No. 14-168

IN THE

Supreme Court of the United States

BLUE CROSS BLUE SHIELD OF MICHIGAN,
Petitioner,

v.

HI-LEX CONTROLS, INC., HI-LEX AMERICA, INC., AND HI-LEX CORPORATION HEALTH AND WELFARE BENEFIT PLAN,
Respondents.

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

BRIEF OF *AMICI CURIAE* BLUE CROSS BLUE SHIELD ASSOCIATION, AMERICA'S HEALTH INSURANCE PLANS, AND PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The Blue Cross Blue Shield Association ("BCBSA") is, among other things, an association that promotes the national interests of the independent, locally operated Blue Cross and Blue Shield companies. Together, the 37 independent, community-based and locally operated BCBSA member companies administer or insure health insurance benefits for more than 105 million individuals – one-third of all Americans – in all 50 states, the District of Columbia, and Puerto Rico. The majority of these individuals receive their health benefits through plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*.

America's Health Insurance Plans ("AHIP") is a national association representing nearly 1,300 companies that administer or provide insurance benefits to more than 200 million Americans, including participants and beneficiaries in employee benefit plans governed by ERISA. AHIP advocates for public policies that expand access to affordable healthcare coverage for all Americans through a competitive marketplace fostering choice, quality, and innovation.

The Pharmaceutical Care Management Association is a national association representing pharmaceutical benefit managers who collectively

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[1] Pursuant to Rule 37.2, both parties received notice of the filing of this brief more than ten days prior to the due date, and have provided their consent to the filing of this brief. Pursuant to Rule 37.6, the *amici* state that no counsel for a party authored this brief in whole or in part, and no person or entity, other than the *amici* and their counsel, made a monetary contribution to the preparation or submission of the brief.

administer prescription drug plans for more than 215 million Americans, many of whom receive their health coverage through ERISA-governed health insurance plans.

In the various settings in which they operate, members of the *amici* associations provide administrative services to ERISA-regulated plans. The Court of Appeals' decision creates uncertainty about when third-party administrators and other service providers will be deemed to be exercising control over plan assets and thus subject to a host of ERISA fiduciary obligations. Third-party administrators and other service providers play an increasingly important role in the administration of ERISA plans. The *amici*, therefore, have a strong interest in a uniform rule for when compensation arrangements for providing administrative services to ERISA plans create fiduciary obligations, and this case offers the Court the opportunity to establish such a uniform rule.

SUMMARY OF ARGUMENT

In this case, an employer – Respondent Hi-Lex Controls, Inc. ("Hi-Lex") – contracted with Petitioner Blue Cross Blue Shield of Michigan ("BCBSM") to provide claims administration services to Hi-Lex's self-funded employee health benefit plan. Hi-Lex did not set up a trust or special fund for benefit claims, as would be required by ERISA § 403, 29 U.S.C. § 1103, if those claims were funded in advance. Instead, the claims were paid on a "pay as you go" basis out of Hi-Lex's general assets. On a weekly basis, Hi-Lex transferred funds to a bank account from which Hi-Lex authorized BCBSM to pay claims and collect compensation to which BCBSM was entitled under its contract with Hi-Lex. The Court of

Appeals held that those funds constituted plan assets. It further held that, by collecting its agreed-upon compensation from those assets, BCBSM exercised control over plan assets and thus became an ERISA fiduciary, even though BCBSM's agreement did not treat funds in the bank account as anything other than Hi-Lex general assets and even though BCBSM had no notice from Hi-Lex that Hi-Lex considered that account to hold plan assets.

In concluding that BCBSM's collection of its agreed-upon compensation constituted an exercise of control over plan assets, the Court of Appeals identified a number of "actions and representations" by BCBSM that it viewed as evidencing the plan's beneficial ownership interest in all the funds transferred to BCBSM, including the amounts to which BCBSM was entitled to retain as its compensation under its contract with Hi-Lex. Cert. Pet. App. 8a. None of these "actions or representations" – including BCBSM's role in making initial claims determinations or submitting documentation for reports required for the Department of Labor – are properly construed to make a third-party administrator or other service provider an ERISA fiduciary or render such compensation payments plan assets. Indeed, the Court of Appeals' decision is in conflict with the Department of Labor's ERISA regulations.

If the Sixth Circuit's decision is allowed to stand, ERISA plans will be deemed to have an ownership interest in amounts contractually designated as the third-party administrator's compensation: (i) for its services; and (ii) for access to its proprietary health provider networks and discounts. In turn, if such compensation were deemed a "plan asset," the

service provider could not exercise any decision-making with respect to when, how, or whether to collect or forego certain elements of its compensation without qualifying as an ERISA fiduciary and potentially committing a prohibited transaction, regardless of the terms of the parties' bargained-for contract. Because the Sixth Circuit's decision conflicts with prior precedent as to which arrangements between third-party administrators and ERISA plans create ERISA fiduciary status, this Court's review is needed.

Third-party administrators and other service providers play an essential role in the administration of ERISA plans. Contracts between plan sponsors and service providers often explicitly specify that the service provider is not an ERISA fiduciary, and are often priced to reflect that assumption. The increased risk that these service providers, contrary to explicit terms in their contractual arrangements with plans, will be deemed to be fiduciaries – with all the attendant obligations and potential liabilities – will increase the cost of offering and maintaining ERISA plans and will penalize third-party administrators for ordinary and customary compensation collection activities. The uncertainty engendered by the Sixth Circuit's decision severely impairs the ability of service providers to execute their responsibilities efficiently, and the costs of that uncertainty will be felt ultimately by plan participants, as employers and their service providers are forced to develop new compensation arrangements in response to the holding below.

ARGUMENT

I. The Court of Appeals' Decision Creates Uncertainty About When a Third-Party Administrator Is Exercising Control Over Plan Assets

A. *Statutory and Regulatory Framework*

ERISA defines "fiduciary" not in terms of formal trusteeship, but in functional terms of control and authority over the plan. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993). Under ERISA, a person is a fiduciary with respect to a plan, among other instances, to the extent he or she "exercises any authority or control respecting management or disposition of its assets." 29 U.S.C. § 1002(21)(A). In turn, a "fiduciary with respect to a plan shall not . . . deal with the assets of the plan in his own interest or for his own account." *Id.* § 1106(b)(1). Here, the Court of Appeals held that a third-party claims administrator violated ERISA's prohibition on self-dealing when it collected bargained-for compensation. The Court of Appeals held that, in collecting this compensation, the claims administrator exercised control over "plan assets" and thus became an ERISA fiduciary.

ERISA does not define what constitutes plan assets, providing only that "the term 'plan assets' means plan assets as defined by such regulations as the Secretary [of Labor] may prescribe." 29 U.S.C. § 1002(42). The Department of Labor's regulations provide the following definition of plan assets: "the assets of the plan include amounts . . . that a participant or beneficiary pays to an employer, or amounts that a participant has withheld from his wages by an employer, for contribution or repayment

of a participant loan to the plan, as of the earliest date on which such contributions or repayments can reasonably be segregated from the employer's general assets." 29 C.F.R. § 2510.3-102(a)(1).

The Department of Labor's regulations do not address the issue presented in this case, namely whether employer contributions to the plan – rather than employee contributions – constitute plan assets. As the Court of Appeals explained, the resolution of whether BCBSM was exercising control over plan assets required determining whether the employer contributions could be deemed "plan assets." *See* Cert. Pet. App. 7a ("The pertinent question, then, is whether the *employer* contributions that Hi-Lex sent to BCBSM must also be considered plan assets.") (emphasis in original).

B. *The Court of Appeals' Decision*

Hi-Lex hired BCBSM to serve as the claims administrator for Hi-Lex's self-funded health benefit plan. Under the parties' contract, Hi-Lex sent money to BCBSM each week to cover its employees' estimated claims and to compensate BCBSM for its services. The contract provided that BCBSM's responsibilities were "limited to providing administrative services for the processing and payment of claims." 6th Cir. App. 11. Moreover, the plan's summary plan description ("SPD") specified that "[b]enefit payments . . . are paid directly out of the general assets of the Company" and that "[t]here is no special fund or trust from which self-insured benefits are paid." *Id*. at 746. Neither BCBSM nor Hi-Lex had a separate bank account set aside exclusively for the funds intended to pay enrollee health expenses. Cert. Pet. App. 10a.

At issue below was BCBSM's collection of what the Court of Appeals referred to as "Disputed Fees," which included BCBSM's compensation for providing access to its provider network. The contract between BCBSM and Hi-Lex stated: "The Provider Network Fee, contingency, and any other cost transfer surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in the Amounts Billed." *Id.* at 123a. The Court of Appeals held that BCBSM exercised control over plan assets when collecting those fees pursuant to its contract with Hi-Lex.

The Court of Appeals' conclusion that the Disputed Fees constituted plan assets rested on a 1992 Department of Labor Advisory Opinion, stating that "'the assets of a welfare plan generally include any property, tangible or intangible, in which the plan has a beneficial ownership interest.'" *See id.* at 8a (quoting U.S. Dep't of Labor, Advisory Op. No. 92-24A, 1992 WL 337539, at *2 (Nov. 6, 1992)). According to the same Advisory Opinion, determining what constitutes "plan assets" requires "consideration of any contract or other legal instrument involving the plan, as well as the actions and representations of the parties involved." *Id.*

Using that framework, the Court of Appeals concluded that, as a result of various "actions and representations," the Hi-Lex plan beneficiaries had a beneficial ownership interest in the funds held by BCBSM, including the compensation amounts to which BCBSM was contractually entitled. Cert. Pet. App. 8a. Those "actions and representations" included the following: (1) "although the SPD gives final claims determination to Hi-Lex, the document

makes clear that enrollees must make the initial benefit claims to BCBSM, which has both the funds and the discretion to pay claims"; (2) the SPD informed enrollees of beneficiaries' rights under ERISA, "including the right to sue 'the fiduciaries' (plural) if they 'misuse the Plan's money'"; (3) BCBSM maintained exclusive check-writing authority over the bank account into which Hi-Lex's funds were wired; and (4) BCBSM annually submitted data to Hi-Lex especially designed for use on the company's ERISA-mandated DOL 5500 forms. *Id.* at 8a-9a.

C. *The Court of Appeals' Decision Departs from Previous Precedent and Creates a Circuit Split*

The Court of Appeals departed from the Department of Labor regulations and existing case law when treating these four "actions and representations" as evidence that BCBSM was controlling plan assets and thus acting as a fiduciary.

First, the district court erred by concluding that BCBSM controlled "plan assets" because the SPD "makes clear that enrollees must make their initial benefit claims to BCBSM." *Id.* at 8a. As the Court of Appeals acknowledged, Hi-Lex retained final authority over claims determinations. *Id.* Claims administrators like BCBSM are not deemed fiduciaries simply because they process benefit claims. *See* 29 C.F.R. § 2509.75-8, D-2 Q&A (processing of claims does not make a third-party administrator an ERISA fiduciary). The Sixth Circuit's decision departs from those of other Courts of Appeals, which have not treated claims processing as conferring fiduciary status. *See, e.g., Faber v. Metro. Life Ins. Co.*, 648 F.3d 98, 105 (2d Cir. 2011)

(establishing and administering beneficiary accounts "in the manner contemplated by" plan documents does not implicate control over plan assets); *Oliver v. Coca-Cola Co.*, 497 F.3d 1181, 1195 (11th Cir. 2007) (treating third-party administrators as de facto fiduciaries "would undercut the ability of employers to contract out the administrative tasks associated with operating an ERISA plan"); *Terry v. Bayer Corp.*, 145 F.3d 28, 35 (1st Cir. 1998) (noting that "[c]ourts have determined that when the plan administrator retains discretion to decide disputes, a third party service provider . . . is not a fiduciary of the plan").

Second, the SPD's reference to "fiduciaries" (plural) rather than "fiduciary" (singular) cannot be deemed to give Hi-Lex beneficial ownership rights in the Disputed Fees. The Court of Appeals offered no justification for its presumption that "fiduciaries" included BCBSM. SPDs typically refer to "fiduciaries" for the simple reason that a plan may have more than one fiduciary. Under the Court of Appeals' approach, a third-party administrator or other service provider could be deemed a fiduciary if plan documents, as to which it had no drafting role, refer generically to "fiduciaries."

Third, the Court of Appeals erred in treating BCBSM's check-writing authority as evidence that BCBSM controlled plan assets. If the funds in BCBSM's account were in fact plan assets, then BCBSM's check-writing authority could arguably be evidence of BCBSM's control over the plan assets. The Court of Appeals, however, improperly conflated the "control" inquiry with the antecedent "plan asset" inquiry. Further, the Court of Appeals failed to ask the "threshold question" of whether BCBSM "was

acting as a fiduciary (that is, performing a fiduciary function) when taking the action subject to complaint." *Pegram v. Herdich*, 530 U.S. 211, 226 (2000). Here, of course, "the action subject to complaint" is BCBSM's collection of its agreed-upon compensation pursuant to its contract with Hi-Lex.

Fourth, the Court of Appeals erred in treating as relevant the fact that BCBSM "annually submitted data to Hi-Lex especially designed for use on the company's ERISA-mandated DOL 5500 forms." Cert. Pet. App. 9a. Department of Labor regulations specifically provide that, where a third-party administrator "ha[s] no power to make any decisions as to plan policy, interpretations, practices or procedures," the "[p]reparation of reports required by government agencies" does not make the third-party administrator a fiduciary with respect to the plan. 29 C.F.R. § 2509.75-8, D-2 Q&A.

The Court of Appeals also committed error when it agreed with the district court "that the Disputed Fees were discretionarily imposed." Cert. Pet. App. 6a. The Court of Appeals cited the fact that the "Disputed Fees were sometimes waived entirely for certain self-funded customers." *Id.* But the fact that BCBSM occasionally exercised discretion not to collect the Disputed Fees as to *other* ERISA plans did not confer to the Hi-Lex plan a property right, or beneficial ownership interest, in those fees under its contract with BCBSM.

As set forth in BCBSM's petition for a writ of certiorari, the Sixth Circuit's decision conflicts with those of other Circuits in conferring on plan participants rights to a third-party administrator's compensation to which the plan is not contractually entitled. Cert. Pet. at 22. For example, in *Chicago*

District Council of Carpenters Welfare Fund v. Caremark, Inc., 474 F.3d 463, 475-76 (7th Cir. 2007), Caremark served as the prescription benefit manager for an ERISA plan's prescription drug coverage. The contract required Caremark to pay to Carpenters rebates in a certain amount for prescriptions filled. The plan argued that the rebate provisions gave Caremark discretionary authority over the negotiations of drug purchase agreements with drug manufacturers on Carpenters' behalf. Essentially, the plan argued that it had an ownership interest in cost savings Caremark negotiated with the drug manufacturers even though the contract entitled the plan to only a small portion of the cost savings.

The Seventh Circuit rejected the plan's argument that Caremark controlled "plan assets" in the form of "the portion of rebates paid by drug manufacturers that belongs to Carpenters." *Id.* at 476 n.6 (internal quotation marks omitted). As the Seventh Circuit explained, "Caremark was not collecting rebates from drug makers on behalf of Carpenters. The contracts clearly specify that Caremark had an independent contractual duty to pay rebates to Carpenters." *Id.* Because "Caremark was not collecting rebates from drug makers for Carpenters and then passing through a portion," Caremark was not controlling assets of the plan "but rather was controlling its own assets in making these contractual rebate payments to Carpenters." *Id.*

Similarly, here, BCBSM had a contractual right to the Disputed Fees, and, in charging those Disputed Fees, BCBSM was exercising control over its own assets, not assets of the Hi-Lex plan.

II. The Court of Appeals Has Created the Specter that All Third-Party Administrators Could Be Deemed ERISA Fiduciaries

The decision below takes an unprecedented and unworkable approach to the determination of whether an entity rendering services to ERISA plans will be deemed an ERISA fiduciary. Under the analysis employed by the Sixth Circuit, third-party administrators and other service providers will, at best, face tremendous uncertainty as to whether they are subject to ERISA's fiduciary obligations any time they accept payment for services related to an ERISA plan, while, at worst, the Sixth Circuit's decision threatens to increase exponentially the number of entities deemed ERISA fiduciaries.

A determination that an entity is a fiduciary under ERISA has "high stakes, for classification as a fiduciary or a nonfiduciary renders a defendant liable for different types of damages." *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 300 (1st Cir. 2005). Indeed, courts have often remarked that "ERISA's fiduciary duties are the 'highest known to law.'" *Fuller v. SunTrust Banks, Inc.*, 744 F.3d 685, 695 (11th Cir. 2014) (citing *ITPE Pension Fund v. Hall*, 334 F.3d 1011, 1013 (11th Cir. 2003)). ERISA provides that fiduciaries must discharge their responsibilities in accordance with the duties of prudence and loyalty, and an allegation that one has breached those duties can subject the fiduciary to personal liability in suits in federal court. *See* 29 U.S.C. §§ 1104, 1109, 1132(a)(2)-(3). Conversely, "ERISA does not regulate the duties of non-fiduciary plan administrators. As such, non-fiduciaries cannot be held liable under ERISA." *Baker v. Big Star Div. of Grand Union Co.*, 893 F.2d 288, 289-90 (11th Cir.

1989) (citing *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564-65 (11th Cir. 1987)). Additionally, a fiduciary has the right to bring suit under § 502(a)(2)-(3) of ERISA, 29 U.S.C. § 1132(a)(2)-(3), for breach of another fiduciary's duties, to enforce a plan's terms, to obtain appropriate equitable relief, or to redress violations of ERISA. Accordingly, the holding that a service provider is an ERISA fiduciary affects who can be sued and be liable under ERISA, and opens the federal courts' doors to those same service providers bringing suit under ERISA in their own right.

Not only is the Sixth Circuit's decision consequential, it is far-reaching. Most obviously, the decision has significant impact for self-insured plans and the wide host of service providers that help those plans manage their administration.[2] Self-insured plans represent a significant and increasing portion of ERISA welfare benefit plans. A recent study estimated that over 58% of workers with health benefits coverage are in self-insured plans, an increase of approximately 17% since 1998. *See* Paul Fronstin, Ph.D., *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, 33 EBRI Notes 2 (Nov. 2012), at 2-3 (http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd-RetRdines.pdf). The Secretary of Labor recently estimated that, in 2010, there were roughly 20,000 self-insured plans, covering

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[2] Health and welfare plans governed by ERISA tend to fall into two groups: fully insured (where an insurance company assumes the risk of offering health insurance) and self-insured (where the employer assumes the financial risk relating to offering health insurance). *See FMC Corp. v. Holliday*, 498 U.S. 52, 62-63 (1990).

approximately 30 million participants, and holding assets totaling about $58 billion. *See* Seth Harris, Acting Secretary of Labor, *Report to Congress: Annual Report on Self-Insured Group Health Plans* (Mar. 2013), at iii (http://www.dol.gov/ebsa/pdf/ACAReportToCongress033113.pdf).

While some sponsors of self-insured plans opt to perform the duties of plan administration internally, most find it more efficient to retain a service provider of one sort or another to administer the plan rather than devote company employees and resources to administrative tasks. For example, many plans hire third-party claims administrators to process and handle benefit claims. The outsourcing of these claims services allow plan sponsors to focus on their core businesses, while at the same time hiring a provider that can perform these administrative functions with an economy of scale that helps reduce the overall cost of services. Additionally, companies often hire third-party administrators because they bring a specialized expertise in a relevant field (*e.g.*, some third-party administrators provide plan sponsors with unique experience in drug utilization review and information technology support that a typical plan sponsor would otherwise be ill-equipped to handle). Many third-party administrators and service providers have contracted to provide their services on the explicit understanding that they are not plan fiduciaries and will not be handling plan assets. They would need to reduce or re-price the services they offer if the mere receipt and calculation of their bargained-for compensation will be sufficient to expose them to fiduciary responsibility (and liability) under ERISA. The ability affordably to outsource the countless ministerial functions required in the administration of large, often multi-

state, plans is of enormous importance to the smooth functioning of ERISA plans nationally.

The Sixth Circuit's decision adds uncertainty for third-party administrators and other plan service providers by dramatically expanding the definition of ERISA "plan asset" to include bargained-for compensation flowing directly from employers. Significantly, under the logic of the Sixth Circuit's decision, any service provider that contracts with an employer to provide services in connection with ERISA plans will face this uncertainty, which will likely result in higher administrative costs (or reduced services) to self-insured employers, as third-party administrators and other service providers are forced to adjust their business model to react to the new potential liability created by the decision below. Such a result is to the ultimate detriment of ERISA plan beneficiaries.

In short, the determination as to whether an entity is an ERISA fiduciary is an important question with far-reaching ramifications that, in the context of the Sixth Circuit's incorrect and aberrational decision, warrants this Court's review. Review of that decision would ensure that the decision does not result in an ill-considered expansion of fiduciary litigation and liability for potentially thousands of ERISA plans covering millions of participants and billions in plan assets.

CONCLUSION

The Court should grant the petition for writ of certiorari.

Respectfully submitted,

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