UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

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December 22, 2023

W. A. Griffin
550 PEACHTREE ST NE STE 1490
ATLANTA, GA 30308

Appeal Number: 23-14123-E
Case Style: In re: W. A. Griffin
District Court Docket No: 1:21-cv-01016-SEG

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DKT-1 Appeal NO Deficiency

NO._____

IN THE

SUPREME COURT OF THE UNITED STATES

W. A. Griffin, M.D.— PETITIONER

v.

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORIGA, INC. —RESPONDENT

APPLICATION TO ASSOCIATE JUSTICE THOMAS SEEKING REVIEW OF PETITION FOR AN EMERGENCY WRIT OF MANDAMUS AND APPENDIX, UNDER SUPREME COURT RULE 11 & 22, FEDERAL RULE OF APPEALS, RULE 2, AND 11TH CIR. R. 2-1

APPLICATION TO ASSOCIATE JUSTICE THOMAS

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December 21, 2023

Associate Justice Clarence Thomas
United States Supreme Court
1 First Street NE
Washington, D.C. 20543

Re: Emergency Application Regarding an attempted coup of Georgia State Mandatory Assignment Law (Georgia § 33-24-54) Affecting Public Interests in the Healthcare Sector and ERISA statutory rights (Brought under United States Supreme Court Rules 11, and 22 Federal Court of Appeals Rule 2, and 11th Circuit Rule 2-1.

To the Honorable Clarence Thomas, Associate Justice of the Supreme Court of the United States and Circuit Justice for the United States Court of Appeals for the Eleventh Circuit:

Petitioner, pro set litigant, W. A. Griffin, M.D. seeks an order pursuant to the above rules to vacate and set aside illegitimate case law created by corruption and fraud in the 11th Circuit that have destroyed Georgia state laws and blocked ERISA rights. Dr. Griffin has spent the past eight years pleading for relief in the form of petitions and appeals without any success. However, the special procedures conducted by an individual Justice in the US Supreme Court rules can provide necessary relief in these extraordinary circumstances that have been active and ongoing in the Eleventh Circuit.

Please forgive any grammar or typographical errors. Dr. Griffin does use grammar and spelling check. However, she suffers from a reading disability and is unable to catch every error that the tools do not fix.

PARTIES TO THE PROCEEDING

Petitioner in this case is W. A. Griffin, M.D.

Respondent in this case is Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT (CIP)

W A GRIFFIN, PETITIONER

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORIGA, INC., RESPONDENT

LINDSEY MANN, COUNSEL FOR RESPONDENT
TROUTMAN PEPPER LAW FIRM

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SAMUEL DAVID LACK, COUNSEL FOR RESPONDENT
TROUTMAN PEPPER LAW FIRM

W. A. Griffin, M.D. is not a corporation. She does not own 10% of more of shares of any organization or corporation. She has nothing to disclose.

December 21, 2023

Submitted by

s/W. A. Griffin, M.D.
W. A. Griffin, M.D.

STATEMENT OF RELATED PROCEEDINGS IN THE ELEVENTH CIRCUIT

1. 11th Circuit Court of Appeals
15-12135
W. Griffin v. Southern Company Services, Inc
No legally valid judgment entered.

2. 11th Circuit Court of Appeals
15-12137
W. Griffin v. Focus Brands Inc.
No legally valid judgment entered.

3. 11th Circuit Court of Appeals
15-12138
W. Griffin v. Health Systems Management, Inc
No legally valid judgment entered.

4. 11th Circuit Court of Appeals
15-12157
W. Griffin v. GMI
No legally valid judgment entered.

5. 11th Circuit Court of Appeals
15-12858
W. Griffin v. Suntrust Bank, Inc.
No legally valid judgment entered.

6. 11th Circuit Court of Appeals
15-13515
W. Griffin v. LMT
No legally valid judgment entered.

7. 11th Circuit Court of Appeals
15-13516
W. Griffin v. Habitat for Humanity International
No legally valid judgment entered.

8. 11th Circuit Court of Appeals
15-13525
W. Griffin v. Verizon Communications, Inc.
No legally valid judgment entered.

9. 11th Circuit Court of Appeals
16-13411
W. Griffin v. CCE
No legally valid judgment entered.

10. 11th Circuit Court of Appeals
16-13485
W. Griffin v. FOCUS Brands Inc.
No legally valid judgment entered.

11. 11th Circuit Court of Appeals
17-13113
W. Griffin v. Aetna Health Inc., et al
No legally valid judgment entered.

12. 11th Circuit Court of Appeals
17-14761
W. Griffin v. Verizon Communications Inc., et al
No legally valid judgment entered.

13. 11th Circuit Court of Appeals
18-10046
W. Griffin v. GE, et al
No legally valid judgment entered.

14. 11th Circuit Court of Appeals
18-10208
W. Griffin v. United Healthcare of Georgia,, et al
No legally valid judgment entered.

15. 11th Circuit Court of Appeals
18-10417
W. Griffin v. Coca-Cola Refreshments USA, In, et al
No legally valid judgment entered.

16. 11th Circuit Court of Appeals
18-10418
W. A. Griffin MD v. Delta Air Lines, Inc., et al
No legally valid judgment entered.

17. 11th Circuit Court of Appeals
22-14187
W. Griffin v. Blue Cross Blue Shield Healthcare Plan of Georgia,, et al
Active Case Pending

18. 11th Circuit Court of Appeals
23-11408
W. A. Griffin, M.D. v. AT&T Services, Inc.
Active Case Pending

19. 11th Circuit Court of Appeals
23-11414
W. A. Griffin v. Blue Cross Blue Shield Healthcare Plan of Georgia,
This current case brought before the US Supreme Court in the form of a Writ of Mandamus

20. 11th Circuit Court of Appeals
23-13429
W. A. Griffin v. United Healthcare Services, Inc.
Active Case Pending

21. 11th Circuit Court of Appeals
23-13943
W. A. Griffin v. Health and Welfare Committee of Savannah River Nuc, et al
Active Case Pending

22. 11th Circuit Court of Appeals
23-13944
W. A. Griffin v. Motion Picture Industry Health Plan, et al
Active Case Pending

STATEMENT OF THE CASE

This petition stems from an Application to Circuit Justice Thomas filed in this court on December 21, 2023, in response a coup in the form of illegal opinions that have destroyed Georgia state laws filed in the 11th Circuit beginning on December 30, 2015, through the most recent date filed on December 19, 2023. The time span is exactly eight years and fifteen days.

This emergency application is filed to address an active, ongoing assault by domestic corporations, corrupt law firms, and the judiciary that have attempted an active coup against the laws in the State of Georgia masquerading as legitimate case law. Specifically, these entities have destroyed Georgia's mandatory assignment of benefit statue by making it ineffective and have deliberately tailored the intent of ERISA to satisfy corporate interest.

Due to years of egregious violations of Dr. Griffin's constitution rights to assignments and ERISA remedies that every doctor of medicine utilizes in every state with a mandatory of assignment law, which by default creates the same risk for every provider, hospital, and healthcare entity that exclusively relies on assignments and ERISA standing to run its healthcare operations in other states, she brings this matter to this court for immediate resolution.

JURISDICTION

The jurisdiction of the court is invoked under 28 U.S.C. s. 1651, which establishes that the Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law. This petition for writ of mandamus is based on FRAP Rule 2's Suspension of rules and 11th Circuit Rule 2-1, as it deemed appropriate based on the imperative public importance of this case, under Rule Supreme Court Rule 11 (see 28 U.S.C. s. 2101), as to justify deviation from normal appellate practice and to require immediate determination by either Circuit Justice Thomas, or if he prefers, the Supreme Court, as a whole.

RELEVANT CONSTITUTIONAL AND STATUTORY PROVISION INVOLVED

Georgia § 33-24-54. Payment of benefits under accident and sickness policies to licensed nonparticipating or nonpreferred providers [1]

[1] Notwithstanding any provisions of Code Sections 33-1-3, 33-1- 5, and 33-24-17 and Chapter 20 of this title or any other provisions of this title which might be construed to the contrary, whenever an accident and sickness insurance policy, subscriber contract, or self-insured health benefit plan, by whatever name called, which is issued or administered by a person licensed under this title provides that any of its benefits are payable to a participating or preferred provider of health care services licensed under the provisions of Chapter 4 of Title 26 or of Chapter 9, 11, 30, 34, 35, or 39 of Title 43 or of Chapter 11 of Title 31 for services rendered, the person licensed under this title shall be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider who has rendered such services, has a written assignment of benefits, and has caused written notice of such assignment to be given to the person licensed under this title or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the person licensed under this title shall be required to send such benefit payments directly to the provider who has the written assignment. When payment is made directly to a provider of health care services as authorized by this Code section, the person licensed under this title shall give written notice of such payment to the insured, subscriber, or other covered person.

RELEVANT CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED *continued*

The All Writs Act, 28 U.S.C. § 1651(a), provides: "The Supreme Court and all courts established by Act of Congress may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law."

ERISA SECTION 502(a) (29.U.S.C. §1132 (a) : (1) claims for penalties under Section 502(a)(1)(A) and Section 502(c) when statutorily mandated information is not provided; (2) claims under Section 502(a)(1)(B) for benefits due under a plan or to enforce rights or clarify rights under a plan; (3) claims for breach of fiduciary duties under Section 502(a)(2) for "appropriate relief" under Section 409 of ERISA; and (4) claims under Section 502(a)(3) – ERISA's "catchall" provision – for injuries that Section 502 does not remedy elsewhere.

RELIEF SOUGHT[2]

Dr. Griffin respectfully requests that this court:

1. Void all related *Griffin* published and non-published 11th Circuit opinions between 2015 – 2023. (See Statement of Related Proceedings Section pages 5-7)
2. Clarify that Dr. Griffins assignment of benefits language "rights and benefits" is sufficient for all remedies under ERISA including statutory penalties.
3. Declare that due to extraordinary circumstances and special procedures permitted under the All Writs Act, the 11th Circuit Justice will oversee the related, remaining pending opinions immediately without further delay in the interest of public policy, Georgia State law, and ERISA. Or alternatively, this Court should provide an order to the 11th Circuit that expressly defines her ERISA rights and state rights.
4. Facilitate the disbarment of all attorneys from the United States Supreme Court and the Georgia Bar that have participated in legal propaganda and judicial misconduct between 2015 -2023 in *Griffin* cases in the 11th Circuit and Northern District Court in Georgia.
5. Mandate 11th Circuit enforcement of ERISA statutory penalty $110.00 per day for each violation. This is necessary to discourage further corruption and fraud.
6. Clarify that the Statue of Limitation is twenty years in the State of Georgia for ERISA statutory penalties in accordance with OCGA § 9-3-22. This is necessary to discourage further corruption and fraud.
7. Clarify that Georgia Mandatory Assignment of Benefit Law is not pre-empted by ERISA.

[2] Dr. Griffin requests this court to act immediately with as little time permitted by law. Due to her resilience to pursue her rights to justice for the past eight years, she has been subjected to extreme retaliation in many aspects of her personal and professional life. She has extremely urgent security concerns that have been reported to the FBI and other security entities. As such, she requests that Respondent is not permitted to reply and immediate orders without any additional delays are written.

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OPINIONS BELOW

Petitioner respectfully prays that an Emergency Writ of Mandamus is issued to force the 11th Circuit to enforce the Supreme Court Order and Georgia Law.

OPINIONS BELOW

The relevant orders of the United States District Court for the Northern District of Georgia and 11th Circuit is included with this Petition as Appendix A.

I. STATEMENT OF THE ISSUES

1. Whether the state of Georgia's mandatory provider assignment of benefit law drafted under Insurance Title 33(Georgia § 33-24-54)[3] is pre-empted by the Employee Retirement Investment Security Act of 1974 ("ERISA").

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[3]also, see Relief Sought, page 12

STATEMENT OF THE CASE

Course of Proceedings and Disposition Below

On March 3, 2022, Dr. Griffin, appearing pro se, filed a complaint against Blue Cross in the State Court of Fulton County, Georgia, asserting claims for statutory penalties under ERISA, 29 U.S.C.§ 1001, *et seq.*

Blue Cross timely removed the case to the United States District Court for the Northern District of Georgia, Atlanta Division, on April 6, 2022, and promptly moved to dismiss Dr. Griffin's complaint under Fed. R. Civ. P. 12(b)(6).

On April 13, 2022, Respondent filed a motion to dismiss and argued, among other things, that Dr. Griffin lacked standing because the assignment of "benefits and rights" did not include rights to statutory penalties.

The District Court agreed, and the case was dismissed on March 22, 2023 and on April 20, 2023, Dr. Griffin timely filed a notice of appeal.

II. Statement of Facts

a. Between February 13, 2013, and November 19, 2014, Dr. Griffin, an out of network provider, treats 22 patients and receives a written assignment of "rights and benefits" in compliance with Georgia § 33-24-54 *and designation of authorized representative consent.*

Dr. Griffin is a practicing dermatologist in Atlanta, Georgia. She is an "out-of-network" provider under the terms of the Plans. Every claim was required to be submitted to the local Blue Cross, the Home Plan and/or Host Plan, due to its role as the claims fiduciary in the Blue Card Program.

The assignment of benefits and rights stated the following:

This is a direct assignment of my rights and benefits under this policy and designation of authorized representative.

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPPA to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims, claim appeals, grievances, and securing payment of benefits. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
- This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable state laws.

b. During the administrative appeals, Dr. Griffin sent Blue Cross certified appeals and requested relevant plans documents including rate tables, fee schedules, Summary Plan Description, and administrative service agreements.

For every patient claim, Blue Cross did not honor the usual and customary benefit level. Dr. Griffin submitted meticulous appeals to Blue Cross and clarified everything that was required in order to fulfill a full and fair review.

Despite submitting dozens of ERISA appeals via certified mail, the appeals went unanswered, a full and fair review did not exist, Blue Cross had a deaf ear to any plan document request, and the doctor never got paid.

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c.During the legal proceedings, Respondent did not attempt to resolve any of these legal matters. In fact, there was hardly any communication between Dr. Griffin and Respondent's counsel.

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d.The District Court grants Respondent's Motion to Dismiss for lack of standing.

The court relied heavily on the published opinion by the 11th Circuit "in hopes of resolving this recurring litigation." *Griffin v. Coca-Cola Refreshments USA, Inc.*, 989 F.3d 923, 927 (11th Cir. 2021). The Eleventh Circuit determined that the assignment language only purported to convey a right to bring claims for benefits, not statutory penalties, because the assignment of benefits was voidable due to anti-assignment provisions in the plan and there no mention of statutory penalties in the assignment language. *Coca-Cola,* 989 F.3d at 932-33. Also, See *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1296 (11th Cir. 2004) (collecting cases across circuits) ("[A]n unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable.")

e. After the District Court dismissed the case due to lack of standing, Dr. Griffin searched for legal defenses and stumbled across a mind-boggling, game-changing case law that she was not able to present in her initial defense to the District Court prior to its dismissal of the case.

If an issue is "properly presented, a party can make any argument in support of that issue; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido* , 503 U.S. 519, 534, 112 S.Ct. 1522, 118 L.Ed.2d 153 (1992) ; see also *Sec'y, U.S. Dep't of Labor v. Preston* , 873 F.3d 877, 883 n.5 (11th Cir. 2017) (" Parties can most assuredly waive positions and issues on appeal, but not individual arguments.....Offering a new argument or case citation in support of a position advanced in the district court is permissible—and often advisable. ".

Hence, Dr. Griffin waived the discussions related to *Rutledge* in the appeal and focused on old, but newly discovered mandatory, binding case law that supported her on-going defense: mandatory state insurance laws are not pre-empted by ERISA. (See *Metropolitan Life Insurance. Co. v. Massachusetts,* 471 U.S. 724 (1985).[4]

[4]This matter is of urgent priority because both *Physicians* and *Coca-Cola* are based upon the assumption that Dr. Griffin*'s* written assignment of benefit is voidable due to plan anti-assignment statutes. But, this is not the case. Her assignment of benefit is not voidable based upon the Supreme Court language in *Metropolitan* because the assignment was obtained in accordance with Georgia's mandatory assignment statue. This state law is not pre-empted by ERISA and attorneys for Blue Cross have intentionally misled the court.

f. *The 11th Circuit issued an opinion dated December 19, 2023, that affirmed the District Court opinion.*

The 11th Circuit Opinion completely ignored Georgia mandatory assignment law and US Supreme Court binding case law. It deprived Dr. Griffin of her constitutional rights provided under Georgia law and ERISA. She is not allowed to be an assignee with derivative standing under ERISA in the 11th Circuit. (See) *Griffin v. Coca-Cola Refreshments USA, Inc.,* 989 F.3d 923, 931 (11th Cir. 2021). The Coca Cola opinion was based upon an invalid assignment of benefit. As such, it only addressed the language of the assignment. However, it did not consider that Dr. Griffin has derivative standing under ERISA to sue for all ERISA rights. It did not discuss ERISA pre-emption of Georgia assignment of benefit law. These are all critical issues that have been ignored by the 11th Circuit to support the coup of Georgia state laws and ERISA rights.

INTRODUCTION

ERISA permits a state to regulate insurance and benefits provided through insurance law — a special exception to the general ERISA preemption of state laws referred to as the "insurance savings clause." Based on this exception, the Supreme Court held in *Metropolitan* that a state can mandate that an insurance policy provide certain coverages or benefits. An employer who buys the regulated policy and/or contracts with an insurer (for example, an administrative services agreement for a self-funded ERISA welfare benefit plan) in the state with an insurance mandate becomes contractually bound to provide the state-mandated coverages and benefits. [5'6]

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[5]Unfortunately, Dr. Griffin has gotten legally beaten to death and tossed out of many courts head-first since 2014, exclusively due to bad case law that was never applicable to her in accordance with Georgia State law and US Supreme Court precedent. Both our District Court and Eleventh Circuit judges put trust into Fortune 500 law firms that are directly responsible for legal propaganda on many levels. Every lawyer had the obligation "to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel." Georgia Rules of Professional Conduct 3.3 (a) (3). Here, Dr. Griffin, the Northern District Court, and the Eleventh Circuit have been duped by money-hungry law firms that put profit before the laws and its ethical obligation to notify the judiciary of controlling case law. Indeed, Dr. Griffin has spent countless hours on Pacer and Casetext for many years and not once did she come across *Metropolitan* until recently.

[6]Rule 2.15 (B) also **requires judges to report to the State Bar of Georgia any violation by a lawyer of the Rules of Professional Conduct**, if the violation raises a substantial question of the lawyer's fitness as a lawyer and, again, if the violation is known to the reporting judge. Ga. Code. Jud. Cond. 2.15.

ERISA plans conform to relevant state insurance law through governing and/or conformity clause in the contracts and/or administrative services agreements. For example, a typical generic, clause may state " The Plan shall be governed by and administered under ERISA, and, to the extent not preempted thereby, under the laws of the State of XYZ…". ERISA specifically precludes assignment of pension plan benefits. As such, there is no ignoring the fact that, when Congress was adopting ERISA, it had before it a provision to bar the assignment of ERISA plan benefits, and chose to impose that limitation only with respect to ERISA pension benefit plans, and *not* ERISA welfare benefit plans. *see Louisiana Health Serv. & Indem. Co. v. Rapides Healthcare Sys.,* 461 F.3d 529, 540 (5th Cir.2006) (taking a contrary view of the congressional silence on assignment of benefits in ERISA and stating, "Congressional silence points in both directions: either leaving assignment of employee welfare benefits to the parties or leaving room for state regulation, should a state desire to intervene.")

SUMMARY OF THE ARGUMENT

Consistent with the US Supreme Courts authority *and* the purposes of ERISA, the Georgia Assignment Statute requires all entities engaged in the business of insurance to honor assignment of benefits when notified of the existence of an assignment. Because the law is a mandate written in the state insurance code, it must be incorporated into insurance contracts and it is saved from preemption as a law regulating insurance because it is directed to entities engaged in the business of insurance and it substantially affects the risk pooling arrangement between insurers and insures. A refusal to honor assignments serves as a great impediment to the recipient of benefits and insureds, as it encourages providers either : (1) to refuse to treat certain patients, or (2) to file suit against patients not forwarding benefit checks to providers. The Georgia Assignment Statue is designed to prevent these adverse situations from developing.

Furthermore, because the Georgia Assignment Statue offers an assignee provider no more than the benefits and rights than the assignor patient had, it does not create a civil enforcement vehicle separate from those authorized by § 502(a) of ERISA. As such, it is not subject to complete preemption by ERISA.

ARGUMENT

Under ERISA, the preemption of statutes which "relate to" ERISA plans is "substantially qualified" by the ERISA saving clause. *Metropolitan Life,* 471 U.S. at 733. That clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). Under the Supreme Court's pronouncement in *Kentucky Assoc. of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), for a state statute to be saved from preemption as one that regulates insurance, the statute must satisfy two criteria:

> First, the state law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

Miller, 538 U.S. at 342 (citations omitted). The Georgia Assignment Statute satisfies both of these requirements.

1. The Georgia Assignment Statue is Specifically Directed Toward Entities Engaged in Insurance under Title 33 Insurance Laws

In order for a statute to be specifically directed to entities engaged in insurance, the law at issue must not only have an impact on the insurance industry, but it must also be specifically directed to that industry, *Rush Prudential v. Moran*, 536 U.S. 355, 365-66 (2002); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1999); or aimed at it, *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990);

Stated another way, the statute must home in on the industry to meet this element of the test. *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 368 (1999). There is zero doubt that question whether the Georgia Assignment Statute is directed to entities engaged in insurance.

2. **The Georgia Assignment Statue Substantially Affects Risk Pooling Arrangement between the Insurer and the Insured.**

With risk pooling, a "number of risks are accepted, some of which involve losses," and the "losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it." *Barber v. UNUM Life Ins.* Co., 383 F.3d 134, 143 (3rd Cir. 2004) (quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 128 n.7 (1982)). Therefore, to affect a risk pooling arrangement, a statute is required to "alter the scope of permissible bargains between insurers and insureds" and affect the arrangements that an insurer may offer. See *Miller*, 538 U.S. at 338-39. Here, it is clear that the Georgia Assignment Statute does just that.[7]

---

[7]Notably, the statute at issue is only required to affect the risk pooling arrangement; the statute is not required to spread the risk. *Miller,* 538 U.S. at 339 n.3.

To ascertain how the Georgia Assignment Statute affects the scope of permissible bargains between an insurer and insured, it is necessary to understand the scope of permissible bargains absent the Georgia Assignment Statute. In enacting ERISA, Congress had before it a provision to limit the alienation of ERISA plan benefits, and it chose to impose the limitation with respect to pension benefits, but not welfare benefits. *Mackey v. Lanier Collection Ag. & Serv., Inc.,* 486 U.S. 825, 837 (1988). Due to Congress' silence on this issue, most courts find that "ERISA- governed plans are contracts, [and] the parties are free to bargain for certain provisions in the plan – like assignability." *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1296 (11th Cir. 2004). Thus, absent (*emphasis added*) the Georgia Assignment Statute, the parties are free to bargain for the assignability of benefits owed under ERISA plans.

However, the Georgia Assignment Statute alters the permissible scope of the bargains that can be negotiated between the insurer and insured by prohibiting the use of anti-assignment provisions such as the one utilized by the Blue Cross plans in this case. By its terms, the statute requires Blue Cross, the claims fiduciary of ERISA plans, to honor the written assignments of benefits in accordance with Georgia insurance law, notwithstanding language to the contrary purportedly "bargained for" in an ERISA plan.

Therefore, the Georgia Assignment Statute alters the scope of the permissible bargains between the insurer and insured. As such, it affects the risk pooling arrangement between the insurer and the insured. *Compare Miller*, 538 U.S. at 341-342 (statute affecting insurers' ability to contract with providers affects risk pooling), *and UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 374 (1999) (notice prejudice rule affects risk pooling), *with Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 51 (1987) (bad faith claim does not define the relationship between the insurer and insured and, therefore does not affect the spreading of risk), and *Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997) (bad faith law does not spread risk because it does not affect the bargain between insurer and insured).

3. The Georgia Assignment Statute Does Not Duplicate, Supplement, or Supplant ERISA's Civil Enforcement Remedies

The Georgia Assignment Statute does nothing to affect, duplicate, supplement or supplant any remedy available under ERISA. There is no cause of action created by the Georgia Assignment Statute. "…..no formalities are required for an assignment to be valid.." *See Gallardo By and Through Vassallo v. Marstiller,* 142 S.Ct. 1751, 1759 (2022). As a rule, "terms of art are not required for a valid assignment." *United States ex rel. Kelly v. The Boeing Co.,* 9

F.2d 743 (9th Cir. 1993). The *Gallardo* opinion stated .. "We must also read §1396k(a)(1)(A) 's text in light of background legal principles, and it is blackletter law that assignments typically cover 'only [those] rights possessed by the assignors at the time of the assignments,' *United States v. Central Gulf Lines, Inc.* , 974 F.2d 621, 629 (C.A.5 1992) ; see also 6A C. J. S., Assignments § 88 (2022), or those rights 'expected to arise out of an existing ... relationship,' see Restatement (Second) of Contracts § 32 1(1) (1981); see also 9 A. Corbin, Contracts § 50.1 (2022). Also See *Conn. State Dental Ass 'n v. Anthem Health Plans, Inc.,* 591 F.3d 1337, 1347 (11th Cir. 2009).

Under the Georgia Assignment Statute, the only issue is to whom the benefits are paid – not whether benefits are owed or at what level. As the Supreme Court held in *Rush*, "a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief" is not preempted. (*see Rush Prudential v. Moran*, 536 U.S. 355 (2002). Stated another way, the "assignee seeking relief in court stands in the place of an assignor, there has been a substitution rather than an expansion of the parties." See *City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223 (1st Cir. 1998)

4. **Georgia Assignment of Benefit Statute is Saved From ERISA Preemption & Is Not Subject to the Deemer Clause**

State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer. See *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys., 461 F.3d 529, 530* (5th Cir.2006) (holding that a state statute that "requires insurance companies to honor all assignments of benefit claims made by patients to hospitals" was not preempted by ERISA); see also *Fontaine v. Metro. Life Ins. Co., 800 F.3d 883, 885* (7th Cir.2015). (holding that Illinois insurance law which "prohibits provisions purporting to reserve discretion to insurers to interpret health and disability insurance policies" is not preempted by ERISA and therefore enforceable against group employer-sponsored insurance plan).

5. **Dr. Griffin's Assignment of Benefit is Valid and confers Statutory Standing for all ERISA claims, including statutory penalties.**

Blue Cross can not have the cake and eat it too. Now, it wants to run away from its historic anti-assignment rhetoric like a stray dog with its tail tucked between the legs. But, not so fast….

The Eleventh Circuit's holding in *Coca-Cola* is expressly based upon a *voidable* assignment of benefit with ERISA preemption. However, today, this is not the case. A valid assignment of benefits permits Dr. Griffin to litigate at every angle. It is a well-established principle of Georgia law that an assignee of a contract acquires its rights from the assignor, has no more rights under the contract than the assignor, and is subject to all the defenses that could have been raised against the assignor. *Pridgen v. Auto-Owners Ins*. Co., 204 Ga. App. 322, 323 (419 SE2d 99) (1992). The 11th Court held in Cagle, that an assignment of benefits confers derivative standing was based on its assessment that "neither § 1132(a) nor any other ERISA provision prevents derivative standing based upon an assignment of rights from an entity listed in that subsection." See *Cagle v. Bruner,* 112 F.3d 1510 (11th Cir. 1997). "The Court's holding applies not only to § 1132(a) in its entirety, but also to the whole of ERISA. ACEP and MAG brought their claims under § 1132(a) and thus have derivative standing to seek equitable relief from Defendants. "*Am. Coll. of Emergency Physicians v. Blue Cross & Blue Shield of Georgia* , 833 Fed.Appx. 235, 239 (11th Cir. 2020).

REASON FOR ACCEPTION THE PETITION

It is of imperative public importance that this court grant this petition for the survival of our Georgia's mandatory assignment of benefit law and ERISA remedies, which have been under siege in the 11th Circuit for eight years. This mandamus unequivocally shows that corrupt Fortune 500 law firms have been successful deceiving the judiciary and using the judiciary to create illegitimate case law that has sabotaged to livelihood of Dr. Griffin and other similarly situated providers in the 11th Circuit. The 11th Circuit has been complacent and equality responsible. It has shown that it has no interest in justice for Dr. Griffin, the only law abiding party in this case.

A WRIT OF MANDAMUS IS WARRANTED GIVEN THE URGENT CIRCUMSTANCES OF THIS CASE

Every Georgian and, more broadly, American in states with mandatory assignment statues, has the right to assign those benefits and rights to their medical provider, which removes the patient from the hassles of appeals and collection ordeals that providers are more knowledgeable and suited to handle. If doctors are not able to sue the health plans, they have no recourse other than suing the patients. Dr. Griffin has sued patients in the past because the 11th denied her assignments and ERISA rights. The greed, corruption, and misconduct of law firms have taken a toll of the judiciary's ability to provide basic rights to Georgians that are mandatory in accordance with state and federal laws.

NO OTHER ADEQUATE MEANS TO OBTAIN RELIEF EXISTS

The Application and subsequent mandamus are necessary due to the imperative public importance based on the current coup by corrupt law firms and members of the judiciary, which has put the integrity of our justice system at risk. For these reasons, there is no other adequate means of relief. The urgency of this matter demands that this court address and remedy the issues at hand, based on S.C. Rule 11, FRAP Rule 2, and11th Circuit Rule 2-1. Neither Griffin nor any other American can risk having this matter bogged down in a lower court when immediate action is necessary. The lower courts have had eight years to do the right thing and they have consistently sided with rich corporations, not the law.

For example, in *Griffin v Coca* the 11th Circuit stated that "…Griffin effectively asks this Court to invalidate an unambiguous contract provision which is valid and enforceable under our precedent based on the policy preferences of another circuit. We cannot depart from our precedent. See *Wilson v. Taylor,* 658 F.2d 1021, 1034 (5th Cir. May 1, 1981) ("It is the firm rule of this circuit that we cannot disregard the precedent set by a prior panel, even though we perceive error in the precedent. ***Absent an intervening Supreme Court decision which changes the law, only the en banc court can make the change***…". (See *Griffin v. Coca-Cola Refreshments USA, Inc.,* 989 F.3d 923,11th Cir.2021). On March 23, 2023, in a related, pending case with the same issues, Dr. Griffin requested an initial enbanc hearing, but that request has been ignored. (See *Griffin v Blue Cross et. al.* docket entry 48, Case 22-14187). There are

zero options for Dr. Griffin in the 11th circuit. These issues can only be resolved in this court by special procedures due to extraordinary circumstances. The matters are of dire importance and cannot be bogged down for endless years or buried by rogue, bought off or blackmailed judges or clerks, which could be contributing to the current scenario that Dr. Griffin is experiencing in this circuit. Nothing else makes much sense to rationalize what has been happening. As such, no other adequate means to obtain relief exists. She and other similarly situated providers have been denied constitutional rights and cannot compete with big corporations, health insurers, and bottom of the barrel law firms that operate better than drug cartels in broad daylight. If this is not fixed, the 11th Circuit will become a run-away-rogue circuit by default and Georgia state law mandates and ERISA rights may be permanently abandoned by the courts. Dr. Griffin only wants justice. She wants desperately exit the courts, but only after justice has been served.

CONCLUSION

Based upon all of the above, Dr. Griffin is asking this honorable court one last time to step-in and help in whatever capacity it can immediately.

Respectfully submitted, 12/21/2023

/s/ W. A. GRIFFIN, M.D.

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Certificate of Compliance

This Application conforms to the word count and format in accordance with US Supreme Court Applications and Eleventh Circuit rules.

Respectfully submitted, 12/21/2023

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CERTIFICATE OF SERVICE

I, W. A. Griffin hereby certify that on December 20, 2023, I served copies of the foregoing **WRIT OF MANDAMUS PETITION AND APPENDIX A** on the following counsel of record by way the Court's PACER CM/ECF system and hard copies via Fed Ex ground shipping to counsel on the records.

/s/ *W. A. GRIFFIN, M.D.*
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APPENDIX A

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[DO NOT PUBLISH]

In the United States Court of Appeals

For the Eleventh Circuit

No. 23-11414

Non-Argument Calendar

W. A. GRIFFIN, MD,

Plaintiff-Appellant,

versus

BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC.,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Georgia
D.C. Docket No. 1:22-cv-01341-SEG

Before WILSON, LUCK, and ANDERSON, Circuit Judges.

PER CURIAM:

W.A. Griffin, M.D., proceeding *pro se*, appeals an order of the district court dismissing her claim under the Employee Retirement Income Security Act ("ERISA") against Blue Cross Blue Shield Healthcare Plan of Georgia ("BCBSHP"). The court dismissed her claim pursuant to Federal Rule of Civil Procedure 12(b)(6), based on its finding that she lacked statutory authority to bring penalty claims under ERISA. On appeal, Griffin argues that her patients assigned her the right to bring statutory penalty claims on their behalf, and that ERISA does not preempt O.C.G.A. § 33-24-54, which allegedly validates the assignments upon which she relies.

We review *de novo* a dismissal pursuant to Federal Rule of Civil Procedure 12(b)(6). *Hoffman-Pugh v. Ramsey*, 312 F.3d 1222, 1225 (11th Cir. 2002). "To survive a 12(b)(6) motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Stillwell v. Allstate Ins. Co.*, 663 F.3d 1329, 1333 (11th Cir. 2011) (quotation marks omitted). The 12(b)(6) plausibility standard requires "pleading factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Mamani v. Berzain*, 654 F.3d 1148, 1153 (11th Cir. 2011) (quotation marks omitted). However, the plausibility standard requires "more

than a sheer possibility that a defendant has acted unlawfully." *Id.* (quotation marks omitted). In considering a complaint under this standard, "[l]egal conclusions without adequate factual support are entitled to no assumption of truth." *Id.*

"*Pro se* pleadings are held to a less stringent standard than pleadings drafted by attorneys and will, therefore, be liberally construed." *Tannenbaum v. United States*, 148 F.3d 1262, 1263 (11th Cir. 1998). However, a *pro se* litigant is nonetheless "subject to the relevant law and rules of court, including the Federal Rules of Civil Procedure." *Moon v. Newsome*, 863 F.2d 835, 837 (11th Cir. 1989).

Section 502(c)(1)(B) of ERISA states that any administrator of an ERISA-governed healthcare plan

> who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

29 U.S.C. § 1132(c)(1)(B). "[T]o maintain an action under ERISA, a plaintiff must have standing to sue under the statute." *Griffin v. Coca-Cola Refreshments USA, Inc.*, 989 F.3d 923, 931 (11th Cir. 2021).

However, in this context, standing "is not jurisdictional, Article III standing, but rather the right to make a claim under the statute." *Id.* at 931 n.4.

To have standing to assert an ERISA claim, a plaintiff must be either a "participant or beneficiary" of an ERISA healthcare plan. 29 U.S.C. § 1132(a)(1). While healthcare providers are generally not "participants" or "beneficiaries" under ERISA, we have stated that a healthcare provider "may obtain derivative standing for payment of medical benefits through a written assignment from a plan participant or beneficiary." *Coca-Cola*, 989 F.3d at 932. However, we have previously ruled that a written assignment of the right to recover benefits provided by an ERISA plan does not necessarily transfer the right to pursue non-payment claims, including statutory penalties. *Id.*). Thus, to assess whether one has transferred the right to assert claims for statutory penalties under ERISA, we must "first determine the scope of the patients' assignments to [the healthcare provider]—whether they purport to give her the right to bring both payment and non-payment (breach of fiduciary duties and statutory penalties) claims." *Id.*

When previously considering a similar argument (raised by the same appellant), we ruled that, in the absence of more specific language, a patient does not transfer of the right to assert ERISA claims for statutory penalties when she executes a written assignment stating "[t]his is a direct legal assignment of my rights and benefits under the policy." *Id.* at 932-33.

Here, the district court did not err in finding that Griffin lacked statutory standing to bring statutory penalty claims under ERISA on behalf of her patients. The assignment in the instant case used the same language—i.e. assigning "my rights and benefits"—as did the assignment in the *Coca-Cola* case. The court properly relied upon our prior decisions in finding that the assignments upon which Griffin relied did not include sufficiently explicit language to transfer the right to bring non-payment, statutory penalty suits under ERISA.[1] Accordingly, we affirm.[2]

AFFIRMED.

[1] The district court's decision concerned only the scope of the assignments upon which Griffin relied, rather than their underlying validity or enforceability. Thus, we do not address Griffin's arguments on appeal related to ERISA preemption and O.C.G.A. § 33-24-54, as they are irrelevant to the basis for the district court's order. Because we agree with the district court that Griffin lacks statutory standing to bring her claims for statutory penalties, we need not address BCBSHP's argument that her claims are barred by the statute of limitations.

[2] We note that Griffin's brief on appeal does not challenge the district court's dispositive ruling; she makes no argument with respect to the specific language of the assignment and whether the language is broad enough to assign claims for statutory penalties. Because this case is controlled in any event by our *Coca-Cola* case, we need not address the issue of whether Griffin should be deemed to have forfeited this dispositive issue.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

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December 19, 2023

MEMORANDUM TO COUNSEL OR PARTIES

Appeal Number: 23-11414-D
Case Style: W. A. Griffin v. Blue Cross Blue Shield Healthcare Plan of Georgia,
District Court Docket No: 1:22-cv-01341-SEG

Electronic Filing
All counsel must file documents electronically using the Electronic Case Files ("ECF") system, unless exempted for good cause. Although not required, non-incarcerated pro se parties are permitted to use the ECF system by registering for an account at www.pacer.gov. Information and training materials related to electronic filing are available on the Court's website.

Enclosed is a copy of the court's decision filed today in this appeal. Judgment has this day been entered pursuant to FRAP 36. The court's mandate will issue at a later date in accordance with FRAP 41(b).

The time for filing a petition for rehearing is governed by 11th Cir. R. 40-3, and the time for filing a petition for rehearing en banc is governed by 11th Cir. R. 35-2. Except as otherwise provided by FRAP 25(a) for inmate filings, a petition for rehearing or for rehearing en banc is timely only if received in the clerk's office within the time specified in the rules. Costs are governed by FRAP 39 and 11th Cir.R. 39-1. The timing, format, and content of a motion for attorney's fees and an objection thereto is governed by 11th Cir. R. 39-2 and 39-3.

Please note that a petition for rehearing en banc must include in the Certificate of Interested Persons a complete list of all persons and entities listed on all certificates previously filed by any party in the appeal. See 11th Cir. R. 26.1-1. In addition, a copy of the opinion sought to be reheard must be included in any petition for rehearing or petition for rehearing en banc. See 11th Cir. R. 35-5(k) and 40-1 .

Counsel appointed under the Criminal Justice Act (CJA) must submit a voucher claiming compensation for time spent on the appeal no later than 60 days after either issuance of mandate or filing with the U.S. Supreme Court of a petition for writ of certiorari (whichever is later) via the eVoucher system. Please contact the CJA Team at (404) 335-6167 or cja_evoucher@ca11.uscourts.gov for questions regarding CJA vouchers or the eVoucher system.

Pursuant to Fed.R.App.P. 39, costs taxed against appellant.

Please use the most recent version of the Bill of Costs form available on the court's website at www.ca11.uscourts.gov.

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OPIN-1A Issuance of Opinion With Costs

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

W.A. GRIFFIN, M.D., Plaintiff, v. BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC., Defendant.	CIVIL ACTION NO. 1:22-CV-01341-SEG

ORDER

This case is before the Court on Defendant Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.'s ("BCBSHP") motion to dismiss. (Doc. 3.) Having carefully considered the parties' respective positions and applicable law, the Court enters the following order.

I. Factual Background

Plaintiff is a dermatologist and frequent *pro se* filer in this Court.[1] This case concerns a number of claims Plaintiff submitted to BCBSHP on behalf of 22 patients she treated from 2013 to 2014. (Doc. 1-1 ¶¶ 19-170.) As a condition of treatment, Plaintiff required each patient to execute a document that

[1] See *Griffin v. Coca-Cola Refreshments USA, Inc.*, 989 F.3d 923, 929 n.2 (11th Cir. 2021) for a non-exhaustive list of Dr. Griffin's cases in this Court.

purported to assign the patient's health insurance benefits to Plaintiff. (*Id.* ¶ 11.) The document stated, in pertinent part, the following:

> This is a direct assignment of my rights and benefits under this policy and designation of authorized representative . . .
>
> I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPPA to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims, claim appeals, grievances, and securing payment of benefits. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions[.]
>
> This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable state laws.

(*Id.*)

Plaintiff alleges that, for all 22 patients, she submitted claims for payments to BCBSHP. (*Id.* ¶¶ 19-170.) She thereafter submitted administrative appeals to BCBSHP for its alleged failure to make certain payments to her. (*Id.*) In each appeal, Plaintiff also allegedly requested certain plan documents from BCBSHP. (*Id.*) Plaintiff alleges that each appeal was either denied or not answered. (*See id.*) She also alleges that she never received from BCBSHP the plan documents she requested. (*See id.*)

Purporting to stand in the shoes of her patients, Plaintiff claims that BCBSHP violated ERISA by failing to comply with her requests for plan documents within 30 days of each request as allegedly required under 29 U.S.C. § 1021. (*Id.* ¶¶ 173-77.) With this lawsuit, Plaintiff asks the Court to award her "[s]tatutory penalties of $110 per day for failure to produce ERISA plan documents." (*Id.* at 46.) BCBSHP has moved to dismiss Plaintiff's complaint. (Doc. 3.) BCBSHP further requests reasonable attorneys' fees and costs that it accrued in connection with this lawsuit. (*Id.* at 16-18.)

II. Motion to Dismiss Standard

Federal Rule of Civil Procedure 8(a)(2) provides that a pleading must contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Although detailed factual allegations are not required, the pleading must contain more than "labels and conclusions" or a "formulaic recitation of the elements of a cause of action." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Importantly, "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Id.* (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). For a complaint to be "plausible on its face," the facts alleged must "allo[w] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Wooten v. Quicken Loans, Inc.* 626 F.3d 1187, 1196 (11th Cir. 2010).

While all well-pleaded facts must be accepted as true and construed in the light most favorable to the plaintiff, *Powell v. Thomas*, 643 F.3d 1300, 1302 (11th Cir. 2011), a court need not accept as true the plaintiff's legal conclusions, including those couched as factual allegations, *Iqbal*, 556 U.S. at 678.

Accordingly, evaluation of a motion to dismiss entails a two-pronged approach: (1) a court must identify any allegations in the pleading that are merely legal conclusions to which the "assumption of truth" should not apply, and (2) where there are remaining well-pleaded factual allegations, a court should "assume their veracity and then determine whether they plausibly give rise to an entitlement to relief." *Id.* at 679.

When a plaintiff is *pro se*, his or her complaint is "held to less stringent standards than formal pleadings drafted by lawyers" and must be "liberally construed." *See Erickson v. Pardus*, 551 U.S. 89, 94 (2007) (citation and quotation omitted); *see also Boxer X v. Harris*, 437 F.3d 1107, 1110 (11th Cir. 2006). At the same time, the Court "need not accept as true legal conclusions or unwarranted factual inferences" in complaints filed by *pro se* litigants. *Montgomery v. Huntington Bank*, 346 F.3d 693, 698 (6th Cir. 2006) (quotation and citation omitted). Further, *pro se* plaintiffs must comply with threshold requirements of the Federal Rules of Civil Procedure. *See Trawinski v. United Techs.*, 313 F.3d 1295, 1299 (11th Cir. 2002).

III. BCBSHP's Motion to Dismiss

In this case, unlike in the majority of cases she has filed in this Court, Plaintiff does not seek recovery for unpaid benefits to which she believes she is entitled as an alleged assignee of benefits. Rather, she brings a claim solely for statutory penalties under ERISA for BCBSHP's alleged failure to provide requested plan documents. Plaintiff's claim, however, fails as a matter of law because the assignment she allegedly received from her patients did not specifically assign the right to bring a claim for statutory penalties under ERISA. And without an enforceable assignment, Plaintiff lacks statutory standing to assert this claim on her patients' behalves.

Section 502(c)(1)(B) of ERISA permits plan participants and beneficiaries to recover a per diem statutory penalty for a plan administrator's failure to comply with a request for healthcare plan documents. 29 U.S.C. § 1132(c)(1)(B). That statute states in pertinent part:

> [An administrator] who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

29 U.S.C. § 1132(c)(1)(B).

To maintain a civil action for the recovery of statutory penalties under § 502(c)(1)(B) of ERISA, a plaintiff must have statutory standing. *Griffin v. Coca-Cola Refreshments USA, Inc.*, 989 F.3d 923, 931 (11th Cir. 2021). To have statutory standing, a plaintiff must be a plan "participant" or a plan "beneficiary."[2] 29 U.S.C. § 1132(a). "Healthcare providers . . . are generally not 'participants' or 'beneficiaries' under ERISA." *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1294 (11th Cir. 2004). A healthcare provider may "obtain derivative standing for payment of medical benefits through a written assignment from a plan participant or beneficiary." *Coca-Cola*, 989 F.3d at 932; *see also Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997) ("[N]either the text of § 1132(a)(1)(B) nor any other ERISA provision forbids the assignment of health care benefits provided by an ERISA plan."). However, an assignment of the right to medical benefits does not necessarily assign the right to pursue non-payment related claims, such as claims for statutory penalties. *Coca-Cola*, 989 F.3d at 932; *Griffin v. Health &*

[2] The statute further creates causes of action for the benefit of the Secretary of Labor and for a plan "fiduciary." 29 U.S.C. § 1132(a). Dr. Griffin, however, does not purport to be acting on behalf of the Secretary of Labor or as a plan fiduciary.

Welfare Comm. of Savannah River Nuclear Sols., LLC, No. 1:21-CV-01016-WMR, 2022 WL 831618, at *2 (N.D. Ga. Mar. 7, 2022). As a result, the Court must determine "the scope of the patients' assignment to Griffin—whether they purport to give her the right to bring both payment and non-payment (breach of fiduciary duties and statutory penalties) claims." *Coca-Cola*, 989 F.3d at 932.

Here, the assignments Plaintiff received are similar to the assignments at issue in several of Plaintiff's prior cases. In each of those cases, this Court and the Eleventh Circuit held that Plaintiff lacked standing to pursue statutory penalty claims under ERISA § 502(c)(1) because the assignment provision at issue did not assign any rights to pursue such claims. *See, e.g.*, *Coca-Cola*, 989 F.3d at 933 ("[T]he assignments make clear that the patients only assigned their right to bring claims for payment . . . ."); *Griffin v. SuntrustBank, Inc.*, 648 F. App'x 962, 967 (11th Cir. 2016) ("Nothing in an assignment of benefits transfers the patient's right to bring a cause of action" for non-payment related claims); *Griffin v. Verizon Commc'ns*, 641 Fed. Appx. 869, 873 n. 4 (11th Cir. 2016) ("Because the insured never assigned to Dr. Griffin the right to bring [civil penalty] claims, she lacks derivative standing to bring these claims under Section 502 of ERISA"); *Griffin v. Habitat for Humanity Int'l, Inc.*, 641 Fed. Appx. 927, 931 n. 4 (11th Cir. 2016); *Griffin v.*

Health Sys. Mgmt., 635 Fed. Appx. 768, 772 n. 4 (11th Cir. 2015); *Griffin v. Focus Brands*, 635 Fed. Appx. 796, 799 n. 4 (11th Cir. 2015); *Griffin v. S. Co. Servs.*, 635 Fed. Appx. 789, 793 n. 4 (11th Cir. 2015).

Plaintiff argues that her assignments in this case are distinguishable from those considered in other cases because of the inclusion of the following sentence: "I hereby authorize any plan administrator or fiduciary . . . to release to such provider(s) any and all plan documents . . . upon written request from such provider(s) *in order to claim such medical benefits, reimbursement or any applicable remedies*." (Doc. 1-1 ¶ 11 (emphasis added).) This language, however, does not provide Plaintiff with standing to pursue claims for statutory penalties for failure to comply with a request for plan documents. In assessing similar assignments in other cases brought by Plaintiff, the Eleventh Circuit determined that Plaintiff's patients only purported to convey a right to bring claims for benefits, not statutory penalties. *Coca-Cola*, 989 F.3d at 932-33; *see also Suntrust*, 648 F. App'x at 967 ("Nothing in an assignment of benefits transfers the patient's right to bring a cause of action . . . to seek statutory penalties for failure to provide plan document[.]"). As in those cases, the "rights" purportedly assigned to Plaintiff here did not "mention . . . statutory penalty claims." *Coca-Cola*, 989 F.3d at 932-33. Moreover, the above-quoted language permits Plaintiff to receive plan

documents only "*in order to*" claim benefits or other payments or remedies. In other words, this provision would allow Plaintiff to request plan documents to facilitate a claim for "medical benefits, reimbursement, or any applicable remedies." But it does not assign an independent right to assert a statutory penalty claim for the administrator's failure to provide plan documents in the absence of a benefits claim.[3] That right remained with the patient. Accordingly, Plaintiff lacks statutory standing to pursue her statutory penalty claim under § 502(c)(1)(B) of ERISA.[4]

IV. BCBSHP's Request for Attorneys' Fees and Costs

BCBSHP requests an award of attorneys' fees and costs in connection with this case. ERISA § 502(g)(1) permits the district court, in its discretion, to "allow a reasonable attorney's fee and costs of action to either party," 29 U.S.C. § 1132(g)(1), if that party achieved "some degree of success on the

[3] The Court has considered whether the phrase "applicable remedies" in the above-quoted assignment language might conceivably refer to the statutory penalties contemplated by 29 U.S.C. 1332(c)(1)(B). But that can't be right. Looking to the plain language of the assignment, it would make no sense for a patient to authorize a "plan administrator" to "release" to a provider the patient's plan documents "*in order to claim* . . . [statutory remedies]." Statutory remedies, after all, are available for *failure* to produce requested plan documents.

[4] Because the Court concludes that Plaintiff lacks standing to bring her claim, it need not address BCBSHP's alternative statute of limitations defense.

merits." *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). This case raises a claim similar to those presented to the Court in many of Plaintiff's prior cases. "At this point, a defendant's entitlement to fees where Dr. Griffin asserts the same or similar causes of action is well established." *Griffin v. United Healthcare of Georgia, Inc.*, No. 1:17-CV-4561-AT, 2018 WL 9986856, at *2 (N.D. Ga. May 24, 2018). The Court therefore incorporates its analyses as previously articulated in prior cases.[5]

After reviewing the record and weighing the factors to be considered when awarding fees to the prevailing party, the Court finds that an award of some amount of fees pursuant to 29 U.S.C. § 1132(g)(1) is appropriate in this case. *See Freeman v. Continental Ins. Co.*, 996 F.2d 1116, 1119 (11th Cir. 1993).

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[5] *Griffin v. Gen. Mills, Inc.*, 157 F. Supp. 3d 1350 (N.D. Ga. Jan. 15, 2016); *Griffin v. Humana Employers Health Plan of Ga., Inc.*, 167 F. Supp. 3d 1337 (N.D. Ga. Mar. 8, 2016); *Griffin v. Sevatec, Inc.*, No. 1:16-CV-0390-AT, Doc. 24 (N.D. Ga. July 1, 2016); *Griffin v. Coca-Cola Enterprises, Inc.*, No. 1:16-CV-0389-AT, Doc. 25 (N.D. Ga. July 27, 2016); *Griffin v. Navistar, Inc.*, No. 1:16-CV-0190-AT, Doc. 23 (N.D. Ga. July 27, 2016); *Griffin v. Applied Industrial Technologies, Inc.*, No. 1:16-CV-00552-AT, Doc. 25 (N.D. Ga. July 27, 2016); *Griffin v. United Healthcare of Georgia, Inc.*, No. 1:17-CV-4561-AT, Doc. 28 (N.D. Ga. May 24, 2018); *Griffin v. Coca-Cola Refreshments USA, Inc.*, No. 1:17-CV-4656-AT, Doc. 19 (N.D. Ga. May 24, 2018); *Griffin v. Delta Air Lines, Inc.*, No. 1:17-CV-4657-AT, Doc. 15 (N.D. Ga. May 24, 2018); and *Griffin v. Aetna Health Inc.*, No. 1:17-CV-0077-AT, Doc. 29 (N.D. Ga. Sept. 27, 2018).

A movant for attorney's fees "shall file and serve a detailed specification and itemization of the requested award, with appropriate affidavits and other supporting documentation." LR 54.2(A)(2), NDGa. Accordingly, the Court directs BCBSHP to submit a well-supported motion for attorneys' fees and costs within fourteen (14) days of this Order. BCBSHP is directed to use prudent billing judgment in its submission.

V. Conclusion

For the reasons stated herein, BCBSHP's motion to dismiss (Doc. 3) is **GRANTED**. The Clerk of Court is directed to close this case.

SO ORDERED this 21st day of March, 2023.

SARAH E. GERAGHTY
United States District Judge

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 18-10417

D.C. Docket No. 1:17-cv-04656-AT

W. A. GRIFFIN, MD,

Plaintiff - Appellant,

versus

COCA-COLA REFRESHMENTS USA, INC.,
UNITED HEALTHCARE INSURANCE COMPANY,

Defendants - Appellees,

UNITED HEALTHCARE OF GEORGIA, INC.,

Defendant.

No. 18-10418

D.C. Docket No. 1:17-cv-04657-AT

W. A. GRIFFIN, MD,

Plaintiff - Appellant,

versus

DELTA AIR LINES, INC.,
UNITED HEALTHCARE INSURANCE COMPANY,

Defendants - Appellees,

UNITED HEALTHCARE PLAN OF GEORGIA, INC.,

Defendant.

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

(February 24, 2021)

Before BRANCH and MARCUS, Circuit Judges, and UNGARO,* District Judge.

BRANCH, Circuit Judge:

Dr. Wakitha Griffin, a dermatologist in Atlanta, Georgia, has filed many appeals in this Court in recent years, all of which have involved her attempts to receive in-network payments despite being an out-of-network provider. Our other opinions have been unpublished; we choose to publish today in hopes of resolving this recurring litigation.

* The Honorable Ursula Ungaro, United States District Court for the Southern District of Florida, sitting by designation.

These consolidated appeals arise from Griffin's treatment of two patients who were insured under two separate employee welfare benefit plans which are administered by United Healthcare ("United"). The Employee Retirement Income Security Act of 1974 ("ERISA") covers both plans. Because Griffin does not have a contract with United whereby she provides services in exchange for reimbursement at a negotiated rate, she is an out-of-network provider under both plans. Generally, patients are reimbursed at lower rates when receiving healthcare services from out-of-network providers rather than in-network providers.

Eschewing a contractual relationship with United and payment from her patients, Griffin instead requested that the two patients assign their benefits under their plans to her. They obliged. Griffin then attempted to collect from United the same payment that she would have received had she been an in-network provider. When United only paid her the benefits she was entitled to as an out-of-network provider, Griffin brought two separate lawsuits—one against Coca-Cola Refreshments, Inc. ("Coca-Cola") and United and the other against Delta Air Lines, Inc. ("Delta") and United (collectively, "Defendants")—asserting various ERISA violations. The district court dismissed both cases for failure to state a claim because the plans' anti-assignment clauses prevented Griffin from obtaining statutory standing under ERISA to sue on behalf of her patients. Griffin appealed both cases to this Court.

These consolidated appeals raise an unsettled issue about whether an ERISA plan administrator or its claims agent may waive its right to rely on an anti-assignment provision in an ERISA-covered plan. We need not reach that issue, however. Even assuming that waiver is available in the ERISA context, Defendants did not waive their ability to assert the anti-assignment provisions as a defense. And regardless of waiver, Griffin's lawsuit still fails to state a claim: United paid her in full, both under the terms of the patients' assignments and the provisions of the healthcare plans. We therefore affirm the district court's orders.

I. Background

Although these consolidated appeals implicate two distinct health benefit plans, patients, and assignments, the facts giving rise to Griffin's claims in each case are largely the same. A few years ago, Griffin provided medical treatment for two patients: Patient J.J., who was insured under the Coca-Cola Plan, and Patient G.A., who was insured under the Delta Plan.[1] United is the Coca-Cola Plan's Claims Fiduciary and the Delta Plan's Claims Administrator. Under the terms of both plans, Griffin is an "out of network" physician. Generally, the plans reimburse the beneficiary at a higher percentage when he visits an in-network physician rather than an out-of-network physician. For example, the Coca-Cola

[1] The Coca-Cola Company Benefits Committee is the Coca-Cola Plan Administrator and the Administrative Committee of Delta Air Line, Inc. is the Delta Plan Administrator.

Plan provides that when a beneficiary has an office visit with an out-of-network physician, the plan pays 60 percent of the cost of service and the beneficiary pays 40 percent. By contrast, if the beneficiary has an office visit with an in-network physician, the plan pays at least 80 percent.

In exchange for medical treatment and in lieu of payment, the two patients executed an assignment of their plan benefits to Griffin. Both assignments are identical. By signing, the patient acknowledges that the document is "a direct legal assignment of my rights and benefits under this policy and designation of authorized representative" and "authorize[s] any plan administrator or fiduciary, insurer, and my attorney to release to such provider(s) any and all plan documents." The assignment further provides that the patient has assigned "all medical benefits and/or insurance reimbursement, if any, otherwise payable to [the patient] for services rendered from such provider(s), regardless of such provider's managed care network participation status."

Griffin believed that the assignments entitled her to full payment for her services, as if she were an in-network provider. She submitted claims to United, which she alleges United only partially paid. Griffin appealed United's payment determinations. In her appeals, Griffin made numerous requests, including: (1) that United disclose the plan's unambiguous anti-assignment provision, should the

plan have one; (2) copies of the plan documents; and (3) the identification of the Plan Administrator.

United denied each appeal and responded directly to the patients, copying Griffin on the communications. In each appeal denial, United explained that Griffin was not reimbursed the full amount of her charges because of the relevant plan's provisions regarding out-of-network coverage and deductibles. United therefore upheld the payment determinations and did not address Griffin's specific requests. Undeterred, Griffin submitted second level appeals for both claims and reiterated her requests. United again denied the appeals without addressing Griffin's requests.

After exhausting her administrative remedies, Griffin, proceeding *pro se*, filed two complaints in Georgia state court: one against United and Coca-Cola, for her treatment of Patient J.J., and the other against United and Delta, for her treatment of Patient G.A. The operative complaints are nearly identical and bring the same four claims: failure to pay plan benefits under 29 U.S.C. § 1132 (Count 1), breach of fiduciary duty under 29 U.S.C. § 1104 (Count 2), failure to provide plan documents under 29 U.S.C. §§ 1024(b), 1104, and 1132(2) (Count 3); and breach of co-fiduciary duties under 29 U.S.C. § 1105(a)(2) (Count 4). Defendants removed both lawsuits to the United States District Court for the Northern District of Georgia and moved to dismiss Griffin's complaints for failure to state a claim.

Griffin was in familiar territory in the district court. In the last four years, Griffin has filed more than two dozen cases either directly in the Northern District of Georgia or in state court that were later removed to that district court.[2] All involve Griffin seeking reimbursement from health plans through her patients' assignment of benefits.

[2] *See Griffin v. Blue Cross and Blue Shield Healthcare Plan of Ga., Inc., et al*, No. 1:14-cv-1610-AT (N.D. Ga. filed May 28, 2014); *Griffin v. S. Co. Servs., Inc.*, No. 1:15-cv-0115-AT (N.D. Ga. filed Jan. 14, 2015); *Griffin v. SunTrust Bank, Inc*., No. 1:15-cv-0147-AT (N.D. Ga. filed Jan. 16, 2015); *Griffin v. FOCUS Brands Inc*., No. 1:15-cv-0170-AT (N.D. Ga. filed Jan. 20, 2015); *Griffin v. Health Sys. Mgmt., Inc*., No. 1:15-cv-0171-AT (N.D. Ga. filed Jan. 20, 2015); *Griffin v. Lockheed Martin Corp*., No. 1:15-cv-0267-AT (N.D. Ga. filed Jan. 28, 2015); *Griffin v. Gen. Mills, Inc*., No. 1:15-cv-0268-AT (N.D. Ga. filed Jan. 28, 2015); *Griffin v. Oldcastle, Inc*., No. 1:15-cv-0269-AT (N.D. Ga. filed Jan 28, 2015); *Griffin v. Habitat for Humanity Int'l, Inc*., No. 1:15-cv-0369-AT (N.D. Ga. filed Jan 28, 2015); *Griffin v. Verizon Commc'ns, Inc*., No. 1:15-cv-0569-AT (N.D. Ga. filed Feb. 26, 2015); *Griffin v. Humana Employers Health Plan of Ga., Inc*., No. 1:15-cv-3574-AT (N.D. Ga. filed Oct. 8, 2015); *Griffin v. Aetna Health Inc.*, *et al*., No. 1:15-cv-3750-AT (N.D. Ga. filed Oct. 26, 2015); *Griffin v. Gen. Elec. Co.*, No. 1:15-cv-4439-AT (N.D. Ga. filed Dec. 22, 2015); *Griffin v. Navistar, Inc*., No. 1:16-cv-0190-AT (N.D. Ga. filed Jan. 21, 2016); *Griffin v. Humana Employers Health Plan of Ga., Inc*., No. 1:16-cv-0245-AT (N.D. Ga. filed Jan. 26, 2016); *Griffin v. Coca-Cola Enters., Inc*., No. 1:16-cv-0389-AT (N.D. Ga. filed Feb. 9, 2016); *Griffin v. Sevatec, Inc*., No. 1:16-cv-0390-AT (N.D. Ga. filed Feb. 9, 2016); *Griffin v. Cassidy Turley Com. Real Estate Servs.s, Inc*., No. 1:16-cv-0496-AT (N.D. Ga. filed Feb. 17, 2016); *Griffin v. Americold Logistics, LLC*, No. 1:16-cv-0497-AT (N.D. Ga. filed Feb. 17, 2016); *Griffin v. Applied Indus. Techs., Inc*., No. 1:16-cv-0552-AT (N.D. Ga. filed Feb. 23, 2016); *Griffin v. Areva, Inc.*, No. 1:16-cv-0553-AT (N.D. Ga. filed Feb. 23, 2016); *Griffin v. FOCUS Brands, Inc*., No. 1:16-cv-0791-AT (N.D. Ga. filed Mar. 10, 2016); *Griffin v. Northside Hosp., Inc*., No. 1:16-cv-1934-AT (N.D. Ga. filed June 10, 2016); *Griffin v. Crestline Hotels & Resorts, LLC*, No. 1:16-cv-2022-AT (N.D. Ga. filed June 16, 2016); *Griffin v. Verizon Commc'ns, Inc*., No. 1:16-cv-2639 (N.D. Ga. filed July 20, 2016); *Griffin v. RightChoice Managed Care, Inc.*, *et al*, No. 1:16-cv-3102 (N.D. Ga. filed Aug. 23, 2016); *Griffin v. Aetna Health Inc.*, *et al*, No. 1:17-cv-00077 (N.D. Ga. filed Jan. 6, 2017); *Griffin v. United Healthcare of Ga., Inc.*, *et al*, No. 1:17-cv-4561-AT (N.D. Ga. filed Nov. 13, 2017); *Griffin v.Coca-Cola Refreshments USA, Inc.*, et al, No. 1:17-cv-4656-AT (N.D. Ga. filed Nov. 20, 2017). *Griffin v. Delta Air Lines, Inc.*, *et al*, No. 1:17-cv-4657-AT (N.D. Ga. Nov. 20, 2017).

Similar to her past claims, her allegations here focus on United's failure to disclose to her whether the plans had anti-assignment provisions, even though she requested them in her claim appeals. And because Defendants did not provide her the plan documents containing those provisions, Griffin's complaints allege that they cannot rely on them in defense of their lawsuit.

In their motions to dismiss Griffin's complaints, Defendants asserted that the plans' anti-assignment provisions rendered the assignment of benefits void. The plans each contain anti-assignment provisions.[3] The Coca-Cola Plan provides:

> 9.02 Assignment. If applicable, an Enrolled Person may authorize the Plan to directly pay the service provider or hospital that provided the Enrolled Person's covered care and treatment. Except as provided in the foregoing sentence, and subject to Section 9.06 of this Plan relating to Qualified Medical Child Support Orders, an Enrolled Person may not assign or alienate any payment with respect to any Benefit which an Enrolled Person is entitled to receive from the Plan, and further, except as may be prescribed by law, no Benefits shall be subject to attachment or garnishment of or for an Enrolled Person's debts or contracts, except for recovery of overpayments made on an Enrolled Person's behalf by this Plan.

Another section of the plan states, "While benefits payable at any time may be used to make direct payments to health care providers, no amount payable at any

[3] The Coca-Cola Plan has two operative plan documents: the Coca-Cola Company Health and Welfare Benefits Plan ("Wrap Document") and the Summary Plan Descriptions and Benefit Policies ("SPD"). The SPD is incorporated by reference into the Plan through the Wrap Document. We refer to them together as the "Coca-Cola Plan."

The Delta Plan also has two operative plan documents: the Account-Based Healthcare Plan ("Wrap Document") and the Summary Plan Descriptions and Benefit Policies ("SPD"). The SPD is incorporated by reference into the Plan through the Wrap Document. We refer to them together as the "Delta Plan."

time shall be subject in any matter to alienation by assignment of any kind. Any attempt to assign any such amount shall be void." The Coca-Cola Plan further provides that beneficiaries "may not assign any rights or cause of action that [they] may have against a third-party to recover medical expenses without the express written consent of the Plan Administrator."

Similarly, the Delta Plan provides:

> 13.07 Anti-Alienation of Benefits. Except as required by law, no benefit, payment or distribution under the Plan shall be subject to the claim of any creditor of the Participant, or to any legal process by any creditor of the Participant, or to any legal process by any creditor of the Participant, and the participant shall not have any right to alienate, commute, anticipate or assign (either at law or in equity) all or any portion of any benefit, payment or distribution under the Plan except to the extent provided herein; provided, however, a Participant may make a voluntary and revocable assignment, but only for such purposes as the Administrative Committee may from time to time specify.

Another section of the plan states:

> Except as required by law, no benefit, payment or distribution under the plans will be subject to the claim of any creditor of a participant, or to any legal process by any creditor of the participant, and the participant will not have any right to alienate, commute, anticipate or assign all or any portion of any benefit, payment or distribution under the plans.
>
> However, a participant may make a voluntary and revocable assignment, but only for such purposes as the Plan Administrator may specify from time to time.

The district court dismissed both of Griffin's complaints for failure to state a claim. Regarding her suit against Delta and United, the district court found the

Delta Plan's anti-assignment provisions barred all of Griffin's claims. In its order dismissing the suit against Coca-Cola and United, the district court similarly found the Coca-Cola Plan's anti-assignment provisions indisputably barred Griffin's claim for payment under the plan (Count 1). The court also found that, even if the language of the anti-assignment provisions did not bar the remaining non-payment claims (Counts 2, 3, and 4), the assignment itself did not include the right to bring those non-payment claims. Accordingly, she lacked derivative statutory standing to bring those claims as well. The district court did not address Griffin's waiver arguments. Griffin appealed the district court's orders to this Court.

Griffin presents three issues on appeal. First, did the patients legally assign Griffin the right to bring the breach of fiduciary duty and statutory penalties claims (the "non-payment-related claims") as well as benefit claims? Second, do the anti-assignment provisions apply to Griffin's claims for underpayment of benefits and/or the non-payment claims? Third, if they do apply to some or all of the claims, are Defendants estopped from relying on the anti-assignment provisions or have they otherwise waived the right to assert them?

We appointed Griffin counsel *sua sponte* and set this case for oral argument. After reviewing the record, the parties' briefs, and oral argument, we affirm the lower court's decisions.

II. Standard of Review and ERISA

The Court of Appeals reviews "*de novo* the district court's grant of a motion to dismiss under [Federal Rule of Civil Procedure] 12(b)(6) for failure to state a claim, accepting the allegations in the complaint as true and construing them in the light most favorable to the plaintiff." *Lanfear v. Home Depot, Inc.*, 679 F.3d 1267, 1275 (11th Cir. 2012) (quoting *Ironworkers Local Union 68 v. AstraZeneca Pharm., LP*, 634 F.3d 1352, 1359 (11th Cir. 2011)).

ERISA, which governs this case, sets the minimum standards for employee benefit plans, such as the healthcare plans at issue here. *See* 29 U.S.C. §§ 1001, 1002. Section 502(a) of ERISA creates federal causes of action for recovery of benefits under such plans. *See* 29 U.S.C. § 1132(a)(1)(B) ("A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]"). ERISA also allows participants to bring actions under section 502(a) against plan fiduciaries for breach of fiduciary duty. 29 U.S.C. § 1104. In addition, section 405(a) of ERISA imposes co-fiduciary liability on all plan fiduciaries in certain circumstances. *Id*.. § 1105. Finally, ERISA requires plan administrators, upon request, to provide plan information to participants and allows for participants to seek statutory penalties for a plan's failure to do so. *Id*. § 1132(c)(1). Critically, to maintain an action under ERISA, a plaintiff must have standing to sue under the statute. *Physicians*

Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc., 371 F.3d 1291, 1293–94 (11th Cir. 2004).[4]

In enacting ERISA, Congress broadly preempted state law relating to employee benefit plans. *Mackey v. Lanier Collection Agency & Serv., Inc.,* 486 U.S. 825, 829 (1988); *see generally Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Where ERISA is silent on an issue, Congress intended for courts to fashion a federal common law governing employee benefit plans. *Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1347 (11th Cir. 1994). We have explained the process for determining federal common law under ERISA:

> To decide whether a particular rule should become part of ERISA's common law, courts must examine whether the rule, if adopted, would further ERISA's scheme and goals . . . ERISA has two central goals: (1) protection of the interests of employees and their beneficiaries in employee benefit plans; and (2) uniformity in the administration of employee benefit plans.

Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1041 (11th Cir. 1998). When tasked with shaping federal common law in the ERISA context, this Court has explicitly relied on rules found in the Restatement of Contracts, *see, e.g., Turner v. Am. Fed'n of Teachers Local 1565*, 138 F.3d 878, 882 (11th Cir. 1998),

[4] As used in this context, standing is not jurisdictional, Article III standing, but rather the right to make a claim under the statute. *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1293–94 (11th Cir. 2004).

and state law, *see, e.g., Tippit v. Reliance Standard Life Ins. Co.*, 457 F.3d 1227, 1235 (11th Cir. 2006) (using Georgia law to interpret ambiguous plan).

III. Analysis

a. The Scope of the Patients' Assignments

We first determine the scope of the patients' assignments to Griffin—whether they purport to give her the right to bring both payment and non-payment (breach of fiduciary duties and statutory penalties) claims.

To maintain an action under ERISA, a plaintiff must have statutory standing. ERISA limits the right to sue for plan participants, plan beneficiaries, plan fiduciaries, and the Secretary of Labor. 29 U.S.C. § 1132(a). "Healthcare providers . . . are generally not 'participants' or 'beneficiaries' under ERISA." *Physicians Multispecialty Grp.*, 371 F.3d at 1294. Still, an assignee may obtain derivative standing for payment of medical benefits through a written assignment from a plan participant or beneficiary. *See Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 813 F.3d 1333, 1339 (11th Cir. 2015).[5]

In this case, no party doubts that the assignments' language purports to convey to Griffin a right to bring the claim for unpaid benefits. But Griffin argues that the patients assigned all their rights—including the right to bring fiduciary and

[5] For the reasons discussed herein, we need not decide whether the assignment of nonpayment claims provides derivative standing.

statutory penalty claims—under the plans because the assignments state: "This is a direct legal assignment of my rights and benefits under the policy." That sentence, Griffin claims, is enough to transfer the participant's right to bring claims both for unpaid payments and non-payment related claims.

In numerous unpublished decisions, we have rejected similar claims (all made by Griffin) regarding the assignment of the right to bring non-payment claims like those in Counts 2, 3, and 4. *See, e.g., Griffin v. SunTrust Bank Inc.*, 648 F. App'x 962, 967 (11th Cir. 2016) ("Nothing in an assignment of benefits transfers the patient's right to bring a cause of action" for similar non-payment-related claims.); *Griffin v. Health Sys. Mgmt. Inc*, 635 F. App'x 768, 772 n.4 (11th Cir. 2015). Griffin argues that these prior decisions only examine particular lines in the assignment, and we have not considered the exact language she points to in this appeal. Because the language Griffin relies on in this appeal assigns both "rights *and* benefits under the policy," Griffin claims, it expressly assigns the right to bring both payment and non-payment-related claims.

Even assuming this "rights and benefits" language evinces the assignment of two distinct rights—the right to bring claims for both payment and non-payment—the assignments themselves contradict Griffin's argument. The general form assignments on which Griffin relies contain 10 separately listed paragraphs outlining the scope of the assignments. The patients checked the box next to each

one. None of the paragraphs mention breach of fiduciary duty or statutory penalty claims. Rather, they provide the details of Griffin's "right" to receive the patients' "medical information" and "payment of benefits" under the Plan. Therefore, the assignments make clear that the patients only assigned their right to bring claims for payment pursuant to 29 U.S.C. § 1132. Accordingly, the district court was correct to dismiss Griffin's non-payment claims.

b. The Plans' Anti-Assignment Provisions

i. Applicability to Griffin's Payment Claim

We next turn to whether Griffin's payment claim survives the language of the plans' anti-assignment provisions. We find that her payment claim does not.

We have held that "an unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable" against healthcare providers. *Physicians Multispecialty Grp.*, 371 F.3d at 1296. The anti-assignment language in the plans at issue is unambiguous and thus enforceable. The Coca-Cola Plan says a participant "may not assign or alienate any payment with respect to any Benefit," and "no amount payable at any time shall be subject in any matter to alienation by assignment of any kind. Any attempt to assign any such amount shall be void." Similarly, the Delta Plan provides that "the participant shall not have any right to alienate, commute, anticipate or assign (either at law or in equity) all or any portion of any benefit, payment or distribution under the Plan." And

another provision similarly states: "the participant will not have any right to alienate, commute, anticipate or assign all or any portion of any benefit, payment or distribution under the plans." On their face, these provisions restrict a patient's ability to assign his rights and therefore bar Griffin's claims.

In fact, Griffin "recognizes the weight of authority from this Court affirming the dismissals of several cases filed by Dr. Griffin based on the application of anti-assignment provisions to similar claims brought by Dr. Griffin under ERISA for unpaid benefits." But she urges this Court to reverse course and follow the Fifth Circuit's lead in its 1992 opinion in *Hermann Hospital v. MEBA Medical and Benefits Plan*, 959 F.2d 569 (5th Cir. 1992), *overruled in part on other grounds by Access Mediquip, L.L.C. v. United Healthcare Insurance Co.*, 698 F.3d 229, 230 (5th Cir. 2012) (en banc).

In *Hermann*, the Fifth Circuit held that the defendant plan's anti-assignment provisions were unenforceable against a healthcare provider. The patient in that case assigned "all rights, title and interest in the benefits payable for services rendered by the [healthcare provider]" to the provider-plaintiff. *Id.* at 571. The anti-assignment provision at issue stated:

> No employee, dependent or beneficiary shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment hereunder, and any such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims.

Id. at 574. The Fifth Circuit held that the anti-assignment clause did not, by its terms, void the assignment to the provider because it did not explicitly cover healthcare providers. *Id.* at 575. The court found it would be inequitable to prevent providers from recovering for the services they rendered unless the participants first sued the plan and the provider then sued the participants. *Id.* Thus, Griffin claims that this Court should find the Coca-Cola Plan's and Delta Plan's anti-assignment provisions do not bar the assignments because she received the assignment in her capacity as a healthcare provider.

But Griffin effectively asks this Court to invalidate an unambiguous contract provision which is valid and enforceable under our precedent based on the policy preferences of another circuit. We cannot depart from our precedent. *See Wilson v. Taylor*, 658 F.2d 1021, 1034 (5th Cir. May 1, 1981) ("It is the firm rule of this circuit that we cannot disregard the precedent set by a prior panel, even though we perceive error in the precedent. Absent an intervening Supreme Court decision which changes the law, only the en banc court can make the change."). Thus, if nothing else prevents Defendants from relying on the anti-assignment provisions in this litigation, the provisions bar Griffin's claims for unpaid benefits.

ii. Void v. Voidable

Before we turn to Griffin's remaining arguments as to why Defendants either waived or are estopped from relying on these anti-assignment provisions, we

must address an often-overlooked threshold issue: whether the anti-assignment provisions make the assignments void or voidable.[6] If the assignments are void *ab initio* then there is no need to proceed to the equitable claims because each assignment is inherently null. On the other hand, if the assignments are merely voidable, then they are effective unless and until they are challenged. *See, e.g., Pitts ex rel. Pitts v. Am. Sec. Life Ins. Co.*, 931 F.2d 351, 356 (5th Cir. 1991) (discussing consequences of determining whether insurance policy was void rather than voidable). Estoppel and waiver would only be available defenses to a voidable anti-assignment clause.

As discussed above, federal courts fill in the gaps Congress left in ERISA with federal common law. *Glass*, 33 F.3d at 1347. ERISA itself does not give an answer to the issue of void versus voidable. Nor have the parties addressed it. And federal courts have not discussed the distinction between void and voidable in the ERISA context. Courts sometimes even use these concepts interchangeably.[7]

[6] Black's Law Dictionary defines "void" as "[o]f no legal effect; to null." *Void*, *Black's Law Dictionary* (11th ed. 2019). Something that is "void *ab initio*" is "[n]ull from the beginning, as from the first moment when a contract is entered into. A contract is void *ab initio* if it seriously offends law or public policy, in contrast to a contract that is merely voidable at the election of one party to the contract." *Id.* The term "voidable" is defined as "[v]alid until annulled," that is, "capable of being affirmed or rejected at the option of one of the parties." *Voidable*, *Black's Law Dictionary* (11th ed. 2019).

[7] "[C]ourts have lamented that '[t]he distinction between void and voidable is not as distinctly defined as could be wished.' As a result, '[c]ourts have used the words "void," "voidable," "invalid," and "unenforceable" imprecisely' or even interchangeably." Jesse A. Schaefer, *Beyond a Definition: Understanding the Nature of Void and Voidable Contracts*, 33 CAMPBELL L. REV. 193, 194 (2010) (quoting *Arnold v. Fuller's Heirs*, 1 Ohio 458, 467 (Ohio

Absent other guidance, we may look to the applicable state law to fill in ERISA's gaps. *Glass*, 33 F.3d at 1347. The Georgia Code renders as void: (1) contracts to do immoral or illegal things, (2) contracts against public policy, and (3) gambling contracts. O.C.G.A. §§ 13-8-1, 13-8-2, 13-8-3. This definition comports with our century-old precedent: in 1906, the former Fifth Circuit explained:

> The distinction between 'void' and 'voidable' in their application to contracts is sometimes one of practical importance. A transaction may be void as to one party, and not as to another. When entire technical accuracy is desired, the term 'void' can only be properly applied to those contracts that are of no effect whatsoever, . . . or in contravention of that which the law requires, and therefore incapable of confirmation or ratification.

Haggart v. Wilczinski, 143 F. 22, 27 (5th Cir. 1906). The assignments here are not illegal. Nor do they contravene public policy. *See Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997) ("[N]either § 1132(a) nor any other ERISA provision prevents derivative standing based upon an assignment of rights[.]"). And they have nothing to do with gambling. Accordingly, the assignments here are merely voidable rather than void *ab initio* and thus are enforceable unless and until Defendants raise the anti-assignment provisions. To put it another way, the

1824) and *Daugherty v. Kessler*, 286 A.2d 95, 97 (Md. 1972)). This confusion is noted in Black's Law Dictionary: "the word [void] is often used and construed as bearing the more liberal meaning of 'voidable.'" *Void*, *Black's Law Dictionary* (11th ed. 2019).

existence of those provisions did not automatically nullify the assignments, and thus equitable doctrines are available. Having said all that, we can turn to Griffin's waiver and estoppel arguments.

c. Waiver

Griffin argues that Defendants waived their right to rely on the anti-assignment provisions because they did not alert her to their existence prior to litigation. We disagree.

"Waiver is the voluntary, intentional relinquishment of a known right." *Glass*, 33 F.3d at 1347; *see also Pitts*, 931 F.2d at 357; Appleman, Insurance Law and Practice, § 9251, at 488–89 (1981). Waiver can be express or implied from conduct. *In re Garfinkle*, 672 F.2d 1340, 1347 (11th Cir. 1982). "Where a party alleges an implied waiver, 'the acts, conduct, or circumstances relied upon to show waiver must make out a clear case'" of intentional relinquishment. *Witt v. Metro Life Ins. Co.*, 772 F.3d 1269, 1279 (11th Cir. 2014) (quoting *In re Garfinkle,* 672 F.2d at 1347).

Because ERISA does not address waiver, courts have fashioned federal common law to address cases where a defendant relies on a contractual provision to defeat a claim. But various circuits have approached the problem differently. For example, the Fourth Circuit considers waiver to be a "prohibited concept" with respect to ERISA. *Gagliano v. Reliance Standard Life Ins. Co.*, 547 F.3d 230, 239

(4th Cir. 2008). Other circuits have reached the opposite conclusion. *See, e.g. Glista v. Unum Life Ins. Co. of America,* 378 F.3d 113, 132 (1st Cir. 2004) (insurance company waived its right to raise a policy's clause for the first time in litigation). This circuit has "left open the question of whether waiver principles might apply under the federal common law in the ERISA context," *Witt*, 772 F.3d at 1279, and we do so again today because we need not decide it.

Even if the doctrine applies in the ERISA context, waiver would not be available under the facts of this case. None of the Defendants expressly relinquished its right to assert the anti-assignment clauses in litigation. And Griffin does not allege any acts that would indicate they intentionally did so. Boiled down, Griffin alleges that defendants ignored her pre-litigation requests for plan documents and any anti-assignment provisions, if they existed. Evidence that an insurance plan's claims administrator ignored a third party's pre-litigation request for information about a contract with another party, without more, is insufficient to show that the claims administrator or provider voluntarily or intentionally abandoned a contractual defense to litigation. Thus, even if waiver applied, Griffin's allegations are insufficient to establish that the Defendants waived the anti-assignment provisions.

d. Estoppel

As an alternative to her waiver claim, Griffin argues that Defendants are equitably estopped from relying on the anti-assignment provisions because they did not respond to her pre-litigation inquiries as to whether the Coca-Cola Plan and the Delta Plan contained such provisions.

In the ERISA context, equitable estoppel applies when "the plaintiff can show that (1) the relevant provisions of the plan at issue are ambiguous, and (2) the plan provider or administrator has made representations to the plaintiff that constitute an informal interpretation of ambiguity." *Jones v. Am. Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1069 (11th Cir. 2004). Equitable estoppel in the ERISA context is "very narrow." *Id.*

The anti-assignments provisions in the two plans at issue here are not ambiguous. Even if they were, Griffin does not submit any evidence, or even allege, that Coca-Cola, Delta, or United made *any* representation to Griffin that informally interpreted the provision. A straightforward application of the narrow ERISA estoppel doctrine compels this Court to find that Griffin cannot turn to it here.

Griffin asks this Court to rely on the Fifth Circuit's decision in *Hermann* and the Sixth Circuit's dicta in *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 404 (6th Cir. 1998) to find that equitable estoppel's ambiguity requirement does not apply to Griffin. We are unpersuaded. In *Hermann*, the Fifth Circuit held that the

defendant was estopped from asserting that the anti-assignment clause applied because Hermann, the medical provider, "was not privy to" the plan documents and it was the defendant plan's "responsibility to notify Hermann" of the anti-assignment clause. 959 F.2d at 574. Similarly, in *Sprague*, the Sixth Circuit observed that the party asserting estoppel's reliance "can seldom, if ever, be reasonable or justifiable if it is inconsistent with the clear and unambiguous terms of the plan documents *available to or furnished to the party*." 133 F.3d at 404 (emphasis added). But the facts of *Hermann* differ from the facts here. In that case, the payor repeatedly made false representations to the provider. *See Hermann*, 959 F.2d at 574. And in *Sprague*, the Sixth Circuit clarified that in order to assert an estoppel claim, "there must be conduct or language amounting to a representation of a material fact." 133 F.3d at 403. Here, none of the Defendants made any representations directly to the provider: they communicated with the beneficiaries and copied Griffin on the communications. And while United did not provide Griffin with the requested information, neither did it lie to her.

Further, Griffin's estoppel argument is foreclosed by our precedent. In the years following *Herman* and *Sprague*, this Court has never disregarded the ambiguity requirement. *See, e.g., Jones*, 370 F.3d at 1070 ("[W]hether proceeding on a breach of contract or equitable estoppel theory, an ERISA plaintiff can only succeed . . . if he can establish that the plan at issue is at least ambiguous with

respect to the relevant benefits for which he claims entitlement."). And, in the past five years, we have addressed Griffin's estoppel argument in a series of unpublished decisions relating to similar claims based on similar facts. Each time, we held that equitable estoppel does not apply. *See Griffin v. United Healthcare of Ga., Inc.*, 754 F. App'x 793, 797 (11th Cir. 2018) ("[E]quitable estoppel cannot apply" where plan documents were not provided); *Griffin v. Coca-Cola Enters., Inc.*, 686 F. App'x 820, 822 (11th Cir. 2017) (same); *Griffin v. Habitat for Humanity Int'l, Inc.*, 641 F. App'x 927, 932 (11th Cir. 2016) (same); *Griffin v. Verizon Commc'ns, Inc.*, 641 F. App'x 869, 874 (11th Cir. 2016) (same); *Griffin v. S. Co. Servs.*, 635 F. App'x 789, 795 (11th Cir. 2015) (same); *Griffin v. Focus Brands*, *Inc.*, 635 F. App'x 796, 801 (11th Cir. 2015) (same); *Griffin v. Health Sys. Mgmt., Inc.*, 635 F. App'x 768, 773 (11th Cir. 2015) (same). A decades-old case from another circuit does not disturb that conclusion. Equitable estoppel does not prevent plan administrators or claims fiduciaries from relying on anti-assignment provisions simply because they did not alert the provider of such provisions.

In sum, although the assignments gave Griffin statutory standing pursuant to ERISA to bring claims for payment for the services she provided, the Defendants' anti-assignment provisions made the assignments voidable. Even assuming waiver is available in the ERISA context, Defendants did not waive their ability to assert the anti-assignment provisions when Griffin filed claims against them. Neither

does estoppel aid Griffin in avoiding the effect of the anti-assignment provisions. Therefore, the anti-assignment provisions deprived Griffin of her ability to bring these ERISA claims.

e. Failure to State a Claim

We make a final observation about Griffin's claims before concluding. Assuming, *arguendo*, that Defendants' plans did not have enforceable anti-assignment provisions and Griffin had statutory standing to bring claims for payment pursuant to ERISA, Griffin would still fail to state a claim because she is not entitled to any more compensation than she already received.

Recall that each assignment at issue is "a direct legal assignment of [the patient's] rights and benefits under this policy and designation of authorized representative." They also state:

> In considering the amount of medical expenses to be incurred, I, [the patient], have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status.

Griffin's "managed care network participation status" is critical. The patients visited an out-of-network provider—Griffin. Had they paid Griffin out of pocket and filed a claim for reimbursement with United, United would have been obligated to reimburse the patients according to their policies for out of network

providers. That analysis does not change simply because the patient assigned the payments to Griffin.[8] Because the patients have no right to full reimbursement for the charged services, neither does Griffin. The assignment changes nothing. Either way, Griffin does not have a claim against Defendants.

We therefore **AFFIRM** the district court's orders.

[8] For example, Griffin charged Patient J.J. $129.96 for the office visit. Patient J.J.'s plan covered 60 percent of that charge. Therefore, United directly paid Griffin $77.98. United paid Griffin exactly what it would have paid the Patient J.J. if that patient had followed the process above.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

For rules and forms visit
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February 24, 2021

MEMORANDUM TO COUNSEL OR PARTIES

Appeal Number: 18-10417-HH
Case Style: W. Griffin v. Coca-Cola Refreshments USA, In, et al
District Court Docket No: 1:17-cv-04656-AT

This Court requires all counsel to file documents electronically using the Electronic Case Files ("ECF") system, unless exempted for good cause. Non-incarcerated pro se parties are permitted to use the ECF system by registering for an account at www.pacer.gov. Information and training materials related to electronic filing, are available at www.ca11.uscourts.gov. Enclosed is a copy of the court's decision filed today in this appeal. Judgment has this day been entered pursuant to FRAP 36. The court's mandate will issue at a later date in accordance with FRAP 41(b).

The time for filing a petition for rehearing is governed by 11th Cir. R. 40-3, and the time for filing a petition for rehearing en banc is governed by 11th Cir. R. 35-2. Except as otherwise provided by FRAP 25(a) for inmate filings, a petition for rehearing or for rehearing en banc is timely only if received in the clerk's office within the time specified in the rules. Costs are governed by FRAP 39 and 11th Cir.R. 39-1. The timing, format, and content of a motion for attorney's fees and an objection thereto is governed by 11th Cir. R. 39-2 and 39-3.

Please note that a petition for rehearing en banc must include in the Certificate of Interested Persons a complete list of all persons and entities listed on all certificates previously filed by any party in the appeal. See 11th Cir. R. 26.1-1. In addition, a copy of the opinion sought to be reheard must be included in any petition for rehearing or petition for rehearing en banc. See 11th Cir. R. 35-5(k) and 40-1 .

Counsel appointed under the Criminal Justice Act (CJA) must submit a voucher claiming compensation for time spent on the appeal no later than 60 days after either issuance of mandate or filing with the U.S. Supreme Court of a petition for writ of certiorari (whichever is later) via the eVoucher system. Please contact the CJA Team at (404) 335-6167 or cja_evoucher@ca11.uscourts.gov for questions regarding CJA vouchers or the eVoucher system.

Pursuant to Fed.R.App.P. 39, costs taxed against the appellant.

Please use the most recent version of the Bill of Costs form available on the court's website at www.ca11.uscourts.gov.

For questions concerning the issuance of the decision of this court, please call the number referenced in the signature block below. For all other questions, please call Christopher Bergquist, HH at 404-335-6169.

Sincerely,

DAVID J. SMITH, Clerk of Court

Reply to: Djuanna H. Clark
Phone #: 404-335-6151

OPIN-1A Issuance of Opinion With Costs