No. 19-196

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as BLUE CROSS BLUE SHIELD OF LOUISIANA,
Petitioner,

v.

ENCOMPASS OFFICE SOLUTIONS, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICI CURIAE THE AMERICAN BENEFITS COUNCIL, THE BLUE CROSS BLUE SHIELD ASSOCIATION, & THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The American Benefits Council (the "Council") is a national non-profit organization dedicated to protecting and fostering privately-sponsored employee benefit plans. The Council's approximately 400 members are primarily large, multistate U.S. employers that sponsor benefit plans for active and retired workers and their families. The Council's membership also includes organizations that offer employee benefit services to employers of all sizes. Collectively, the Council's members directly sponsor or provide services to employee benefit plans covering virtually every American who participates in an employer-sponsored benefit program. The Council regularly participates as *amicus curiae* in cases with the potential to affect the design and administration of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA").

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that coordinates and promotes the national interests of thirty-six independent, community-based, and locally-operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide healthcare coverage to nearly 106 million people—nearly one-third of all Americans—in every zip code in all fifty states, the District of Columbia,

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[1] Pursuant to Rule 37.6, no counsel for any party authored this brief in whole or in part and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for the parties received timely notice of the intent to file this brief. All parties have consented to the filing of this brief.

and Puerto Rico. The Blue Plans supply insurance and administrative services to all segments of the population, including private and public employer groups, small businesses, and individuals. The Blue Plans are committed to making healthcare work for all Americans and have extensive knowledge of and experience with the health insurance marketplace. As the national voice of the Blue Plans, the BCBSA frequently serves as *amicus curiae* in cases involving issues important to the health insurance industry.

The ERISA Industry Committee ("ERIC") is a national trade association representing nearly 100 of the nation's largest employers that sponsor health, retirement, and compensation benefit plans governed by ERISA. Through their ERISA plans, ERIC's member companies voluntarily provide benefits to millions of people across the United States and in every major sector of the economy. ERIC advocates for large employer plan sponsors on public policies relating to employee benefits at the federal, state, and local levels, and it often participates as *amicus curiae* in cases that affect employee benefit plan design and administration.

The Council, BCBSA, and ERIC (collectively, "*amici*") have a strong interest in the Court reviewing the decision below.[2] The Fifth Circuit held that

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[2] This brief focuses solely on the second question presented in the petition, concerning when, if at all, healthcare providers can sue as assignees under ERISA. The petition also raises a second question, about how federal courts determine governing state law for state-law claims under *Erie Railroad Co. v. Tompkins*, 304 U.S. 64 (1938); *amici* take no position on that question or whether it warrants the Court's review.

an ERISA plan administrator waives a plan's prohibition on assignments of plan-related rights simply by fulfilling a healthcare provider's request for payment. In so doing, the Fifth Circuit created a circuit split, subjecting *amici*'s members—many of whom operate across jurisdictional lines—to a patchwork of conflicting rules. Further, the decision below contradicts both ERISA's text and this Court's longstanding precedent interpreting and applying the statute.

Many of *amici*'s members sponsor or administer employee benefit plans with anti-assignment provisions similar to the one effectively nullified by the Fifth Circuit in this case. The decision below threatens to obliterate the anti-assignment provisions in these plans, putting pressure on *amici*'s members to forgo processing claims in a manner many plan participants find convenient, and compromising the members' ability to provide benefit plans on terms advantageous to American workers and their families. Ensuring the proper application of the ERISA principles in this case is vitally important to *amici*, their members, and the plan participants they serve, and can only be accomplished through this Court's review of the decision below.

INTRODUCTION AND SUMMARY OF ARGUMENT

This Court has long recognized that ERISA comprehensively regulates employee benefit plans. The statute provides a meticulously calibrated enforcement scheme, and establishes the supremacy of the terms of ERISA-governed plans themselves. The decision below fundamentally conflicts with these prin-

ciples.

ERISA authorizes only plan participants and beneficiaries to sue to enforce plan terms. Respondent, however, is neither a plan participant nor a beneficiary, but a vendor of healthcare-related products with no relation to the plan. The plan documents at issue here expressly prohibit participants and beneficiaries from assigning their plan-related rights to anyone. Still, healthcare providers can and sometimes do submit benefit claims *on behalf of* plan participants (as their authorized agents, not their assignees), or may otherwise be eligible to seek direct payment (as in-network providers, for example), and plan administrators' initial claims processing procedures generally provide for the prompt payment of provider-submitted claims even if the provider would not be recognized as the participant's assignee under the terms of the plan.

The Fifth Circuit nevertheless held below that a plan administrator's direct payment to a provider alone suffices to waive the plan's anti-assignment provision, thereby allowing providers—neither participants nor beneficiaries but purported assignees—to sue under ERISA for the denial of plan benefits. In the Fifth Circuit, therefore, there is effectively no way, short of refusing to pay providers directly, for plan fiduciaries to prevent plan participants and beneficiaries from assigning their plan-related rights, even through clear-cut plan provisions. The Fifth Circuit's unprecedented decision violates this Court's ERISA jurisprudence. That is reason enough for this Court's review.

But that is not the only reason. The decision be-

low created a circuit conflict on the question whether routine initial claims processing by a plan administrator waives a plan's anti-assignment provision. In contrast to the Fifth Circuit, the Third and Ninth Circuits have held in materially identical circumstances that there is no waiver of a plan's anti-assignment provision when a plan administrator pays a provider for a provider-submitted claim, meaning that providers cannot simply by reason of direct payment bring suit to enforce plan terms. The resulting circuit conflict invites precisely the multitude of conflicting interpretations of plan documents that ERISA was designed to prevent, with all the predictable practical consequences that Congress sought to avoid by enacting a comprehensive federal scheme for regulating employee benefit plans.

Worse still, the Fifth Circuit's decision effectively requires the administrators of plans with assignment prohibitions to forgo paying providers directly during the initial claims processing, lest they waive the plan sponsor's ability to enforce those terms. Yet direct payment is a service that administrators generally provide not for their own benefit, but for the convenience of plan participants and beneficiaries. If left to stand, the decision below therefore threatens to make employee benefits *less* accessible and *more* costly for American workers and their families. That result is intolerable. The petition should be granted, and the decision below reversed.

ARGUMENT

A. The Decision Below Contravenes ERISA's Text And This Court's Caselaw

Time and again, the Court has explained that

ERISA provides a "comprehensive" and "carefully integrated" enforcement regime governing employee benefit plans. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004) (quotation marks omitted); *see also, e.g.*, *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (ERISA is a "comprehensive and reticulated" statute (quotation marks omitted)); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995) (ERISA "establishes a comprehensive civil enforcement scheme"). The Court has further held that ERISA's detailed design provides "strong evidence that Congress did *not* intend to authorize" any type of litigation it failed "to incorporate expressly." *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985).

Most relevant here, Congress took "care [to] delineat[e] the universe of plaintiffs who may bring . . . civil actions" under ERISA's denial-of-benefits provision, 29 U.S.C. § 1132. *Harris Tr. & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 247 (2000) (emphasis omitted). That provision gives individuals covered by health insurance plans the right to sue to "recover benefits due . . . under the terms of [the] plan." 29 U.S.C. § 1132(a)(1)(B). But that right is strictly limited to "participant[s]" and "beneficiar[ies]," *id.* § 1132(a)(1), with those terms limited respectively to employees eligible to receive benefits under the plan, *id.* § 1002(7), and to persons designated by a participant or the terms of the plan to receive some benefit thereunder, *id.* § 1002(8).

Based on this deliberately enumerated language, the Court has held that both the remedies created by ERISA and the parties it expressly authorizes to

seek them are exclusive. *See, e.g.*, *Great-W.*, 534 U.S. at 220-21; *Harris Tr.*, 530 U.S. at 247; *Mass. Mut.*, 473 U.S. at 146-48; *Franchise Tax Bd. v. Constr. Laborers Vacation Tr.*, 463 U.S. 1, 27 (1983). As the Court has explained, § 1132, in particular, "does not provide anyone other than participants [or] beneficiaries . . . with an express cause of action" for the denial of plan benefits, *Franchise Tax Bd.*, 463 U.S. at 27, and it thus strictly limits which plaintiffs may bring denial-of-benefits actions under ERISA, *Harris Tr.*, 530 U.S. at 247.

No provision in ERISA authorizes a healthcare provider to initiate a denial-of-benefits suit, either on its own behalf or as a participant or beneficiary's purported assignee. And the Court simply has "no[] . . . authority to revise the text of [ERISA]." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 259 (1993); *see also, e.g.*, *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 419 (2014) (rejecting "presumption of prudence" widely recognized by lower courts because it could not be found anywhere in ERISA's text). While lower courts have invoked "federal common law" to permit provider-assignees to sue under ERISA, Pet. 26-27 & n.4 (collecting cases), this Court has never recognized the validity of assignee-filed suits, *id.* 30-31, 33.

Even if provider-assignees may sue under a fair interpretation of ERISA's text, however, basic principles of ERISA law demand that plan sponsors be able to select plan terms that forbid it. Nothing in ERISA requires plans to *allow* participants and beneficiaries to assign their health-plan related rights to healthcare providers or anyone else. *See, e.g.*, *Am. Orthopedic & Sports Med. v. Independence Blue*

Cross Blue Shield, 890 F.3d 445, 450 (3d Cir. 2018) (although "anti-assignment clauses have become an increasingly prominent feature of health insurance contracts," and "Congress . . . has had ample opportunity to mandate assignability if indeed that were its intent[,] . . . it has not done so" (citation omitted)); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) ("ERISA leaves the . . . non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties"); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1480-81 (9th Cir. 1991) (concluding Congress's "carefully consider[ing] the subject and cho[osing] to remain silent" demonstrated its "inten[t] *not* to mandate assignability").

For good reason. Anti-assignment clauses are an important tool used by ERISA welfare plans to reduce uncertainty, minimize expenses, and protect patients from the loss of rights under their plans. The provisions protect participants from unwittingly ceding their rights under a plan to their healthcare providers, and from potentially costly disputes with providers over who possesses the rights in question. The clauses likewise conserve plan resources, by extending a plan's ERISA obligations only to the plan participants and beneficiaries that the plan was established to serve. Properly understood, the provisions should not interfere with a plan's ability to make direct payments to service providers, or a participant's ability to avail themselves of that convenience. Indeed, anti-assignment clauses in ERISA-governed health plans are typically paired with express plan language stating that the plan is willing to pay providers directly as a convenience to the

members.

When plans have determined to include a prohibition on assignments, it is critically important that this plan term be enforced. The Court's longstanding precedent emphasizes the preeminence of an ERISA plan's terms, recognizing that rigorously enforcing terms as written furthers ERISA's core aim of encouraging employers to sponsor benefit plans for their employees. *See* Pet. 31; *see also, e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) (discussing "the public interest in encouraging the formation of employee benefit plans"). Despite ERISA's comprehensive coverage, "[n]othing in ERISA . . . mandate[s] what kind of benefits employers must provide if they choose to have [an employee benefit] plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Rather, "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (brackets in original) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)). It does so, in important part, by placing the enforcement of a plan's "'contractually defined benefits' . . . at the center of ERISA." *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100-01 (2013) (quoting *Mass. Mut.*, 473 U.S. at 148); *see also, e.g.*, *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013) ("the linchpin of [the ERISA] system" is the statute's "focus on the written terms of the plan" (internal quotation marks and brackets omitted)). Consequently, the Court has recognized, "[t]he principle that contractual . . . pro-

visions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA plan." *Heimeshoff*, 571 U.S. at 108. That principle applies with particular force when it comes to terms that are designed to protect the interests of participants and increase the resources available for the actual payment of benefits by avoiding costly provider-driven litigation.

The Fifth Circuit's analysis gets this principle exactly backwards. Like many others, the plan's sponsor here included express plan language prohibiting the assignment of plan rights. Yet the Fifth Circuit held that the plan administrator waived that express prohibition simply by fulfilling a provider's request for direct payment at the initial claims processing stage. That ruling—i.e., that plan administrators waive employers' anti-assignment provisions based on routine administrative activity—seriously weakens such provisions. As a result of the decision below, provider-assignees will be able to sue under ERISA in the mine run of cases, in direct violation of ERISA's carefully calibrated enforcement regime. And the decision below effectively nullifies a plan sponsor's prerogative to select terms for its plan with the expectation that they will be enforced. Surely, the employer in this case did not expect that routine claims processing by a third-party administrator—who is not even a party to the plan—could erase a clear-cut term in its own plan.

Moreover, the plan may permit direct payments to providers on grounds other than assignment. Patients may authorize their providers to act as their representatives to pursue payment of their ERISA claims without even attempting to assign the provid-

ers their right to the underlying plan benefit, *see* 29 C.F.R. § 2560.503-1(b)(4), for example, or the providers may have some other, non-assignment basis for seeking direct payment. It makes no sense to infer waiver of an anti-assignment provision based on a plan administrator's claims-processing activity simply because the provider has sought direct payment. From the administrator's perspective, there is no reason to treat provider claims differently depending on the precise basis on which the provider is seeking payment, and the administrator may not even have the ability to make that determination without gathering additional information. Requiring administrators to undertake such an inquiry at the initial claims processing stage will delay payment or—more likely, given the deadlines imposed by state prompt-pay laws—simply force them to channel payment to the participants. *See infra* at 13-14.

This Court should grant review to restore Fifth Circuit caselaw to its proper jurisprudential track.

B. The Decision Below Created A Square Circuit Conflict

For the reasons just explained, the decision below is unsound even without the circuit conflict identified in the petition. But that decisional conflict exacerbates the consequences of leaving the decision below intact. As the petition explains in detail (Pet. 25-30), the courts of appeals are divided as to whether an ERISA plan administrator waives a plan's anti-assignment provision—with the consequence of allowing a provider to sue in court as an assignee for ERISA benefits—just by fulfilling the provider's request for benefits at the initial claims processing

stage. In the Fifth Circuit, the answer to that question is yes. *Id.* 27-28. But in the Third and Ninth Circuits, the answer is no. *Id.* 28-29 (citing *Am. Orthopedic & Sports Med.*, 890 F.3d at 453-54; *Eden Surgical Ctr. v. Cognizant Tech. Sols. Corp.*, 720 F. App'x 862, 863 (9th Cir. 2018)). District courts nationwide are conflicted on the question as well. *Id.* 29-30 & n.6. And *amici*'s members are now subject to starkly conflicting rules across the country.

This state of affairs would be unacceptable in any area of the law, but it is especially problematic in the context of ERISA. When ERISA was enacted, one of Congress's primary goals was to create a "uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208. To that end, ERISA establishes "predictable" and "uniform" rules. *Conkright*, 559 U.S. at 517 (internal quotation marks and alteration omitted). Divergent legal obligations in different circuits undermine the statute's goals of predictability and uniformity. *See Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001) ("Uniformity is impossible . . . if plans are subject to different legal obligations in different [places]."). A "patchwork scheme of regulation" is likely to "introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987).

By creating a circuit split on an important issue of ERISA law, the Fifth Circuit's decision directly undermines ERISA's goal of ensuring predictable and uniform regulation of employee benefit plans nationally. Now, the enforceability of anti-assignment language in an employee benefit plan turns entirely

on the jurisdiction in which suit is filed (which may or may not correspond to the jurisdiction from which the claim was submitted). That disuniformity threatens to directly affect the benefits American workers and their families receive across the nation.

This disuniformity, moreover, will also breed forum-shopping in cases involving large plans. ERISA suits may be brought "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." 29 U.S.C. § 1132(e). If the Fifth Circuit's decision stands, purported provider-assignees will flood that court with claims seeking to circumvent plans' anti-assignment provisions. Only this Court's review can reestablish the uniform federal policy ERISA mandates, and the decision below destroys.

C. If Allowed To Stand, The Decision Below Will Have Significant Adverse Practical Consequences

That is all bad enough. But there is more. If left standing, the decision below will have significant adverse practical consequences for all those involved in the health insurance industry. *See* Pet. 32-33.

The Fifth Circuit's decision on waiver discourages plan administrators from dealing with providers at the initial claims processing stage, and to reject providers' demands for benefits, whether offered on the participant's behalf, as an assignee, or on some other basis—distinctions that may not always be apparent to an administrator from the information provided in an initial claim. If an administrator risks negating a plan's anti-assignment provision, enabling providers to sue under ERISA, merely by fulfilling a provider's

claim, administrators will be discouraged from paying providers in the first place. Administrators will instead be obliged to direct payments to participants alone, who would then bear responsibility for transmitting payments to their providers. Many participants and beneficiaries appreciate the convenience of direct provider payment, which can save them paperwork and burden, not to mention the security of knowing that direct payment will not imperil their own rights under the plan. The Fifth Circuit's decision deprives them of that option. In short, if the Fifth Circuit's ruling is left standing, plans and the American workers and families they serve will suffer its consequences.

CONCLUSION

The petition should be granted, and the decision below reversed.

Respectfully submitted,

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September 13, 2019