

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

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Fifth Circuit, consistent with decisions from at least five other circuits, has long distinguished between (1) the doctrine of ERISA estoppel, which prohibits an ERISA plan beneficiary from seeking benefits not unambiguously provided in the plan documents based on a misrepresentation about those benefits, and (2) the doctrine of waiver, which prohibits a plan from asserting for the first time in litigation a basis for denying benefits different from the basis it relied on during the administrative claims process established by the plan. In applying this well-settled waiver rule, citing circuit precedent dating back to 1992, the Fifth Circuit held that the district court erred in holding that, as a matter of law, petitioners could fail to invoke an anti-assignment provision during the administrative claims process and, causing significant prejudice, raise the clause belatedly for the first time in litigation. The court of appeals then remanded for further proceedings and fact determinations to be made by the district court. The question presented is:

Whether an ERISA plan administrator can waive the right to assert an anti-assignment clause as a defense in litigation when it underpays benefits without ever mentioning or relying on the clause during more than five years of administrative proceedings, while also refusing to provide plan documents containing the clause despite repeated requests.

CORPORATE DISCLOSURE STATEMENT

No respondent has a parent corporation, and no publicly held company owns 10% or more of any respondent.

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BRIEF IN OPPOSITION

Petitioners ask this Court to review a decision the Fifth Circuit did not make, based on a description of the case that bears no resemblance to reality, to resolve a split in authority that does not exist. In petitioners' telling, this Court's intervention is required because the Fifth Circuit invented a brand-new rule of "ERISA estoppel" that allows a party to seek benefits in conflict with an ERISA plan's unambiguous terms. According to petitioners, the Fifth Circuit's new rule conflicts with decisions from ten other circuits, threatens the "predictability and financial stability on which employer-provided benefits plans of all types depend," "jeopardizes the interests of millions of American workers," and "flies in the face of this Court's precedents." Pet. 2-3. None of that is accurate.

Although the petition never mentions this fact, the Fifth Circuit's decision below relies on a waiver rule that has been consistently applied in that circuit—in peaceful coexistence with the doctrine of ERISA estoppel—for more than thirty years. See *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569 (5th Cir. 1992). The Fifth Circuit has long distinguished between, on one hand, an attempt by a plan beneficiary to change the unambiguous terms of an ERISA plan based on an alleged misrepresentation (what is referred to as "ERISA estoppel") and, on the other, a failure by a plan administrator to raise a defense in the administrative claims process and then try to assert that defense years later for the first time in litigation (what is often referred to as "waiver"). That basic waiver rule, which prevents gamesmanship

and prejudice, has been recognized and applied by numerous other courts, including the First, Second, Eighth, Ninth, and Tenth Circuits. It is also consistent with this Court's precedents and the general principle that a plan can waive its rights by failing to raise them in a timely fashion.

Applying these well-settled principles, the court below unanimously held that the district court should not have granted summary judgment without making evidentiary findings necessary to determine whether the plans had waived their rights to invoke anti-assignment clauses. The Fifth Circuit recognized that respondents had established an evidentiary basis for finding waiver because the plans made (partial) payments during a five-year administrative claims process without ever invoking an anti-assignment clause or turning over plan documents containing such a clause.

The petition's puzzling failure to acknowledge these distinctions and accurately describe the Fifth Circuit's decision underscores the many reasons this case is not worthy of review. Far from inviting a "deluge" of litigation, as petitioners suggest, the decision below has the opposite effect—it discourages sandbagging by requiring plan administrators to act in good faith and identify the provisions on which they intend to rely during the claims process, rather than forcing beneficiaries through an expensive years-long administrative process and then invoking undisclosed defenses for the first time in litigation. Despite being in existence for thirty years, the Fifth Circuit's waiver rule has not caused "significant uncertainty" or an "increase" in costs; it has not made "it borderline

impossible to predict who may assert claims, in what forum, under what procedures”; and it has not harmed consumers or undermined plans’ ability to rely on anti-assignment clauses. *Cf.* Pet. 32-34. Under the Fifth Circuit’s waiver rule, a plan administrator retains control over the enforcement of anti-assignment clauses and other plan exclusions, as long as it timely asserts them during the administrative claims process—a process the plan itself establishes to narrow areas of dispute and requires beneficiaries to complete before pursuing litigation.

Because the question petitioners seek to litigate is not fairly presented, this case is not an appropriate vehicle for addressing that question or for resolving a non-existent conflict over the requirements for applying the doctrine of ERISA estoppel. Nor do the fact-bound circumstances of this case warrant this Court’s attention. The Fifth Circuit’s decision is interlocutory because it reversed a grant of summary judgment, leaving the district court to oversee further evidentiary proceedings into the validity of petitioners’ belated attempts to invoke anti-assignment clauses. Even if petitioners could identify a question of law on which the lower courts were divided, further proceedings could resolve this case in ways that could moot any disagreement, making this Court’s review unnecessary.

The Court should deny the petition.

STATEMENT OF THE CASE

A. Respondents’ emergency room services

1. Respondents are groups of emergency-room physicians who staff emergency departments at

hospitals across Texas. App.3a. This case addresses their rights to receive payment for medical services they provided to patients who are members of petitioners' health-insurance plans. App.3a.

Instead of directly hiring individual physicians, many hospitals contract with physician groups—like respondents here—to staff their various departments, including their emergency departments. App.4a. Because each respondent is based in the emergency department of a particular hospital, respondents are what the healthcare and insurance industries consider facility-based providers. ROA.81870 ¶ 3.¹ They are responsible for the safe and efficient treatment of patients suffering emergency medical problems. ROA.81871 ¶ 5.

Emergency-department patients differ from other hospital patients because they have little (if any) say in which physicians treat them. Patients experiencing medical emergencies are ordinarily transported to the nearest hospital emergency room for immediate treatment by an available physician. ROA.81871 ¶ 5. They are often unconscious or otherwise incapacitated, and so—even if they were familiar with the hospital's emergency staff—they are in no position to review a list of emergency physicians to identify who might qualify as an “in-network” provider. ROA.81871 ¶ 5.

2. The federal Emergency Medical Treatment and Active Labor Act requires hospitals and their

¹ References to ROA refer to the record on appeal prepared by the district court for the U.S. Court of Appeals for the Fifth Circuit.

emergency physicians to screen and treat patients suffering medical emergencies regardless of ability to pay and without inquiring into the existence or nature of the patients' insurance coverage. 42 U.S.C. § 1395dd; App.4a. As a result, a hospital often does not know whether its emergency-department staff are in-network for any particular patient before providing treatment. "Because of this information gap, it is common practice in emergency care settings for patients to assign their insurance benefits when they arrive at a hospital emergency room. The emergency provider then pursues reimbursement from the insurer, and the patient is billed for any remaining cost of services." App.4a.

The system is efficient for all involved. Patients receive the emergency services they need without having to worry whether the emergency-room physician happens to be an in-network provider. Patients assign their insurance benefits to the hospital, which then submits to the insurer payment requests for the emergency services provided. And the insurer benefits by having claims submitted correctly and in an orderly fashion without the difficulties of receiving individual claims from thousands of patients who are typically unfamiliar with the process. In the ERISA context, when disputes arise, they are supposed to be addressed first through an administrative process established and overseen by the plans and then, if the parties cannot reach agreement, through litigation.

B. Petitioners' underpayments

1. At all times relevant to this litigation, the payment process for out-of-network emergency

services worked as follows: After a respondent treated a patient who is a member of one of the plans, that respondent submitted a claim for reimbursement to the “host” plan—*i.e.*, the Blue Cross plan for the state where treatment took place. App.5a. For the claims in this litigation, all of which involved payment for treatment in Texas hospitals, the host plan was Blue Cross Blue Shield of Texas (BCBSTX). App.5a. BCBSTX then transmitted the claim to the patient’s out-of-state healthcare plan—the “home” plan—which, according to petitioners, “adjudicate[d] the claim in accordance with the terms of the patient’s health benefit plan ... and transmit[ted] back to BCBSTX the claim determination for processing and payment.” App.5a (quotation marks omitted). BCBSTX then transmitted payment to respondents according to the home plan’s instructions about how much to pay. App.5a.

Petitioners’ payment obligations to respondents were governed by federal regulations implementing the Patient Protection and Affordable Care Act of 2010. App.5a. Those regulations impose a requirement known as the “greatest-of-three rule,” under which an insurer must pay the greatest of three amounts for out-of-network emergency services: (1) the median amount negotiated with in-network providers for the emergency services, (2) an amount calculated using the method the plan uses to calculate rates for out-of-network services, or (3) the Medicare rates. App.5a-6a; *see* 45 C.F.R. § 147.138(b)(3)(i).²

² The facts of this case pre-date the passage of the No Surprises Act, which was part of the Consolidated Appropriations Act,

2. Through their agent BCBSTX, petitioners refused to pay respondents the amounts required by the greatest-of-three rule. Petitioners did not deny any claim; they simply paid less than the full amount required by law. Despite extensive communications between respondents and BCBSTX, and despite paying hundreds of thousands of claims, neither BCBSTX nor any petitioner ever took the position that an anti-assignment clause in the patient's plan barred respondents' claims.

Respondents challenged these underpayments through administrative appeals to BCBSTX. BCBSTX responded to each appeal in one of three ways. First, it "replied with generic statements that did not explain the underpayment or point to provisions justifying the underpayment, stating simply that '[o]ur records indicate that the claim disposition was based on the member's benefit coverage.'" App.6a. Second, it returned the appeal documents, mailing them back in a box, with no explanation of any kind. App.6a. *see also* ROA.81874 ¶ 27. Third, it failed to respond at all. App.6a. BCBSTX never identified or relied on an anti-assignment clause to reject any of respondents' appeals. App.18a, 22a-23a; *see also, e.g.*, ROA.81874 ¶¶ 24-28; ROA.82805, 82807, 82813, 82819.

The record shows that, in response to inquiries, BCBSTX occasionally directed respondents to a member's out-of-state home plan, but those plans then referred respondents back to BCBSTX. App.6a-7a,

2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020). That Act altered the greatest-of-three rule.

27a. As with BCBSTX, no home plan ever identified or relied on an anti-assignment clause as a basis for not paying the provider directly. App.18a, 22a-23a.

Throughout the administrative claims process, respondents repeatedly asked BCBSTX and petitioners to provide copies of the plan documents relevant to each claim. App.26a-27a; ROA.81873-74 ¶¶ 17-19, 26. Because respondents were out-of-network providers who had been assigned patients' reimbursement rights, respondents themselves had no access to the plan documents or their terms. App.23a, 29a. Despite repeated requests, BCBSTX and petitioners refused to provide any plan documents to respondents, in plain violation of ERISA's requirements. App.23a, 29a-30a; ROA.81873-74 ¶¶ 17-28.

Respondents thus had no way to learn about any of the plans' provisions. App.23a. If they had been given access to the plan documents, or if petitioners had objected on grounds that the documents included an anti-assignment clause, respondents could have returned to the patients and arranged for them to pursue their own administrative appeals. Instead, because petitioners did not provide the plan documents, and because they made partial payment without raising anti-assignment provisions as a defense, there was no reason for respondents to know that the plans intended to claim that the plan documents barred the patients from assigning their claims.

C. The decisions below

1. After exhausting their administrative remedies, respondents filed suit against BCBSTX and petitioners, seeking complete payments on 290,000 claims. App.7a. More than 75% of the claims were dismissed following a settlement with BCBSTX and certain other entities. App.7a. The parties thereafter selected 182 bellwether claims for summary judgment and potential trial. App.7a. The district court granted summary judgment to petitioners on all 182 bellwether claims, holding that respondents “did not have standing because the[ir] assignments of benefits did not actually transfer any rights to [respondents] for multiple, overlapping reasons.” App.8a.

2. In a unanimous decision, the Fifth Circuit affirmed in part and vacated and remanded in part. It affirmed with respect to twenty-nine patients for whom respondents lacked written assignments. App.17a-18a. It otherwise vacated the grant of summary judgment and remanded for further proceedings.

First, the Fifth Circuit rejected the district court’s findings that certain assignments either did not assign any rights to respondents or did not assign the right to seek legal relief. App.11a-17a. The Fifth Circuit held that the plan documents assigned a right to seek legal relief, and that ambiguities as to the assignments’ scope precluded summary judgment as to whether respondents were parties to the assignments. App.11a-17a. Petitioners do not seek review of that decision.

Second, the Fifth Circuit rejected the district court's conclusion that respondents had failed to properly exhaust their appeals. App.24a-30a. The Fifth Circuit held that petitioners' refusal to provide plan documents to respondents excused any noncompliance with the appeals process described in those documents. App.24a-30a. Petitioners do not seek review of that decision either.

Third, the Fifth Circuit rejected the district court's holding that anti-assignment clauses in petitioners' plans barred respondents' claims. App.18a-24a. In the district court, respondents argued that petitioners had waived their right to rely on any anti-assignment clauses by partially paying claims without ever invoking or identifying an anti-assignment clause as a basis for denying those claims. *See* App.18a. The district court misinterpreted respondents' argument as relying on "ERISA estoppel," an equitable doctrine that applies when a plan beneficiary seeks benefits not unambiguously provided by a plan based on a misrepresentation by the plan about those benefits. App.19a; *see Mello v. Sara Lee Corp.*, 431 F.3d 440, 444-45 (5th Cir. 2005).

The Fifth Circuit held that ERISA estoppel did not apply to respondents' claims. Unlike in ERISA estoppel cases, respondents did not seek to expand or modify the benefits to which they were entitled under a plan. Respondents instead sought to preclude petitioners from asserting anti-assignment clauses as a defense for the first time in litigation. The Fifth Circuit held that argument was governed, not by ERISA estoppel, but by "a line of cases predating [the court's] adoption of ERISA estoppel." App.19a.

Specifically, the Fifth Circuit relied on its 1992 decision in *Hermann Hospital v. MEBA Medical & Benefits Plan*, 959 F.2d 569 (5th Cir. 1992), which held that a plan cannot wait until litigation “to assert an anti-assignment clause that the third party bearing the assignment had no way of learning about.” App.22a. *Hermann’s* reasoning, the Fifth Circuit concluded, matched the facts here, where petitioners “engage[d] in partial payment and discussion with” respondents but never identified any anti-assignment clause and refused to provide the underlying plan documents. App.23a.

Because the district court “appl[ie]d the incorrect test to determine whether [petitioners] should be estopped from enforcing the anti-assignment clauses,” the Fifth Circuit vacated the summary judgment. App.23a. The Fifth Circuit remanded the case “to the district court for evidentiary determinations as to the validity of the underlying assignments.” App.30a.

3. Petitioners sought en banc rehearing. The Fifth Circuit did not grant rehearing en banc but granted panel rehearing to make certain non-substantive edits to the opinion. App.2a-3a. The mandate issued at the same time as the amended opinion.

REASONS FOR DENYING THE PETITION

The Court should deny the petition for certiorari. Contrary to the petition’s characterizations, the Fifth Circuit’s decision does not implicate any circuit split or conflict with this Court’s precedent. Nor does the decision threaten any negative consequences for the ERISA system. The decision instead enforces the long-

standing principle that a plan administrator may not sandbag its beneficiaries by offering one basis for denying benefits during the administrative claims review process and then asserting a new, never-before-disclosed basis for the first time in litigation. There is no reason this Court should review the Fifth Circuit's rejection of that abusive practice.

I. There is no circuit split.

Petitioners misstate both the Fifth Circuit's rationale and the law in other circuits. The Fifth Circuit did not depart from other circuits' approach to ERISA estoppel; rather, it applied a long-standing waiver rule that has been adopted in multiple other circuits. As to both ERISA estoppel and this separate waiver rule, there is no circuit split supporting review.

1. There is a logical and well-recognized difference in the law between, on one hand, applying equitable estoppel principles to change the terms of plan documents based on alleged misrepresentations and, on the other hand, finding that a party has waived its right to raise a defense based on its failure to timely raise that defense during an administrative process established for the purpose of narrowing (and, if possible, resolving) disputes. That distinction matters. Contrary to petitioners' sweeping assertions, the Fifth Circuit did not hold that "equitable estoppel under ERISA ... can supersede clear provisions in the plan documents and can be triggered by mere silence or informal representations." Pet. 2. What petitioners call "equitable estoppel under ERISA" is a specific doctrine known as "ERISA estoppel," which applies only when a plaintiff seeks benefits for which a plan does not unambiguously provide, based on a

misrepresentation by a plan administrator about those benefits. See *High v. E-Sys. Inc.*, 459 F.3d 573, 579-80 (5th Cir. 2006).

The decision below did not apply that doctrine, so it does not implicate any “circuit split over the requirements for and scope of ERISA estoppel.” Pet. 16 (capitalization omitted). Respondents did not invoke ERISA estoppel because they did not sue for any benefits other than those unambiguously provided by the relevant plans. Nor did respondents seek to modify the plans’ terms by “bind[ing] [petitioners] to [their] representations.” Pet. *i*. Respondents instead sought to preclude petitioners from *raising as a defense in litigation* anti-assignment clauses that petitioners had never mentioned (much less invoked) when providing partial payments during the multi-year claim and appeal process (or in connection with any of the parties’ earlier interactions). In their briefs, respondents phrased this argument in terms of “waiver,” not estoppel. 5th Cir. Opening Br. 49-53.

The Fifth Circuit thus distinguished ERISA estoppel from the rule it applied, which dates back at least as far as its 1992 decision in *Hermann*. App.18a-22a. The Fifth Circuit’s decision below expressly relied on *Hermann*, but the petition never even mentions it. That omission is damning. Far from creating “a new federal common law rule,” as petitioners suggest, the Fifth Circuit has consistently applied *Hermann* for more than thirty years. Pet. 16.

In *Hermann*, the Fifth Circuit held that an ERISA plan was “estopped to assert [an] anti-assignment clause” against a hospital because the plan “failed to assert the anti-assignment clause until more than

three years after [the hospital] first requested payment.” 959 F.2d at 574-75. The Court held that “it was unreasonable for [the plan] to lie behind the log for three years without once asserting the anti-assignment clause, of which [the hospital] had no knowledge.” *Id.* at 574. *Hermann* has been consistently interpreted by the Fifth Circuit as holding that a party that waives its right to assert a defense can be estopped from raising it in later proceedings. *See Cell Sci. Sys. Corp. v. La. Health Serv.*, 804 F. App’x 260, 265 (5th Cir. 2020) (per curiam) (in *Hermann*, “our court held that the plan was estopped from asserting an anti-assignment clause after failing to assert the clause at any point during the three years of ongoing investigation and communication regarding the claim”); *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 351 (5th Cir. 2002) (in *Hermann* “[t]he ERISA plan was estopped from enforcing its anti-assignment clause because of the Plan’s protracted failure to assert anti-assignment when the hospital requested payment under an assignment of payment provision for covered benefits”); *see also Pitts ex rel. Pitts v. Am. Sec. Life Ins. Co.*, 931 F.2d 351, 356 (5th Cir. 1991) (finding ERISA administrator had “waived its right to assert a defense to liability”).

Although petitioners never mention *Hermann*, they do not dispute that the Fifth Circuit correctly applied that decision to the particular facts of this case. The record supports a finding that, over the more than five years during which petitioners systematically underpaid respondents, petitioners never asserted that any anti-assignment clause

prohibited respondents from seeking payment. App.22a-23a; *see, e.g.*, ROA.81874 ¶¶ 24-28; ROA.82805, 82807, 82813, 82819. The record also shows that petitioners denied respondents access to the relevant plan documents, thus preventing them from learning about any anti-assignment clauses. App.23a, 27a-30a; *see* ROA.81873-74 ¶¶ 17-28. Accordingly, the Fifth Circuit correctly held that *Hermann*, not ERISA estoppel, governs whether petitioners' past "fail[ure] to assert the anti-assignment clause[s]" bars them from invoking those clauses for the first time as a defense in litigation. *Hermann*, 959 F.2d at 574-75.

It has long been apparent that *Hermann's* rule is independent of ERISA estoppel. The Fifth Circuit first endorsed and limited ERISA estoppel in *Mello*, 431 F.3d at 444-45, thirteen years after *Hermann*. App.19a. Far from treating *Hermann* as a version of ERISA estoppel, *Mello* stated that the Fifth Circuit had not yet "adopt[ed] ERISA-estoppel as a cognizable legal theory." 431 F.3d at 444. *Mello* did not overrule or purport to limit *Hermann*, and the Fifth Circuit has subsequently treated waiver under *Hermann* and ERISA estoppel under *Mello* as complementary rather than conflicting doctrines. App.19a-22a. Indeed, Judge Smith joined both *Mello* and the decision below, without suggesting any tension between those two decisions.

Hermann thus reflects a different doctrine that applies in different circumstances than ERISA estoppel. ERISA estoppel is an offensive doctrine that permits a plan beneficiary to receive benefits not unambiguously provided by its plan. By contrast,

Hermann estoppel is a defensive waiver rule that bars a plan from relying on an undisclosed anti-assignment clause in litigation when the plan sat on its rights during the pre-litigation administrative claims process.

2. Because the Fifth Circuit did not apply ERISA estoppel below, its decision does not conflict with any of the cases petitioners cite addressing ERISA estoppel. *See* Pet. 17-22. Petitioners describe those cases as permitting ERISA estoppel only “(1) if the plan itself is ambiguous; or (2) in otherwise exceptional circumstances, such as if a party made a separate, fraudulent, written misrepresentation.” Pet. 2 (emphasis omitted). These requirements, petitioners argue, ensure that a court will not “enforce something other than the plan documents themselves.” Pet. 20 (quoting *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 404 (6th Cir. 1998) (en banc)).

There is no difference between petitioners’ description of ERISA estoppel and the Fifth Circuit’s approach. As petitioners admit, *see* Pet. 9, the Fifth Circuit applies ERISA estoppel only when a plan beneficiary can prove “(1) a material misrepresentation; (2) reasonable and detrimental reliance upon the representation; and (3) extraordinary circumstances.” App.19a (quoting *Mello*, 431 F.3d at 444-45). The Fifth Circuit has also held, relying on the Sixth Circuit’s decision in *Sprague*, that a beneficiary may not invoke ERISA estoppel “in the face of unambiguous [p]lan terms.” *Mello*, 431 F.3d at 446-47; *see also High*, 459 F.3d at 580 (“ERISA-estoppel does not apply” when the relevant plan term “is not ambiguous”).

The Fifth Circuit’s approach to ERISA estoppel is thus identical to petitioners’ own description of that

doctrine. When it comes to “the requirements for and scope of ERISA estoppel,” Pet. 16 (capitalization omitted), there is no conflict between the Fifth Circuit and other circuits.

3. Petitioners contend that the Fifth Circuit departed from other circuits by recognizing a form of estoppel *other than* ERISA estoppel, but that is also false. Other circuits agree with the Fifth Circuit that a plan administrator can waive the right to enforce an anti-assignment or other restrictive clause in litigation when it fails to assert that clause during the administrative claims process as a basis for denying or underpaying benefits.

For example, the Ninth Circuit has held that “an insurer or claim administrator may waive the ability to raise an anti-assignment provision as a defense when they take action inconsistent with that provision or are aware that the claimant is acting as an assignee.” *Beverly Oaks Physicians Surgical Ctr. LLC v. Blue Cross & Blue Shield*, 983 F.3d 435, 441 (9th Cir. 2020). *Beverly Oaks* enforced the Ninth Circuit’s longstanding rule that “an administrator may not hold in reserve a known or reasonably knowable reason for denying a claim, and give that reason for the first time when the claimant challenges a benefits denial in court.” *Id.* at 440 (quoting *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1296 (9th Cir. 2014)).

The Ninth Circuit held that Blue Cross could not rely on an anti-assignment provision to challenge a hospital’s standing in circumstances almost indistinguishable from those here: “Blue Cross processed the claim form, denied in full or underpaid

[the hospital's] billed charges, and at no time during the administrative claim process did Blue Cross raise the anti-assignment provision as a basis to deny benefits." *Id.* at 440-41. Like the Fifth Circuit, the Ninth Circuit described this waiver rule and ERISA estoppel as "alternative legal theories" that coexist peacefully. *Id.* at 442; see also *Collier v. Lincoln Life Assurance Co.*, 53 F.4th 1180, 1186-87 (9th Cir. 2022) (summarizing precedent holding that plan administrators may not "present[] a new rationale to the district court that was not presented to the claimant as a specific reason for denying benefits during the administrative process"); *Harlick v. Blue Shield*, 686 F.3d 699, 719-20 (9th Cir. 2012) (holding administrator "forfeited" medical-necessity defense "[b]y failing to assert [it] during the administrative process").

In their en banc petition, petitioners argued that *Beverly Oaks* supported their assertion that the panel's decision created a circuit split over ERISA estoppel. 5th Cir. Reh'g Pet. 7. Respondents pointed out that *Beverly Oaks* in fact applied a waiver rule just like the Fifth Circuit's. 5th Cir. Reh'g Opp. 8-10. Now petitioners omit any mention of *Beverly Oaks* from their petition. Petitioners doubtless know that the Ninth Circuit has endorsed rather than rejected the rule applied in *Hermann* and the decision below.

The same is true of the First, Second, Eighth, and Tenth Circuits, all of which have endorsed a similar waiver rule in ERISA cases. In *Glista v. Unum Life Insurance Co.*, 378 F.3d 113 (1st Cir. 2004), the First Circuit joined the other "courts [that] have held that [an] administrator waive[s] defenses to coverage not

articulated to the insured during the claims review process when the administrator had sufficient information to have raised those defenses if it so chose.” *Id.* at 131. The First Circuit held that a plan administrator had waived its ability to assert a preexisting-conditions clause in litigation when it “failed to raise the ... [c]lause in the claims review process.” *Id.* at 132.

Similarly, the Second Circuit held in *Lauder v. First Unum Life Insurance Co.*, 284 F.3d 375, 380-82 (2d Cir. 2002), that a plan administrator “waived its defense of lack of disability” when it failed to raise that defense during the administrative claims process. The Eighth and Tenth Circuits likewise prohibit plan administrators from asserting in litigation a basis for denying benefits different than the basis they gave during the administrative claims process. *Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998); *Garrett v. Principal Life Ins. Co.*, 555 F. App’x 809, 812-13 (10th Cir. 2014); *Spradley v. Owens-Ill. Hourly Emps. Welfare Benefits Plan*, 686 F.3d 1135, 1140-41 (10th Cir. 2012).

Even in circuits that have not decided the question, district courts have held that plan administrators can waive defenses they raise for the first time in litigation. *E.g.*, *Otero v. Unum Life Ins. Co.*, 226 F. Supp. 3d 1242, 1274-75 (N.D. Ala. 2017); *Becknell v. Severance Pay Plan of Johnson & Johnson*, 2014 WL 1577723, at *3-6 (D.N.J. Apr. 21, 2014); *Russo v. Abington Mem’l Hosp.*, 2002 WL 1906963, at *11-12 (E.D. Pa. Aug. 1, 2002).

The waiver rule applied in all these courts is an ERISA-specific application of the “general rule” that,

even though “[a] contract of ... insurance cannot be created by estoppel,” when “an insurer with knowledge of facts which would bar liability under an issued and outstanding policy continues to recognize liability by treating the policy as being in force and effect, it waives the bar and becomes estopped to plead such facts to escape liability.” *Sec. Ins. Co. v. White*, 236 F.2d 215, 218-19 (10th Cir. 1956); *see Glista*, 378 F.3d at 131 (supporting waiver under ERISA by reference to “traditional insurance law”); *Lauder*, 284 F.3d at 382 (relying on traditional “waiver principle”). That longstanding rule has been widely recognized and enforced across the circuits. *E.g.*, *Lexington Ins. Co. v. Integrity Land Title Co.*, 721 F.3d 958, 978 (8th Cir. 2013); *Mid-Continent Cas. Co. v. Basdeo*, 477 F. App’x 702, 706-07 (11th Cir. 2012) (per curiam); *New York v. AMRO Realty Corp.*, 936 F.2d 1420, 1431 (2d Cir. 1991); *Goulding v. Sands*, 355 F.2d 230, 232-33 (3d Cir. 1966); *W. Cas. & Sur. Co. v. Herman*, 318 F.2d 50, 55 (8th Cir. 1963).

Petitioners cite no case to the contrary. Each of the cases they cite involved a plan beneficiary who sought benefits to which he or she was not unambiguously entitled, arguing that the administrator should be bound by a conflicting representation about benefits. *E.g.*, *Griffin v. Coca-Cola Refreshments USA, Inc.*, 989 F.3d 923, 928, 936-37 (11th Cir. 2021); *Ret. Comm. of DAK Ams. LLC v. Brewer*, 867 F.3d 471, 477-81, 484-85 (4th Cir. 2017); *Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 951-52, 958-61 (9th Cir. 2014); *Guerra-Delgado v. Popular, Inc.*, 774 F.3d 776, 780-81 (1st Cir. 2014); *Pearson v. Voith Paper Rolls, Inc.*, 656 F.3d 504, 506-09 (7th Cir. 2011); *Neumann v. AT&T Commc’ns, Inc.*,

376 F.3d 773, 782-84 (8th Cir. 2004); *Sprague*, 133 F.3d at 399, 403-04; *Lee v. Burkhardt*, 991 F.2d 1004, 1006-07, 1009-11 (2d Cir. 1993); *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1311-12, 1318-20 (3d Cir. 1991); *Rosen v. Hotel & Rest. Emps. & Bartenders Union*, 637 F.2d 592, 597-98 (3d Cir. 1981). That is the sort of argument to which ERISA estoppel applies, and it is not what respondents argued here.

None of petitioners' cases holds that waiver cannot apply under ERISA or that ERISA estoppel is the *exclusive* means of precluding reliance on an anti-assignment clause. To the contrary, the Eleventh Circuit in *Griffin* distinguished waiver from ERISA estoppel and "left open the question of whether waiver principles might apply under the federal common law in the ERISA context." 989 F.3d at 935-36 (quoting *Witt v. Metro. Life Ins. Co.*, 772 F.3d 1269, 1279 (11th Cir. 2014)); *see also Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 650 (7th Cir. 1993) (acknowledging "it might be appropriate to apply certain waiver principles to ERISA claims"). *Griffin* distinguished *Hermann* without rejecting it, holding that the situation in *Hermann* was different from the situation involved in ERISA estoppel cases. 989 F.3d at 936. Similarly, the Sixth Circuit in *Sprague* stated that its rejection of ERISA estoppel depended on the fact that "the clear and unambiguous terms of plan documents" were "*available to or furnished to the party*" seeking benefits. 133 F.3d at 404 (emphasis added). Here, by contrast, petitioners refused to provide the relevant plan documents to respondents, preventing them from learning about any anti-assignment clauses until petitioners debuted them in litigation.

Far from supporting petitioners, therefore, other circuits' precedent confirms the Fifth Circuit's holding that ERISA estoppel coexists with other equitable doctrines such as waiver. Petitioners seize on a single glancing use of the phrase "general estoppel" in the Fifth Circuit's opinion, App.22a, then repeat that phrase ad nauseum as though it reflects a distinct doctrine followed only in the Fifth Circuit. It does not. Although other circuits call their doctrines "waiver" rather than "estoppel," they are substantively no different than the Fifth Circuit's rule. In all these circuits, a plan that denies or underpays claims without ever invoking an anti-assignment clause (or other basis for denial) may not invoke that clause for the first time in litigation. To the extent petitioners' complaint is that the Fifth Circuit used the term "estoppel" rather than "waiver," such a debate over word choice hardly justifies this Court's review. *See Pitts*, 931 F.2d at 357 ("*waiver* and *estoppel* are sometimes used interchangeably").

4. Other circuits also confirm rather than contradict the Fifth Circuit's description of "ERISA estoppel" as being based "on promissory estoppel principles with the added requirement of extraordinary circumstances." App.22a. On its face, that is not a holding that ERISA estoppel "applie[s] *only* to promissory estoppel." Pet. 2 (emphasis added). As explained above, the Fifth Circuit's requirements for ERISA estoppel are no different than other circuits'. *See Mello*, 431 F.3d at 444-47; *High*, 459 F.3d at 579.

The cases petitioners cite hold that ERISA estoppel requires, at a minimum, reasonable reliance

on an administrator's representations about plan benefits. Pet. 22-26; e.g., *Martinez v. Plumbers & Pipefitters Nat'l Pension Plan*, 795 F.3d 1211, 1223 (10th Cir. 2015); *Guerra-Delgado*, 774 F.3d at 782; *Paneccasio v. Unisource Worldwide, Inc.*, 532 F.3d 101, 109 (2d Cir. 2008); *Coker v. Trans World Airlines, Inc.*, 165 F.3d 579, 585 (7th Cir. 1999); *Sprague*, 133 F.3d at 403; *Bakery & Confectionery Union & Indus. Int'l Pension Fund v. Ralph's Grocery Co.*, 118 F.3d 1018, 1027 (4th Cir. 1997); *In re Unisys Corp. Ret. Med. Benefit "ERISA" Litig.*, 58 F.3d 896, 907 (3d Cir. 1995); *DeVoll v. Burdick Painting, Inc.*, 35 F.3d 408, 412 (9th Cir. 1994); *Alday v. Container Corp.*, 906 F.2d 660, 666 (11th Cir. 1990). Petitioners do not and cannot deny that those are "promissory estoppel principles," even if (as the Fifth Circuit recognized) ERISA estoppel has more requirements than classic promissory estoppel. App.22a (emphasis added); see Pet. 2 ("At common law, estoppel generally requires a knowing, material misrepresentation on which another reasonably and detrimentally relies."). Here too, petitioners' argument constitutes semantic nitpicking unworthy of this Court's attention.

II. There is no conflict with this Court's precedent.

The Fifth Circuit's decision also presents no conflict with this Court's ERISA cases. As this Court has recognized, equitable doctrines such as "waiver or estoppel may prevent [ERISA] administrator[s] from invoking" written plan provisions "as a defense." *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 114 (2013); see also *Dwyer v. United Healthcare Ins. Co.*, 115 F.4th 640, 653 (5th Cir. 2024). Far from

undermining ERISA's "interests in efficiency, predictability, and uniformity," *Conkright v. Frommert*, 559 U.S. 506, 518 (2010), requiring plan administrators to identify the provisions on which they intend to rely *during the administrative claims process* promotes those interests by "minimiz[ing] the number of frivolous lawsuits," "promot[ing] consistent treatment of claims," and "decreas[ing] the cost and time of claims settlement," *Glista*, 378 F.3d at 129.

In fact, it is petitioners' position that would undermine ERISA's goals. The statute and its implementing regulations "require that the plan administrator provide a claimant with the specific reasons for its denial of a claim." *Id.* at 128; see 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(f)-(h). That requirement "ensures expeditious judicial review of ERISA benefit decisions and keeps district courts from becoming substitute plan administrators." *Collier*, 53 F.4th at 1187 (cleaned up) (quoting *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993)). So courts agree "that a plan administrator undermines ERISA and its implementing regulations when it presents a new rationale to the district court that was not presented to the claimant as a specific reason for denying benefits during the administrative process." *Id.* at 1186-87; e.g., *Spradley*, 686 F.3d at 1140-41; *Glista*, 378 F.3d at 129, 131; *Marolt*, 146 F.3d at 620.

These principles are reinforced by the fact that plan administrators establish the administrative claims process and require beneficiaries to go through that process before filing litigation. The justification for requiring an administrative process is to avoid or narrow disputes. There is no reason to allow plan

administrators to abuse the process that they have established and required. Indeed, when a plan timely raises an anti-assignment clause during the administrative process, an assignee can review the clause and cure any defect by, for example, contacting the relevant patients and asking the patient to name the provider as their authorized representative. But no cure is possible when, as in this case, a “plan administrator[] ha[s] available sufficient information to assert a basis for denial of benefits, but choose[s] to hold that basis in reserve rather than communicate it to the beneficiary.” *Glista*, 378 F.3d at 129.

Here, as noted above, the administrative process lasted for years, and yet petitioners refused to disclose plan documents and never invoked any anti-assignment clauses. To the contrary, by partially paying respondents’ claims, petitioners acted wholly inconsistent with their later decision to raise the anti-assignment provisions as a defense in litigation. “Such conduct prevents ERISA plan administrators and beneficiaries from having a full and meaningful dialogue regarding the denial of benefits,” *id.*, and unfairly prejudices patients and assignees from receiving the benefits to which they are entitled. Courts are properly “unwilling to endorse manipulative strategies that attempt to take advantage of beneficiaries in this manner.” *Lauder*, 284 F.3d at 382.

III. This case does not warrant review.

Even if there were a conflict of authority that could justify this Court’s review in an appropriate case, this case would not be a suitable vehicle.

First, the decision below is interlocutory and fact-bound. The Fifth Circuit reversed the grant of summary judgment to petitioners, but it did not hold that petitioners in fact *were* estopped from enforcing anti-assignment clauses against respondents. The Fifth Circuit remanded for the district court to resolve disputed “fact issue[s]” under the correct test. App.23a-24a; *see* App.30a (remanding “for evidentiary determinations as to the validity of the underlying assignments”). Further proceedings could resolve the case in any number of ways that could moot any disagreement over estoppel or waiver, making this Court’s review unnecessary.

Second, the decision below does not raise any broadly applicable issue that could warrant this Court’s review. The Fifth Circuit applied long-settled precedent to an exceptional set of facts: petitioners’ unlawful practice of underpaying tens of thousands of claims without ever mentioning an anti-assignment clause, while also refusing to provide plan documents containing such a clause despite respondents’ requests. That well-reasoned decision has few implications beyond the fact-bound circumstances of this case.

Third, this Court should disregard petitioners’ doomsaying over the supposed effects of the decision below. Pet. 32-34. The Fifth Circuit decided *Hermann* in 1992, and other circuits adopted a similar ERISA waiver rule shortly thereafter. If that rule were as harmful as petitioners say, the evils they foretell would have manifested at *some* point in the last thirty years. But they have not. That is because nothing about the waiver rule applied below or in the other

circuits interferes in any way with plan sponsors' and administrators' ability to draft and enforce anti-assignment or other restrictive clauses. That rule simply enforces ERISA's unambiguous requirement that if a plan administrator is going to assert a restrictive clause as a basis to deny a claim, it cannot "lie behind the log" in a way that can only prejudice its beneficiaries' rights. *Hermann*, 959 F.2d at 574-75. Instead, it must identify and rely on the clause *during the claims process*. *Collier*, 53 F.4th at 1187; *Spradley*, 686 F.3d at 1140-41; *Glista*, 378 F.3d at 129; *Marolt*, 146 F.3d at 620.

Far from undermining predictability, this rule gives plan administrators control over the enforcement of anti-assignment clauses and other plan exclusions. Plans may continue to prohibit assignments, and if an administrator properly asserts an anti-assignment clause during the claims process, it preserves its ability to raise the clause in court. But if the administrator does *not* assert the clause during the claims process, it knows it is waiving the right to raise that clause as a defense. And that is exactly how it should be: courts should not "permit[] ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation." *Marolt*, 146 F.3d at 620; *Spradley*, 686 F.3d at 1140.

CONCLUSION

The Court should deny the petition for certiorari.

Respectfully submitted,

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