No. 18-____

IN THE

Supreme Court of the United States

UNITEDHEALTH GROUP INC. ET AL.,

Petitioners,

v.

LOUIS J. PETERSON, D.C., ON BEHALF OF PATIENTS E, I, K, L, N, P, Q AND R, AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, ET AL.,

Respondents.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This Court held in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that a highly deferential standard of judicial review applies to interpretations of ERISA plans by administrators to whom the plans delegate interpretive discretion. The questions presented are:

1. Whether the Eight Circuit erred in holding—consistent with decisions of the First Circuit but in conflict with those of the Third, Fifth, and Seventh Circuits—that under the deferential *Firestone* standard of review, an administrator's determination that the plan authorizes certain remedial actions or measures is necessarily unreasonable merely because the plan is silent on the matter.

2. Whether the *Firestone* deference standard allows courts to reject an otherwise reasonable plan construction that is lawful under ERISA but, in the court's view, pushes ERISA's boundaries.

PARTIES TO THE PROCEEDING

Petitioners are UnitedHealthGroup Incorporated, United HealthCare Services, Inc., UnitedHealthcare Insurance Company, UnitedHealthcare Service LLC, and Optum, Inc., defendants-appellants in the court below.

Respondents are Louis J. Peterson, D.C., on behalf of Patients E, I, K, L, N, P, Q and R; and Riverview Health Institute, plaintiffs-appellees in the court below.

RULE 29.6 DISCLOSURE

UnitedHealthGroup Incorporated, a publicly held corporation, does not have a parent corporation, nor does any publicly held corporation own 10% or more of UnitedHealth Group Incorporated's stock.

United HealthCare Services, Inc. is a direct, 100%-owned subsidiary of UnitedHealth Group Incorporated.

UnitedHealthcare Insurance Company is an indirect, 100%-owned subsidiary of UnitedHealth Group Incorporated.

UnitedHealthcare Service LLC is an indirect, 100%-owned subsidiary of UnitedHealth Group Incorporated.

Optum, Inc. is an indirect, 100%-owned subsidiary of UnitedHealth Group Incorporated.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners (collectively referred to in this brief as "United") respectfully request a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

OPINIONS BELOW

The decision of the court of appeals is reported at 913 F.3d 769 and reprinted in the Appendix to the Petition ("App.") at 1a-15a. The judgment of the district court is reported at 242 F. Supp. 3d 834 and reprinted at App. 16a-52a.

JURISDICTION

The court of appeals denied United's petition for rehearing en banc on March 1, 2019. App. 53a-54a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

RELEVANT STATUTORY PROVISIONS

The pertinent provisions of the U.S. Code are reprinted at App. 55a-83a.

INTRODUCTION

This Court has held that if an ERISA plan gives an administrator the "power to construe disputed or doubtful terms," then "the [administrator's] interpretation will not be disturbed if reasonable." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989); *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115-19 (2008). This "broad standard of deference" promotes ERISA's overriding purposes, including the conservation of plan resources, predictability, and uniformity. *See Conkright v. Frommert*, 559 U.S. 506, 513, 517 (2010).

The decision below exacerbates several related circuit conflicts concerning the scope of this deferential standard. And if left to stand, the decision will undermine the very efficiency, predictability, and uniformity that standard (like ERISA more generally) was meant to ensure. This Court's review is warranted.

United is the nation's leading health and well-being company. One of United's core services is administering health benefit plans (the "United Plans") nationwide. This case concerns a system United and other leading insurers have developed and implemented over the past decade to recover overpayments to out-of-network healthcare providers, thereby conserving the assets of all United Plans.

United's administrative services include paying the medical professionals who provide care to Plan members. United is committed to meeting state law requirements to pay these claims quickly and efficiently. But occasionally United discovers that it has *overpaid* providers on its initial claim adjudications, whether because of United's error, the provider's error, or even the provider's fraud. When overpayments occur, United requests refunds, considers any provider appeals, and then—if the overpayments are confirmed—recovers the overpayments from payments otherwise due. All agree the terms of the pertinent plans entitle United to use offsets to recover overpayments if (i) the provider has contractually agreed to offsetting by joining United's network or (ii) the provider is out-of-network and both the overpayment and the payment due pertain to the same plan, regardless

whether the claims relate to the same patient or different patients. Respondents assert, however—and the court of appeals agreed—that the exact same types of recoveries among *different* plans are not permissible, and that the plans are powerless to instruct United jointly to recover overpayments from each other's payments.

This proposed "intra-plan" limitation significantly impedes the effectiveness of offsetting, because benefit payments are usually routed to providers rather than to patients, and each provider sees members of many different United Plans; a single provider may not see two members of the same Plan for months or years, if ever. When such providers refuse to refund even undisputed overpayments, they unjustly enrich themselves at the Plans' expense, retaining Plan assets to which they are not entitled.

To address that problem, United exercised its discretion to develop a payment system that allows United (after provider appeals) to offset overpayments from payments due under any United-administered Plan. This practice, which respondents call "cross-plan offsetting," has undisputedly saved substantial plan assets over the past decade.

It is undisputed that each Plan grants United broad discretion to interpret the Plan, App. 11a, which means that *Firestone* deference is accorded its construction of the Plans to allow for cross-plan offsetting. The court of appeals nevertheless rejected United's construction, and it did so for two related reasons, each of which implicates an important legal question of ERISA administration warranting this Court's review.

First, the court of appeals held that because the Plans are silent as to whether cross-plan offsetting is authorized, United's determination that cross-plan offsetting is an appropriate remedy was unreasonable. An administrator cannot claim authority from plan silence, the court maintained, because such a rule would undermine ERISA's rule that all plan terms must be in writing.

That decision broadens a circuit conflict on an important legal question: whether a court applying *Firestone* deference may invalidate as unreasonable an administrator's action merely because the plan is silent on the matter. The Eighth Circuit joins the First Circuit in adopting this approach, whereas the Third, Fifth, and Seventh Circuits hold the opposite: "When as in this case the plan document does not furnish the answer to the question, the answer given by the plan administrator, when the plan vests him with discretion to interpret it, will ordinarily bind the court." *Gallo v. Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996). This circuit conflict means that the same multi-state or nationwide plans will be interpreted differently in different jurisdictions. And the Eighth Circuit's answer to the first question presented is wrong: holding that an administrator's construction of a plan is unreasonable merely because the plan is silent on the relevant matter is irreconcilable with *Firestone*'s deferential standard of review.

Second, the court of appeals held that an administrator's plan construction should be viewed with "skepticism," App. 15a, when the construction does not violate ERISA, but approaches its boundaries. But "skepticism" is the opposite of deference, meaning

that the court below adopted an exception to *Firestone* deference for otherwise reasonable and perfectly lawful plan interpretations. This Court has expressly rejected such exceptions because they invite the very disuniformity that deference is meant to prevent. *See Conkright*, 559 U.S. at 513.

The questions presented, in short, are critical to the uniform administration of ERISA plans. And this case presents an ideal vehicle through which to resolve them. The petition should be granted, and the decision below reversed.

STATEMENT OF THE CASE

A. Factual Background

United administers thousands of ERISA-governed health plans across the country. Consequently, healthcare providers like respondents routinely see patients covered by different United-administered plans. When providers bill United, their claims are paid quickly, sometimes under the direction of state "prompt pay" laws, *e.g.*, N.Y. Ins. Law § 3224-a, and otherwise for the convenience of members and providers alike. This system, however, necessarily results in overpayments, which United identifies through audits conducted *after* providers have been paid. *See Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204, 210 (D.N.J. 2013). Both United's audits and the ability to recover later-discovered overpayments are essential for United to be able to pay claims promptly. *Id.* If United correctly determines that a provider has been overpaid, and the provider neither remits the overpayment nor appeals through United's administrative review procedures, then United pays

the provider for a new claim by extinguishing the provider's outstanding debt and paying any additional amount owed in cash.[1]

More than a decade ago, United offered plan sponsors an innovative payment system that provided numerous benefits to United Plans, including the ability to aggregate an unlimited number of claims from multiple plans into a single check to providers. C.A. Special Appendix ("SAPX") 470.[2] In addition to reducing the costs associated with issuing thousands of checks, United's multi-claim "summarized" payment system allows Plans to cooperatively recover overpayments by *netting* offsets into summarized

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[1] Under United's system, plans that overpaid providers effectively *assign* that debt to other plans that receive claims from the same providers. The plan-assignees are then authorized under the common law to pay providers by offsetting the debts that they have been validly assigned. *See, e.g.*, *In re U.S. Aeroteam, Inc.*, 327 B.R. 852, 864 (Bankr. S.D. Ohio 2005).

[2] When United first offered plan sponsors the option to adopt this aggregate recovery system, it also provided plans that preferred not to participate in the new process the opportunity to opt out, and continue their United services without the aggregate recovery features. SAPX-112. Additionally, United's Strategic Account Executives were directed to contact their respective plan accounts to ensure that United's customers received answers to any questions they had about the changes. *See* SAPX-472-73, 479.

Since 2007, United has explained its payment-and-recovery system to potential new customers through the RFP process, and to actual customers "as part of [its] standard" onboarding process. *See* SAPX-559-60, 571, 584. New customers elect to participate in the system by proceeding with enrollment after receiving this disclosure. SAPX-584.

payments, regardless of whether the outgoing payments are on behalf of the same Plans that are owed outstanding overpayments. SAPX-112-15. In other words, if United overpays a provider for services to a participant of one Plan, United may "offset" the amount of that overpayment against a future payment to the same provider for services to a participant of a *different* Plan. As a result, all providers and Plans end up in a financial position consistent with their obligations and entitlements.

The undisputed record demonstrates that United's payment-and-recovery process benefits all Plans. By combining payments and recoveries into a single payment instrument, Plans save significant amounts on administrative costs—*e.g.*, the reduced cost of processing multiple payments—as well as checks and postage. Additionally, because Plans no longer need to wait for one of their members to visit a provider the Plan overpaid before the Plan can recover, the summarized system enhances the rate at which Plans recover overpayments, to the direct and obvious benefit of Plans and their participants. *See* SAPX-112.

These benefits are not merely theoretical: In the proceedings below, United produced undisputed data showing that, on average, a sample of Plans that paid the Respondent providers recovered nearly 25% more through aggregate recoveries than they could have recovered through only same-plan offsets—an average of more than $290,000 recovered per Plan. *See* SAPX-529. The savings across all United Plans is enormous.

B. District Court Proceedings

Respondents (plaintiffs below) are out-of-network healthcare providers who treat United Plan members. SAPX-49, 441, 443. They contend that United paid various benefits by canceling overpayment debts that respondents owed to other United-administered Plans.

Respondents offered no evidence challenging the *fact* that they were overpaid by the amounts United recovered through cross-plan offsetting. Respondents have also repeatedly conceded that ERISA permits cross-plan offsetting. *See, e.g.,* DE60, at 35 ("[I]f [the defendants] wanted this right, this cross-plan offset[] right, they can put it in the plan."); *accord* SAPX-134-35; DE168, at 53. And respondents have never disputed that each Plan grants United interpretive discretion to construe Plan terms. App. 11a.[3] But they

[3] Each Plan also grants United broad authority to administer benefits. *E.g.*, SAPX-89 (delegating authority to "[d]ecide the amount, form and timing of benefits"). In addition, almost all United Plans provide their administrators with an express grant of overpayment recovery authority. SAPX-372. The language among the Plans varies, SAPX-373-74, but these provisions generally authorize plans to recover overpayments, including through offsets, without limiting the specific recovery methods that may be employed. For example, many Plans explicitly reserve to the plan or its administrator non-enumerated recovery authority. *See* SAPX-93-94, 96-98, 107 (providing the plan "may have other rights in addition to the rights to reduce future Benefits," or materially similar language); *see also* SAPX-105 (Exemplar O (providing that "[i]f the Plan overpays a health care provider, [United] *reserves* the right to recover the excess amount" (emphasis added))). Other Plans similarly describe offset powers in purely illustrative terms, *e.g.*, by citing recovery authority that "includ[es]" the power to offset, or by "reserv[ing]"

argued the Plans' text could not reasonably be construed to authorize the practice. *See* App. 41a. On that basis alone, respondents sought payment of benefits allegedly owed under 29 U.S.C. § 1132(a)(1)(B), and injunctive relief prohibiting "cross-plan offsets" under § 1132(a)(3).

Recognizing that respondents' claims would fail if the United Plans were construed to allow cross-plan offsetting, the district court called for "Phase I" of the litigation to be limited to "whether the applicable plans of the [relevant] patients authorize or prohibit" the practice. DE65.

At summary judgment on Phase I, the district court acknowledged that United's plan "interpretation is . . . reviewed for abuse of discretion." App. 33a. The district court also acknowledged that the question whether cross-plan offsetting violated ERISA was not before it. *Id*. Still, the court held that absent "*explicit* language" authorizing cross-plan offsetting, the Plans could not be construed to allow the practice, particularly because the plans included other provisions expressly authorizing *intra*-plan offsetting but failed to mention cross-plan offsetting. *Id.* 41a (emphasis added).

The district court *sua sponte* certified its order for immediate appeal under 28 U.S.C. § 1292(b). The court noted that while it "has never certified an order for interlocutory appeal during [its] almost 11 years

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the right to offset without forbearing other powers, *see* SAPX-102, 108 (Exemplars L & R).

on the bench," this is an "extraordinary" matter warranting immediate appeal, not only because it satisfies the preconditions of § 1292(b), but because "this is an exceptional case":

> United is, by far, the largest health insurer in the United States, and it is one of a handful of the largest health insurers in the world. United has engaged in cross-plan offsetting for the past decade. If United is ultimately enjoined from engaging in the practice, United will have to undertake the extremely expensive and disruptive process of unwinding its cross-plan offsetting practice. Having lost its initial (and, it appears to the Court, strongest) argument in favor of cross-plan offsetting, United now faces a lengthy period of uncertainty concerning a major component of its business.

SAPX-392-94.

C. Decision Below

The Eighth Circuit affirmed the district court's decision. The court of appeals acknowledged that courts review "administrators' plan interpretations" to determine whether a plan interpretation is "reasonable." App. 11a. But despite this deferential standard, and despite United's undisputedly "broad authority to administer the plan," *id.* 12a, the Eighth Circuit held the plans could not reasonably be construed to authorize cross-plan offsetting.[4]

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[4] The parties disputed before the court of appeals whether United was operating under a conflict of interest when construing the Plans. Respondents argued that United was conflicted

The court's principal basis for that conclusion was that "not one of th[e] plans *explicitly authorizes* cross-plan offsetting." *Id*. (quotation marks omitted; emphasis added). The court determined that adopting "United's argument that the plan language granting it broad authority to administer the plan is sufficient to authorize cross-plan offsetting would be akin to adopting a rule that anything not forbidden by the plan is permissible." *Id.* The court also believed that explicit authorization is required by "ERISA's requirement that '[e]very employee benefit plan shall be established and maintained pursuant to a written instrument.' 29 U.S.C. § 1102(a)(1)." *Id*. 12a. United had explained to the Court that the Fifth Circuit had previously construed materially identical plans to authorize cross-plan offsetting, but the court of appeals declined to follow that decision. *Id.* n.5.

The court also held that United's interpretation should be viewed skeptically because "it approaches the line of what is permissible," although the Court did not actually decide whether cross-plan offsetting "violates ERISA." *Id*. 13a. "Considering this, alongside the fact that there is no plan language—only

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because United itself benefited from cross-plan offsetting with respect to fully-insured United Plans. United argued that (i) there was no conflict because plan sponsors (not United) themselves chose cross-plan offsetting through the negative-consent process discussed above, *see supra* n.2, and (ii) any conflict in any event would not alter the standard review under *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), and United's construction was reasonable under that standard. The court of appeals did not address this dispute because it assumed there was no conflict and held that United's plan construction was unreasonable. App. 14a n.6.

broad, generic grants of administrative authority—that would authorize the practice, leads us to conclude that United's interpretation is not reasonable." *Id.* 15a.

4. The Eighth Circuit denied rehearing on March 1, 2019. App. 54a. This petition followed.

REASONS FOR GRANTING THE WRIT

This Court held in *Firestone* that when, as here, an ERISA-governed plan delegates interpretive authority to an administrator of that plan, courts must review the administrator's plan construction deferentially, and may set it aside only if it is unreasonable. This Court should grant certiorari to resolve two important questions concerning the scope of that deferential standard of review.

The first question is whether an administrator's determination to take a particular action under the plan is unreasonable under *Firestone* merely because the plan is silent as to that action. That is what the Eighth Circuit held, and its decision adds to an existing circuit conflict. The decision below, moreover, answered the question incorrectly: reading plan silence to *preclude* an administrator with interpretive authority from acting in pursuit of legitimate plan objectives is flatly inconsistent with this Court's long-held understanding of *Firestone* deference.

The second question is whether a reviewing court must view with "skepticism" rather than deference a plan construction that does not violate ERISA, but "approaches the line of what is permissible." App. 13a. That question all but answers itself—there is no basis under *Firestone* or its progeny to invalidate an

otherwise reasonable and lawful plan construction. The Eighth Circuit's decision to the contrary adopts precisely the sort of exception to *Firestone* deference that this Court has flatly rejected.

Both questions, moreover, are crucial to the uniform nationwide administration of ERISA-governed plans. The inevitable result of the Eighth Circuit's decision is *dis*uniformity in ERISA plan construction, including construction of plans that span multiple jurisdictions—a result that contravenes ERISA's goals of efficiency and uniformity in plan administration. This case presents the Court with an ideal vehicle to resolve both questions presented.

I. THE COURTS OF APPEALS ARE SPLIT AS TO THE FIRST QUESTION PRESENTED, WHICH THE EIGHTH CIRCUIT DECIDED INCORRECTLY.

A. The Courts Of Appeals Are In Conflict Over Whether Plan Silence About A Particular Action Precludes An Administrator With Broad Interpretive Authority From Taking Such Action.

The court of appeals held that United's plan construction was unreasonable because the United Plans do not "explicitly authorize" cross-plan offsetting. App. 12a. Indeed, the court held that implying ambiguity from plan silence would violate "ERISA's requirement that '[e]very employee benefit plan shall be established and maintained pursuant to a written instrument.' 29 U.S.C. § 1102(a)(1)." App. 12a. That decision implicates at least three related conflicts among the courts of appeals.

1. As the Eighth Circuit itself recognized, *see* App. 12a n.5, there is a direct conflict over whether United's construction of the plan language is reasonable.

In *Quality Infusion Care, Inc. v. Health Care Service Corp.*, 628 F.3d 725 (5th Cir. 2010) ("*QIC*"), the Fifth Circuit held that cross-plan offsetting is allowed under plan language that is *materially identical* to the plan language at issue here. *Id.* at 728-30. None of the plans in *QIC* contained provisions expressly authorizing offsets from benefit payments involving other plans. Still, the court construed each plan, and concluded that plans that said nothing about cross-plan offsets—and in one case, a plan limiting its express remedies to same-plan offsets—were not only reasonably but *correctly* construed to allow cross-plan offsetting because each plan granted its administrator broad remedial authority. *See id.* The Eighth Circuit expressly recognized this decision, but rejected it because it was "not bound by its reasoning." App. 12a n.5.[5]

That direct conflict over whether a ubiquitous construction of nationwide ERISA plans' available remedies is itself exceedingly important, *see infra* Part III.A, but the disagreement over the particular plan language here derives from two related, broader

[5] The court of appeals also noted that *QIC* did not apply ERISA's deferential standard of review. App. 12a n.5. (ERISA did not apply in *QIC*, presumably because the employer in that case was the government.) But that only aggravates the conflict—the Eighth Circuit held that the plan language cannot even *reasonably* be construed the way the Fifth Circuit construed it de novo.

disagreements over the interaction of plan silence and deferential administrator review.

2. The Eighth Circuit's decision that an administrator with interpretive discretion cannot act in the face of plan silence exacerbates an existing conflict over the proper application of *Firestone* deference to plan silence.

a. The First Circuit, like the Eighth Circuit, has held that plan silence on a matter precludes an administrator with interpretive discretion from acting on that matter. That is because, according to the First Circuit, "silence is telling in an ERISA case because the discretion of a plan administrator is cabined by the text of the plan and the plain meaning of the words used." *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 65 (1st Cir. 2013). Like the court below, the First Circuit believes that allowing an administrator to act despite plan silence on the matter "would undermine the integrity of an ERISA plan," so any administrator interpretation to this effect would be "simply unreasonable." *Id.*

b. These decisions squarely conflict with the decisions of the Third, Fifth, and Seventh Circuits. As the Seventh Circuit explained: "When as in this case the plan document does not furnish the answer to the question, the answer given by the plan administrator, when the plan vests him with discretion to interpret it, will ordinarily bind the court. That is implicit in the idea of deferential review of the plan administrator's interpretation." *Gallo v. Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996). The Third and the Fifth Circuits agree. *See Dowling v. Pension Plan for Salaried*

Emps. of Union Pac. Corp & Affiliates, 871 F.3d 239, 248 (3d Cir. 2017) ("Given the silence, we cannot say that either approach is unreasonable."); *McCall v. Burlington N./Santa Fe Co.*, 237 F.3d 506, 513 (5th Cir. 2000) ("While [administrators are] bound by statements in the Plan documents, they are not bound by silence."). The rule in these circuits is irreconcilable with the decision below, which holds that when the plan document does not furnish an answer, the administrator *cannot* provide one because doing so would violate ERISA's written-plan requirement.

3. The decision below also implicates another, related circuit conflict over the interaction of *Firestone* deference and plan silence.

Respondents have always argued that cross-plan offsetting was prohibited not only because the United Plans were silent about it, but also because the Plans expressly authorized *intra*-plan offsetting while failing to authorize cross-plan offsetting. The theory here is *expressio unius est exclusio alterius*—i.e., "expressing one item of [an] associated group or series excludes another left unmentioned," *NLRB v. SW Gen., Inc.*, 137 S. Ct. 929, 940 (2017). That was the district court's express reasoning, App. 40a-43a, and the Eighth Circuit similarly noted that the United Plans here expressly allow *intra*-plan offsetting, App. 12a n.5.

That reasoning—a variant on the view that plan silence precludes administrator action—implicates a related but distinct circuit conflict over whether the *expressio unius* canon applies where an ERISA administrator receives *Firestone* deference.

The Second Circuit holds that the *expressio unius* canon applies in this context. *Novella v. Westchester Cty.*, 661 F.3d 128, 142 (2d Cir. 2011). That court reasons that administrators should not be allowed "to pick and choose language from disparate sections of the Plan," as that could "subvert the intention of the Plan's drafters and the reasonable expectations of Plan participants." *Id.* at 142.

On the other side of the conflict is the Third Circuit. In *Dowling*, that court explained that *expressio unius* "cuts the opposite way when [a court is] paying deference to a plan administrator, because when a plan administrator interprets a text that contains a 'mandate in one section and silence in another,' the silence 'often suggests . . . simply a decision not to mandate any solution . . . , i.e., to leave the question' open to the reasonable interpretation of the administrative decisionmaker." *Dowling*, 871 F.3d at 248 (quotation marks omitted).

* * *

This state of affairs is intolerable. Currently, the scope of an administrator's ability to interpret ERISA plan silence turns entirely on the jurisdiction in which suit is filed. That would be a problem in any area of the law, but it is particularly problematic for ERISA plans: Because many plans are nationwide, a single administrator's construction of a single plan will be reviewed differently in different courts. This conflict, in other words, undermines ERISA's goal of "securing national uniformity in . . . plan administration." *Boggs v. Boggs*, 520 U.S. 833, 838 (1997). And that disuniformity directly affects the benefits employees and retirees receive across the Nation.

B. The Eighth Circuit's Ruling Is Incorrect.

The Eighth Circuit's approach conflicts with not only with the decisions of other courts of appeals, but also this Court's precedents and the purposes of ERISA.

This Court has repeatedly set forth "a broad standard of deference" to plan fiduciaries authorized to construe and administer ERISA plans. *Conkright v. Frommert*, 559 U.S. 506, 513 (2010); *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115-19 (2008); *Firestone*, 489 U.S. at 111. That deferential standard promotes ERISA's purposes: it "promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation." *Conkright*, 559 U.S. at 517. "It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review." *Id.* And it "serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions." *Id.*

The Eighth Circuit's decision here is inconsistent with ERISA's overriding objectives. The Eighth Circuit acknowledged that the Plans all contain broad grants of authority to interpret and implement them, so "courts must apply a deferential abuse-of-discretion standard of review." App. 11a (quotation marks omitted). And the court did not dispute that the Plans grant United broad power to "[d]ecide the amount, form and timing of benefits," SAPX-89, expressly authorize intra-plan offsetting, App. 12a, and provide

that any remedial authority in the Plans is non-exclusive. Nevertheless, the court held that because "not one of th[e] plans *explicitly* authorizes cross-plan offsetting," App. 13a (quotation marks omitted; emphasis added), the plans could not reasonably be construed to allow such offsetting.

This approach to judicial review of ERISA plan construction is inconsistent with *Firestone*'s deferential standard of review. ERISA plans delegate discretion to plan fiduciaries in large part to allow them to handle unforeseen challenges and to take advantage of innovations that would improve the plans' operations and finances. When the plan grants such discretion, it makes no sense to limit an administrator's remedial authority just because a particular remedy is not expressly set forth in the plan. That approach would hurt plan participants by weakening administrators' ability to adopt remedial measures that protect plans' fiscal integrity, as cross-plan offsetting does.

Thus, as the Third Circuit in *Dowling* explained, plan silence in these circumstances does not imply prohibition—"when a plan administrator interprets a text that contains a 'mandate in one section and silence in another," the silence suggests "a decision not to mandate any solution . . . , i.e., to leave the question open to the reasonable interpretation of the administrative decisionmaker" on an unaddressed issue. *Dowling*, 871 F.3d at 248 (quotation marks omitted). This does not mean, as the court of appeals believed, that "anything not forbidden by the plan is permissible." App. 12a. Rather, it simply means that when a

plan grants broad remedial and interpretive authority, including express authority to offset overpayments, *Firestone* requires a court to recognize a plan's silence as to other remedial measures (including cross-plan offsetting) as authorizing administrative discretion rather than precluding administrative action. *See, e.g.*, *Dowling*, 871 F.3d at 248.

The consequence of the approach of the court below, however, will be to require plans to add express written authorization every time they or their claims administrators recognize problems requiring solutions. That rule not only serves no purpose, but is exactly backwards: the whole point of delegating broad administrative and remedial authority to plan fiduciaries is to allow them to take needed actions *without* express enumeration. If plan fiduciaries required express written authorization to respond to every unaccounted for problem, plan administration would grind to a halt. That does not, contrary to the Eighth Circuit's view, violate ERISA's requirement of a written plan, App. 12a—it *gives effect* to that requirement by notifying plan participants that the administrator will have broad discretion, including remedial authority, to solve unaccounted-for problems.

The decision below thus not only exacerbates circuit disagreement over the question presented, but is wrong to boot. Review should be granted and the decision below reversed.

II. THE EIGHTH CIRCUIT'S DECISION AS TO THE SECOND QUESTION PRESENTED IS INCONSISTENT WITH THIS COURT'S PRECEDENTS.

As a second reason for rejecting United's plan construction, the court of appeals held that United's interpretation should be viewed skeptically because "it approaches the line of what is permissible" under ERISA. App. 13a. The court of appeals did *not* hold that cross-plan offsetting *does* violate ERISA. *Id.* But it nevertheless concluded that United's construction was unreasonable because "we view interpretations that authorize practices that push the boundaries of what ERISA permits with some skepticism." App. 14a-15a. Even if cross-plan offsetting did "push[] the boundaries" of ERISA—when properly understood as a mutually beneficial cooperative arrangement among plans, it does not[6]—that would be irrelevant:

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[6] Respondents *admitted* in the district court that cross-plan offsetting would be legal if authorized by the plan language. *See supra* at 8-9. The court of appeals nevertheless held that cross-plan offsetting is in "tension" with ERISA because it amounts to "failing to pay a benefit owed to a beneficiary under one plan in order to recover money for the benefit of another plan." App. 14a. But there is no support for the proposition that cross-plan offsetting pushes ERISA's boundaries. Each United Plan participates in United's aggregate recovery process for its own benefit in the form of mutual reductions in overpayment losses. Common law trust principles recognize that trusts may engage in such mutually beneficial transactions. *See* Restatement (Third) of Trusts § 78, cmt. (c)(7) (2007). It is true that participating plans also benefit from other plans' decision to participate in cross-plan offsetting. But ERISA does not prohibit plan sponsors from acting to benefit their own plans just because other plans also incidentally benefit. *Cf. Bussian v. RJR Nabisco, Inc.*, 223

a plan construction that pushes *but does not cross* the boundaries of ERISA is lawful, and rejecting a lawful plan construction that is otherwise reasonable cannot be reconciled with *Firestone*'s deferential standard of review. Indeed, this unprecedented clear-statement rule would preclude plan construction that is admittedly reasonable *and* lawful, thus turning the *Firestone* abuse-of-discretion standard on its head.

This Court's decision in *Conkright* is instructive. There, Xerox administered an ERISA plan, which it had discretionary authority to interpret. 559 U.S. at 509. A group of Xerox employees who left the company received lump-sum distributions of retirement benefits they had earned up to that point; these same employees were later rehired. *Id.* To avoid paying these employees twice, the plan administrator employed a method to reduce the benefits they received after being rehired. *Id.* The employees challenged this method in court. The Second Circuit held that the method—which was not expressly allowed by plan documents—was unreasonable. *Id.* at 513. In reaching this conclusion, it relied on the fact that Xerox had previously construed the same plan terms in a way that a federal court had rejected, which the Second

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F.3d 286, 302 (5th Cir. 2000). Indeed, DOL advisory opinions establish that plans may share costs cooperatively, so long as there is a reasonable method for determining each plan's contribution and relative benefit. See DOL Adv. Op. 1993-06A (plans can share the cost of compensating several full-time employees who can assist with their administration); DOL Adv. Op. 1989-09A (same). Here, it is undisputed that United provides a reasonable method for determining each Plan's contributions to and benefits from aggregate payment transactions.

Circuit took to mean that Xerox was not entitled to *Firestone* deference for subsequent interpretations of those same terms. *Id.* This Court reversed, explaining that *Firestone*'s "broad standard of deference" was not "susceptible to ad hoc exceptions." *Id.*

The same analysis holds here. The Eighth Circuit's view that deference to an otherwise reasonable interpretation is unwarranted when the interpretation is lawful but "approaches [ERISA's] line" conflicts with the Supreme Court's repeated "refus[al] to create . . . exception[s] to *Firestone* deference." *Id.* (citation omitted). Obviously, a plan's ambiguity cannot be construed to allow what is unlawful. But precluding a plan fiduciary from adopting a *legal* construction because the court believes that construction approaches ERISA's boundary is just another way of saying that a court should not defer to a reasonable plan interpretation in these circumstances. That is precisely the type of exception to deferential review that this Court has expressly rejected.

The Eighth Circuit's decision, moreover, would hamstring administrators, preventing them from adopting creative ways to conserve plan resources. For example, here cross-plan offsetting provides the United Plans substantial savings by allowing them to efficiently recover overpayments. There is no reason to deny United Plans (and their participants) this lawful means of saving substantial amounts of money when its construction is fully legal, even if (in the court of appeals' view) cross-plan offsetting approaches ERISA's boundaries. The Eighth Circuit's decision to the contrary is irreconcilable with this Court's precedents.

III. THE QUESTIONS PRESENTED ARE EXCEEDINGLY IMPORTANT, AND THIS CASE PRESENTS AN IDEAL VEHICLE THROUGH WHICH TO RESOLVE THEM.

Finally, there is no doubt that the questions presented here are sufficiently important to warrant this Court's review. ERISA covers the health benefit and retirement plans of most of the Nation's employees, and the questions presented implicate issues fundamental to their administration by plan fiduciaries. This petition, moreover, provides an ideal vehicle through which to resolve those questions. The petition should be granted.

A. The Petition Presents Two Questions Crucially Important To ERISA Plan Administration.

1. The first question presented is important for obvious reasons. There are untold numbers of ERISA-governed plans throughout the Nation, and few of them—as with any legal document—can answer in advance every possible question. An administrator thus will have to determine what authority it has in the face of plan silence, including (as in this case) whether it has authority to take remedial measures that the plan does not explicitly authorize. *See supra* at 5-8. And because most ERISA plans grant their administrators broad interpretive discretion, the manner in which courts review an administrator's plan construction under the *Firestone* standard directly affects how plans (including nationwide plans) are administered, and thus how benefits are determined and paid (among other things).

It is no surprise, then, that this Court has repeatedly granted certiorari to determine the appropriate standard for judicial review of administrators' plan construction, including (for example) whether review is de novo or deferential, *Firestone*, 489 U.S. at 111, how and whether the deferential standard of review applies in a case of a conflicted administrator, *Metro. Life Ins.*, 554 U.S. at 115-19, and whether the deferential standard applies after the administrator's construction had previously been declared unreasonable, *Conkright*, 559 U.S. at 513. The manner in which courts should review administrator conduct in the face of plan silence is likewise worthy of this Court's consideration.

2. The second question is important for similar reasons. As explained, the Eighth Circuit's determination that an administrator's construction should be construed "with some skepticism" rather than with deference, App. 15a, effectively creates an exception to *Firestone*'s deferential standard of review. And as this Court explained in *Conkright*, *Firestone* "deference to plan administrators serves the[] important purposes" of "efficiency, predictability, and uniformity" in plan administration, and such exceptions to *Firestone* deference necessarily undermine the those purposes. 559 U.S. at 518. But under the Eighth Circuit's rule, the permissibility of plan interpretation will be based *not* on whether the administrator's construction is reasonable, but rather on the *court's* view of whether the administrator's lawful construction is close to ERISA's boundary. And because different courts will have different views about what ERISA allows and about how close to the ERISA

line is too close, the result of the Eighth Circuit's rule will be heterogeneous interpretations of nationwide plans.

3. The risk of uneven construction of nationwide plans is hardly theoretical. As explained, the Fifth Circuit in *QIC* construed materially *identical* plan language and determined that the plans authorize cross-plan offsetting. *See supra* Part I.A.1. Without this Court's intervention, countless such divergent constructions of similar plan language are inevitable.

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) (emphasis added), and some courts have construed the emphasized language to mean any district with which the plan has minimum contacts. *See Waeltz v. Delta Pilots Ret. Plan*, 301 F.3d 804, 809 (7th Cir. 2002); *I.A.M. Nat'l Pension Fund v. Wakefield Indus., Inc.*, 699 F.2d 1254, 1257 (D.C. Cir. 1983). If the Eighth Circuit decision stands, plan participants (and their assignees) throughout the nation will flood that court with cases seeking to invalidate administrators' decisions on the ground that action in the face of plan silence is unreasonable, or that the *Firestone* standard does not apply because the decision approaches ERISA's boundaries. A single court of appeals should not be allowed to establish a *de facto* nationwide rule on important questions of ERISA plan administration without this Court's review.

4. The questions presented are also exceptionally important because of the practical consequences of the decision below to the administration of thousands of United Plans. If left to stand, the Eighth Circuit's decision will require United to significantly alter how it processes provider payments. And because the United Plans are normally not limited to the Eighth Circuit but are multi-state or nationwide, the Eighth Circuit's decision in effect establishes a nationwide rule for cross-plan offsetting. As the district court explained, this will cause "extreme[] . . . disrupt[ion]" to a procedure that United has been utilizing for a decade. SAPX-393. The resulting "legal limbo," *id.* at 394—which, again, results from a conflict with the decisions of other courts of appeals—can now only be resolved by this Court.

This problem, moreover, is not limited to United: at least Blue-Cross/Blue-Shield, *QIC*, 628 F.3d at 725, Aetna,[7] and Cigna[8] also have interpreted ERISA plans to permit cross-plan offsetting. The Eighth Circuit's decision puts this established practice in legal

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[7] *See Mayer v. Aetna Inc.*, No. 15-cv-02595 (D.N.J.). Aetna has expressly relied on the lack of any plan prohibition against cross-plan offsetting to support the practice. *See* Opposition to Plaintiffs' Memorandum of Law in Support of Motion for Class Certification, DE121, at 18 ("Plaintiffs' argument that no plan expressly mentions 'cross-plan' offsets (Mot. 18 n.7) is a red herring, because Plaintiffs themselves manufactured that term. The plans unquestionably vest Aetna with broad overpayment recovery authority, and, as countless courts have held, the question is whether any plan restricts Aetna's authority to offset payments across plans." (citing *QIC*, 628 F.3d at 730)).

[8] *See Rojas v. Cigna Health & Life Ins. Co.*, No. 14-cv-06368 (S.D.N.Y.).

jeopardy. Without cross-plan offsetting, not only the claims administrators and plan sponsors, but also the customers and patients they serve—all of whom unambiguously benefit from the practice—will suffer.

B. The Petition Presents An Ideal Vehicle To Resolve The Questions Presented.

This case is also an ideal vehicle to resolve these questions. Both questions present purely legal issues on which the Eighth Circuit has taken a clear position. Moreover, a decision from this Court on *either* question would be outcome-determinative. While the court of appeals offered two reasons for rejecting United's construction, it made clear that neither reason independently supported that holding. *See* App. 12a ("Two points are key to our analysis."); *id*. 15a ("Considering this [supposed tension with ERISA], alongside the fact that there is no plan language—only broad, generic grants of administrative authority—that would authorize the practice, leads us to conclude that United's interpretation is not reasonable."). Thus, if this Court disagreed with the Eighth Circuit as to either question presented, the decision below would have to be reversed and a remand would be required. The Eighth Circuit could then consider whether either of its reasons alone suffices to support its view that United's plan construction is unreasonable.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

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