No. 14-1286

In The Supreme Court of the United States

UNITED HEALTHCARE OF ARIZONA, INC., *et al.*,

Petitioners,

v.

SPINEDEX PHYSICAL THERAPY, U.S.A., INC., *et al.*,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR *AMICI CURIAE* AMERICA'S HEALTH INSURANCE PLANS AND THE AMERICAN BENEFITS COUNCIL IN SUPPORT OF PETITIONERS

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America's Health Insurance Plans ("AHIP") and the American Benefits Council ("Council") respectfully submit this brief as *amici curiae* in support of petitioners, with the written consent of the parties.[1]

[1] Counsel gave the parties timely notice of *amici*'s intent to file this brief and filed the requisite consent letters with the Clerk. No party or counsel for a party authored this brief in whole or in part, and no counsel or party, or any person other than *amici*, their members, and counsel, made a monetary contribution intended to fund the brief's preparation or submission.

STATEMENT OF INTEREST OF *AMICI CURIAE*

America's Health Insurance Plans ("AHIP") is a national trade association representing companies that provide or administer health insurance benefits to more than 200 million Americans, including participants and beneficiaries in employee benefit plans governed by ERISA. Its members offer a wide range of insurance and health coverage options to consumers, employers of all sizes, and governmental purchasers nationwide, providing AHIP with a unique understanding of how the Nation's healthcare and health insurance processes work. AHIP advocates for public policies that expand access to affordable healthcare coverage for all Americans through a competitive marketplace that fosters choice, quality, and innovation.

The American Benefits Council is a broad-based, nonprofit trade association dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's members include approximately 300 employer-sponsors of employee benefit plans large and small, who collectively administer plans covering more than 100 million plan participants and beneficiaries. The Council and its members seek to ensure that voluntary employer-sponsored health plans remain a workable, affordable, and vital feature of the American employment landscape.

Amici and their members have a demonstrated interest in ensuring that courts correctly interpret

and apply ERISA. In furtherance of that interest, *amici* regularly participate in this Court in cases that present ERISA questions or otherwise affect employee benefit plan design or administration. *See, e.g.*, *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (AHIP and the Council participated as *amici*); *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006) (same).

This case is of significant importance to *amici*, whose members sponsor, insure, and provide administrative services to a significant percentage of all employer-sponsored health plans offered in the United States. As explained below, nearly half of all such plans are either fully or partially self-funded, and most of those plans rely on a third-party administrator to process participant benefit claims. The Court of Appeals' ruling could result in dramatically increased claims administration expenses for *amici*'s members and plan participants alike, with little or no corresponding benefit to anyone.

SUMMARY OF ARGUMENT

The question in this case is not *whether* an ERISA plan beneficiary may bring suit under 29 U.S.C. § 1132(a)(1)(B) to recover benefits due to him. Rather, the question is *who* he may sue.

All Courts of Appeals agree that a plan participant may sue his health plan, as well as the entity

identified in the plan documents as the "plan administrator" (if any). *See* Pet. 10-15 (collecting authorities). The Ninth Circuit went a step further, however, by joining those courts holding a plan participant also may sue a mere *claims* administrator under section 1132(a)(1)(B), even though that claims administrator has no legal obligation to pay the benefits due under the plan.

This holding portends grave consequences for claims administrators that provide claims-processing services to the increasing number of health plan sponsors that offer "self-funded" plans – that is, plans where the sponsor (usually an employer) chooses to pay claims out of its own assets instead of contracting with an insurer to assume that risk. These claims administrators play a crucial role in helping plans comply with their obligations under ERISA by offering a range of administrative services, including some or all of the following: assembling networks of physicians and hospitals, negotiating rates for services, establishing claims-payment systems, and processing claims for benefits.

Under the Court of Appeals' ruling, it will become more expensive to hire a third-party claims administrator to perform these vital tasks. Claims administrators will face an increased risk of litigation, including the potential for sprawling, complex multi-plan suits like the one at issue here. Moreover, claims administrators will face uncertainty concerning their responsibility to pay for settlements and judgments in suits seeking plan assets, which in turn could

result in additional litigation between plans and their claims administrators.

These uncertainties cannot help but drive up the cost of claims-administration services. Those increased costs, in turn, will be borne by everyone involved: claims administrators, who will face these additional risks; plans, who will be forced to pay higher claims-administration fees to compensate for this risk; and even plan participants, who inevitably will face higher plan premiums and/or reduced benefits as a result. In short, nobody wins – except the attorneys who wish to repackage otherwise routine ERISA claims into sprawling multi-plan suits that may become too expensive to litigate.

The Ninth Circuit's reasoning appears to rest on a misconception that *amici* and their members are uniquely positioned to dispel. The panel seemed to believe that there is no difference between an ERISA *plan* administrator and a mere *claims* administrator. *See* Pet. App. 28a ("We are unable to reconcile the district court's holding [that United was not a plan administrator] with Defendants' apparent concession [that it was a mere claims administrator]."). As *amici*'s members know well from serving as plan sponsors, insurers, and claims administrators, those roles are different indeed. In fact, the record in this very case highlights the stark contrasts between plan administrators and claims administrators. Unfortunately, however, the panel failed to appreciate that crucial distinction.

This Court should grant the petition for a writ of certiorari and reverse the Court of Appeals' judgment. Like the Second, Third, Seventh, Eighth, and Tenth Circuits, this Court should hold that mere claims administrators, who are not responsible for funding the benefits owed by an ERISA plan, are not proper defendants in a participant's suit "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B).

ARGUMENT

I. THE NINTH CIRCUIT MISUNDERSTOOD THE ROLE PLAYED BY A MERE CLAIMS ADMINISTRATOR FOR A GROUP HEALTH PLAN.

1. "The universe of group health insurance plans . . . is diverse and complicated." U.S. Dep't of Labor, Employee Benefits Security Administration, Abstract of 2012 Form 5500 Annual Reports (Jan. 2015 (Version 1.0)) ("ESBA 2015 Annual Report") at 1.[2] In broad terms, these plans fall into three categories: "fully-insured," "self-insured," or "mixed-insured." *Id. Amici*'s members play a key role in sponsoring or providing administrative services to each type of plan.

[2] A copy of the ESBA's 2012 Abstract is available at: http://www.dol.gov/ebsa/pdf/ACA-ARC2015.pdf (Version 1.0) (last visited May 18, 2015).

A fully-insured plan works just like it sounds: a plan "provides health benefits by purchasing a group health insurance policy or contract from a state-licensed insurance carrier or similar organization" – often, one of *amici*'s members. *Id.* at 35; *cf. also* 29 U.S.C. § 1144(b)(6)(D) (a multi-employer plan is "fully insured" if the Secretary determines its benefits "are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State"). The insurance company that sells the policy bears the insurance risk in return for a premium paid by the plan and/or its participants. For the latest year for which official government data is available (2012), approximately 26,000 of the 50,000 private-sector employer-sponsored group health plans filing the required Form 5500 with the Department of Labor[3] – or approximately 51% of all such plans – "can be categorized as fully-insured." ESBA 2015 Annual Report at 1.

A self-insured plan, by contrast, is one where "the sponsor generally assumes the financial risks

[3] The Department of Labor and Internal Revenue Service "jointly developed the Form 5500 Series to allow employers who sponsor an employee benefit plan for their employees to satisfy the annual reporting requirements under" ERISA and the Internal Revenue Code. ESBA 2015 Annual Report at 36; *see also* 29 U.S.C. § 1021; 29 C.F.R. § 2520.104b-1 (imposing disclosure requirements on plans). Certain plans are exempted from the Form 5500 filing requirements because of their size and/or the manner in which they are funded.

associated with covering the health benefit expenses of the plan's participants." *Id.* at 35.[4] Approximately 21,000, or 41% of the plans that filed a Form 5500 in the latest year for which data is available, are self-insured plans. *Id.* at 1.

Finally, a "mixed-insured" plan is one that "can be described as having both self-insured and fully-insured characteristics." *Id.* at 1. Approximately 4,000 plans, or 8% of those filing a Form 5500 in the latest year, "can be categorized as mixed-insured." *Id.*

Over the last decade, self-funded plans have become increasingly popular, particularly for large employers. "The percent of covered workers enrolled in self-funded plans has increased for large firms since 2004" and "has remained stable for both large and small firms over the last couple of years." Kaiser Family Foundation, 2014 Employer Health Benefits Annual Survey ("2014 Kaiser Health Benefits Survey") at 7.[5] Indeed, "[f]ifteen percent of covered workers at small firms (3-199 workers) *and 81% of covered workers at larger firms* are enrolled in plans which are either partially or completely self-funded." *Id.*

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[4] To hedge a portion of this risk, self-funded plans often "obtain stop-loss insurance coverage," which "limits the liability (stops the loss) the plan or employer bears" by covering all claims in excess of certain amounts specified in the relevant policy. ESBA 2015 Annual Report at 35-36.

[5] A copy of the 2014 Kaiser Health Benefits Survey is available at: http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report (last visited May 18, 2015).

(emphasis added); *see also* ESBA 2015 Annual Report at 7, Table A3 (showing that approximately 84% of participants in plans that filed a Form 5500 are enrolled in either self-funded (32.3 million) or mixed-insured (26.0 million) plans).

There are numerous reasons why a plan sponsor may elect to establish a self-funded health plan. For example, the plan sponsor may wish to customize the benefits offered in the plan to match known attributes of its employee base or to encourage healthier behaviors. Alternatively, an employer may wish to bear some claims insurance risk in the hopes that its overall health care costs will be less in years where it experiences lower-than-average claim volumes. Or, in some instances, the employer may create a self-funded health plan hoping to capture the perceived cost and/or tax benefits of self-funding.

Whatever the sponsors' motivations, large, self-funded plans have become commonplace in today's insurance market. Therefore, it is crucial that courts applying ERISA understand how such plans work. In particular, courts must understand the many distinct roles that *amici*'s members play in designing, funding, and administering self-funded plans. Unfortunately, the Ninth Circuit's decision makes clear that it did not understand the crucial distinction between an ERISA *plan* administrator and a mere *claims* administrator.

2. ERISA governs welfare benefit plans established by any employer or employee organization

"engaged in commerce or in any industry or activity affecting commerce." 29 U.S.C. § 1003(a). The statute requires every plan to have both a "plan sponsor" and "plan administrator." As this Court has recognized, "ERISA carefully distinguishes these roles." *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1877 (2011) (citing *Varity Corp. v. Howe*, 516 U.S. 489, 498 (1996)).

The "plan sponsor" is the entity that sponsors the ERISA plan, such as an employer or employee organization. 29 U.S.C. § 1002(16)(B). "The plan's sponsor (*e.g.*, the employer), like a trust's settlor, creates the basic terms and conditions of the plan, executes a written instrument containing those terms and conditions, and provides in that instrument 'a procedure' for making amendments." *Amara*, 131 S. Ct. at 1877 (2011). The "plan administrator," by contrast, is "a trustee-like fiduciary" that "manages the plan, follows its terms in doing so, and provides participants with the summary documents that describe the plan (and modifications) in readily understandable form." *Id.* (citing 29 U.S.C. §§ 1002(21)(A), 1021(a), 1022, 1024).

In some instances, "the same entity . . . fill[s] both roles." *Id.* "But that is not always the case." *Id.* When a plan wishes to designate a separate plan administrator, it must do so in the "instrument under which the plan is operated." 29 U.S.C. § 1002(16). If no separate administrator is named in the plan documents, as in the case of the American Express plan at issue here (*see* Pet. App. 27a, 51a), then the plan sponsor is by definition the plan administrator. *Id.*

Many self-funded plans also involve a third kind of entity that is neither a plan sponsor nor a plan administrator: a "claims administrator." "While some self-insured plans are self administered, employers usually enter into a contract with a third party administrator (TPA) or use another outside entity to handle enrollment, pay claims, collect premiums, provide customer service, and perform other administrative duties." ESBA 2015 Annual Report at 35. *Amici*'s members are often selected to play this administrative role due to their expertise in assembling provider networks and negotiating rates, processing claims, adjudicating appeals, and complying with any and all other rules and regulations set forth by Congress and the many federal and state administrative agencies that regulate insurance and healthcare matters. *See America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1323 n.3 (11th Cir. 2014) ("TPAs are often insurance companies acting solely in an administrative capacity."). These arrangements with insurance companies serving as claims administrators are often referred to as "Administrative Services Only" or "ASO" agreements.

The record in this case highlights the important differences between plan administrators and claims administrators. As noted above, "plan administrators" are obligated by statute and regulation to perform numerous tasks. *See, e.g.*, 29 U.S.C. §§ 1021(a)-(b), 1022, 1024.

In contrast, a *claims* administrator's duties are set forth in its contracts with the relevant plan. As

the Ninth Circuit recognized, United acted as a claims administrator for the two self-funded plans sued in this case: Discount Tire and American Express. Pet. App. 25a-26a. Excerpts of Administrative Services Agreements between United and those plans, which are in the record below, illustrate the limited and carefully circumscribed role that claims administrators play in administering group health plans.

The record contains excerpts of an Administrative Services Agreement between United and American Express Company, which is representative of the kinds of standard terms and conditions that appear in many of *amici*'s ASO agreements. It states: "We" – meaning United – "*are not the plan administrator of the plan*." DE 424-2, p. 5 (emphasis added).[6] Rather, the plan administrator is "you [American Express] or someone you designate." *Id.* Moreover, in that Agreement, American Express agreed to "accept responsibility for the Plan . . . including its benefit design and compliance with any laws that apply to you or the Plan." *Id.*

As with the agreements in the record, a claims administrator's duties and responsibilities generally are spelled out in the relevant administrative services agreement. *See* DE 424-2, pp. 6-7. For example, in the American Express agreement in the record here, United agreed to use its expertise in assembling

[6] All references in this Brief to Docket Entries ("DE") are to the district court docket in Case 2:08-cv-00457 (D. Ariz.).

managed care networks to provide the plan with a "Managed Care Network, located in agreed to geographical sites with Network Providers who render health care." DE 424-2, p. 7.

In that contract, United also agreed to use its claims-processing expertise to help implement the terms of the plan American Express designed. When a participant submits a claim, United agreed to make an initial determination as to "whether a benefit is payable under the Plan's provisions." DE 424-2, p. 6. If a participant appeals that initial benefit determination, United further agreed to "process the appeal and decide whether a Plan benefit is available." *Id*.

In the event such an appeal was unsuccessful, United also agreed to "notify the claimant of this second level denial and of their right to further appeal the denial *to you* [American Express] for a full and fair review *which will be final and binding*." *Id.* (emphasis added). Thus, under this representative, sample ASO agreement, the plan – and not the claims administrator – retained the "discretionary authority to construe and interpret the terms of the Plan and to make final, binding determinations concerning the availability of Plan benefits." DE 424-2, p. 6.

Because the plan is self-funded, the Administrative Services Agreement included in the record informs American Express: "you have the sole responsibility to pay, and provide funds, for all Plan benefits." DE 424-2, pp. 5-6. "We have no liability to

provide these funds. . . . even if we provide stop loss insurance to you." *Id.*, p. 5.

To enable United to process claims, American Express agreed to "open and maintain a Bank Account at the Bank for purposes of providing [United] a means to access your funds for payment of Plan benefits and expenses." DE 424-2, p. 6. American Express must "maintain a balance in the Bank Account in an amount equal to not less than 1 day of expected Plan benefits," and must replenish that account daily. *Id.* Because United, as a mere claims administrator, is not obligated to pay any claims from its own funds, it has a contractual right to "stop issuing checks and suspend any of our other services under this Agreement for the period of time you do not provide the required payment," or to terminate the agreement if American Express fails to correct any underfunding within three days of receiving notice. *Id.*, p. 7.

United's agreement with Discount Tire, also included in the record below, is similar.[7] United provides only administrative services to the Discount Tire plan. As with the American Express plan, Discount Tire is the plan's sponsor and is "solely

[7] Although the claims against Discount Tire were subject to dismissal in light of the anti-assignment provision in the relevant ERISA plan document (Pet. App. 26a), the relevant administrative services agreement is discussed here to give the Court a sense of the common terms and conditions under which claims administrators provide services to ERISA plans.

responsible for providing funds for payment for all Plan benefits payable to Network Providers or non-Network Providers." DE 424-1, p. 6. Under the Agreement, Discount Tire must "maintain a minimum balance in the Bank Account in an amount equal to not less than 5 days of expected Bank Account activity." *Id.* Once again, United reserved the right to "stop issuing checks" if the account is underfunded, and to "terminate this Agreement effective as of any date after one business day after we have given you notice of the funding deficiency, if you do not provide the required payment within this time period." *Id.*

These representative terms and conditions underscore the limited role played by a mere claims administrator. Claims administrators generally do not design the plans at issue. Rather, they use their expertise to assemble a network of providers and make initial claims determinations based on the terms of the specific plan designed by the ERISA plan sponsor. The plan – and not the claims administrator – usually retains the discretion to interpret the plan and make final and binding determinations about its meaning.

Moreover, claims administrators have no legal or contractual obligation to fund welfare benefit claims. Nor do they have unfettered access to plan assets. On the contrary, claims administrators generally can access only special bank accounts that contain, at most, a few days' worth of claims payments.

These limitations are not accidental. It is in everyone's interest that ASO agreements be carefully crafted to avoid exposing claims administrators to the kind of risk they would face if they were underwriting the benefits in question. That way, claims administrators can offer their expertise to self-funded plans at rates far lower than would be possible if they were required to price their services to include the insurance risk attendant to the claims they process.

The Ninth Circuit's rule upends this carefully negotiated balance by making every entity involved in the administration of a health plan a potential defendant under section 1132(a)(1)(B), regardless of the role they play in its administration. As explained below, that expansive rule could have substantial consequences for the employer-sponsored health coverage marketplace.

II. ALLOWING ERISA SUITS AGAINST MERE CLAIMS ADMINISTRATORS WILL ADD NEEDLESS COST AND COMPLEXITY TO ERISA PLAN ADMINISTRATION.

Allowing ERISA plan participants to sue claims administrators will add needless cost and complexity to ERISA welfare plan administration. Those costs will be borne not only by the claims administrators, but also by ERISA plans and their beneficiaries. Worse, these costs come with no corresponding benefits, as it is already clear that plan participants have

the right to sue an ERISA plan to recover benefits due under the plan's terms.

As described in some detail above, claims administration services are provided pursuant to contracts with ERISA plans. As in any contractual arrangement, the price plans pay for these administrative services depends upon the complexity of the services offered and the degree of risk assumed by the claims administrator. The Court of Appeals' rule adds multiple levels of uncertainty for claims administrators that can only have the effect of increasing the price of claims-administration services – perhaps substantially.

First, the Ninth Circuit's rule creates a meaningful risk of increased litigation against claims administrators. According to the Department of Labor's latest data, approximately half of all private-sector employer-sponsored health plans are either fully (41%) or partially (8%) self-funded. *See* ESBA 2015 Annual Report, p. 1. That number is even higher for employees of large companies: "81% of covered workers at larger firms are enrolled in plans which are either partially or completely self-funded." 2014 Kaiser Health Benefits Survey, p. 7. And, of course, these employers "usually enter into a contract with a third party administrator" to process these claims. ESBA 2015 Annual Report at 35. Thus, claims administrators process millions of welfare benefit claims every single day.

Under the Ninth Circuit's rule, each of these processed claims could subject the claims administrator to suit, even though it was never responsible for funding the benefits sought from the plan. Claims administrators therefore could be brought into any of the thousands of ERISA benefits suits filed each year. *See, e.g.*, Federal Judicial Center, Statistical Tables for the Federal Judiciary, Table C-2 (noting 7,660 ERISA suits filed in 12-month period ending June 30, 2014).

Moreover, the suits most impacted by this rule are not run-of-the-mill ERISA benefits litigation – even assuming there is such a thing. *Cf. Conkright v. Frommert*, 559 U.S. 506 (2010) ("As in many ERISA matters, the facts of this case are exceedingly complicated."). Rather, the rule at issue here is most important in large, multi-plan suits where plaintiffs attempt to combine disparate claims arising under the terms of many different plans, solely by suing plans that happen to use a common claims administrator.

The case below neatly illustrates this danger: it concerns more than 10,000 separate claims brought against 44 different ERISA plans. In another recent example, a hospital sued Cigna over claims arising under "*more than 8,000* insurance plans," even though "[m]ost [plans] are funded by employers, with Cigna acting only as an administrator." *North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182 (5th Cir. 2015) (emphasis added). It goes without saying that such suits – which are closer to

large class actions or complex multidistrict litigation proceedings than routine benefits litigation – could make claims administration a significantly more expensive enterprise.

The Court of Appeals' rule also could create confusion by inserting claims administrators into litigation about the meaning of plan language that they did not draft and, often, have no final authority to construe. An ERISA plan is, of course, a contract between the plan and its participants. *See US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1549 (2013) ("Courts construe ERISA plans, as they do other contracts, by 'looking to the terms of the plan' as well as to 'other manifestations of the parties' intent.' " (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989))). Disputes about the meaning of that contract arise between the real parties in interest: the plan and the plan participants. Yet, under the Court of Appeals' rule, third parties with no direct financial interest in the outcome of that dispute – mere claims administrators – could find themselves the target of litigation meant to determine the meaning of the plan and its terms.

Similarly, the Court of Appeals' rule could create uncertainty about who will pay any adverse judgments against claims administrators. As noted in the Petition, some Circuits permitting suits against *plan* administrators have likened their role to that of a trustee who can be ordered to pay funds from a trust's assets. *See* Pet. 10 (quoting *Hahnemann Univ. Hosp. v. All Shore, Inc.*, 514 F.3d 300, 308 (3d Cir. 2008)).

That rule is sensible in many instances, as the plan administrator and the plan sponsor are one and the same unless the plan document specifies otherwise. *See* 29 U.S.C. § 1002(16).

Claims administrators generally have no corresponding right to access the plan's assets, however. Instead, they often are limited to withdrawing funds from a special bank account that contains only a few days' worth of anticipated claims payments. *See, e.g.*, DE 424-1, p. 6; DE 424-2, p. 6. Thus, if a claims administrator were ordered to pay a substantial judgment, that judgment presumably could be enforced against the administrator itself, requiring it to expend its own assets to pay benefits it never owed (which it may or may not be able to recover from the plan).

These added uncertainties undoubtedly bring added costs, which will be borne by everyone involved. Claims administrators will bear these costs directly, of course. Plan sponsors will be affected, too, because they will either have to pay more to administer a self-funded plan, or will face increasing pressure to forgo the benefits of self-funding for a more costly fully-insured plan. Even plan participants will be impacted by higher premiums and/or reductions in benefits. In short, no one will be immune from the added costs that the Court of Appeals' rule would impose on the marketplace.

These harsh consequences are entirely unnecessary. There is no dispute that, under any Circuit's

rule, section 1132(a)(1)(B) benefits claims may be brought against plans and plan administrators. *See* Pet. at 10-15 (summarizing differing views of the Courts of Appeals). Thus, a plan participant can always bring suit against one (or more) parties even if he cannot sue a mere claims administrator – who, in any event, is not obligated to pay those claims and generally does not have access to plan funds to satisfy judgments.

Indeed, it appears that the benefits of the Court of Appeals' rule inure primarily – if not exclusively – to plaintiffs and attorneys wishing to aggregate otherwise disparate claims arising under separate plans with different terms into multi-plan actions that approximate complicated class actions and multi-district litigation proceedings. Those attorneys can leverage the breadth of a claims administrators' client base by including as many claims as possible in a single case, hoping to put pressure on the administrator and the plans to settle instead of litigating a sprawling case that could stretch on for years – as this case has done without advancing beyond the dispositive motion stage.

Moreover, because claims administrators often operate in numerous states, plaintiffs wishing to exploit the Circuit split at issue here may simply file suit in one of the courts that permits ERISA suits against mere claims administrators. *See, e.g.*, *North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182 (5th Cir. 2015). Only this Court can end that costly practice of litigation arbitrage and restore

the national uniformity ERISA was meant to provide. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."). This Court should grant the petition and reverse the Court of Appeals' judgment, clarifying that only entities that actually owe benefits may be sued under 29 U.S.C. § 1132(a)(1)(B).

CONCLUSION

For the foregoing reasons, the Court should grant the petition for a writ of certiorari.

Respectfully submitted,

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