

No. 25-1020

In the Supreme Court of the United States

BLUE CROSS AND BLUE SHIELD OF ALABAMA, *ET AL.*,

Petitioners,

v.

ANGELINA EMERGENCY MEDICINE ASSOCIATES PA,

ET AL.,

Respondents.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit**

**BRIEF FOR AMERICA'S HEALTH INSURANCE
PLANS, INC. AND AMERICAN BENEFITS
COUNCIL AS *AMICI CURIAE* SUPPORTING
PETITIONERS**

STEPHANIE SCHUSTER

Counsel of Record

PRANAV MULPUR

MORGAN, LEWIS & BOCKIUS LLP

1111 Pennsylvania Ave., NW

Washington, DC 20004

(202) 739-3000

stephanie.schuster@

morganlewis.com

Counsel for Amici Curiae

QUESTION PRESENTED

Whether general estoppel can override an ERISA plan's unambiguous text.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED.....	i
INTEREST OF <i>AMICI CURIAE</i>	1
INTRODUCTION AND SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. Respecting Plan Terms Is Critical To ERISA’s Core Purpose Of Encouraging Employers To Offer Benefits To Employees	5
II. The Fifth Circuit’s Broad Estoppel Doctrine Undermines ERISA’s Core Purpose.....	10
CONCLUSION	14

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Aetna Health Inc. v. Davila</i> , 542 U.S. 200 (2004).....	5
<i>Black & Decker Disability Plan v. Nord</i> , 538 U.S. 822 (2003).....	5, 11
<i>Carlson v. Northrop Grumman Severance Plan</i> , 67 F.4th 871 (7th Cir. 2023).....	5
<i>Conkright v. Frommert</i> , 559 U.S. 506 (2010).....	5, 11
<i>Curtiss-Wright Corp. v. Schoonejongen</i> , 514 U.S. 73 (1995).....	6
<i>Egelhoff v. Egelhoff ex rel. Breiner</i> , 532 U.S. 141 (2001).....	6
<i>Gobeille v. Liberty Mut. Ins. Co.</i> , 577 U.S. 312 (2016).....	6
<i>Health Ins. Plans v. Hudgens</i> , 742 F.3d 1319 (11th Cir. 2014).....	7
<i>Heimeshoff v. Hartford Life & Accident Ins. Co.</i> , 571 U.S. 99 (2013).....	6
<i>Kennedy v. Plan Adm’r for DuPont Sav. & Inv. Plan</i> , 555 U.S. 285 (2009).....	6, 10

TABLE OF AUTHORITIES—continued

	Page(s)
<i>Lockheed Corp. v. Spink</i> , 517 U.S. 882 (1996).....	5
<i>M&G Polymers, LLC v. Tackett</i> , 574 U.S. 427 (2015).....	6
<i>Mertens v. Hewitt Assocs.</i> , 508 U.S. 248 (1993).....	10
<i>N. Cypress Med. Ctr. Operating Co. v. Aetna Life Ins. Co.</i> , 898 F.3d 461 (5th Cir. 2018).....	7
<i>Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.</i> , 371 F.3d 1291 (11th Cir. 2004).....	8
<i>US Airways, Inc. v. McCutchen</i> , 569 U.S. 88 (2013).....	7, 10
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996).....	6
<i>Wehr Constructors, Inc. v. Assurance Co.</i> , 384 S.W.3d 680 (Ky. 2012)	12

TABLE OF AUTHORITIES—continued

Page(s)

Statutes

Employee Retirement Income Security

Act

29 U.S.C. § 1001 <i>et seq.</i>	2–7, 8–11, 13, 14
29 U.S.C. § 1001(a)	5
29 U.S.C. § 1102(a)	6
29 U.S.C. § 1104(i)	6, 13
29 U.S.C. § 1104(a)(1)(A)	6, 13
29 U.S.C. § 1132(a)	8
29 U.S.C. § 1132(a)(1)(B)	6

Other Authorities

119 Cong. Rec. 30,004 (1973)	5
------------------------------------	---

Kaiser Family Found., *Employer Health*

Benefits: 2025 Annual Survey (Oct.

22, 2025), [https://files.](https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf)

[kff.org/attachment/Employer-](https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf)

[Health-Benefits-Survey-2025-](https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf)

[Annual-Survey.pdf](https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf).....

National Survey of 5,310 employees with

employer-sponsored insurance,

America's Health Insurance Plans

(Dec. 2025), [https://ahiporg-](https://ahiporg-production.s3.amazonaws.com/documents/AHIP-EPC-Fact-Sheet-FINAL.pdf)

[production.s3.amazonaws.com/docu-](https://ahiporg-production.s3.amazonaws.com/documents/AHIP-EPC-Fact-Sheet-FINAL.pdf)

[ments/AHIP-EPC-Fact-Sheet-](https://ahiporg-production.s3.amazonaws.com/documents/AHIP-EPC-Fact-Sheet-FINAL.pdf)

[FINAL.pdf](https://ahiporg-production.s3.amazonaws.com/documents/AHIP-EPC-Fact-Sheet-FINAL.pdf)

INTEREST OF *AMICI CURIAE*¹

America’s Health Insurance Plans, Inc. (“AHIP”) is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and care more affordable, accessible, and equitable for everyone. AHIP’s members offer health and supplemental benefits through employer-provided coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Combined, AHIP’s members provide healthcare coverage, services, and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation’s healthcare and health insurance systems work.

The American Benefits Council (the “Council”) is a public policy organization and trade association dedicated to protecting and fostering privately sponsored employee benefit plans. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Collectively, the Council’s more than 415 members either directly sponsor or administer health and retirement benefits for virtually all Americans

¹ Counsel of record for *Amici* affirms that no counsel for any party authored this brief in whole or in part, that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief, and that no person other than *Amici* and their counsel made such a monetary contribution. Counsel for *Amici* further affirms that counsel of record for all parties received timely notice of *Amici*’s intent to file this brief at least ten days before the due date.

covered by employer-sponsored plans. The Council regularly participates as *amicus curiae* in cases affecting employee benefits plans.

The petition for a writ of certiorari presents a question of profound importance to *Amici* and their members. *Amici* are trade associations that represent participants in the health insurance industry and employers who provide healthcare to hundreds of millions of Americans. An important pillar of America's healthcare system is the voluntary provision of health benefits by employers under the Employee Retirement Income Security Act ("ERISA"). That pillar, however, will buckle under the weight of the Fifth Circuit's misapplication of a broad, equitable estoppel exception in ERISA cases. *Amici* are uniquely situated to highlight, as they do in this brief, how the Fifth Circuit's estoppel doctrine undermines ERISA's purposes, exposes insurers and employers to unnecessary risk, and ultimately threatens the health benefits of millions of Americans.

INTRODUCTION AND SUMMARY OF ARGUMENT

For much of the twentieth century, employees suffered under a frenzied patchwork of sparse benefits with little security. In the aftermath of high-profile pension failures, Congress carefully designed the Employee Retirement Income Security Act to encourage employers to offer benefit plans to their employees. ERISA includes a robust system of protections and incentives that make benefit plan administration predictable and uniform nationwide. A core component of this system is the primacy of the written document setting out the plan's terms. To keep costs predictable and preserve the broad latitude ERISA affords employers to design the plans they offer, employers must be able to rely on a plan's written terms.

Time and again, this Court has insisted on enforcing plan terms as written in ERISA cases, even when faced with conflicting principles of equity or common law. Nearly all courts of appeals have followed that approach. As Petitioners explain, ten courts of appeals do not apply equitable principles of estoppel to supersede a written plan unless the term is ambiguous and/or the case presents extraordinary circumstances. Consistent with ERISA's manifest purpose of encouraging employers to establish benefit plans voluntarily, these circuits have appropriately ensured that the so-called "ERISA estoppel" doctrine remains narrow.

The Fifth Circuit took a radically different approach here. It refused to enforce unambiguous ERISA plan terms even absent extraordinary circumstances, creating a new, exceptionally broad estoppel

doctrine for ERISA cases. Such a broad notion of estoppel in ERISA cases hurts all involved. It undermines the predictability and uniformity Congress intended ERISA to provide in order to induce employers to establish benefit plans. It also threatens to increase litigation risk and plan administration costs, resulting in higher premiums and less comprehensive benefits for employees and their families.

The Fifth Circuit's expansion of ERISA estoppel—a dramatic departure from approaches adopted in other circuits—also risks creating a singular venue where parties can flood the courts with claims anytime they disagree with or wish to evade otherwise unambiguous and longstanding plan terms. That eventuality will conflict with ERISA's promise of a national, uniform system and undermine employers' and their plan administrators' ability to rely on otherwise carefully designed plan terms to deliver benefits in a consistent and uniform manner.

This case presents a question of profound importance to all who offer, administer, or benefit from ERISA plans. The 10–1 circuit conflict the Fifth Circuit's decision creates is untenable. The Court should take this case and clarify that equitable doctrines like estoppel cannot be used to avoid unambiguous terms in ERISA plans, least of all absent extraordinary circumstances.

ARGUMENT

I. Respecting Plan Terms Is Critical To ERISA’s Core Purpose Of Encouraging Employers To Offer Benefits To Employees.

Millions of Americans access healthcare through benefit plans provided by their employers. Indeed, such plans are the prevailing method of providing health benefits in the United States. However, the law generally does not *require* employers to establish these plans. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Rather, Congress “careful[ly]” crafted ERISA to “encourag[e]” employers to establish employee benefit plans *voluntarily*. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (citation omitted).

In particular, ERISA “induces employers to offer benefits” by guaranteeing predictability and uniformity. *Conkright v. Frommert*, 559 U.S. 506, 516 (2010) (cleaned up). Congress gave employers the flexibility “to design” benefit plans “as they see fit.” *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003); see 29 U.S.C. § 1001(a); 119 Cong. Rec. 30,004 (1973) (noting that the legislation’s minimum standards were designed to be consistent with employer authority over plan “design, coverage, and benefits,” which, subject to the minimum standards, “[are] a matter of free choice by employers”); *Carlson v. Northrop Grumman Severance Plan*, 67 F.4th 871, 874–75 (7th Cir. 2023) (stating that the terms of ERISA welfare benefit plans are “entirely in the control of the entities that establish them” and when making plan design decisions employers may act on their own interest). And Congress protected this system by making ERISA broadly preempt state law,

thus allowing employers to design and structure benefit plans with the confidence that “plans [will] be administered, and benefits be paid, in accordance with plan documents.” *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 150 (2001). In this regard, ERISA “make[s] the benefits promised by an employer more secure.” *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320–21 (2016). At the same time, ERISA mandates that plans be operated “for the exclusive purpose” of “providing benefits to participants and their beneficiaries”—*i.e.*, employees and their families. 29 U.S.C. § 1104(a)(1)(A), (i).

For the system to work as Congress intended, employers and their plan administrators must be able to rely on the plan terms, as reflected in the “written instrument” ERISA requires. 29 U.S.C. § 1102(a); see *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (ERISA was “built around reliance on the face of written plan documents”). That is why Congress ensured that any claim for benefits under an ERISA covered plan “stands or falls by ‘the terms of the plan.’” *Kennedy v. Plan Adm’r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (quoting 29 U.S.C. § 1132(a)(1)(B)); see *M&G Polymers, LLC v. Tackett*, 574 U.S. 427, 434–35 (2015) (“[T]he rule that contractual ‘provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA *** plan.’” (citation omitted)). Congress’s “focus on the written terms of the plan is the linchpin of ‘a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.’” *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013) (quoting *Varity Corp. v.*

Howe, 516 U.S. 489, 497 (1996)). “The plan, in short, is at the center of ERISA.” *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 101 (2013).

The central importance of the written plan has also dictated how ERISA group health plans are administered. Employer-sponsored health plans generally follow one of two models: fully insured or self-funded. See *Am.’s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324–25 (11th Cir. 2014). For both types of plans, a third-party plan administrator is typically responsible for processing benefits claims, see *N. Cypress Med. Ctr. Operating Co. v. Aetna Life Ins. Co.*, 898 F.3d 461, 468 (5th Cir. 2018), which involves implementing the terms of the plan to determine whether a given service is covered and, if so, the allowed charges. In the fully insured model, the plan administrator (*e.g.*, a health insurer) uses its own funds to pay claims. *Ibid.* For self-funded plans, the employer is ultimately responsible for paying claims and bears the financial risk of covering the healthcare costs of its employees. *Ibid.* Employers rely on the selected model in pricing premiums and allocating risk.

Likewise, the primacy of the written plan allows employers to design well-functioning networks of providers. A plan’s network consists of healthcare providers that have contracted with the plan to offer services to plan participants at rates that are lower than those providers’ standard billed charges. Plans set high standards for these networks to ensure that in-network-providers deliver safe and effective care. And although plans typically offer financial incentives encouraging beneficiaries to utilize in-network

providers, in many plan designs those beneficiaries may opt for care from an out-of-network provider and still receive some level of benefits.

To sustain this system, employers often include anti-assignment provisions in their plans to ensure benefits are uniformly and consistently administered for all beneficiaries. These provisions, which are permissible under Section 502(a) of ERISA, forbid employees from assigning their rights to ERISA benefits to someone else. See *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1294–96 (11th Cir. 2004) (collecting cases). Anti-assignment provisions protect both employers and their employees from the risk that out-of-network providers will seek to undermine an employer’s carefully designed plan by bootstrapping assignments of benefits into tools for aggressive litigation aimed at recovering amounts exceeding those allowed under the plan’s terms for out-of-network services. Consistent with ERISA’s goal of allowing employers to design their own benefit plans, anti-assignment provisions ensure that third parties (whose transient financial interests in a single claim for benefits generally do not align with the ERISA beneficiary’s and plan’s broader, long-term interests) cannot stand in the shoes of employees to then rewrite an employer’s otherwise carefully considered and unambiguous plan terms for their own benefit.

ERISA’s carefully crafted system of incentives works. With the security and predictability of nationally uniform plan administration governed by plan documents, employers committed to the health and wellbeing of employees and their families regularly

opt to provide benefit plans for their employees and their families. About 2.8 million ERISA group health plans covered roughly 135 million Americans as of 2023. See Lori Chavez-DeRemer, *2026 Report to Congress: Annual Report on Self-Insured Group Health Plans*, U.S. Dep't of Lab. 5 (Mar. 2025), <https://beta.dol.gov/system/files/research-data/2026-03/ebsa-annual-report-on-self-insured-group-health-plans-2026.pdf>. Recent data is more staggering. Employers now provide health benefits for about 154 million Americans under the age of sixty-five, which accounts for at least forty-five percent of the total U.S. population and roughly fifty-eight percent of people under the age of sixty-five. See Kaiser Family Found., *Employer Health Benefits: 2025 Annual Survey* 64 (Oct. 22, 2025), <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf>. Of those, sixty-seven percent are enrolled in self-funded group health plans governed by ERISA. *Id.* at 11.

Moreover, employees enrolled in employer-provided plans are overwhelmingly satisfied with the quality of their coverage. A recent national survey of over 5,000 employees found 89% were satisfied with their coverage, and more than two-thirds of workers rate it as their top workplace benefit. *National Survey of 5,310 Employees with Employer-sponsored Insurance*, America's Health Insurance Plans (Dec. 2025), <https://ahiporg-production.s3.amazonaws.com/documents/AHIP-EPC-Fact-Sheet-FINAL.pdf>.

II. The Fifth Circuit’s Broad Estoppel Doctrine Undermines ERISA’s Core Purpose.

ERISA’s “principal function [is] to ‘protect contractually defined benefits.’” *US Airways*, 569 U.S. at 100 (citation omitted). That “means declining to apply rules—even if they would be ‘equitable’ in a contract’s absence—at odds with the parties’ expressed commitments.” *Id.* at 98. When principles of common law or equity conflict with plan documents, “the documents control.” *Kennedy*, 555 U.S. at 304 (citation omitted); see *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 259 (1993) (“The authority of courts to develop a ‘federal common law’ under ERISA is not the authority to revise the text of the statute.”).

Consistent with ERISA’s text, Congress’s goals, and this Court’s precedents, the courts of appeals have overwhelmingly rejected attempts to use estoppel principles to evade plan terms, save in very narrow circumstances. Ten circuits hold that estoppel cannot override an ERISA plan’s terms unless (i) the terms are ambiguous and/or (ii) the case presents extraordinary circumstances (*e.g.*, fraud or intentional deception). Pet. 17–22. The Fifth Circuit alone has now taken a more expansive view. In the decision below, the Fifth Circuit applied equitable estoppel to nullify unambiguous anti-assignment provisions in ERISA covered plans despite the absence of any extraordinary circumstances. Pet. App. 22a–24a.

The Fifth Circuit’s capacious understanding of estoppel in ERISA cases is deeply problematic. Rejecting unambiguous plan terms in even ordinary circumstances threatens the predictability ERISA promises employers to induce them to establish benefit plans in

the first instance. See *Conkright*, 559 U.S. at 516. It also makes hollow the flexibility ERISA grants employers over the design of their benefit plans. See *Black & Decker Disability Plan*, 538 U.S. at 833. And it creates significant uncertainty for those entities tasked with administering ERISA plans. Without these incentives, and faced with enhanced litigation risk and associated costs in the Fifth Circuit, employers may not establish or maintain their benefit plans—the exact opposite of what Congress intended and to the ultimate detriment of employees and their families.

The operational realities of sponsoring and administering an ERISA group health plan illustrate the problems with the Fifth Circuit’s broad ERISA estoppel across both fully insured and self-funded employer-sponsored plans. Take anti-assignment provisions. These provisions shield employers from exposure to unknown assignees and the litigation risks they carry. But this predictability benefits employees too, as it allows employers to keep premiums down.

Conversely, when courts override anti-assignment clauses through estoppel, an employer who self-funds a group health plan bears all financial risk. Broadening equitable estoppel effectively compounds this reallocation of risk, which is a particularly acute concern for many mid-size and large employers that self-fund. Likewise, in situations where an employer sponsors a fully insured plan, overriding anti-assignment clauses through estoppel creates significant uncertainty for the plan administrator providing that coverage and thus tends to push up premiums. Cf.

Wehr Constructors, Inc. v. Assurance Co., 384 S.W.3d 680, 683 (Ky. 2012) (“The purpose of an anti-assignment clause is to protect the insurer from unforeseen exposure and increased liability that may ensue if the policy was assigned to an entity that the insurer would prefer not to insure; or, would have insured only at a higher premium.”).

For example, consider the common practice of third-party administrators paying for a service provided by an out-of-network provider. Under a plan’s own unambiguous terms, that payment may fully satisfy the entire out-of-network benefit due under the plan, even if that amount is less than the out-of-network provider’s full billed charge. Anti-assignment clauses serve an important function of ensuring that the out-of-network provider cannot then stand in the shoes of the employee to seek payment of (often excessive) charges that otherwise exceed the amount allowed under the plan’s unambiguous terms. Thus, these provisions provide security for plan administrators to protect employees from balance billing by dealing directly with out-of-network providers regarding payment—without risk that the same providers will then be able to sue the plan administrator, under the plan’s own terms, as a result of the plan’s engagement with that provider.

But under the Fifth Circuit’s broad approach, that practice might be construed as giving rise to estoppel, even when plan documents unambiguously bar assignment. Uncertainty about the reach of anti-assignment clauses would invite parties that otherwise had no role in designing a plan to rewrite unambiguous plan terms, including those who may stand to benefit

financially or have other self-interests at stake (*e.g.*, out-of-network providers). In other words, by threatening anti-assignment clauses, the Fifth Circuit’s approach leaves employees vulnerable from the risk of third parties hijacking plan terms to their own benefit, rather than the “exclusive” benefit of beneficiaries. 29 U.S.C. § 1104(a)(1)(A), (i).

Regardless of the specific administrative function impacted, or whether an employer-sponsored plan is self-funded or fully insured, any uncertainty about whether unambiguous plan terms will be upheld and enforced will generate a host of collateral risks. The associated costs of those risks can only be accounted for either through higher premiums (if fully insured) or premium equivalents (if self-funded), or employers offering coverage for fewer benefits, increasing cost-sharing obligations for their employees, or foregoing benefits altogether. Left intact, the Fifth Circuit’s decision effectively allows third-party providers to free-ride on employees’ claims (and potential litigation), notwithstanding unambiguous plan terms reserving these processes and rights exclusively to employees and their families. This fundamentally undermines ERISA’s goal of ensuring the uniform administration of plan terms and protecting employees’ predictable receipt of clearly defined benefits.

The Court should take up the important question presented by the Petition now. Enterprising litigants can easily exploit these yawning cracks in ERISA emerging under the specter of the Fifth Circuit’s new estoppel, leaving employers and administrators with inconsistent obligations. Parties will assuredly flock to the Fifth Circuit anytime they seek to clear the

hurdle of otherwise unambiguous plan terms. That undermines the national, uniform system Congress intended for ERISA to create. It also will inevitably increase the costs of plan administration, leading to higher premiums or less comprehensive benefits. The Court should take this case to clarify that, consistent with ERISA's core purposes, estoppel cannot override unambiguous plan terms, especially absent extraordinary circumstances.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

STEPHANIE SCHUSTER

Counsel of Record

PRANAV MULPUR

MORGAN, LEWIS & BOCKIUS LLP

1111 Pennsylvania Avenue, NW

Washington, DC 20004

(202) 739-3000

stephanie.schuster

@morganlewis.com

Counsel for Amici Curiae

APRIL 3, 2026