[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 20-11511
Non-Argument Calendar

D.C. Docket No. 1:18-cv-03414-MLB

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
MEDICAL ASSOCIATION OF GEORGIA,

Plaintiffs-Appellants,

versus

BLUE CROSS AND BLUE SHIELD OF GEORGIA, et al.,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Georgia

(October 22, 2020)

Before MARTIN, GRANT, and LUCK, Circuit Judges.

PER CURIAM:

The American College of Emergency Physicians (ACEP) and the Medical Association of Georgia (MAG) appeal the district court's dismissal of their

amended complaint against Blue Cross and Blue Shield of Georgia, Inc.; Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; and Anthem Insurance Companies, Inc.[1] for failure to state a claim and lack of standing. See Fed. R. Civ. P. 12(b)(1); 12(b)(6). After careful review, we reverse the district court's judgment and reinstate ACEP and MAG's claims brought under the Employee Retirement Income Security Act (ERISA) and the Patient Protection and Affordable Care Act (ACA) against Blue Cross Blue Shield.

I.

ACEP and MAG are organizations dedicated to promoting the "rights of their physician members, and patients alike, for the delivery of the highest quality of care." ACEP represents over 38,000 emergency physicians, medicine residents, and medical students. MAG is a non-profit organization that "works with physicians, hospitals, insurers, and legislators in an effort to reform our health care system." The physicians who belong to ACEP and MAG require their patients, including those insured by Blue Cross Blue Shield, to assign their health insurance benefits to the physicians. These assignments include the right to "payment for emergency care and treatment" and the "rights to appeal denials for emergency department claims."

[1] We refer to Defendants collectively as "Blue Cross Blue Shield."

As set out in the ACA, a "prudent layperson" standard applies to all federal health-care plans, all insurance plans governed by ERISA, and qualified health insurance plans in state-operated health insurance exchanges. This standard requires health plans to cover health services provided by an emergency department whenever a patient has an "emergency medical condition." An emergency medical condition is defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention" to result in serious negative health outcomes.[2] 42 U.S.C. § 300gg-19a(b)(2)(A). It is notable that this standard does not look to the ultimate diagnosis that the patient receives. The only relevant considerations are the presenting symptoms and whether a prudent layperson would think that emergency medical attention is necessary based on those symptoms.

In their complaint, MAG and ACEP allege that Blue Cross Blue Shield violated the prudent layperson standard when it implemented a new emergency department visit review process (the "ED review") in 2017. That year Defendants sent letters to their insureds in Georgia cautioning that they should only go to the

[2] Another statutory provision clarifies what types of negative health outcomes. See 42 U.S.C. § 1395dd(e)(1)(A).

emergency room for emergencies, otherwise their insurance would not cover their emergency room visits. Blue Cross Blue Shield also gave presentations publicizing their new ED review policy. During at least one of these presentations, Defendants confirmed that their new ED review process was "based on diagnosis codes in addition to medical records." The reviews are performed by a physician. Blue Cross Blue Shield then began retrospectively denying payments to healthcare providers by reclassifying certain emergency department visits as "non-emergent" using the diagnostic codes that were assigned to the visits. In the second half of 2017, Blue Cross Blue Shield reviewed 10,000 claims (out of 51,000 received claims) for ER visits in Georgia and denied 3,500 of them. At various times Blue Cross Blue Shield has claimed that its ED review process appropriately applies the prudent layperson standard.

In October 2018 MAG and ACEP filed the First Amended Complaint (the operative complaint here) against Defendants. The complaint alleged the ED review process violated the prudent layperson standard and sought declaratory and injunctive relief for violations of the ACA and ERISA.[3] Blue Cross Blue Shield filed a pre-answer motion to dismiss, asserting that MAG and ACEP failed to

[3] ACEP and MAG do not contest the dismissal of their claims under the Emergency Medical Treatment and Active Labor Act (EMTALA) and state and federal group health regulations.

plead sufficient facts to support their allegation and that Plaintiffs lacked standing to bring these claims.

The district court granted Defendants' motion and dismissed the complaint with prejudice. The district court found ACEP and MAG's pleadings insufficient because they did not identify a specific instance in which "Defendants' ED Review improperly applies the prudent layperson standard." The district court also relied upon Defendants' claims that their ED review process did not violate the prudent layperson standard. The district court found that the members of ACEP and MAG lacked standing because the assignment of insurance plan benefits to them did not give them standing to seek equitable relief and because Plaintiffs failed to allege how the ED review process harmed their members.

Plaintiffs timely appealed.

II.

"We review de novo the district court's grant of a Rule 12(b)(6) motion to dismiss for failure to state a claim, accepting the complaint's allegations as true and construing them in the light most favorable to the plaintiff." Chaparro v. Carnival Corp., 693 F.3d 1333, 1335 (11th Cir. 2012) (per curiam) (quotation marks omitted). To prevent dismissal under Rule 12(b)(6), a plaintiff must allege sufficient facts to state a claim for relief that is "plausible on its face." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570, 127 S. Ct. 1955, 1974 (2007). Claims are

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