, HR certainly was not informed of the "specific reason for the denial," based on the explanation of benefits sent to the provider, and had no "reasonable opportunity . . . for a full and fair review by an appropriate named fiduciary of the decision denying the claim," as the statute requires. 29 U.S.C. § 1133. To the contrary, HR had no reason to believe that he or she needed to do anything to perfect the claim for benefits under the Plan that he or she had assigned the claim to SJN because HR was never told that Blue Cross was not going to honor this assignment. In failing to inform HR of its intent to rely on the Plan's anti-assignment provision as a basis for disallowing SJN from asserting the claim for benefits, Blue Cross "unduly inhibit[ed] or hamper[ed]" the "processing of [HR's] claims for benefits," 29 C.F.R. § 2560.503-1(b)(3), failed to inform HR of "the specific plan provisions on

which the determination is based," *id*. at § 2560.503-1(g)(i), or what HR needed to do "to perfect the claim," *id*. at § 2560.503-1(g)(ii), and failed to give HR a "reasonable opportunity to appeal [the] adverse benefit determination." *Id*. at § 2560.503-1(h)(1).

In *Abram v. Cargill, Inc.*, the Eighth Circuit concluded that failing to provide a claimant with the doctor's report that was the basis for a denial of benefits "was not consistent with a full and fair review." 395 F.3d 882, 886 (8th Cir. 2005). The same is true here. As in *Abram*, where the doctor's report "was solicited after the deadline for an appeals decision had passed, and was sent to [the claimant] only after the Plan issued its final denial decision," *id.*, the anti-assignment clause at issue here was raised by Blue Cross only after the assignee, standing in the shoes of HR, had exhausted the administrative process and filed suit. "This type of 'gamesmanship' is inconsistent with full and fair review." *Id.* (citing, *Wilczynski v. Lumbermens Mut. Cas. Co.,* 93 F.3d 397, 403 (7th Cir. 1996); *Richardson v. Central States, Southeast & Southwest Areas Pension Fun*d, 645 F.2d 660, 665 (8th Cir. 1981) ("ERISA and its regulations were not intended to be used 'as a smoke screen to shield' the plan from legitimate claims")).

This failure to provide the full and fair review required by the statute and Claims Regulation has real world consequences, not only for medical providers such as SJN, but also inevitably for plan participants and beneficiaries such as HR,

whose interests are at the heart of ERISA. When the district court dismissed SJN's suit for benefits based on Blue Cross's newly asserted refusal to honor HR's assignment, SJN was left with two choices. One choice is to attempt to recover the cost of the surgery from HR, who likely is now precluded by time limits and the exhaustion of the administrative process by SJN from asserting a claim for benefits against Blue Cross. In other words, even though HR was covered under a health insurance plan, he or she may now have to pay out-of-pocket for medical care that should have been covered under his or her Plan.

SJN's second choice is simply to absorb the loss. In 2017, the American Hospital Association estimated that the cost of uncompensated medical care absorbed by community hospitals in the previous year was in excess of $38.3 billion. *See* American Hosp. Ass'n, Uncompensated Hospital Care Cost Fact Sheet (Dec. 2017), *available at*, https://www.aha.org/system/files/2018-01/2017-uncompensated-care-factsheet.pdf. Obviously, there is a limit to the losses that any one medical provider can absorb. Too many unreimbursed procedures will either lead medical providers to go out of business or will lead them to demand prepayment from their patients who are covered under ERISA plans. *See, e.g.*, Barbara Martinez, *Cash Before Chemo*, Wall St. J., April 28, 2018 (noting growing trend among healthcare providers of demanding prepayment from patients). Because at least some, and likely many patients would be unable to come up with

the required cash to pay for needed surgery or other expensive medical procedures, they would have to forego such procedures, to the detriment of their health and well-being, despite being participants in medical plans that promise to cover medically necessary treatment.

There can be little serious doubt here that Blue Cross was well aware that HR had assigned the claim for benefits under the Plan to SJN. As then Circuit Judge Alito stated in a concurrence in *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393 (3d Cir. 2004):

> What happened here is very common. Participants of a health care plan received treatment from a provider; the participants did not pay for those services but instead gave the provider the information needed to bill their plan; the provider then billed the plan pursuant to a contract obligating the plan to pay the provider on the assigned claims of participants; and the plan paid, albeit at a discounted rate. These facts are more than sufficient to prove that the claims were implicitly assigned to the provider. In holding that the summary judgment record is insufficient to prove assignments, the Court ignores the obvious reality of the situation.

Id. at 405. In this case, of course, there is even more because the assignment was attached to the complaint, ER 135-36, and the claims form that SJN submitted informed Blue Cross of the assignment. ER 137-38. These factual allegations distinguish this case from *Spinedex* because they more than suffice to establish that Blue Cross waived its right to rely on the Plan's anti-assignment provision and to allow SJN to state a derivative claim for benefits under ERISA.

CONCLUSION

For the reasons set forth above, United Policyholders requests that the Court reverse the decision of the district court dismissing the case on the basis of the Plan's anti-assignment provision.

Respectfully submitted,

DATED: August 16, 2019

KANTOR & KANTOR LLP

/s/ *Elizabeth Hopkins*
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United Policyholders

CERTIFICATE OF COMPLIANCE

I certify, pursuant to Fed. R. App. P. 32(a)(7)(C)(i), that this brief contains 3,927 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5)-(6) because this brief has been prepared in a proportionally spaced typeface using Word in 14-point Times New Roman typeface.

DATED: August 16, 2019

KANTOR & KANTOR LLP

/s/ Elizabeth Hopkins
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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing ***Brief of United Policyholders as Amicus Curiae*** with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on august 14, 2019.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

DATED: August 16, 2019

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