

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30

In the
United States Court of Appeals
For the Second Circuit

AUGUST TERM, 2015

ARGUED: SEPTEMBER 21, 2015

DECIDED: MAY 13, 2016

No. 14-3993-cv

AMERICAN PSYCHIATRIC ASSOCIATION, on behalf of its members and
their patients, et al.
Plaintiffs-Appellants,

v.

ANTHEM HEALTH PLANS, INC., et al.
Defendants-Appellees.

Appeal from the United States District Court
for the District of Connecticut.
No. 3:13 Civ. 494 – Janet Bond Arterton, *Judge*

Before: WALKER and RAGGI,¹ *Circuit Judges.*

¹ The Honorable Robert D. Sack is recused in this case, and therefore the case is decided by the remaining two members of the panel, who are in agreement. *See* Second Circuit Internal Operating Procedure E(b).

1 Plaintiffs-Appellants are two individual psychiatrists, Susan
2 Savulak, M.D., and Theodore Zanker, M.D. (“the psychiatrists”), and
3 three professional associations of psychiatrists, the American
4 Psychiatric Association, the Connecticut Psychiatric Society, Inc.,
5 and the Connecticut Council of Child and Adolescent Psychiatry
6 (collectively, “the associations”). They brought suit in the United
7 States District Court for the District of Connecticut against
8 Defendants-Appellees, four health-insurance companies: Anthem
9 Health Plans, Inc. (doing business as Anthem Blue Cross & Blue
10 Shield of Connecticut); Anthem Insurance Companies, Inc. (doing
11 business as Anthem Blue Cross and Blue Shield); Wellpoint, Inc.;
12 and Wellpoint Companies, Inc. (collectively, “the health insurers”).
13 The psychiatrists and the associations allege that the health insurers’
14 reimbursement practices discriminate against patients with mental
15 health and substance use disorders in violation of the Mental Health
16 Parity and Addition Equity Act of 2008 (“MHPAEA”), Pub. L. No.
17 110-343, Div. C §§ 511-12, 122 Stat. 3861, 3881, codified at 29
18 U.S.C. § 1185(a), and the Employee Retirement Income Security Act

1 (“ERISA”), 29 U.S.C. §§ 1001-1461. The associations brought suit on
2 behalf of their members and their members’ patients, while the
3 psychiatrists brought suit on behalf of themselves and their patients.
4 The district court dismissed the case after concluding that the
5 psychiatrists lacked a cause of action under the statute and the
6 associations lacked constitutional standing to pursue their respective
7 claims. We AFFIRM.

8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

AARON M. PANNER (Matthew A. Seligman, *on the brief*), Kellogg, Huber, Hansen, Todd, Evans & Figel, P.L.L.C., Washington, D.C., *for Plaintiffs-Appellants*.

PETER R. BISIO (Jessica L. Ellsworth, Erica K. Songer, Sean Marotta, *on the brief*), Hogan Lovells US LLP, Washington, D.C., *for Defendants-Appellees*.

D. Brian Hufford and Jason S. Cowart, Zuckerman Spaeder LLP, New York, N.Y., and David A. Reiser, Washington, D.C., *for Amici Curiae American Medical Association and Connecticut State Medical Society in support of Plaintiffs-Appellants*.

1 JOHN M. WALKER, JR., *Circuit Judge*:

2 Plaintiffs-Appellants are two individual psychiatrists, Susan
3 Savulak, M.D., and Theodore Zanker, M.D. (“the psychiatrists”), and
4 three professional associations of psychiatrists, the American
5 Psychiatric Association, the Connecticut Psychiatric Society, Inc.,
6 and the Connecticut Council of Child and Adolescent Psychiatry
7 (collectively, “the associations”). They brought suit in the United
8 States District Court for the District of Connecticut against
9 Defendants-Appellees, four health-insurance companies: Anthem
10 Health Plans, Inc. (doing business as Anthem Blue Cross & Blue
11 Shield of Connecticut); Anthem Insurance Companies, Inc. (doing
12 business as Anthem Blue Cross and Blue Shield); Wellpoint, Inc.;
13 and Wellpoint Companies, Inc. (collectively, “the health insurers”).
14 The psychiatrists and the associations allege that the health insurers’
15 reimbursement practices discriminate against patients with mental
16 health and substance use disorders in violation of the Mental Health
17 Parity and Addition Equity Act of 2008 (“MHPAEA”), Pub. L. No.
18 110-343, Div. C §§ 511-12, 122 Stat. 3861, 3881, codified at 29
19 U.S.C. § 1185(a), and the Employee Retirement Income Security Act

1 (“ERISA”), 29 U.S.C. §§ 1001-1461. The associations brought suit on
2 behalf of their members and their members’ patients, while the
3 psychiatrists brought suit on behalf of themselves and their patients.
4 The district court dismissed the case after concluding that the
5 psychiatrists lacked a cause of action under the statute and the
6 associations lacked constitutional standing to pursue their respective
7 claims. We AFFIRM.

8 **BACKGROUND**

9 The psychiatrists and the associations allege that the health
10 insurers discriminate against patients with mental health and
11 substance use disorders by systemically reimbursing providers of
12 services to treat these disorders at a less favorable rate than for other
13 healthcare services. They argue that this less favorable
14 reimbursement policy prevents many psychiatrists from accepting
15 health insurance. The policy limits patients’ access to necessary
16 services and frequently forces them to change providers. Plaintiffs
17 allege that this practice discriminates against patients with mental

1 health and substance use disorders in violation of the MHPAEA and
2 ERISA.

3 Congress enacted the MHPAEA to end discrimination in the
4 provision of insurance coverage for mental health and substance use
5 disorders as compared to coverage for medical and surgical
6 conditions in employer-sponsored group health plans. *See Coalition*
7 *for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010). The
8 MHPAEA expanded the scope of prior legislation, the Mental
9 Health Parity Act of 1996, Pub. L. No. 104–204, §§ 701–02, 110 Stat.
10 2874, 2944.

11 Under the MHPAEA, if a covered insurer’s “plan or coverage”
12 does not include aggregate lifetime limits “on substantially all
13 medical and surgical benefits, the plan or coverage may not impose
14 any aggregate lifetime limit on mental health or substance use
15 disorder benefits.” 29 U.S.C. § 1185a(a)(1)(A). The same is true with
16 respect to annual limits. *Id.* § 1185a(a)(2)(A). Additionally, if an
17 insurer “provides both medical and surgical benefits and mental
18 health or substance use disorder benefits,” the insurer must ensure

1 that both “the financial requirements” and “the treatment
2 limitations” applicable to mental health and substance use disorder
3 benefits “are no more restrictive” than the predominant financial
4 requirements and treatment limitations that apply to medical and
5 surgical benefits. *Id.* § 1185(a)(3)(A).

6 Insurers are forbidden, for example, from having either
7 “separate cost sharing requirements that are applicable only with
8 respect to mental health or substance use disorder benefits,”
9 § 1185(a)(3)(A)(i), or “separate treatment limitations that are
10 applicable only with respect to mental health or substance use
11 disorder benefits,” *id.* § 1185(a)(3)(A)(ii); *see also* 26 U.S.C.
12 § 9812(a)(3) (parallel provisions in Internal Revenue Code); 42 U.S.C.
13 § 300gg-5(a) (“A group health plan and a health insurance issuer
14 offering group or individual health insurance coverage shall not
15 discriminate with respect to participation under the plan or coverage
16 against any health care provider who is acting within the scope of
17 that provider’s license or certification under applicable State law.”).

1 The psychiatrists and the associations, on behalf of their
2 various patients and members (and in the case of Dr. Savulak, as
3 assignee of two of her patients), allege that the health insurers'
4 conduct violates the foregoing anti-discrimination provisions of the
5 MHPAEA and breaches the insurers' fiduciary duties under
6 § 502(a)(3) of ERISA. The psychiatrists and the associations also
7 allege state-law claims for breach of contract and tortious
8 interference with contract. The complaint seeks a declaration of the
9 health insurers' obligations under the MHPAEA; an order enjoining
10 the health insurers from continuing to discriminate against
11 individuals with mental health and substance use disorders; and
12 damages related to the state-law claims.

13 The district court (Janet Bond Arterton, *J.*) dismissed the
14 action. The district court concluded that the psychiatrists lack third-
15 party "statutory standing" to bring claims on behalf of their patients.
16 The district court also rejected Dr. Savulak's distinct assignee-based
17 theory of a cause of action. The district court assumed without
18 deciding that the assignments of ERISA claims made by two patients

1 to Dr. Savulak were not precluded by the anti-assignment
2 provisions of their plans. But the district court concluded that the
3 assignment conveyed legal rights only, and moreover that the
4 complaint did not plead any facts suggesting that the assignment
5 was in exchange for medical treatment, as required for a provider to
6 have a cause of action under ERISA. More generally, the district
7 court held that the physician-patient relationship does not grant
8 third-party standing in this case because the psychiatrists asserted
9 no constitutional claims on behalf of their patients and because the
10 statutes at issue did not broadly confer a private right of action upon
11 providers. Finally, the district court found that the associations
12 lacked constitutional standing because their individual members
13 lacked standing.

14 Although the district court concluded that the psychiatrists
15 and the associations lacked standing, it went on to address the
16 health insurers' argument that the psychiatrists and the associations
17 had failed to state a claim.

1 The district court first rejected the psychiatrists' and the
2 associations' contention that the health insurers were acting as
3 fiduciaries "with respect to a plan" under ERISA § 3(21)(A), 29
4 U.S.C. § 1002(21)(A).² The district court determined that the health
5 insurers' setting of system-wide reimbursement rates and policies
6 regarding the extent of coverage was a business decision that—
7 unlike discretionary determinations about an individual claimant's
8 eligibility for benefits—does not constitute a fiduciary act under
9 ERISA. The court also held that even if the insurers were acting as
10 fiduciaries, ERISA § 502(a)(1)(B) provides adequate relief, thus
11 requiring dismissal of the ERISA § 501(a)(3) claims.

² ERISA provides that "a 'person is a fiduciary with respect to a plan,' and therefore subject to ERISA fiduciary duties, 'to the extent' that he or she 'exercises any discretionary authority or discretionary control respecting management' of the plan, or 'has any discretionary authority or discretionary responsibility in the administration' of the plan." *Variety Corp. v. Howe*, 516 U.S. 489, 498 (1996) (quoting ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A)). A plan administrator "engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents." *Id.* at 511. "[G]eneral fiduciary duties under ERISA [are] not triggered," however, when the decision at issue is, "at its core, a corporate business decision, and not one of a plan administrator." *Flanigan v. Gen. Elec. Co.*, 242 F.3d 78, 88 (2d Cir. 2001).

1 The district court accordingly dismissed plaintiffs' federal
2 claims and declined to exercise supplemental jurisdiction over their
3 state claims. Plaintiffs appeal. Because we agree that plaintiffs lack
4 standing, it is unnecessary for us to address the district court's
5 determination that the complaint failed to state a claim.

6 DISCUSSION

7 We review de novo the district court's determination on
8 standing. *W.R. Huff Asset Mgmt. Co. v. Deloitte & Touche LLP*, 549
9 F.3d 100, 106 (2d Cir. 2008). "Because standing is challenged on the
10 basis of the pleadings, we accept as true all material allegations of
11 the complaint, and must construe the complaint in favor of the
12 complaining party." *Id.* (internal quotation marks omitted).

13 I. The psychiatrists lack standing.

14 We reject the psychiatrists' argument that they have standing
15 to assert their ERISA § 502(a)(3) claims as third parties bringing suit
16 on behalf of their patients. As we shall explain, this argument
17 conflates the prudential third-party standing doctrine with the

1 requirement that the plaintiff have a cause of action under the
2 statute—a requirement formerly known as “statutory standing.”

3 We begin by briefly noting the parameters of constitutional
4 standing, prudential standing, and what was formerly known as
5 “statutory standing,” the differences between them, and their
6 relationships to one another.

7 Constitutional standing refers to the requirement that parties
8 suing in federal court establish that a “Case” or “Controversy” exists
9 within the meaning of Article III of the United States Constitution.
10 Constitutional standing requires (1) that the plaintiff have suffered
11 an “injury in fact”—that is, “an invasion of a legally protected
12 interest which is (a) concrete and particularized and (b) actual or
13 imminent, not conjectural or hypothetical”; (2) that there is “a causal
14 connection between the injury and the conduct” of which the
15 plaintiff complains; and (3) that it is “likely . . . that the injury will be
16 redressed by a favorable decision.” *Lujan v. Defenders of Wildlife*, 504
17 U.S. 555, 560-61 (1992) (internal citations and quotation marks
18 omitted).

1 Unlike the “immutable requirements of Article III,” the
2 “prudential principles that bear on the question of standing” are
3 “judicially self-imposed limits on the exercise of federal
4 jurisdiction,” and may be altered. *Bennett v. Spear*, 520 U.S. 154, 162
5 (1997) (internal quotation marks omitted). They are “founded in
6 concern about the proper—and properly limited—role of the courts
7 in a democratic society.” *Warth v. Seldin*, 422 U.S. 490, 498 (1975).
8 Prudential principles are “closely related to Art. III concerns but
9 essentially matters of judicial self-governance.” *Id.* at 500. Unlike the
10 requisites of constitutional standing, prudential limits “can be
11 modified or abrogated by Congress.” *Bennett*, 520 U.S. at 162. One
12 prudential limit on standing is the principle “that when the asserted
13 harm is a ‘generalized grievance’ shared in substantially equal
14 measure by all or a large class of citizens, that harm alone normally
15 does not warrant [the] exercise of jurisdiction.” *Warth*, 422 U.S. at
16 499. Another prudential principle is that a plaintiff may ordinarily
17 assert only his own legal rights, not those of third parties. *Id.*; *see also*
18 *Singleton v. Wulff*, 428 U.S. 106, 113 (1976).

1 This rule against third-party standing is not absolute. For
2 example, a plaintiff may assert the legal rights of another as a “next
3 friend” when he or she establishes: “(1) a close relationship to the
4 injured party and (2) a barrier to the injured party’s ability to assert
5 its own interests.” *W.R. Huff*, 549 F.3d at 109 (citing *Kowalski v.*
6 *Tesmer*, 543 U.S. 125, 130 (2004)). Similarly, a physician or other
7 professional may raise the *constitutional* rights, but generally not the
8 statutory rights, of his or her patients. *See, e.g., Griswold v.*
9 *Connecticut*, 381 U.S. 479, 480-81 (1965) (holding that licensed
10 physician and non-physician director of family-planning group had
11 standing to raise the constitutional rights of people “with whom
12 they had a professional relationship” in challenging state law
13 against prescribing contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438,
14 443-46 (1972) (holding that distributor of contraceptives and
15 advocate for right to contraceptives had standing to challenge law
16 impairing ability to obtain contraceptives, even though “he was
17 neither a doctor nor a druggist”). Plaintiffs here raise only statutory
18 claims.

1 Finally, a plaintiff must have a cause of action under the
2 applicable statute. This was formerly called “statutory standing.”
3 In the past, we suggested that this was either “a separate aspect of
4 standing or a part of the prudential aspect of standing.” *Lerner v.*
5 *Fleet Bank, N.A.*, 318 F.3d 113, 126 n.12 (2d Cir. 2003); *see also Kendall*
6 *v. Emps. Ret. Plan of Avon Prods.*, 561 F.3d 112, 118 (2d Cir. 2009). The
7 Supreme Court has recently clarified, however, that what has been
8 called “statutory standing” in fact is not a standing issue, but simply
9 a question of whether the particular plaintiff “has a cause of action
10 under the statute.” *Lexmark Int’l, Inc. v. Static Control Components,*
11 *Inc.*, 134 S. Ct. 1377, 1387 (2014). This inquiry “does not belong” to
12 the family of standing inquiries, *id.*, because “the absence of a valid
13 . . . cause of action does not implicate subject-matter jurisdiction, i.e.,
14 the court’s statutory or constitutional *power* to adjudicate the case.”
15 *Id.* at 1386 n.4 (emphasis in original) (internal quotation marks
16 omitted); *see also Nw. Airlines, Inc. v. County of Kent*, 510 U.S. 355, 365
17 (1994) (“The question whether a federal statute creates a claim for
18 relief is not jurisdictional.”).

1 Because the Supreme Court made clear in *Lexmark* that the
2 “statutory standing” appellation is “misleading” and “a misnomer,”
3 134 S. Ct. at 1386, 1387 & n.4 (internal quotation marks omitted), we
4 avoid this appellation going forward. *See City of Miami v. Bank of*
5 *Am. Corp.*, 800 F.3d 1262, 1273 (11th Cir. 2015) (noting that *Lexmark*
6 signaled that “the longstanding doctrinal label of ‘statutory
7 standing’ . . . is misleading”); *see also Leyse v. Bank of Am. Nat’l Ass’n*,
8 804 F.3d 316, 320 n.3 (3d Cir. 2015) (similar).

9 Turning to this case, we now address each of these concepts in
10 turn. *See Kendall*, 561 F.3d at 118 (in order to have standing under
11 ERISA, a plaintiff must both “assert a constitutionally sufficient
12 injury arising from the breach of a statutorily imposed duty” *and*
13 “identify a statutory endorsement of the action”).

14 The health insurers do not contest that the psychiatrists have
15 constitutional standing, and we agree with the district court that the
16 psychiatrists’ personal financial stakes in the suit (as a result of
17 “dramatically reduced” reimbursement rates) meet the

1 constitutional requirements of injury in fact, causation, and
2 redressability. *Lujan*, 504 U.S. at 560-61.

3 Moreover, although the plaintiffs argue that they have
4 “prudential standing,” this argument cannot prevail in the absence
5 of a cause of action under the ERISA. The district court concluded
6 as much. Notwithstanding its reference to prudential limitations on
7 standing, the district court ultimately concluded that plaintiffs
8 lacked “statutory standing,” i.e., a cause of action under the statute.
9 The parties make reference to prudential limitations on standing in
10 their briefs mostly in the context of addressing whether plaintiffs
11 have a cause of action under the statute. As we shall explain, this
12 unnecessarily confuses the issue. Because Congress specified in the
13 statute who may sue, prudential standing principles do not apply.

14 We turn now to the core issue in this appeal: whether
15 plaintiffs have a cause of action under ERISA against the health
16 insurers arising from the health insurers’ alleged MHPAEA
17 violations. We consider whether, applying the “traditional
18 principles of statutory interpretation,” the plaintiffs here fall “within

1 the class of plaintiffs whom Congress has authorized to sue.”
2 *Lexmark*, 134 S. Ct. at 1387-88. We agree with the district court that
3 they do not.

4 Section 502(a)(3) unambiguously provides that a civil action
5 under ERISA may be brought “by a participant, beneficiary, or
6 fiduciary.” 29 U.S.C. § 1132(a)(3). The psychiatrists do not argue
7 that they are participants, beneficiaries, or fiduciaries under ERISA,
8 nor could they. Indeed, the psychiatrists’ arguments are aimed at
9 circumventing this hurdle. Because “[c]ourts have consistently read
10 [this provision] as strictly limiting ‘the universe of plaintiffs who
11 may bring certain civil actions,’” the psychiatrists lack a cause of
12 action under § 502(a)(3). *Connecticut v. Physicians Health Servs. of*
13 *Conn.*, 287 F.3d 110, 121 (2d Cir. 2002) (quoting *Harris Trust & Savs.*
14 *Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 247 (2000)); see also
15 *Franchise Tax Bd. of the State of Calif. v. Constr. Laborers Vacation Tr.*,
16 463 U.S. 1, 27 (1983) (“ERISA carefully enumerates the parties
17 entitled to seek relief under [§ 502(a)(3)]; it does not provide anyone

1 other than participants, beneficiaries, or fiduciaries with an express
2 cause of action . . .”).

3 The psychiatrists, as well as the American Medical
4 Association and Connecticut State Medical Society as *amici curiae*,
5 argue in substance that, in accordance with prudential principles,
6 the psychiatrists may stand in the shoes of their patients and thus
7 they have their patients’ cause of action under the statute. *Amici*
8 note that mental healthcare providers have a close relationship with
9 their patients, and that stigma and disability often hinder the ability
10 of patients to protect their own interests.

11 We acknowledge that policy reasons might support allowing
12 physicians to bring suit on behalf of patients with mental health and
13 substance use disorders in the absence of statutory authorization for
14 such an action. But in *Lexmark*, the Supreme Court distinguished the
15 “‘prudential’ branch of standing”—which includes the doctrine of
16 third-party standing as an exception to “the general prohibition on a
17 litigant’s raising another person’s legal rights”—from the
18 requirement that the plaintiff be part of the “particular class of

1 persons” to whom Congress has given “a right to sue under this
2 substantive statute.” 134 S. Ct. at 1386-87 (internal quotation marks
3 omitted). “We do not ask whether in our judgment Congress *should*
4 have authorized [plaintiffs’] suit, but whether Congress in fact did
5 so.” *Id.* at 1388 (emphasis in original). We may neither “apply [our]
6 independent policy judgment to recognize a cause of action that
7 Congress has denied” nor “limit a cause of action that Congress has
8 created merely because ‘prudence’ dictates.” *Id.* In sum, *Lexmark*
9 teaches that we cannot expand the congressionally-created statutory
10 list of those who may bring a cause of action by importing third-
11 party prudential considerations. The psychiatrists here lack a cause
12 of action under ERISA’s § 502(a)(3), irrespective of whether they
13 may stand in the shoes of their patients in other matters. *See*
14 *Physicians Health Servs.*, 287 F.3d at 120.

15 Neither *New York State Psychiatric Association, Inc. v.*
16 *UnitedHealth Group*, 798 F.3d 125 (2d Cir. 2015) (“NYSPA”), nor
17 *Pennsylvania Psychiatric Society v. Green Spring Health Services, Inc.*,
18 280 F.3d 278 (3d Cir. 2002), both cited by plaintiffs, are to the

1 contrary. In *NYSPA*, there was “no serious dispute” that the
2 members of the plaintiff association had “standing to sue [the
3 defendant] in their own right,” both as assignees of ERISA benefits
4 and to prevent interference with their provision of mental
5 healthcare. 798 F.3d at 131. By contrast, the plaintiffs here—with an
6 exception, discussed below—claim a cause of action under the
7 statute on behalf of their respective members and patients, rather
8 than on their own behalf.

9 Likewise, *Pennsylvania Psychiatric Society* does not stand for
10 the proposition that third-party standing can substitute for a
11 statutorily-specified plaintiff’s cause of action under the statute. The
12 district court in that case examined third-party standing stemming
13 from state-law contract and tort claims rather than from ERISA. 280
14 F.3d at 282. The Third Circuit never expressly addressed the
15 question of whether the plaintiffs had a cause of action under the
16 statute. *Pennsylvania Psychiatric* therefore provides little support for
17 the psychiatrists’ position in this purely statutory case.

1 In sum, because the psychiatrists are not among those
2 expressly authorized to sue, they lack a cause of action under
3 ERISA. Therefore, the district court correctly dismissed the case
4 irrespective of prudential considerations.

5 Separately, Dr. Savulak argues that she has a cause of action
6 under the statute for another reason: she holds an assignment of
7 claims from two of her patients. The district court assumed, without
8 deciding, that the assignments were valid.

9 Dr. Savuluk's argument fails. Our precedent makes clear that,
10 for purposes of conferring an ERISA cause of action upon a
11 provider, an assignment to a provider must be made in exchange for
12 consideration, in the form of the provision of healthcare services.
13 Such consideration is lacking in this case.

14 Like most of our sister circuits, we have allowed physicians to
15 bring claims under § 502(a) based on a valid assignment from a
16 patient. *See, e.g., I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting*
17 *Eng'rs Council Ins. Tr. Fund*, 136 F.3d 114, 117 n.2 (2d Cir. 1998)
18 (“[T]he assignees of beneficiaries to an ERISA-governed insurance

1 plan have standing to sue under ERISA.”); *see also Tango Transp. v.*
2 *Healthcare Fin. Servs. LLC*, 322 F.3d 888, 891 (5th Cir. 2003) (collecting
3 cases from other circuits on derivative standing in general).

4 However, “[t]his narrow exception grants standing only to
5 healthcare providers to whom a beneficiary has assigned his claim in
6 exchange for health care benefits.” *Simon v. Gen. Elec. Co.*, 263 F.3d
7 176, 178 (2d Cir. 2001); *see also Montefiore Med. Ctr. v. Teamsters Local*
8 *272*, 642 F.3d 321, 329 (2d Cir. 2011) (holding that the “exception to
9 the [ordinary] ERISA standing requirements” for “healthcare
10 providers to whom a beneficiary has assigned his claim in exchange
11 for health care” is “narrow” (internal quotation marks omitted)).³

12 Therefore, simply asserting that claims under ERISA
13 § 502(a)(3) for violations of MHPAEA have been assigned by the
14 patients to Dr. Savulak is insufficient by itself to give Dr. Savulak a
15 cause of action under the statute. Rather, to obtain standing, the
16 patients’ assignment of the right to sue for benefits must be

³ Other circuits have applied the same limitation. *E.g., Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1289 (9th Cir. 2014); *Pascack Valley Hosp. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 403 (3d Cir. 2004); *Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997).

1 exchanged for healthcare benefits.⁴ Therefore, Dr. Savulak lacks
2 standing.

3 II. The association plaintiffs lack standing.

4 We also agree with the district court that the association
5 plaintiffs lack constitutional standing under Article III because their
6 members, as we have shown, lack standing. *See Hunt v. Wash. State*
7 *Apple Adver. Comm'n*, 432 U.S. 333, 343 (1977) (holding that when an
8 association sues on behalf of its members, it must demonstrate that
9 “(a) its members would otherwise have standing to sue in their own
10 right; (b) the interests it seeks to protect are germane to the
11 organization’s purpose; and (c) neither the claim asserted nor the
12 relief requested requires the participation of individual members in
13 the lawsuit.”).

⁴ In *Physicians Health Services*, we noted that “[w]e have never decided whether a state may obtain standing as an assignee of a plan participant under § 1132 generally or whether different rules of standing apply under § 1132(a)(3) than under § 1132(a)(1)(B).” 287 F.3d at 115 n.4. Because we concluded in *Physicians Health Services* that the State in that case lacked Article III standing, we did not “reach the question of whether, as a matter of statutory construction, a State could ever obtain standing as an assignee under § 1132(a)(3).” *Id.* Our decision today does not purport to address the issue left open in *Physicians Health Services*.

1 While the associations' members could assert their own
2 Article III injuries related to the restrictions imposed on their ability
3 to provide care, as *amici* note, none are plaintiffs and the complaint
4 here does not sufficiently plead facts to show that its members have
5 a cause of action under § 502(a)(3).

6 CONCLUSION

7 For the reasons stated above, we find that the plaintiff
8 psychiatrists lack a cause of action under the statute, and the
9 association plaintiffs lack constitutional standing to pursue their
10 respective ERISA and MHPAEA claims. We therefore AFFIRM the
11 judgment of the district court.