No. 17-1744

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

LOUIS J. PETERSON, D.C.,

Plaintiffs-Appellees,

v.

UNITEDHEALTH GROUP INC.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Minnesota

BRIEF FOR THE SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLEES

NICHOLAS C. GEALE
Acting Solicitor of Labor

THOMAS TSO
Counsel for Appellate and Special Litigation

G. WILLIAM SCOTT
Associate Solicitor
for Plan Benefits Security

SUSANNA BENSON
Senior Attorney
Office of the Solicitor
Plans Benefits Security Division
U.S. Department of Labor
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210
(202) 693-5682

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QUESTION PRESENTED

UnitedHealth Group ("United") is one of the world's largest health insurers. It adjudicated and paid health claims for plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, et. seq.. At times, United believed it overpaid a healthcare provider for services rendered to a plan participant. United could have pursued the provider directly to recoup the alleged overpayment. Instead, United took the payment it admits was due to the same provider for services rendered to a different plan participant in a different plan and kept it for itself, rather than pay the provider as required by the plan. That practice deprived this second participant of benefits to which he was entitled and exposed him to potential liability to the provider for the services rendered. This practice is described as "cross-plan offsetting."

The question certified for interlocutory appeal is:

Whether United acted reasonably in interpreting ERISA-covered plans to permit cross-plan offsetting?

THE SECRETARY'S INTEREST

The Secretary of Labor bears primary responsibility for interpreting and enforcing Title I of ERISA. Sec'y of Labor v. Fitzsimmons, 805 F.2d 682, 698 (7th Cir. 1986) (en banc). In this capacity, he has a strong interest in ensuring that

courts correctly and uniformly interpret ERISA and give appropriate deference to the Department of Labor's relevant interpretive guidance.

STATEMENT OF THE CASE

A. Factual Background[1]

Plaintiffs Dr. Louis Peterson and Riverview Health Institute ("Plaintiffs") are out-of-network providers who provided services to patients insured by ERISA-covered health plans administered by United. United Br. 2. United administers fully-insured health plans, for which United collects insurance premiums from the employer's plans and then uses its own funds to pay claims. It also administers self-insured plans, for which United uses the funds drawn from the employer which sponsors the plan and the sponsor's employees to pay claims. Louis J. Peterson v. UnitedHealth Group, Nos. 14-CV-2101, 15-CV-3064, --- F.Supp.3d ---, 2017 WL 991043 at *1 (D. Minn. 2017); see, e.g., Boyle v. Anderson, 68 F.3d 1093, 1097 (8th Cir. 1995) ("The [self-insured] plans are funded through contributions by the covered workers and their employers."). In both arrangements, United is responsible for adjudicating benefit claims and many aspects of the plan's administration. Peterson, 2017 WL 991043 at *1. It is undisputed that United is an ERISA fiduciary to both the self-insured and fully-insured plans. United Br. 31 (acknowledging it was granted broad discretion over

[1] These facts are derived from the District Court Opinion and undisputed facts in the record.

plan administration); United Br. 29 (requesting deference as a fiduciary). Fully-insured plans account for 22 percent of United's claim payments, the remainder come from self-insured plans. Peterson, 2017 WL 991043 at *1.

United's health insurance plans generally cover both in-network and out-of-network healthcare providers. United Br. 2. In contrast to in-network providers, out-of-network providers do not have a pre-existing contractual relationship with any employer-sponsored health plan or United; their relationship with the employer-sponsored health plan or United is through the patient who is a plan participant. Id.; see, e.g., Schoedinger v. United Healthcare of Midwest, Inc., 557 F.3d 872, 874-75 (8th Cir. 2009) (describing "out-of-network" relationship). The patient-participants assign their rights to benefits under the health plan to the out-of-network providers so that the providers may pursue reimbursement for their services directly from the health plan. Peterson, 2017 WL 991043 at *3. Both Plaintiffs are pursuing claims as assignees of the ERISA plan participants. Separate Appendix of Appellants (SAPX), Vol. 1 pp. 205-213, 214-230. The Plaintiff-providers filed their assigned claims with United. Peterson, 2017 WL 991043, at *3. United paid the claims but later determined that it had overpaid the providers. United Br. 2. Instead of seeking recoupment of the alleged overpayments directly from Plaintiff-providers, United engaged in "cross-plan offsetting," a practice it started in 2007. Peterson, 2017 WL 991043 at *4.

In this case, United recouped the alleged overpayment to a provider by withholding a payment due to the same provider for services rendered to a different plan participant in a different ERISA-covered plan and keeping it for itself. Id. To recoup this overpayment using a subsequent payment admittedly due to the provider from a self-insured plan, United transferred to itself the funds from the self-insured plan due to the provider and did not pay the provider. Those funds typically consisted of contributions from the plan sponsors, i.e., the employers, and their employees. Id. To recoup the overpayment using a subsequent payment to the provider from a fully-insured plan, United simply kept the money it would have paid to the provider. Id.

The parties refer to the plans that overpaid the provider as "A plans." Id. The plans United used to recoup overpayments through withheld or diverted plan payments are "B plans." Id. None of these plans explicitly authorized cross-plan offsetting. Id. at *6. The district court noted that "[i]n this litigation, every Plan A—that is, every plan that made overpayments—was fully insured . . . . Conversely, the majority of the Plan Bs -- that is, the majority of plans from which the overpayments were recovered -- were self-insured. . . . In other words, every one of the cross-plan offsets at issue in this litigation put money in United's pocket, and most of that money came out of the pockets of the sponsors of self-insured plans." Id. at *4. In effect, for the offsets at issue, United withheld payments from

self-insured plans (typically funded by the plan sponsor and its employees) and diverted those payments to reimburse itself for overpayments United alleges it made from its own account on behalf of fully-insured plans. As a result, the Plan B participants were denied benefits from Plan B to which United admitted they were entitled and the participants were exposed to liability to the provider for the services rendered.

B. Procedural History

Riverview Health Institute and Dr. Peterson filed separate suits against United as assignees of their patients, alleging that United violated its fiduciary duties under ERISA and the terms of their patients' plans by engaging in cross-plan offsetting. Plaintiffs contend that United breached its fiduciary duty of loyalty and illegally diverted plan assets to itself. Peterson, 2017 WL 991043 at *3. The two cases were consolidated.

The district court found that United did not reasonably interpret the Plan Bs to permit cross-plan offsetting. Peterson, 2017 WL 991043 at *10. The court applied the factors outlined in Finley v. Special Agents Mutual Benefits Association, 957 F.2d 617 (8th Cir. 1992), to determine the reasonableness of United's interpretation. The Finley factors are: "[(1)] whether [the] interpretation is consistent with the goals of the Plan, [(2)] whether [the] interpretation renders any language in the Plan meaningless or internally inconsistent, [(3)] whether [the

plan] interpretation conflicts with the substantive or procedural requirements of the ERISA statute, [(4)] whether [the administrator] has interpreted the relevant plan language consistently; and [(5)] whether the interpretation is contrary to the clear language of the Plan." 957 F.2d at 621.

After applying these factors, the court found that (1) "most of the plans contain specific overpayment and recovery language that would be rendered meaningless" if the plans were interpreted to permit cross-plan offsetting, a practice not discussed in the plans; (2) United had not consistently interpreted any plan language to permit cross-plan offsetting but only looked for authority in the plan language after it got sued; and (3) cross-plan offsetting raised "serious concerns under ERISA, especially in this situation, where United administers all of the plans but insured only some of the plans." Peterson, 2017 WL 991043 at *10. Based on these factors, the court found United's plan interpretation unreasonable, and the practice of cross-plan offsetting not authorized by the plan documents. Id.

This Court granted the petition for interlocutory appeal. Id. at *11-12; Order, 04/06/2017. The Secretary argues in this brief that United's cross-plan offsetting violates ERISA.

SUMMARY OF THE ARGUMENT

1. United's practice of cross-plan offsetting violated United's fiduciary duties under ERISA to act exclusively in the plan participants' interests and to

provide participants their plan benefits and was self-dealing prohibited by ERISA. United denied benefits to participants and exposed them to the risk of personal financial liability and harm. When United refused to pay legitimate claims on behalf of the participants of one plan ("Plan B") in order to recoup overpayments on behalf of different participants in a separate plan ("Plan A"), United burdened the participants in Plan B with the obligation to pay for services that should be covered by their plan. United's conduct harmed the Plan B participants to further the interests of unrelated participants in other plans. Moreover, these transactions were structured by United to allow United to profit by recouping its own alleged overpayments for its fully-insured plans that are funded through its own accounts with payments from self-insured plans that are funded by plan sponsors and their employees. United failed to act in the exclusive interests of Plan B participants or for the purpose of providing them benefits as required by ERISA and engaged in self-dealing transactions explicitly prohibited by ERISA.

2. United's defenses are meritless. United cites inapposite case-law and regulatory guidance, while ignoring case-law and guidance that found similar transactions violated ERISA's fiduciary duties and were prohibited by ERISA. United also asserts three justifications: (a) United's conflict-of-interest is permitted; (b) the practice is easier for United to recoup overpayment and,

therefore, benefits its customers; and (c) United obtained "negative consent" from the plans for this practice. Each defense fails.

a. While a conflict-of-interest is permissible under ERISA in some circumstances, United was not just conflicted, but acted on interests adverse to the plan and its participants in clear violation of ERISA.

b. United fails to refute the district court's conclusion that participants are exposed to an unjustified risk of financial liability. United's speculation about benefits to its customers as a whole does not justify United's violation of its statutory duties to protect individual plan participants from a risk of harm just to recoup its unrelated overpayments.

c. No consent can absolve United of its statutory obligation to satisfy its fiduciary duties. United mistakenly relies on regulatory guidance that concerns "negative consent" in distinctly different circumstances concerning entities that are not fiduciaries.

ARGUMENT

United Unreasonably Interpreted the Plan Documents to Permit Cross-Plan Offsetting Because the Practice Violates ERISA

A. Standard Of Review

Whether a fiduciary's interpretation of the plan document is contrary to ERISA is reviewed de novo. Eisenrich v. Minn.Retail Meat Cutters & Food Handlers Pension Plan, 574 F.3d 644, 648 (8th Cir. 2009). "Because the Plan may

not disregard federal law, any decision that is 'erroneous as a matter of law' is an abuse of discretion and cannot stand." Id. "Although we must defer to the Plan's reasonable interpretation of the Plan itself, we owe no deference to the Plan's interpretation of controlling law." Id. This standard governs the review and outcome in this case; there is no need to rely on the Finley factors.

This de novo standard of review is especially appropriate because ERISA does not permit a fiduciary to adhere to interpretations of plan documents that violate ERISA and renders void any plan provision that relieves a fiduciary of his responsibilities. See ERISA sections 404(a)(1)(D) and 410(a), 29 U.S.C. §§ 1104(a)(1)(D) and 1110(a) ; see also Fifth Third Bancorp v. Dudenhoeffer, 134 S. Ct. 2459, 2468-469 (2014); Central States, Se. & Sw. Areas Pension Fund, 472 U.S. 559, 568 (1985) ("trust documents cannot excuse trustees from their duties under ERISA"). If a practice violates ERISA, the "reasonableness" of a fiduciary's plan interpretation is irrelevant.

B. United's Practice Of Cross-Plan Offsetting Violates ERISA

United violated its duty of loyalty under ERISA section 404 and engaged in a prohibited transaction in violation of ERISA section 406 by cross-plan offsetting. As a fiduciary, United has a duty to "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries and--(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii)

defraying the reasonable expenses of administering the plan." ERISA section 404(a)(1)(A)(i), (ii), 29 U.S.C. § 1104(a)(1)(A)(i), (ii) (emphasis added). This is known as ERISA's fiduciary duty of loyalty. See generally Pegram v. Herdrich, 530 U.S. 211, 224–25 (2000) (describing this duty as derived from the "fundamental" duty of loyalty in trust law). United bears this fiduciary duty not just to a plan but also to each plan participant. ERISA 404(a)(1)(A)(i), 29 U.S.C. § 1104(a)(1)(A)(i). ERISA also prohibits a plan fiduciary from dealing with the assets of the plan in the fiduciary's own interest and from acting in any capacity on behalf of a party whose interest is adverse to those of the plan or plan participants in transactions with the plan. ERISA § 406(b)(1)-(2), 29 U.S.C. § 1106(b)(1)-(2);[2] see also Braden v. Wal-Mart Stores, Inc., 588 F.3d 585, 602 (8th Cir. 2009) (applying ERISA Sections 404 and 406). In short, a fiduciary cannot represent both sides in a transaction between a plan and another party, including another plan to which he is a fiduciary. 29 U.S.C. § 1106(b)(2). As the Third Circuit explained in Cutaiar v. Marshall, 590 F.2d 523, 530 (1979), in discussing a fiduciary that acted on behalf of two plans in a transaction with each other, section 406(b)(2) requires that a plan "must be administered *without regard for the interest of any*

[2] "A fiduciary with respect to a plan shall not -- (1) deal with the assets of the plan in his own interest or for his own account, (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries." 29 U.S.C. § 1106(b)(1)-(2).

other plan." (emphasis added). "Fiduciaries acting on both sides of a . . . transaction cannot negotiate the best terms for either plan. . . . each plan deserves more than a balancing of interests. Each plan must be represented by trustees who are free to exert the maximum economic power manifested by their fund whenever they are negotiating a commercial transaction." Id. Furthermore, ERISA also strictly prohibits a fiduciary from dealing in these transactions in its own interests. 29 U.S.C. § 1106(b)(1). Based on the clear statutory text, United's practice of cross-plan offsetting violated these fundamental protections.

As the district court found, United's practice exposed the Plan B participant, whose medical bills were not paid because of an offset, to financial liability for healthcare costs that should have been covered by his plan, because the out-of-network provider could "balance bill" the participant for costs left unpaid by Plan B when United diverted the Plan B's payment to itself. Peterson, 2017 WL 991043 at *8; 32nd St. Surgery Ctr., LLC v. Right Choice Managed Care, 820 F.3d 950, 956 (8th Cir. 2016) (describing "balance billing"). United does not dispute this fact, conceding that out-of-network providers like Plaintiffs may "balance bill" their patients as a result of United's cross-offsetting practice. United Br. 40. United presents no legal or factual reason the district court's conclusion that United's practice imposes this risk of harm on participants is erroneous. Id. The participant's risk of not receiving benefits due and then incurring the risk of

financial liability for covered services is clearly a harm United must prevent as a fiduciary. See Shea v. Esensten, 107 F.3d 625, 628 (8th Cir. 1997) (fiduciary has a duty to protect participant from a known risk of harm); see also Chao v. Merino, 452 F.3d 174, 182 (2d Cir. 2006) ("If a fiduciary was aware of a risk to the fund, he may be held liable for failing to investigate fully the means of protecting the fund from that risk."). This specific harm has been recognized by other courts. See Wirth v. Aetna U.S. Healthcare, 469 F.3d 305, 309 (3d Cir. 2006) (recognizing that benefits are not fully paid to the beneficiary when the plan seeks reimbursement because they are "under something of a cloud"). Likewise, the Plan Bs, funded by sponsoring employers and employees, have an interest to ensure that their plan participants' benefits are truly paid and that the participants are not under a cloud of liability for medical bills that are undisputedly covered by Plan Bs.

In addition to this risk of harm and the plan's interest in protecting its participants, the district court also identified an underlying conflict of interest when claims administrators like United administer both fully and self-insured plans. Peterson, 2017 WL 991043 at *8. "As the single biggest payor of claims [, because it pays more claims than the individual self-insured plans], United's personal stake in cross-plan offsetting dwarfs that of any self-insured plan. An administrator in this circumstance [, United] has every incentive to be aggressive about looking for overpayments from its own fully insured plans (which

overpayments can be recovered from self-insured plans) and less aggressive about looking for overpayments from self-insured plans (which overpayments might be received from fully insured plans)." Id. To recover overpayments made by fully-insured plans from self-insured plans, United withholds the payment to providers from the self-insured plans and diverts them to reimburse United's overpayment on behalf of a fully-insured plan to that same provider; in the process, a payment from an employer funding the self-insured plan is diverted to United as reimbursement for United's overpayment made from its own pockets. United thereby deals with self-insured plans in its own interests. United acts as the "judge, jury, and executioner" for its own claim to recoup alleged overpayments. Peterson, 2017 WL 991043 at *3. United does not dispute that the potential for bias exists, but it disputes its impact and extent and claims it took steps to mitigate potential bias. United Br. 43-44. By executing these transactions, United committed a prototypical self-dealing transaction in violation of the duty of loyalty and ERISA's prohibited transaction provisions at section 406(b)(1) and (2) as these transactions are adverse to the self-insured plans and their participants while also benefiting United as their fiduciary.

In fact, United benefited from all the overpayment recoupments. Peterson, 2017 WL 991043 at *4. All 60 Plan As that allegedly overpaid service providers were fully-insured plans, plans for which United made the original benefit payment

from its own accounts. Id. In the overwhelming majority of the cross-plan offsets at issue, the relevant Plan B was a self-insured plan, so the recoupments came from funds contributed by a plan sponsor or its employees and were intended to go to the provider but were diverted to reimburse United's alleged overpayment to the provider for services to a Plan A participant. Id. In other words, "every one of the cross-plan offsets at issue in this litigation put money in United's pocket, and most of that money came out of the pockets of the sponsors of self-insured plans." Id. United's internal documents confirm this intent. Id. The district court stated that United's September 2004 internal documents "gush" that the new cross-plan offset system "[a]llows recovery of fully insured overpayments on self-funded claim payments!" Id. at 4. The court also referenced United's August 2004 presentation, which stated, "[c]rossing policies for bulk recovery helps recover FI [fully insured] dollars faster." Id. Finally, the court quoted a United 2005 chart showing emphatically a "[f]ully insured o/p recovery on a [self insured] payment!" Id. The evidence of United benefitting from these offset transactions by design only confirms its violations of the duty of loyalty and the prohibited transaction provisions as United plainly represented plans in transactions to further its own self-interest.

An analogous case in the Ninth Circuit reinforces this conclusion. Standard Ins. Co. v. Saklad, 127 F.3d 1179, 1182 (9th Cir. 1997). In Saklad, a disability

insurer issued a lump-sum settlement to a claimant in 1984. Id. at 1180. Two years later, the insurer discovered that the claim was fraudulent when it received another disability claim from the same person, who was now employed at a different company. Id. The second disability claim was legitimate, but the insurer obtained a judgment against the employee for the prior fraudulent claim and sought to setoff the payments under the first plan against any obligations owed to the claimant under the second disability plan. Id. The court found that while the insurer was a fiduciary of both plans "and the insurer of the benefits under both, the fact remain[ed] that each plan is a separate entity." Id. at 1181. The court held that setoff was illegal because "[a]n ERISA fiduciary cannot refuse to pay a beneficiary of a plan by using a setoff from a wholly separate source of debt, be that an ordinary debt or a debt to a wholly separate ERISA plan." Id. at 1182. This decision is analogous to this case because it barred offsets that benefit the insurer of one plan at the expense of a participant of another and supports the district court's analysis.

In conclusion, United violated its fiduciary duties and committed prohibited transactions when it imposed on innocent participants a financial risk and potential harm in order to recoup an alleged, unrelated overpayment for another plan.[3]

[3] Offsetting for in-network providers is distinguishable, because in-network providers typically have contractual relationships with the plans and insurers, removing any plan or participant interest in disputes over their payment amounts,

C. Department of Labor Advisory Opinions Support the Conclusion that United's Practice of Cross-Plan Offsetting Violates ERISA

The Department of Labor issued two Advisory Opinions ("AOs") that support the conclusion that United's cross-plan offsetting is prohibited by ERISA. AO 77-34, 1977 WL 5397, and AO 81-62A, 1981 WL 17785. AO 77-34 considered the question of whether a fiduciary could reduce benefits under one plan to remedy a participant's failure to repay overpayments from a sister plan. The Department stated that such conduct violated both ERISA sections 403(c)(1) and 404(a)(1), [29 U.S.C. § 1103(c)(1) and 1104(a)(1)] reasoning that "problems relating to another plan have no relevance to the plan in question." AO 77-34. The Department explained that "if the plan pays amounts to another plan to reimburse the other plan for erroneous payments . . . , such reimbursement would not constitute a use of plan assets for the exclusive purpose of providing benefits to participants in the plan . . . . Therefore, such payment would contravene the requirements of section 404(a)(1)(A) and section 403(c)(1) of ERISA [exclusive

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which are paid pursuant to those in-network contracts. See, e.g., Brown v. BlueCross BlueShield of Tenn., Inc., 827 F.3d 543, 549 (6th Cir. 2016); Lone Star OB/GYN Assocs. v. Aetna Health Inc., 579 F.3d 525, 530-31 (5th Cir. 2009); Pascack Valley Hosp. Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393 (3d Cir. 2004). In these situations, the plan participants are not subject to financial risk because these contracts typically bar balance billing. Id.

purpose provisions]."[4] Likewise, Advisory Opinion 81-62A considered whether funds from more than one benefit plan may be commingled. In response, the Department cautioned that "if assets of more than one employee benefit plan are held in a common vehicle, a separate accounting of the interest of each plan in such vehicle must be maintained in order to avoid using the assets of one such plan to pay benefits to participants and beneficiaries of another such plan in contravention of section 403(c)(1) and 404(a)(1)(A)." United does not dispute the district court's characterization of the analogous facts in this case: "In stark terms, cross-plan offsetting involves using assets from one plan to satisfy debt allegedly owed to a separate plan," Peterson, 2017 WL 991043 at *7. Thus, based on analogous facts, the Department has interpreted ERISA to forbid a fiduciary to multiple plans from using one plan to pay or recoup benefits for another, and this Court should accord Skidmore deference to the Advisory Opinions. Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon, 541 U.S. 1, 18 (2004).

D. United's Defense Of Cross-Plan Offsetting Is Meritless

1. United Cites Inapposite Authorities

United mistakenly relies heavily on Quality Infusion Care, Inc. v. Health Care Service Corp., 628 F.3d 725 (5th Cir. 2010). United Br. 32-33. In that case,

[4] Like ERISA section 404, ERISA section 403(c)(1), 29 U.S.C. § 1103(c)(1), requires that plan assets "shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan."

the Fifth Circuit did not decide or even consider whether this practice violates ERISA. Instead, the court considered only the "narrow legal dispute" as to whether the practice was permitted under state contract law. Quality Infusion Care, 628 F.3d at 726-28. The court concluded that under the terms of each plan, the insurer had a contractual right to deduct the overpayment amount paid to a provider on a patient's claim from the amount it owes that same provider for a subsequent claim against one of the other two plans. Id. at 728. The court found that "no language in any of the three plans required [the insurer] to confine its contractual set off rights to deductions from subsequent benefit payments to the same patient under the same plans." Id. at 730. As the district court correctly observed in the present case, "whatever the merits of the Fifth Circuit's approach, it is not the approach of the Eighth Circuit," which requires courts to consider the fiduciary duties imposed by ERISA when interpreting ERISA plan provisions. Peterson, 2017 WL 991043 at *9; see also Central States, 472 U.S. at 568; Eisenrich, 574 F.3d at 648; see generally Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008) ("ERISA imposes higher-than-marketplace quality standards on insurers").

United also incorrectly relies on Pilger v. Sweeney, 725 F.3d 922 (8th Cir. 2013), which permitted *same*-plan offsets with respect to the *same* participant, but this decision does not extend to *cross*-plan offsets for *different* participants. In

Pilger, this Court allowed a pension fund to recoup overpayments mistakenly paid to retired participants by withholding future payments to those same participants of the same plan. 725 F.3d at 924. As the district court stated, Pilger dealt with offsets involving "not only the same plan, but the same beneficiaries." Peterson, 2017 WL 991043 at *9. Although the pension plan contained no language expressly permitting the recoupment through withholding, this Court held that the fund was authorized by "the broad language granting Defendants discretion to take remedial action on behalf of the [plan]." Pilger, 725 F.3d at 926. In sum, Pilger only addressed the plan's relationship to a specific participant. The rationale in Pilger rested on the plan's ability to ensure each participant does not receive more than the share of plan benefits he deserves. "Fiduciary obligations extend primarily to the plan as it relates to all beneficiaries, not just to individual claimants." Barnhart v. UNUM Life Ins. Co. of Am., 179 F.3d 583, 589 (8th Cir. 1999). This principle clearly does not apply here where a plan participant is *deprived* of the benefits to which he is entitled in order to reimburse an overpayment for a different plan and a different participant.

2. United's Purported Justifications Cannot Override ERISA

United also raises other meritless justifications: (a) United's conduct in the cross-plan offset program arose from a permissible conflict-of-interest; (b) United's

program benefits its customers overall; and (c) United's conduct is justified because no party contested its overpayment claims.

a. United's Violations Are Not a Permissible "Conflict-of-Interest"

United is correct that ERISA permits conflicts of interest in some circumstances, but the pertinent question here is how the fiduciary acts in light of this conflict, not whether a conflict exists. See Pegram, 530 U.S. at 225 ("ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions."). The answer to that question in ERISA is clear. "The central issue is the independence of the plan fiduciaries who must always be able to act solely for the benefit of those whose funds are entrusted to them." Leigh v. Engle, 727 F.2d 113, 132 n.29 (7th Cir. 1984) (emphasis added). Fiduciaries must take practical actions to avoid acting on interests adverse to the plan.

United's actions fit within well-established ERISA cases where a conflicted fiduciary violated ERISA by acting on behalf of its own or other interests to the detriment of the plan or its plan participants. See, e.g., Shea, 107 F.3d at 628; Braden, 588 F.3d at 598; Cutaiar, 590 F.2d at 530. As in those cases, United executed transactions for the plans it administered in which United represented both sides of the transactions and chose to harm the plan and participants by

exposing participants to a risk of financial liability while reaping benefits from those transactions.

United incorrectly relies on Glenn, which addressed how a structural conflict of interest affects the judicial deference accorded to conflicted fiduciaries who interpret plan documents. 554 U.S. at 115. Glenn is irrelevant here, where United has *acted* in violation of ERISA by executing transactions against the plan and participants' interests and depriving participants of their benefits to further United's own interests. Obviously, no deference is accorded to the fiduciary defending an action that is itself a clear violation. E.g., Eisenrich, 574 F.3d at 648 ("Whether the Plan's decision is erroneous as a matter of law is a question we review de novo.").

b. Alleged "Overall" Benefits To Its Customers Cannot Justify Violations

United also argues that cross-plan offsetting benefits all customers, United Br. 42, and therefore the practice must benefit each plan and its participants. Neither facts nor logic support this conclusion, as the district court found. United cannot show that no plans or participants were burdened with a risk of harm by this practice, see Peterson, 2017 WL 991043 at n.5 (discussing the absence of evidence). Nor is such a result likely as nothing in United's description of its cross-plan off-setting program ensures each plan or participant is guaranteed to only benefit from the practice. Cf. United Br. 17-18. United's obligation under ERISA is to keep an "eye single" to the plans' and participants' interests in all

fiduciary actions and plan transactions and to provide participants the benefits promised in the plan documents. Leigh, 727 F.2d at 123; 29 U.S.C. § 1104(a)(1)(A) and (D). Instead of ensuring that United provides benefits to participants, United deprives plan participants of their benefits on behalf of other plans in order to reap a financial benefit for itself. As the district court concluded, the evidence presented establishes United as the true beneficiary from the cross-plan offset practice, Peterson, 2017 WL 991043 at *4.

c. Failure to Contest Overpayment Is Irrelevant

United also contends on appeal that because neither the provider or the Plan A patient-participant disputed United's claim that it made an overpayment, United is justified in recovering an overpayment from the provider's subsequent Plan B patient-participant, see United Br. 10-12; see also Peterson, 2017 WL 991043 at *6, fn. 8. United misses the point. United cannot burden an innocent participant with debt due to an overpayment United made on behalf of a different participant in a different plan for its own self-interest. United's ERISA violations cannot be absolved simply by instituting some mechanism to protest overpayments.

Specifically, the provider's or his Plan A patient's alleged failure to dispute the overpayment has no bearing on the risk of harm imposed on the Plan B patient from whom the overpayment amount is taken, because that Plan B patient cannot force the provider or the Plan A patient to dispute the overpayment. Moreover, as

United admits, overpayments could be caused by United's own "administrative mistakes," United Br. 10, making it unfair for providers or patients to bear the harm from those alleged mistakes by placing the burden on the provider or patient to challenge these "mistakes" while also imposing on the providers' subsequent patients the risk of financial liability and harm for these mistakes. Id.

Furthermore, even assuming cross-plan offsetting was permitted, no mechanism actually exists for the Plan B participants to challenge an overpayment made on behalf of different participants in Plan A. Absent any contractual relationship with out-of-network providers, United has no legal basis to require providers to pursue administrative remedies to dispute the overpayment claims and, in some circumstances, providers may seek remedies under state law to resolve the disputes. Cf. Access Mediquip LLC v. UnitedHealthcare Ins. Co., 662 F.3d 376, 386 (5th Cir. 2011) (alleged right to payment by out-of-network provider did not depend on the terms of the ERISA plan but on oral promises), reinstated, 698 F.3d 229 (5th Cir. 2012) (en banc); McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc., 857 F.3d 141, 150 (2d Cir. 2017) (same). United is also free to contract with frequent out-of-network providers to address these specific issues, by insulating the patient and his plan from these disputes similar to in-network providers. See 32nd St. Surgery Ctr., LLC, 820 F.3d at 956 ("ancillary contracts"); supra note 3. United did not do so here.

3. Plans Cannot Consent To United's Practice Of Cross-Plan Offsetting Through "Negative Consent"

United argues that cross-plan offsetting is permitted because the plan sponsor or "relevant fiduciary decision-maker" provided "negative consent" to the practice through a 2007 letter. United Br. 45. In support of this "negative consent" argument, United relies on three Department of Labor Advisory Opinions, Nos. 2003-09A, 2001-02A, and 1997-16A, which, for reasons discussed below, are inapposite. Moreover, United fails to address more pertinent Advisory Opinions, discussed supra at Section C.

United's reliance on the "negative consent" Opinions is incorrect for several reasons.[5] First, whether a plan sponsor or other fiduciary consented to cross-plan offsetting is immaterial here, where United's practice at issue violates ERISA. Negative consent can be relied on in certain instances concerning otherwise legitimate transactions as explained below, but cannot be relied upon to allow an ERISA violation to stand. Therefore, United cannot use the Department's Advisory Opinions to absolve it from fiduciary responsibility for a claims payment practice that violates ERISA. As a fiduciary, United will always have the responsibility not to commit fiduciary breaches even if another fiduciary permitted the conduct whether by direct or negative consent. See 29 U.S.C. §§ 1104 (listing

[5] Courts accord heightened deference to agencies when they interpret their own guidance even in amicus briefs. Cf. Auer v. Robbins, 519 U.S. 452, 462-63 (1997).

fiduciary obligations required by statute), 1105(a)(3) (co-fiduciary liability for failure to remedy a known breach by another fiduciary); 1110(a) (with irrelevant exceptions, "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility . . . for any . . . duty under this part shall be void as against public policy"). As we noted earlier, if plan documents cannot permit fiduciary breaches, see Dudenhoeffer, 134 S. Ct. at 2468, it would make no sense if fiduciaries could obtain consent to commit such breaches.

Second, the Advisory Opinions on "negative consent" concern the narrow context where a non-fiduciary service provider seeks confirmation that reliance on "negative consent" in activating an investment default option on behalf of the plan will not render the service provider a fiduciary with respect to that decision. For example, in Advisory Opinion 2001-02A, a service provider to a 401(k) pension plan asked the Department whether it would become a fiduciary if it implemented a "default option" after presenting the "option" to plan administrators in two letters and the administrator did not reply. The Department agreed that the service provider would not be serving as a fiduciary for activating that option "as long as the plan fiduciary actually chooses the default allocation." AO 2001-02A. The Department noted that "whether a fiduciary actually chooses the default allocation is an inherently factual question." Id.; see also AOs, 2003-09A (applying the principle to bundled service arrangement where service provider offers proprietary

mutual funds along with other services but does not become a fiduciary if the provider discloses the options and obtains negative consent); 1997-16A (applying the principle to a reallocation of assets or investment menus). According to these Opinions, the service providers under the facts in those opinions could rely on negative consent for those limited purposes only if the provider (1) disclosed all material information, (2) gave the plan sponsor a reasonable time to consider whether to opt out of the new menu, and (3) remained neutral and took care to ensure that each client's decision was truly his own. AOs. 97-16A, 2003-09A.

This case presents an entirely different situation. Here, United is already a fiduciary who must adhere to his ERISA duties. United cannot absolve responsibility for its violations by pointing to its clients' negative consent. Thus, the Advisory Opinions are irrelevant.

The Department agrees with the district court that even assuming the Advisory Opinions were relevant, the evidence showed that United did not meet the conditions required by the Advisory Opinions for negative consent to be effective. United "did not fully and accurately disclose all material information to its clients. Some clients may not have received *any* information about cross-plan offsetting, and those who did get information were not told that United itself would be the largest single beneficiary of the cross-plan offsetting system that it was proposing." Peterson, 2017 WL 991043 at *10 (emphasis in original). When

United did present some information on its cross-plan offsetting practice, United "certainly did not remain neutral and take care to ensure that each client's decision was truly its own; instead, United 'strongly encouraged' its clients to participate in cross-plan offsetting." Id.

Full disclosure and consent cannot excuse the violation here because neither a fiduciary, a plan sponsor, nor anyone else can consent to ERISA violations and harm participants. It is difficult to imagine how an effective disclosure regime would work, even if ERISA permitted United's cross-plan offsetting process, which it does not. Hypothetically, if United wanted to provide its clients meaningful disclosure of its cross-plan offsetting practice, United would have to reveal the risk of harm to plan participants. United would have to disclose that the practice exposes plan participants to risks of personal financial liability for their covered medical claims because United may have to recoup overpayments, sometimes caused by its own mistake, made to a provider on behalf of a different participant in a different plan. United would also have to disclose that plan participants cannot predict whether a medical claim will be paid in full, because a claim may be subject to a random and retroactive offset unrelated to them, their plan, or their covered medical claim. Nothing in the record identifies any such disclosure by United.

CONCLUSION

For the foregoing reasons, the Secretary requests that this Court affirm the district court's ruling that United's plan interpretations were unreasonable and its cross-plan offsetting practice, as described in this case, violates ERISA.

Respectfully submitted,

NICHOLAS C. GEALE
Acting Solicitor of Labor

G. WILLIAM SCOTT
Associate Solicitor
for Plan Benefits Security

THOMAS TSO
Counsel for Appellate Litigation

_/S/ Susanna Benson____
SUSANNA BENSON
Senior Attorney
Plans Benefits Security Division
Office of the Solicitor
U.S. Department of Labor
200 Constitution Ave., N.W., N-4611
Washington, DC 20210
(202) 693-5682

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 29(d) and 32(a)(7)(B)-(C), I certify that this amicus brief uses a mono-spaced typeface of 14 characters per inch and contains 6,475 words.

Dated: September 5, 2017

/s/ Susanna Benson
SUSANNA BENSON
Senior Attorney
United States Department of Labor
Plan Benefits Security Division
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210

CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of September, 2017, I electronically filed the foregoing Brief of the Secretary, United States Department of Labor, as Amicus Curiae, in Support of Plaintiffs-Appellants, with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ Susanna Benson
SUSANNA BENSON
Senior Attorney
United States Department of Labor
Plan Benefits Security Division
200 Constitution Ave., N.W., N-4611
Washington, D.C. 20210