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What Is Adequate Assignment Language to Confer Derivative ERISA Standing?

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Due to the sweeping implications of rulings by the United States District Court for the District of New Jersey, the failure of health-care providers to strengthen the language in their assignment of benefit forms may result in the outright surrender of their legal rights to recover reimbursements under the Employee Retirement Income Security Act. ERISA, a potent legal tool, permits providers to bring actions to recover benefits from intransigent insurance companies on behalf of patients or customers enrolled in most employee benefit plans.

Recent New Jersey federal court decisions have infused the mundane task of securing an assignment of insurance benefits with vital significance. Typically, a single sheet of paper tucked among HIPAA releases and patient information questionnaires, the assignment of benefits form, easily overlooked by health-care service and equipment providers, constitutes the foundation of a provider's right to maintain derivative lawsuits for recovery of insurance benefits on behalf of their patients or customers.

New Jersey federal judges have ruled unequivocally that the assignment of benefits form functions as a key, empowering providers to institute derivative ERISA, breach of contract and tort actions. However, in the absence of sufficiently robust assignment language, these gateways to recovery may be inaccessible.

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Rulings Concerning the Scope of Effective Assignment Language

The United States District Court for the District of New Jersey over the last decade has issued numerous, often conflicting, decisions contouring the requisite content of an effective assignment of benefits. Although district judges remain split on what constitutes a valid assignment, a recent decision authored by Judge Esther Salas, recognized for her more lenient approach to assignment language, set a floor as to the minimum content permissible.

Ruling for Horizon, Judge Salas in *Atlantic Spinal Care v. Horizon*, No. 13–4800, 2014 U.S. Dist. LEXIS 89472 (D.N.J. June 30, 2014), rejected an out-of-network provider's contention that a patient-executed New Jersey Department of Banking and Insurance (DOBI)-issued "Consent to Representation in UM Appeals and Arbitration of Claims" form authorized the provider to institute an action for recovery of benefits under ERISA after the insurer denied claims for medically necessary and reasonable services.

According to Judge Salas, the essential predicate to an effective assignment is conferral of the right to recover payment directly from the insurer, and she consistently has validated assignments containing such language. However, because the DOBI "Consent to Representation" form makes no mention of payment to the provider, she held that it does not endow providers with standing to maintain a derivative lawsuit.

At the other end of the spectrum, Judge Chesler in *MHA v. Aetna Health*, No. 12-2984, 2013 U.S. Dist. LEXIS 25743 (D.N.J. Feb. 25, 2013), held that an assignment must explicitly *transfer all of the patient's rights and benefits* under the subject insurance plan to confer standing to maintain an ERISA reimbursement action. In adopting this exacting position, Judge Chesler emphasized two primary concerns. First, the

court expressed apprehension that, when coupled with the retention of a provider's right to balance-bill a patient, giving effect to assignment language reflecting anything less than an unequivocal surrender of all rights to proceed against an insurer posed an unacceptable risk that a provider may opt to balance-bill the patient in lieu of suing the insurer, stripping the patient of any recourse. Conversely, the court reasoned that retention of a provider's prerogative to balance-bill a patient coupled with preservation of the patient's right to sue the insurer directly raised double-recovery concerns.

This strict formulation bars providers from maintaining a derivative ERISA action in the absence of language conferring an unambiguous surrender of all rights and benefits under an employee benefits plan. The *MHA* court's reasoning appears to leave some leeway for a provider with a less-than-categorical assignment to argue that the assignment is adequate insofar as the provider waives his right to balance-bill the patient. Even if such an argument proved persuasive, the provider would be left with the unpalatable choice of irrevocably waiving the right to balance-bill a patient or preserving derivative standing to maintain an ERISA reimbursement action, the success of which would be far from assured.

In an Aug. 28 opinion in *Premier Health Center v. UnitedHealth Goup*, No. 11-425, 2014 U.S. Dist. LEXIS 120589 (D.N.J. Aug. 28, 2014), Judge Debevoise entered the fray, embracing the more liberal position that a simple assignment of a right to reimbursement logically includes the right for the assignee to enforce those rights. In doing so, he offered a well-articulated rejoinder to the concerns raised in Judge Chesler's *MHA* opinion.

Characterizing the purported risks arising from a patient's unwitting assignment of ERISA rights as illusory, Judge Debevoise acknowledged that a "patient who assigns his right to receive benefits for a given claim to a health-care provider loses his right to press ERISA claims regarding those benefits…." He reasoned, however, that:

[Although] it is…theoretically possible that a health-care provider that receives a repayment demand from an insurer on a given claim that was assigned to that health-care provider would simply balance-bill the patient who is then left without recourse under ERISA…[,] such a scenario is unlikely, as it would only serve to poison the relationship between the patient and health-care provider and ultimately drive patients away.

The more likely scenario, explained Judge Debevoise, "is that providers would dispute overpayment determinations or seek relief under ERISA regarding claims assigned to them by their patients," because providers are better financially situated to pursue legal action against an insurer. Moreover, continued the court, refusal to enforce assignment language would visit more harm on patients than the alternative because providers would opt to simply balance-bill their patients to avoid the risk of not having a sufficiently precise assignment.

Though it represents the latest and one of the most comprehensive district opinions regarding the requirements for an effective assignment, the *Premier Health Center* decision remains but one of several divergent approaches employed by district judges confronted with ERISA derivative standing issues.

The Third Circuit's May 6 ruling in *Cardionet v. Cigna Health Corp.*, 751 F.3d 165 (3d Cir. 2014), however, may herald a shift away from the strict assignment standard applied by some New Jersey federal judges. The Third Circuit in *Cardionet* conclusively held for the first time that "health-care providers may obtain standing to sue by assignment from a plan participant." In so doing, it favorably referenced an opinion by Judge Salas applying the more lenient assignment standard. While the Third Circuit did not explicitly adopt the Salas formulation in its *Cardionet* decision, the court's election to approvingly cite to Judge Salas rather than to stricter standards adopted by judges of the six district courts over which it exercises jurisdiction is a positive development for providers.

It remains to be seen, however, whether the Third Circuit will expressly endorse the concept—embraced by Judges Salas and Debevoise—that an assignment of the right to reimbursement alone confers derivative standing, and how lower courts will interpret the Third Circuit's intent in *Cardionet*.

Overcoming an Anti-Assignment Clause

Even in the presence of an unequivocal assignment of benefits, providers may still be required to overcome the additional obstacle to recovery imposed by an "anti-assignment clause" in the underlying insurance policy. Where an anti-assignment clause exists, a provider may demonstrate that an insurer waived its right to enforcement by implicitly or explicitly acknowledging the validity of the assignment.

In order to defeat an anti-assignment clause, it is imperative that providers maintain records of claims processing correspondence with insurers. Past direct payments by an insurer to an out-of-network provider and/or a course of correspondence between the insurer and provider regarding the subject claim may support a conclusion that the insurer acted in a manner consistent with the assignment, thereby waiving the anti-assignment clause. To compile such course-of-dealings evidence, it is advisable that a provider maintain "claims activity logs" memorializing the subject matter and outcomes of billing communications, denials, appeals and phone correspondence with insurers.

Conclusion

In order to preserve their legal right to maintain derivative reimbursement lawsuits against insurers, providers must be proactive. In addition to undertaking immediate review of their assignment of benefits forms to ensure compliance with recently-articulated legal standards, providers also should implement a protocol to compile and maintain evidence of interactions with insurers regarding claims processing. ■

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