

04 February 2016

Practice Groups:

Commercial Disputes

Health Care

*Benefits, ESOPs, and
Executive
Compensation*

Do Your Assignment of Benefits Clauses Need a Check-up? Recent Southern District of Florida Decision Highlights the Importance of Carefully-Drafted Provider Assignment Clauses

By Lauren Garraux and Steven R. Weinstein

A frequently litigated issue in reimbursement cases brought by in- and out-of-network healthcare providers against insurers under the Employee Retirement Income Security Act of 1974 (“ERISA”) is provider standing. Because providers lack independent standing to bring ERISA claims against insurers, providers must — and generally do — rely upon assignment of benefits agreements executed by patients as a basis for derivative standing under the statute. As ERISA payor-provider litigation increases, however, insurers have frequently challenged the scope of those assignments, requiring courts to analyze the assignments and determine whether they are sufficiently drafted to confer derivative standing on the provider to assert ERISA claims.

The United States District Court for the Southern District of Florida (the “Court”) recently addressed this issue in its February 1, 2016 decision in *BioHealth Medical Laboratory, Inc., et al. v. Connecticut General Life Insurance Company, et al.*, No. 1:15-cv-23075-KMM, once again underscoring, for providers, the importance of carefully drafted assignment clauses.

The underlying facts of *BioHealth* are straightforward and typical of those seen in ERISA reimbursement cases: the plaintiffs (the “Laboratories”), out-of-network providers, provided blood and urine testing to participants in various employer-sponsored health and welfare benefit plans (including self-funded plans) administered by defendants Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (collectively, “Cigna”). Before undergoing testing, participants were required to execute patient consent forms, which included an assignment of benefits clause pursuant to which the participant agreed to, in relevant part, “irrevocably assign to [the Laboratories]... all benefits under any policy of insurance, indemnity agreement, or any collateral source as defined by statute for services provided,” including “all rights to collect benefits directly from [the participant’s] insurance company and all right to proceed against [the participant’s] insurance company in any action, including legal suit, if for any reason [the participant’s] insurance company fails to make payment of benefits due.”

Cigna subsequently began to delay payment or deny the claims submitted by the Laboratories and the Laboratories ultimately filed suit asserting claims under ERISA (both for benefits due and for breach of fiduciary duty pursuant to 29 U.S.C. § 1132(a)(1)) and Florida state law. Cigna moved to dismiss the Laboratories’ complaint on a number of grounds, including that the Laboratories lacked standing to assert ERISA fiduciary duty claims and claims relating to self-funded plans.

Do Your Assignment of Benefits Clauses Need a Check-up? Recent Southern District of Florida Decision Highlights the Importance of Carefully-Drafted Provider Assignment Clauses

With respect to the fiduciary duty claims, the Court held that the plain language of the assignment was broad enough to encompass the fiduciary duty claims and, as a result, denied Cigna's motion as to those claims.

By contrast, the Court determined that the Laboratories lacked standing to assert claims relating to self-funded plans. While the assignment conferred the Laboratories the right to collect benefits stemming from a "collateral source," the "core focus" of the assignment was on the assignee's ability to recover benefits "owed under any policy of *insurance*" and to pursue any rights to collect from the insurance company if for any reason the "*insurance company fails to make payments due.*" Because a self-funded plan is not a form of insurance, the Court granted Cigna's motion to dismiss with respect to those claims.

The *BioHealth* decision is the latest in a number of cases in which a healthcare provider's ability to bring ERISA claims against insurers has turned on the language of the assignment, further underscoring the importance of careful drafting of those provisions. Prudent providers may want to have experienced health counsel review their assignment of benefits language on their patient intake forms.

Authors:

Lauren Garraux

lauren.garraux@klgates.com

+1.412.355.6757

Steven R. Weinstein

steven.weinstein@klgates.com

+1.305.539.3353

K&L GATES

Anchorage Austin Beijing Berlin Boston Brisbane Brussels Charleston Charlotte Chicago Dallas Doha Dubai
Fort Worth Frankfurt Harrisburg Hong Kong Houston London Los Angeles Melbourne Miami Milan Newark New York
Orange County Palo Alto Paris Perth Pittsburgh Portland Raleigh Research Triangle Park San Francisco São Paulo Seattle
Seoul Shanghai Singapore Sydney Taipei Tokyo Warsaw Washington, D.C. Wilmington

K&L Gates comprises approximately 2,000 lawyers globally who practice in fully integrated offices located on five continents. The firm represents leading multinational corporations, growth and middle-market companies, capital markets participants and entrepreneurs in every major industry group as well as public sector entities, educational institutions, philanthropic organizations and individuals. For more information about K&L Gates or its locations, practices and registrations, visit www.klgates.com.

This publication is for informational purposes and does not contain or convey legal advice. The information herein should not be used or relied upon in regard to any particular facts or circumstances without first consulting a lawyer.

© 2016 K&L Gates LLP. All Rights Reserved.