UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

JULIE A. SU, Acting Secretary of Labor,

Plaintiff,

v.

BCBSM, INC., d/b/a Blue Cross and Blue Shield of Minnesota,

Defendant.

Case No. 0:24-cv-00099-JRT-TNL

AMICUS BRIEF OF PATIENTRIGHTSADVOCATE.ORG, INC. IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Amicus Curiae PatientRightsAdvocate.org, Inc. is a nonprofit corporation. It has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

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INTEREST OF AMICUS CURIAE[1]

PatientRightsAdvocate.org, Inc. (PRA) is a 501(c)(3) nonprofit, non-partisan organization that provides a voice for consumers—patients, employees, employers, and taxpayers—to have competition, transparency, and meaningful choices in healthcare. PRA advocates for patients to have easy, real-time access to complete health information and real price transparency. PRA further aims to support patients and employers in ensuring that health plan assets are spent prudently, transparently, and in the best interests of health plan participants.

PRA believes, and research has shown, that transparency and accountability will usher in price, quality, and outcome differentiation and allow for competition and innovation. Empowered with such information, patients and employers will shop for the best quality of care at the lowest possible price. Consumers will then be in control through choice to reduce their costs of care and coverage, and eliminate the large disparities charged to different patients for the same care. With price certainty, patients can protect their health and wealth for themselves, their families, and the generations to come.

PRA embraces free market principles. PRA believes that price transparency will foster a competitive, functional marketplace and restore trust and accountability to the healthcare system. PRA's website, PatientRightsAdvocate.org, shines a light on both the problem and the free-market solution, and features patients and innovative employers who are already saving substantially by using price transparent providers.

[1] No party's counsel authored this brief in whole or in part, and no one besides amicus and its counsel contributed money to fund the brief's preparation or submission.

PRA submits this brief on behalf of consumers and patients to ensure that their voices are heard and their interests represented in this critically important case. PRA has extensive experience with healthcare-related issues and has participated in prior litigation germane to its interests, including litigation involving ERISA and federal price-transparency regulations. *See, e.g.*, *Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.*, 66 F.4th 307 (1st Cir. 2023); *Am. Hosp. Ass'n v. Azar*, 983 F.3d 528 (D.C. Cir. 2020); *Am. Hosp. Ass'n v. Azar*, 468 F. Supp. 3d 372 (D.D.C. 2020).

INTRODUCTION AND SUMMARY OF ARGUMENT

Blue Cross Blue Shield of Minnesota (BCBS) wants to have it both ways. First, it wants discretion to negotiate contracts that reimbursed providers for $66.8 million in state taxes between 2016 and 2020, while passing on these costs to the employee healthcare plans that it administers. But BCBS also wants to implement this self-serving scheme without any express contractual authorization from the Plans. It wants the Plans to remain under the misimpression that BCBS is simply negotiating the best possible prices for the Plans while keeping the Plans in the dark—unaware of significant costs that BCBS is secretly passing on through its control over the invoicing process. BCBS also wants to have zero accountability for this behavior. It wants the Court to declare that nobody is harmed by what BCBS has done and that BCBS has no fiduciary responsibility for its abuses of discretionary authority.

This Court should reject BCBS's effort to dismiss this important case at the pleading stage. The Employee Retirement Income Security Act of 1974 (ERISA) imposes strict fiduciary duties on any entity that "exercises any discretionary authority … respecting [the] management of" an employee benefit plan or that "has any discretionary authority or …

responsibility in the administration of [the] plan." 29 U.S.C. §1002(21)(A). A third-party administrator may thus be deemed a fiduciary under ERISA if it determines—as BCBS did here—how much the plan will pay for covered care. *See, e.g.*, *Peters v. Aetna Inc.*, 2 F.4th 199, 229-32 (4th Cir. 2021); *Pipefitters Loc. 636 Ins. Fund v. Blue Cross & Blue Shield of Mich.*, 722 F.3d 861, 866-67 (6th Cir. 2013).

BCBS's contrary arguments are untenable. It asserts that as long as an employee benefit plan contracts with a plan administrator to negotiate the cost of care with its providers, then *nobody*—neither the plan administrator who negotiates and sets the price of claims, nor the benefit plan that pays the claims—has *any* fiduciary duty under ERISA to ensure that those claims are priced and billed prudently and in the best interests of plan participants.

That is not the law, and such a ruling would enable plan administrators—as BCBS did here—to inflate healthcare prices and thus drain self-funded plan assets, all while knowing that there is no accountability under ERISA. The Court should reject such a crabbed reading of ERISA's fiduciary obligations. ERISA accountability for what BCBS did here, and other similar abuses by health insurers, is badly needed to protect workers, prevent waste, protect health plan assets, and reform our broken healthcare system.

Indeed, this case is only the tip of the iceberg. Third-party administrators such as BCBS are notorious for wasting health plan assets by overpricing and overcharging claims from their network healthcare providers; keeping secret the prices charged for healthcare under the plan; and not taking basic steps to ensure that beneficiaries can identify which providers in the network offer the highest quality and most cost-efficient care. Without ERISA's fiduciary protections for plan participants, such abuses and inefficiencies will continue to plague our

insurance system, betraying ERISA's promise to workers and their families. BCBS's motion to dismiss should be denied.

ARGUMENT

I. BCBS was an ERISA fiduciary, and it cannot escape essential fiduciary duties by contracting around them.

BCBS argues that it was not a fiduciary when it used its control over the claims process to increase the price of claims to recoup its losses from agreeing with its providers to pay their state revenue taxes. According to BCBS, because the Plans agreed to pay the claim prices that BCBS negotiated with its providers, BCBS is absolved of ERISA fiduciary status over its tax-shifting scheme. *See* Mot. 4-8, 17, 19-25. That is wrong on several levels, and if upheld it would eviscerate an important federal safeguard against the types of abuses alleged in this case.

A. BCBS is wrong to assert that it was not a fiduciary under the contract.

BCBS administers self-funded employee health plans in Minnesota. Compl. ¶7. Under its contracts[2] with the Plans, BCBS is the named fiduciary over processing, approving, and denying claims. *Id.* ¶11; *see* Mot. Ex. 2 (2016 Summary Plan Description) at 10. The contracts also give BCBS discretion over setting the price of claims that it bills to the Plans. *See* Compl. ¶12; Mot. Ex. 2 at 11 (the "allowed amount" the Plan must pay "for a given covered service" is the "negotiated amount" between BCBS and its providers, and BCBS may "adjust the negotiated amount … at the time [the] claim is processed"). BCBS routinely exercises this discretion by, for example, wrapping its providers' tax liability into claim amounts before billing the claims to the Plan. *See* Compl. ¶¶22-24; Mot. Ex. 3 at 22.

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[2] BCBS's has two contracts with each plan: an administrative service agreement and a summary plan description. *See* Mot. 4.

BCBS's contracts with the Plans also limit BCBS's discretion over what it may bill as a "claim." *See* Compl. ¶¶25-30. A "claim" includes only "services," which is defined to include only "*health* service[s] or suppl[ies]." Mot. Ex. 2 at 11-13 (emphasis added); *see* Compl. ¶26 (the administrative service agreements with BCBS state that a "claim" is a "a request for payment of *medical* services" (emphasis added)); Opp. at 3-4. It does not include a provider's taxes. *See id.*; Opp. at 6-7; Opp. Ex. 2 at 41. BCBS does not dispute that its contracts with the Plans say nothing about the Plans having to reimburse BCBS for paying its providers' taxes. *See* Mot. at 16-17 (arguing that BCBS can charge the Plans for its providers' taxes simply because the contracts let BCBS "establish its network without any obligation to employers/Plans" and negotiate claim amounts with its providers). Thus, BCBS's tax-shifting scheme was not "'follow[ing] a specific contractual term'" between BCBS and the Plans; rather, the scheme was "'a unilateral action respecting plan management or assets without the plan or its participants having an opportunity to reject [BCBS's] decision.'" *Rozo v. Principal Life Ins. Co.*, 949 F.3d 1071, 1073 (8th Cir. 2020) (defining when a "provider acts as a fiduciary").

By processing, approving, and denying claims, and increasing the price of the claims that it billed to the Plans to secretly include the cost of its providers' taxes, BCBS clearly "exercise[d] … discretionary authority … respecting [the] management of" the Plans and "ha[d] … discretionary authority or … responsibility in the administration of" the Plans. 29 U.S.C. §1002(21)(A); *see, e.g.*, *Peters*, 2 F.4th at 210-11, 229-32 (insurer "operat[ed] as an ERISA fiduciary" when it used "dummy codes" and "bundled rates" to "bury" its providers' administrative fees in claims so that the insurer could secretly invoice the fees to the plan); *Pipefitters*, 722 F.3d at 866-67 (insurer acted as a "fiduciary," not a "'pass-through,'" when it

negotiated discount prices with in-network providers, invoiced the plan the full amount, and used the savings from the provider discount to pay a state tax); *Negron v. Cigna Health & Life Ins.*, 300 F. Supp. 3d 341, 355-56 (D. Conn. 2018) (finding that Cigna "went beyond any ministerial action by disregarding the plan terms to charge excessive cost-sharing amounts"). "A reasonable factfinder could conclude that" BCBS "imposed" its providers' taxes on the Plans "at [BCBS's] discretion, but without authority under the Plan[s] and in direct violation of the [contracts]." *Peters*, 2 F.4th at 231.

According to BCBS, its tax-shifting scheme was "spelled out" in its contracts with the Plans because the contracts say (1) that BCBS will provide the Plans with a network of services at "'negotiated pricing,'" (2) that BCBS "'owes no duties or obligations to'" the Plans in "'negotiating, contracting, or enforcing'" these prices in its contracts with providers, (3) that BCBS may "'determine, in its discretion, whether a Claim is eligible to be paid in accordance with the criteria of the Plan,'" and (4) that the Plans agree in advance that BCBS's "'charges and fees'" for "'services'" are "'reasonable.'" Mot. at 2, 5-8, 19-20.

But that is wrong both factually and legally. None of these provisions expressly "spell out" BCBS's authority to make the Plans pay inflated claim amounts to reimburse BCBS for paying its providers' taxes. At best, BCBS's fee-shifting scheme is an exercise of discretion regarding a matter not directly addressed by the contracts. *See id.* at 5-6 (BCBS has "discretion" to decide whether claims are eligible for payment); Compl. ¶12 (BCBS has "discretionary authority to grant and deny claims … and to determine the specific amount payable by the Plans"); Mot. Ex. 2 at 11 (BCBS may "adjust the negotiated amount … at the time [the] claim is processed"). At worst, BCBS's scheme flatly violates the contracts by forcing the Plans to

pay costs that are not "medical" services. *See id.* Ex. 2 at 11-13; Compl. ¶26. In either case, ERISA confers fiduciary status over the exercise of such discretion, and BCBS's efforts to get this suit dismissed at the pleading stage must fail. *See, e.g.*, *Peters*, 2 F.4th at 210-11, 229-32; *Pipefitters*, 722 F.3d at 866-67.

B. ERISA overrides any contract that would disclaim fiduciary duties from a party that is exercising fiduciary functions.

Even if BCBS's interpretation of the *contracts* were correct, ERISA's protections would override it. If BCBS and the Funds could implicitly agree to let BCBS manipulate claim amounts to cover the cost of any self-serving contracts that BCBS makes with its providers—thereby letting BCBS drain Fund assets at the expense of the Fund beneficiaries—then the Funds' health plans would not be a "promise" of benefits but an "illusion." S. Rep. No. 93-127, p.15 (Apr. 18, 1973), bit.ly/3d9WDpO. Under BCBS's view, once a fund agrees to let a plan administrator set and process claim amounts, then *nobody* is a fiduciary anymore over that process because *nobody* "performs a [fiduciary] function" over it. *Peters*, 2 F.4th at 228. This would effectively allow a plan and its third-party administrator to contract away ERISA's fiduciary duties, absolving *anyone* of the duty to ensure that one of the most important aspects of a healthcare plan—the cost of claims—is set fairly, charged transparently, and administered solely for the benefit of employee beneficiaries.

Congress prohibited such arrangements that would "contract around the requirements of ERISA." *E.g.*, *Borroughs Corp. v. Blue Cross Blue Shield of Mich.*, 2012 WL 3887438, at *4 (E.D. Mich.). ERISA was "'landmark reform legislation,'" *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting S. Rep. No. 93-127, p.36), enacted to address "malfeasance and maladministration in [employer] plans" and ensure such plans would "become a reality rather

than an illusion," S. Rep. No. 93-127, p.15. Congress thus designed ERISA as "a comprehensive statute" to "promote the interests of employees and their beneficiaries." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). It sets "uniform standards, including rules concerning … fiduciary responsibility," *id.* at 91, with the "principal object" of protecting plan beneficiaries—not the economic interests of employers or insurance companies, *Boggs v. Boggs*, 520 U.S. 833, 845 (1997); *see* 29 U.S.C. §§1001(c), 1001b(c). ERISA is "remedial legislation," so it is "liberally construed to effectuate Congress's intent to protect plan participants." *Brown v. J.B. Hunt Transp. Servs., Inc.*, 586 F.3d 1079, 1086 (8th Cir. 2009).

It is axiomatic that remedial legislation cannot be contracted away but must "be applied even to those who would decline its protections." *Tony & Susan Alamo Found. v. Sec'y of Lab.*, 471 U.S. 290, 302 (1985). Congress designed ERISA so that plan fiduciaries could not "evad[e] ERISA's regulatory scope, thereby depriving employees of the protections of that statute." *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 16 (1987); *see, e.g.*, *Borroughs*, 2012 WL 3887438, at *4. In other words, neither plan sponsors nor insurance companies that provide administrative services to a plan can get around ERISA fiduciary status simply by "characteriz[ing] [their] arrangement … as a service agreement between two companies." *Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740, 746 (6th Cir. 2014).

For good reason. ERISA "sets *minimum standards* for most … health plans in private industry to provide protection for individuals in these plans." U.S. Dep't of Labor, *ERISA*, bit.ly/3ADwuHP (emphasis added). Putting bare minimum standards in law '"was an essential step in the protection of worker [plans].'" *Chami v. Provident Life & Accident Ins. Co.*, 188 F. Supp. 2d 1084, 1088 (N.D. Ind. 2002) (quoting 1978 Message of Pres. Carter). Those standards

"assure American workers that they may look forward with anticipation" to the benefits of their health plan "without fear that … [they] will be lacking in the necessities to sustain them as human beings within our society." S. Rep. No. 93-127, p.13. ERISA is not a guarantee of "the highest quality care" or "perfec[t]" prices, but it does require a fiduciary "loyalty," ""care, skill, prudence, and diligence"' in the management and administration of a plan. Amy B. Monahan & Barak D. Richman, *Hiding in Plain Sight: ERISA's Cure for the $1.5 Trillion Health Benefits Market*, Yale J. on Reg. (forthcoming 2024) (manuscript at 11-12, 49), bit.ly/49rXHwr.

ERISA's standards also "increase stability within the framework of our nation's economy," and they "restore credibility and faith in the … plans designed for American working men and women," which "encourage[s] rather than diminish[es] efforts by management and industry to expand pension plan coverage and to improve benefits for workers." S. Rep. No. 93-127, p.13 Accomplishing those lofty goals required sweeping legislation by Congress that imposed fiduciary duties on those who manage and administer health plans—duties that are ""the highest known to the law."' *Chao v. Hall Holding Co., Inc.*, 285 F.3d 415, 426 (6th Cir. 2002). BCBS's arguments, if accepted, effectively make these duties optional and subject to being contracted away, thereby directly thwarting Congress's express objectives in ERISA. That would be unacceptable "at a time when the burdens of health insurance are intolerable" and "the costs of employer-provided health plans have eaten into worker take-home pay, forced layoffs, and exacerbated economic inequality." Monahan & Richman, *supra* at 6.

The dangers of such a ruling are readily apparent in this case. BCBS overcharged the Fund's employee beneficiaries for health insurance claims by $66.8 million and actively

concealed its inflated rates from plan participants. Compl. ¶¶21-33. BCBS thus did "the bidding of its in-network providers," rather than protecting the interests of the Plans and their participants. *See id.* ¶¶47-48. Such behavior flagrantly violates BCBS's duty to act "solely" in the interest of plan beneficiaries. 29 U.S.C. §1104(a)(1). But there will be only a limited ability to police such misconduct if the court adopts BCBS's extraordinarily narrow definition of fiduciary status and lets BCBS contract around its fiduciary duties under ERISA. Most employers are unable to "shop around" for third-party administrators of their self-funded plans because there may be only one or two options.

Worse still, according to BCBS, beneficiaries have *nowhere* to turn for relief even if the provider taxes should not have been billed to the Plans: the Funds were not fiduciaries because they had no discretion over setting claim amounts, and BCBS was not a fiduciary because it had absolute discretion. *See* Mot. at 17 ("In signing the SA, Plans agreed that … Blue Cross's charges for provider services were reasonable."); *id.* at 28 ("Blue Cross followed contract terms when including Tax expenses in its negotiated … amounts, in pricing each claim, and when invoicing Plans."). Simply put, adopting BCBS's interpretation of ERISA would eviscerate the broad statutory protections that Congress promised to participants in employee benefit plans and immunize from ERISA liability even egregious misuse of plan assets.

This Court should reject the central error in BCBS's argument—the idea that ERISA simply takes a health insurer's contracts as given and does not subject those contracts to any fiduciary duties. True, BCBS has contracts with the Plans to process claims for the Plans, but ERISA still imposes fiduciary duties on BCBS to exercise prudence and loyalty in the discretionary authority it has and exercises over claims. 29 U.S.C. §1002(21)(A). That is also

why the Department has standing to sue. BCBS's decision to embed its providers' taxes into the price of claims was not harmless merely because BCBS made that decision under the auspices of a contractual relationship with the Plans. *See* Mot. 16-17. Instead, BCBS used and abused its discretion to secretly drain millions of dollars from the Funds, a clear harm to the Funds and their beneficiaries. BCBS's attempt to avoid any responsibility for this by repeatedly explaining that it was implementing its contracts with its providers, *see* Mot. at 16-17, 20-21, 24-25, 28-29, misses the point. ERISA *regulates* BCBS's provider contracts to the extent those contracts concern BCBS's discretionary authority in the administration and management of a healthcare plan. *See* 29 U.S.C. §1002(21)(A).

II. ERISA's fiduciary protections are needed to police third-party administrator contracts that hide healthcare prices from beneficiaries and obstruct beneficiaries from finding high-quality, cost-efficient care.

It is imperative for this Court to deny BCBS's motion to ensure that plan participants and their representatives have the tools needed to fight wasteful and anticompetitive practices and ensure much-needed legal accountability in the healthcare market. Third-party administrators of self-funded insurance plans, such as BCBS, are notorious for undermining patients' interests by entering into contracts with healthcare providers in their network that "impede competition and increase prices" for services. Nat'l Acad. for State Health Pol'y, *NASHP Model Act to Address Anticompetitive Terms in Health Insurance Contracts* (Apr. 12, 2021), bit.ly/3RsdfHL. Those insurer-provider contracts often include harmful clauses such as "anti-steering clauses, anti-tiering clauses, all-or-nothing clauses, and gag clauses," making it harder for beneficiaries to compare healthcare prices and find lower-cost, better-quality care. *Id.* If the third-party administrator can evade fiduciary status simply by asserting that it is abiding by

the terms of its provider contracts, as BCBS seeks to do here, many of those anticompetitive and anti-consumer practices will be immunized from any scrutiny under ERISA.

A. Gag clauses

Third-party administrators routinely enter contracts with providers that include "gag clauses, or price secrecy contract provisions, [that] prohibit a contractual party from disclosing price or other information." Katherine L. Gudiksen *et al.*, *Preventing Anticompetitive Contracting Practices in Healthcare Markets* 47 (Sept. 8, 2020), bit.ly/3TyiAiP. This case is no different. BCBS kept its tax-shifting scheme secret from the Plans and required providers in its Policy & Procedure Manual to "[m]aintai[n] [the] confidentiality of Blue Cross' contractual and financial arrangements." *See* Mot. Ex. 3 at 7. Gag clauses like these "prevent patients, competing providers, and employers from knowing the negotiated provider payment rates," based on the "erroneous assumption that provider payment rates are trade secrets." Gudiksen, *supra* at 47. By cloaking the negotiated charges in a "shroud of secrecy," gag clauses make it impossible for health plan administrators to "assess the relative value of healthcare services from competing providers," and "hinder [them] from effectively using outside firms to analyze their claims for waste or low-value care." *Id.* at 47-48. Gag clauses also "amplify" the harm of other clauses—for example, by "conceal[ing] the magnitude of variation in provider rates so that the effects of an anti-steering clause remain hidden." *Id.* at 48.

Notably, ERISA itself expressly prohibits such gag clauses. ERISA specifically requires plan fiduciaries to provide employees, upon request, "a copy of the latest updated summary[,] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, *contract, or other instruments under which the plan is established or operated*." 29 U.S.C.

§1024(b)(4) (emphasis added). This language plainly includes information about contracts between plan administrators and network providers, including the negotiated rates that plan participants are charged for care under the plan.

Moreover, the Consolidated Appropriations Act of 2021 amended ERISA to expressly provide that any "group health plan or health insurance issuer … may not enter into an agreement with a health care provider, network[,] or association of providers" that would restrict the insurer from "providing provider-specific cost or quality of care information or data" to the plan sponsor or beneficiaries. 29 U.S.C. §1185m(a)(1). Insurers and health plan administrators must also submit annual disclosures to the HHS Secretary attesting their compliance with this requirement. *Id.* In short, all participants in employer-sponsored health plans have a federal-law right under ERISA to know the price of their care upfront, and there is no basis for employers, third-party administrators, or providers to claim that this critical information must be kept secret.

Unfortunately, however—as this case demonstrates—gag clauses and price secrecy remain pervasive, thereby allowing providers to charge grossly inflated prices for care and opening the door to waste, fraud, and abuse. In a properly functioning market, both patients and plan administrators would "need to compare price and quality measures among providers for many of their efforts to control the cost of … healthcare services." Gudiksen, *supra* at 47-48. Gag clauses, however, prevent patients and employers from "us[ing] pricing information to make more informed decisions when choosing which providers to use for both health care and network inclusion." *Id.* at 52. This lack of price transparency deprives patients of potential cost savings that would improve their overall plan benefits and allow them to shop for high-

quality, cost-effective care. *See id.* This case starkly illustrates the problems resulting from a lack of transparency, as BCBS actively concealed its tax-shifting scheme and inflated claim amounts to benefit itself and its provider network at the expense of beneficiaries.

Price concealment is a concern that goes far beyond this case. There can be no meaningful reform of America's healthcare system without price transparency. Price transparency lowers prices, empowering consumers to choose the best quality care at the lowest price. It also rewards those providers who serve their patients most efficiently, thereby putting downward pressure on prices of high-cost providers, and spurring innovation. *See generally* Brian Blase, Ph.D., *Transparent Prices Will Help Consumers and Employers Reduce Health Spending*, Galen Inst. & Tex. Pub. Pol'y Found. (Sept. 27, 2019), bit.ly/2H3viC9; U.S. Dep'ts. of HHS, Treasury, & Labor, *Reforming America's Healthcare System Through Choice and Competition* (Dec. 3, 2018), bit.ly/3bl9obg.

Indeed, for the handful of healthcare services that consumers typically purchase out of pocket, those services are characterized by robust competition, falling prices, and increasing quality. For example, LASIK eye surgery is rarely covered by insurance, so prices are advertised prominently, and surgeons must compete for patients and consumer dollars. Due to this price transparency, inflation-adjusted prices of LASIK surgery fell by about 25% between 1999 and 2011 even as quality significantly improved. *See* Devon M. Herrick, Pol'y Rep. No. 349, *The Market for Medical Care Should Work Like Cosmetic Surgery* 8-9, Nat'l Ctr. for Pol'y Analysis (May 2013), bit.ly/2S6Lmcw.

Price drops due to price transparency also have "spillover effects" for the entire market, including patients who do not comparison shop. A 2017 study found that when California

implemented a reference pricing system and price transparency for state employees, higher-cost facilities began to lower their prices for everyone, even for those who did not comparison shop. *See Reforming America's Healthcare System* 96-97. Similarly, a New Hampshire study revealed that when only 8% of patients used transparent prices to comparison shop, there were spillover effects for all patients because of downward pressure on high-cost providers. *See Transparent Prices Will Help Consumers* 14.

In sum, a lack of price transparency is one of the foundational flaws in the dysfunctional U.S. healthcare system. ERISA contains multiple tools to promote transparency and attack unlawful gag clauses, yet BCBS's narrow reading of fiduciary status would significantly hinder efforts to use ERISA to attack these anticompetitive and anti-consumer policies.

B. Anti-steering and anti-tiering clauses

Another common anticompetitive provision in provider contracts is the "anti-steering clause," which "prohibit[s] insurance carriers from giving incentives to patients to utilize cheaper or higher value healthcare facilities." Amy Y. Gu, *[Case Brief] Atrium Health Settlement Encourages Enforcement of Anti-tiering/Anti-steering Clauses in Healthcare Contracts* (Nov. 16, 2020), bit.ly/3cDfA3U. By agreeing not to "steer" plan participants to "lower-cost, higher-value providers" in the network, plan administrators like BCBS remove a "primary mechanism … [to] control costs." Gudiksen, *supra* at 39. Without the ability to "direct patients to higher-value providers or have patients pay a higher co-pay for seeing such providers," employee beneficiaries often end up receiving lower-quality, more expensive care. *Id.* at 41. An anti-steering clause is thus an expressly "'anti-incentive' clause[]" designed to "lessen competition"

and increase provider profits at the expense of plan participants and the employers who pay the bills under a self-funded arrangement like the one at issue here. Gu, *supra*. The only entities who ultimately benefit from these clauses are high-cost, low-quality providers. *See, e.g.*, Michelle Yost Hale *et al.*, *Anti-Steering Provisions in Healthcare Contracts: Anticompetitive or Acceptable?*, Am. Bar Ass'n (Jul. 18, 2022), bit.ly/3RqBzud (such clauses "inhibit the development of new insurance programs," "reduce competing providers' investments," and "inhibit insurers' ability to accentuate certain aspects of patient choice, such as prioritizing cost-effectiveness").

A health insurer or third-party administrator that adopts anti-steering clauses in its contracts with providers wastes the assets of self-funded plans on needlessly overpriced claims from high-cost providers. Such behavior falls well short of its duty to manage plan assets prudently, to act "solely in the interest of the participants and beneficiaries" for the "exclusive purpose of … providing [them] benefits," and "defraying reasonable expenses of administering the plan." 29 U.S.C. §1104(a)(1).

Insurance companies and plan administrators also routinely make contracts with their network providers that contain "anti-tiering" clauses that harm patients by preventing the insurer from "tiering" the network. Without these clauses, insurers would normally have "a tiered network, [where] the insurer separates providers into distinct tiers based on cost and quality and assigns corresponding co-pay amounts for each tier." Gu, *supra*. "A low-cost and high-quality provider is considered better value that would provide savings for both the insurer and the patient," so that provider would be "assign[ed] … to a higher tier with lower copay to incentivize patients to choose them." *Id.* Another alternative is "a narrow-network plan,"

which "enables insurers to exclude higher-cost providers from the provider network." *Id.* Both forms of "tiered" plans can help "control costs" for patients. Gudiksen, *supra* at 39. "[T]iering … can have procompetitive effects on both the demand side, as patients choose higher-value providers, and on the supply side, as providers reduce their prices and improve their quality"—all while "preserv[ing] consumer choice." *Id.* at 40.

"Anti-tiering" clauses, however, "inhibit payers from placing a system hospital in anything other than the most favorable cost-sharing tier." Gu, *supra.* In other words, these clauses "prohibit an insurer from placing a health system on a lower-value tier or, in some cases, from even signaling to patients that there are higher-value alternatives." Gudiksen, *supra* at 41. This "insulate[s] providers from market forces by eliminating price signals that encourage patients to choose higher-value care," to the detriment of beneficiaries, with "few procompetitive explanations [to] justify [it]." *Id.* at 46. Like anti-steering clauses, these anti-tiering clauses violate the insurer's duty of care and loyalty to the plan beneficiaries. *See, e.g.*, 29 U.S.C. §1104(a)(1).

C. All-or-nothing clauses

Another way provider contracts routinely disadvantage patients is through so-called "all-or-nothing clauses, which require a health plan that wants to contract with a particular provider or affiliate in a provider system to contract with all other providers in that system" and to pay "higher … rates for the entire system." Gudiksen, *supra* at 22. This typically happens when there is an outsized provider in a region, such as a large and prominent hospital, that the health plan "must have within its network to be commercially viable because of geographic proximity, referrals, legal obligations, reputation, specialized services, or a lack of an alternative

in a geographic location." *Id.* "As a result of [this] must-have status," the provider "can demand supracompetitive rates for all providers and facilities within [its] system." *Id.* And once providers obtain this "must-have" status, they use "all-or-nothing" clauses to stamp out competition. *See id.* at 23.

These clauses are the product of a market failure, "an extreme form of a concept known as tying, or the practice of a dominant provider utilizing their market power over services in one market (the tying product) to pressure health plans to buy their services in other markets (the tied product)." *Id.* This gives the plan administrator a powerful incentive to agree to all-or-nothing clauses and makes it unlikely it will reject those clauses without a contrary legal obligation, such an ERISA fiduciary duty to act in the patient's interests.

* * *

In short, today's healthcare marketplace is riddled with anticompetitive practices that result in higher prices, lower quality, and a dysfunctional market that fails to reward low-cost, high-value providers and punish high-cost, low-value providers. Patients and employers have achieved some victories against these practices, including a major settlement with Sutter Health in 2021 that resulted in more price and quality transparency and an elimination of all-or-nothing clauses. *See* Cal. Dep't of Justice, *Attorney General Bonta Announces Final Approval of $575 Million Settlement With Sutter Health Resolving Allegations of Anti-Competitive Practices* (Aug. 27, 2021), bit.ly/3U0Ps3V. But far more remains to be done, and ERISA is one of the most potent tools for reform.

Yet granting BCBS's motion to dismiss based on a narrow interpretation of fiduciary status under ERISA would allow many wasteful and anticompetitive provisions in insurer-

provider contracts to evade meaningful scrutiny. This Court should deny BCBS's motion to ensure that ERISA remains available to plan participants to ensure that plan assets are not being wasted and patients are not being harmed by secretive, self-serving, overpriced, and anticompetitive provider contracts.

CONCLUSION

The Court should deny Defendant's motion to dismiss.

Dated: April 22, 2024

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Per Local Rule 7.1(f)(2), this brief contains 5,286 words in proportionally spaced font, excluding the caption, tables, signature block, and certificates of compliance. This word count was generated by Microsoft Word version 16.83 and is less than half the 12,000 words that Local Rule 7.1(f)(1) gives each party. *Cf.* Fed. R. App. P. 29(a)(5) (allowing amici to file briefs half the size of the parties' briefs). This brief also complies with Local Rule 7.1(h) because it is prepared in 13-point Garamond font and satisfies all other requirements of that rule.

Dated: April 22, 2024 *_/s/ Nicholas Nelson_*

CERTIFICATE OF SERVICE

If the Court grants the Project's motion for leave, this brief will be filed via this Court's ECF system, which will electronically notify all counsel of record. Because the Court has not yet ruled on that motion, this brief was emailed to all counsel of record on April 22, 2024.

Dated: April 22, 2024 *__/s/ Nicholas Nelson__*