No. 21-471

In the Supreme Court of the United States

JOHN DOE 1, ET AL., PETITIONERS

v.

EXPRESS SCRIPTS, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

Under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, a person is a "fiduciary" with respect to an ERISA plan "to the extent" that, as relevant here, "he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets" or "he has any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. 1002(21)(A). The questions presented are:

1. Whether a company that administers certain prescription-drug benefits for an ERISA plan is a "fiduciary" of the plan with respect to drug pricing if the company can affect the prices paid by the plan or its participants through negotiated agreements with third parties and the company enters into such an agreement that is applicable to a broad range of healthcare consumers and not just the specific ERISA plans at issue.

2. Whether fiduciary status based on a person's discretionary authority or control over the administration or management of a plan can be established where that discretion is conferred by contractual agreement.

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INTEREST OF THE UNITED STATES

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. This case under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., involves ERISA's definition of "fiduciary," 29 U.S.C. 1002(21)(A). It arises out of a series of contractual relationships concerning prescription-drug benefits under health benefits plans. Cf. 29 U.S.C. 1002(1)(A). When a plan participant purchases a prescription drug, at least "six entities [are] potentially involved": the participant, the plan, the plan's Pharmacy Benefits Manager (PBM), the pharmacy, the drug wholesaler, and

the drug manufacturer. Advisory Council on Employee Welfare & Pension Benefit Plans, *PBM Compensation and Fee Disclosure* 6 (Nov. 2014) (*PBM Report*), https://go.usa.gov/xus3p. "Generally speaking, PBMs serve as intermediaries between prescription-drug plans and the pharmacies that beneficiaries use." *Rutledge* v. *Pharmaceutical Care Mgmt. Ass'n*, 141 S. Ct. 474, 478 (2020). Under that arrangement, a PBM's "contracts with pharmacies" will specify the amount that the PBM will pay a pharmacy for filling prescriptions, and a PBM's contracts with prescription-drug plans will specify how the PBM is paid for supplying prescription drugs to the plans' participants through the pharmacies. *Ibid.* And in this case, there is an additional entity: Each relevant ERISA plan contracted with respondent Anthem, Inc. (Anthem), a national company, to administer certain aspects of each plan. Anthem, in turn, contracted with respondent Express Scripts, Inc. (ESI), a national PBM company, to perform the PBM portion of those services. Pet. App. 5a. The result is an "exceedingly complex" system of "[d]rug pricing" in which the terms of each entity's contractual relationships have the potential to affect the price of drugs ultimately paid by an ERISA plan and its participants. *PBM Report* 7; see *id.* at 8-10.

ERISA protects "the interests of participants in employee benefit plans and their beneficiaries" by, *inter alia*, "establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." 29 U.S.C. 1001(b). A fiduciary must perform its duties "solely in the interest of the [plan] participants and beneficiaries" "for the exclusive purpose" of "providing [them] benefits" and "defraying reasonable expenses of administering the plan"; must do so "in accordance with

the documents and instruments governing the plan"; and must exercise the "care, skill, prudence, and diligence" that a "prudent man" would use in similar circumstances. 29 U.S.C. 1104(a)(1)(A), (B), and (D).

ERISA provides that every employee benefit plan "shall be established and maintained pursuant to a written instrument" that provides for "one or more named fiduciaries" having "authority to control and manage the operation and administration of the plan." 29 U.S.C. 1102(a)(1); see 29 U.S.C. 1002(1) and (3). ERISA also defines the term "fiduciary" in "*functional* terms" to include "anyone else who exercises discretionary control or authority over the plan's management, administration, or assets." *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 251, 262 (1993); see 29 U.S.C. 1002(21)(A) (definition).

2. a. The relevant petitioners in this Court are two ERISA plan sponsors, Stamford Health, Inc. (Stamford) and Brothers Trading Co. (Brothers), and two individuals, John Doe Two and Robert Shullich. Pet. App. 25a-26a, 30a-33a.[1] Stamford and Brothers were sponsors of, and fiduciaries for, their self-funded ERISA plans that provided healthcare benefits to their employees. Pet. App. 31a-33a; C.A. App. 69-71. Unlike the sponsor of a fully insured plan that obtains an insurance contract to satisfy its obligations to plan participants, the sponsor of a "self-funded" plan is responsible for paying the cost, and it therefore bears the financial risk, of providing plan benefits. *Gobeille* v. *Liberty Mut. Ins.*

[1] Petitioners Doe One and Corrigan did not obtain healthcare benefits from plans covered by ERISA. C.A. App. 53, 68. Petitioners Burnett and Farrell participated in ERISA plans that did not obtain prescription-drug benefits through Anthem. Pet. App. 37a-39a.

Co., 577 U.S. 312, 317 (2016); see *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54, 61 (1990).

Doe Two and Shullich received healthcare benefits as participants in ERISA plans sponsored by their employers, MUFG Union Bank (MUFG) and AmTrust Financial Services (AmTrust). Pet. App. 25a-27a, 30a-31a. Under those plans, Doe Two and Shullich each made co-insurance payments equal to a predetermined percentage of certain prescription drugs' cost to his plan. Id. at 23a-24a.

b. Anthem offers insured healthcare plans to employers and individuals under which Anthem pays the cost of providing benefits in exchange for health-insurance premiums. See C.A. App. 42. Anthem also provides certain administrative services to self-insured healthcare plans pursuant to Administrative Services Only (ASO) agreements, under which Anthem collects fees for its services but is not responsible for paying the plan's healthcare-benefit costs. See *id.* at 42, 59-60. Anthem's fully-insured plans and ASO plans constitute, respectively, about 40% and 60% of Anthem's business. *Id.* at 44. Stamford, Brothers, MUFG and AmTrust each entered into an ASO agreement with Anthem to provide certain services, including PBM services, to their plans. *Id.* at 55, 65, 69-71.

Contracts between sponsors of self-insured plans and companies that provide PBM services typically include provisions governing the price that a plan will pay for prescription drugs. For example, a drug's "Average Wholesale Price" (AWP), as reported by a third-party national database company, "frequently provides the basis for pricing * * * between PBMs and plan sponsors" and thus for their "negotiated contract price" for prescription drugs. *PBM Report* 7. The AWP is usually

calculated to be 20% above "[t]he price at which drug manufacturers sell branded drugs to wholesalers," which is known as the drug's "Wholesale Acquisition Cost" (WAC). *Ibid.* A company providing PBM services may also set a "Maximum Allowable Cost" (MAC) for generic drugs—sometimes called a Maximum Reimbursement Amount (MRA)—which typically is the amount that the company will pay pharmacies for such drugs. *Id.* at 7, 10 (emphasis omitted). As a result, "PBM contracts with plan sponsors" may "base generic [drug] pricing [paid by a plan] on MAC" or "on a discount off AWP." *Id.* at 7; see, *e.g.*, *Chicago Dist. Council of Carpenters Welfare Fund* v. *Caremark, Inc.*, 474 F.3d 463, 467-468, 472-473 (7th Cir. 2007) (discussing ERISA plan's contracts with PBM that based brand-name drug prices for plan on AWP and generic prices on both AWP and MAC).

The "[t]raditional" contract model in this context is that a company providing PBM services "agrees to provide drugs to the plan at a specified aggregate rate which is usually stated as AWP minus a percentage," for instance, "AWP minus 16%." *PBM Report 7*, 10. Such an aggregate rate can serve to account for temporal and other drug-pricing variability that may make it difficult to negotiate fixed-dollar prices *ex ante*.

Petitioners' complaint (C.A. App. 41-178) does not contain allegations concerning any specific contract terms in Anthem's ASO agreements with Stamford, Brothers, MUFG, and AmTrust, and most of those contract terms are not in the record.[2] Anthem added to the

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[2] The complaint quotes Stamford's "plan documents" (not specifically Stamford's ASO agreement with Anthem) as stating that "The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem BCBS using prescription drug cost informa-

record limited excerpts from its ASO agreements with Stamford, *id.* at 199-204; Brothers (doing business as Victory Wholesale, *id.* at 213), *id.* at 206-213; MUFG, *id.* at 182-184; and AmTrust, *id.* at 195-197, that contain no or minimal information about prescription-drug pricing.[3] But the excerpts do state that each employer designated Anthem to serve as a fiduciary solely to determine or process benefits claims and/or appeals of adverse determinations under the employer's plan. *Id.* at 183, 196, 202, 208-209. Three of the contracts further provide that Anthem shall have no "fiduciary responsibility in connection with any other element of the administration of the Plan." *Id.* at 196, 202, 209; see *id.* at 184, 197, 203, 210-211 (similar).

c. ESI is the largest PBM in the United States. Pet. App. 15a. In December 2009, ESI and Anthem's predecessor corporation entered into a PBM Agreement providing that, for ten years, ESI would perform PBM services for Anthem by processing claims by participants who fill their prescriptions at retail pharmacies, directly filling prescriptions through ESI's mail-order pharmacies, and providing related administrative services. *Ibid.*

The 2009 PBM Agreement, C.A. App. 354-690 (as redacted), and the 2012 amendments thereto, *id.* at 324-

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tion provided by the [PBM]," C.A. App. 70, but identifies no other language from petitioners' plan documents.

[3] The excerpts suggest that Stamford would pay "[t]he amount charged to [it]" for covered services provided by "Vendor[s]," which would equal "the amount Anthem actually pa[id]" each vendor less any "discounts" detailed in provisions not in the record. C.A. App. 200, 204. The excerpts also suggest that Brothers would pay "the amount Anthem invoice[d] it for Prescription Drugs," *id.* at 207, 212, but do not identify how that provision was implemented. Nothing in the record addresses pricing under MUFG's or AmTrust's ASO agreements.

352 (redacted excerpts), include provisions governing ESI's charges to Anthem for prescription drugs. The redacted version of Section 5.4 of the agreement indicates that that pricing is "set forth in Exhibit A" to the agreement and that, if "the methodology used for calculating AWP" changes, the parties will modify "the terms of any financial relationship between [them] that relate to AWP." *Id.* at 422. The unredacted version of Section 5.4 and Exhibit A are filed under seal. See 6/7/2018 C.A. order. Another provision, Section 5.6 (C.A. App. 424), contemplates that Anthem will periodically "conduct a market analysis" during the ten-year agreement to "ensure that [it] is receiving competitive benchmark pricing." Pet. App. 18a-19a (citation omitted). If Anthem determines that the pricing is "not competitive," Section 5.6 provides that Anthem may propose new "pricing terms" over which ESI "agrees to negotiate in good faith," but that "any new pricing terms must be agreed to by [ESI] in writing" to become effective. *Id.* at 19a (citation omitted).

Anthem and ESI executed their 2009 PBM Agreement in conjunction with an agreement (C.A. App. 215-320) in which ESI purchased Anthem's in-house PBM companies (collectively, NextRx), *id.* at 240, 248. As a condition of that sale, ESI and Anthem agreed to execute the "PBM Contract" at closing. *Id.* at 220, 241-243; see Pet. App. 6a, 15a-16a. ESI allegedly "offered to pay $500 million" for the companies and then provide prescription medications at "lower prices" to Anthem during the ten-year PBM Agreement or, alternatively, "to pay $4.675 billion" upfront for the companies but "charge higher prices for prescription medications during the PBM agreement." *Id.* at 6a, 16a. Anthem chose the latter option. *Ibid.*; see C.A. App. 240.

3. a. Petitioners allege in their complaint (C.A. App. 41-178) that, under their plans' ASO agreements with Anthem, Anthem had both discretion to choose a PBM to provide prescription-drug-management services, *id.* at 44, and discretionary authority and control over their plans by "negotiating the terms of [a] PBM agreement [with ESI], purportedly for the benefit of the [p]lans," that "directly impacted the prices for prescription medications paid by the [p]lans and by plan participants," *id.* at 105. Petitioners further allege that the resulting PBM Agreement—through Section 5.6's "competitive benchmark pricing" provision—produced "inflated and excessive prices" as compared to "solely referring to prices that result from utilizing standard industry pricing metrics such as AWP," "MAC," and "WAC." *Id.* at 47-48. Petitioners also allege that the PBM Agreement enabled ESI to "exclusively set[] the prices for [the] prescription medications (subject to the terms and limitations of [that] Agreement)" and thereby "control[] what Anthem * * * charge[s]" self-funded plans and participants for drugs. *Id.* at 75-76; see *id.* at 104. Petitioners argue that the resulting higher drug prices that ESI charged Anthem under the PBM Agreement were passed on to the self-funded ERISA plans that entered ASO agreements with Anthem and to plan participants in their co-insurance payments. Pet. 10-11 (citing C.A. App. 47-48, 75-78, 104); see Pet. 3-4.[4]

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[4] Petitioners' allegations regarding the PBM Agreement are largely derived from allegations in Anthem's suit against ESI for purportedly overcharging Anthem for drugs under that agreement. See, *e.g.*, C.A. App. 41 n.1, 47, 79-102. The district court in that case recently entered partial summary judgment for ESI on Anthem's drug-pricing claims. *Anthem, Inc.* v. *Express Scripts, Inc.*, No. 1:16-cv-2048, 2022 WL 1558879, at *2, *5-*11 (S.D.N.Y. Mar. 31, 2022).

b. The district court dismissed petitioners' complaint. Pet. App. 13a-80a. As relevant here, the court concluded that petitioners' allegations were insufficient to establish that Anthem (*id.* at 58a-65a) or ESI (*id.* at 49a-58a) performed fiduciary functions with respect to ERISA plans when taking the alleged actions that petitioners challenged.

The district court determined that "Anthem's decisions to sell its PBM business and to contract the provision of PBM services out to ESI did not trigger fiduciary duties." Pet. App. 61a; see *id.* at 58a-65a. The court stated that although petitioners' allegations focused on Anthem's PBM Agreement with ESI, which allegedly produced higher drug prices, petitioners had failed to show that Section 5.6 of that agreement gave petitioners any "right under ERISA to receive 'competitive benchmark pricing'" or that Anthem otherwise violated any provision "requir[ing] [Anthem] to provide [petitioners] with certain pricing levels for prescription drugs." *Id.* at 61a, 64a.

The district court further determined that petitioners' allegations failed to show that ESI performed relevant fiduciary functions with respect to petitioners' plans. Pet. App. 49a-58a. The court rejected petitioners' contention that Section 5.6 of ESI's PBM Agreement with Anthem gave ESI discretion as a plan fiduciary over drug prices paid by plans and participants. *Id.* at 50a-54a. The court determined that ESI's drug prices under that agreement were "constrained by the more specific requirements of Section 5.4 and Exhibit A," *id.* at 54a, and that ESI's adhering to such "terms of a contract" is not an "exercise [of] discretionary authority," *id.* at 53a. Section 5.4, the court explained, "lays out additional pricing requirements and limita-

tions" and "contradicts [petitioners'] allegations that ESI had the discretion to set drug prices paid by [petitioners]." *Id.* at 51a & n.34; see C.A. Sealed App. 29-30 (sealed portion of order discussing the PBM Agreement).

4. The court of appeals affirmed in a nonprecedential summary order. Pet. App. 1a-12a.

The court of appeals rejected petitioners' argument that Anthem exercised discretion to "manage [petitioners'] prescription benefit," and thus acted as a fiduciary, when Anthem "negotiated the agreement to sell the NextRx Companies to [ESI] for a higher price knowing it would result in [ESI] charging a higher price for prescription drugs." Pet. App. 8a; see *id.* at 8a-10a. The court noted that under ERISA's "functional approach" to fiduciary status, a person is a fiduciary only when performing a fiduciary function, *id.* at 8a-9a, and that an entity is not a fiduciary when it makes a decision that "is, at its core, a corporate business decision, and not one of a plan administrator," *id.* at 10a (citation omitted). Here, the court concluded, "Anthem did not act as an ERISA fiduciary when it entered into the NextRx and PBM Agreements, even though its decisions may ultimately affect how much plan participants pay for drug prices." *Ibid.* The court supported that conclusion by citing and including a parenthetical quoting from a Sixth Circuit decision in a similar case, which stated that a company like Anthem did not act as a fiduciary in certain "'business dealings'" with providers that were "'generally applicable to a broad range of health-care consumers'" rather than "'directly associated with the benefits plan at issue.'" *Ibid.* (quoting *DeLuca* v. *Blue Cross Blue Shield*, 628 F.3d 743, 747 (2010)).

The court of appeals likewise rejected petitioners' arguments regarding ESI. Pet. App. 10a-12a. First, the court "agree[d]" with the district court that "when a PBM sets prices for prescription drugs pursuant to the terms of a contract, it is not exercising discretionary authority and therefore not acting as an ERISA fiduciary." *Id.* at 11a. The court further stated that "[e]ven fully crediting [petitioners'] allegations that the PBM Agreement provided [ESI] with extraordinarily broad discretion in setting prescription drug prices, at bottom the ability to set such prices is a contractual term, not an ability to exercise authority over plan assets." *Id.* at 11a-12a.

DISCUSSION

Petitioners contend (Pet. 18-37) that the court of appeals erroneously applied a categorical "business decision" exception to ERISA's definition of "fiduciary" in concluding that Anthem was not acting as a fiduciary. Petitioners further contend (Pet. 37-40) that the court erroneously determined that ESI was not a fiduciary on the ground that its ability to determine prices under a contract does not constitute the exercise of authority over plan assets. The court of appeals' reasoning is not entirely clear, and under one reading it may be erroneous at least with respect to Anthem. But it also appears that petitioners may misunderstand the court's rationale.

In any event, review by the Court is not warranted. The decision of the court of appeals does not conflict with any decision of this Court or any other court of appeals. And because the decision below is nonprecedential, the Second Circuit will be free to evaluate the issues here afresh in a future case. Moreover, this case would be a poor vehicle for the Court's review.

Meaningful analysis of Anthem's relationship with and obligations to the relevant ERISA plans with respect to drug pricing would require careful consideration of Anthem's ASO agreements with those plans, but the record here does not contain key contract provisions. And even before reaching the merits, the Court would need to address a threshold question of appellate jurisdiction that the court of appeals did not address and that has itself engendered a division of authority, which could prevent the Court from addressing the merits. No further review is warranted.

1. The court of appeals concluded that "Anthem did not act as an ERISA fiduciary when it entered into the NextRx and PBM Agreements, even though [Anthem's] decisions may ultimately affect how much plan participants pay for drug prices." Pet. App. 10a. The basis for that conclusion is not entirely clear. The court's parenthetical description of *DeLuca* v. *Blue Cross Blue Shield*, 628 F.3d 743 (6th Cir. 2010), however, suggests that the court may have concluded that Anthem did not act as a fiduciary in those transactions because they were "'business dealings'" "'generally applicable to a broad range of health-care consumers'" rather than "'directly associated with the benefits plan at issue.'" Pet. App. 10a (quoting *DeLuca*, 628 F.3d at 747).

a. ERISA defines fiduciary status in "*functional* terms," such that a "fiduciary" includes those "who exercise[] discretionary control or authority over the plan's management, administration, or assets." *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 251, 262 (1993). But a person is a fiduciary only "to the extent" that he has or exercises such authority. 29 U.S.C. 1002(21)(A). An ERISA fiduciary therefore may "wear different hats" and will be subject to fiduciary duties only when

wearing a fiduciary one. *Pegram* v. *Herdrich*, 530 U.S. 211, 225 (2000).

The question, then, is whether Anthem was acting as a fiduciary of petitioners' plans when it negotiated or implemented its ten-year 2009 PBM Agreement with ESI. The premise for fiduciary status would be that Anthem had discretionary authority or control to manage or administer the plans by negotiating on the plans' behalf with others (like ESI) to set the price that the plans would pay for prescription drugs. If such actions involved fiduciary functions on behalf of the plans, ERISA "require[d]" that Anthem act as a fiduciary when making those "fiduciary decisions." *Pegram*, 530 U.S. at 225. The fact that Anthem might combine any such fiduciary functions with other non-fiduciary aspects of its business—such as negotiating the sale of its in-house PBMs, or simultaneously negotiating the price that Anthem would itself pay for prescription drugs for Anthem's insured healthcare plans—would not excuse Anthem from any fiduciary responsibility to petitioners' plans when negotiating prices that those plans would pay. Otherwise, a fiduciary could entirely escape its obligations to ERISA plans simply by combining them with other business functions.

Pegram does not suggest otherwise. *Pegram* addressed a unique context involving the structure of a Health Maintenance Organization (HMO), where coverage "eligibility decisions" made by a physician were "inextricably mixed"—and thus could not "be untangled" —from "[t]reatment decisions" made by the same physician. 530 U.S. at 228-229. The Court held that those mixed decisions—which were inherent to the basic "structure" of HMOs—were not fiduciary primarily because treating them as such would result in "nothing

less than the elimination of the for-profit HMO" and "might well portend the end of nonprofit HMOs as well," contravening both Congress's recognition that ERISA plans would utilize HMOs and Congress's long-standing "promo[tion of] the formation of HMO practices" through legislation. *Id.* at 233-234 & n.11. No similar considerations apply here.

As noted above, the court of appeals' brief order in this case quoted the Sixth Circuit's decision in *DeLuca* in a parenthetical. Pet. App. 10a. In *DeLuca*, the court determined that Blue Cross Blue Shield (BCBS) did not act as a fiduciary when it negotiated revisions of reimbursement rates with hospital providers for BCBS's three healthcare coverage options: a traditional open-access plan, a preferred provider (PPO) plan, and an HMO plan. *DeLuca*, 628 F.3d at 745-748. BCBS (like Anthem) offered "insured health-care coverage" in which BCBS collected fixed premiums and then paid the "actual expenses" of providing healthcare. *Id.* at 745. And BCBS (like Anthem) also offered its services to administer the same coverage for "self-insured plans" that themselves paid the "actual medical expenses" of providing healthcare. *Ibid.* The rates paid by each category of plans (*e.g.*, PPO)—both those insured by BCBS and those for self-insured plans—were "standard within each category." *Ibid.* The court determined that BCBS's negotiation with hospital providers to reduce the rates for HMO plans to be the same as "those paid by the PPO plan[s]," which involved increases in PPO rates, *id.* at 745-746, were not fiduciary acts "principally because those business dealings were not directly associated with the [self-funded] benefits plan at issue [t]here but were *generally applicable* to a broad range of health-care consumers." *Id.* at 747 (emphasis added).

DeLuca might be viewed as concluding that BCBS was not acting as a fiduciary because it was negotiating on behalf of its own insured plans as well as self-insured plans. If so, that could reflect an intuition that a health-care company offering both insured plans and parallel services to self-insured plans would have appropriate incentives in rate negotiations with providers if (as in *DeLuca*) the rates that the company pays to providers for its insured plans are the same as those paid by the self-insured plans. It may well be difficult in such contexts for a plaintiff to show that the negotiations failed to satisfy the "prudent man" standard, 29 U.S.C. 1104(a)(1)(B), where the company was negotiating what it would itself pay. Yet whatever the force of that intuition, it would not support the view that such a company is not performing a fiduciary function when exercising authority to negotiate with third parties on behalf of ERISA plans.

But it is by no means clear that such a reading of *DeLuca* is correct, much less that the Sixth Circuit (or the court below) intended to adopt a categorical "exception" to ERISA's definition of fiduciary for "business decisions." As Judge Kethledge's dissent in *DeLuca* explained, the dispute in that case was whether, under the particular contract between BCBS and the plaintiff's plan, BCBS was acting as a fiduciary by negotiating rates on behalf of the plan, or whether BCBS, as a contractual counter-party, simply sold the plan a "*product* —off-the-shelf access to [BCBS's] provider network"— at rates BCBS negotiated, effectively on its own behalf, to be applied to both its insured plans and self-insured plans with which it had contracts. 628 F.3d at 749-750. The majority appears to have concluded it was the latter —and that BCBS therefore was not acting in a fiduciary

capacity—principally because the rate revisions "were generally applicable to a broad range of health-care consumers." *Id.* at 747. Judge Kethledge agreed that the fact that BCBS negotiated rates for self-funded plans in gross, rather than individually, provided some support for that conclusion. *Id.* at 750. But he found that the ASO agreement was insufficiently clear to warrant ruling for BCBS as a matter of law. *Id.* at 749-751.

The Second Circuit's parenthetical quotation from *DeLuca* thus might reflect its view that Anthem was acting solely in a business capacity pursuant to contracts to furnish a product that involved access to PBM services for both Anthem's insured plans and self-insured plans. If that was the court's conclusion, Anthem's dealings with respect to that product would not involve fiduciary responsibilities to the plans that purchase the product as a part of their ASO agreements with Anthem. And under that view, neither *DeLuca* nor the Second Circuit's decision in this case would recognize a categorical "business exception" to fiduciary status.

b. In any event, even if the court of appeals in this case erred, any such error would not warrant this Court's review.

As an initial matter, the court of appeals' summary order has no "precedential effect," 2d Cir. R. 32.1.1(a), and thus will not be "binding authority" in later cases. *Aguas Lenders Recovery Grp. LLC* v. *Suez, S.A.*, 585 F.3d 696, 702 n.4 (2d Cir. 2009). The fact that future panels of the Second Circuit will be free to evaluate afresh the questions presented here significantly undermines any need for this Court's review in this case.

Moreover, the court of appeals' decision does not implicate a division of authority. Petitioners incorrectly

contend (Pet. 19-22) that a circuit conflict exists over whether there is a "'business' exception" to ERISA fiduciary status. The court of appeals' citation to *DeLuca*, Pet. App. 10a, does not reflect such a broad ruling. *DeLuca* simply determined that BCBS's pricing negotiations with providers in that case were not fiduciary acts because they "were generally applicable to a broad range of health-care consumers" and thus "not directly associated with the [self-funded] benefits plan at issue." *DeLuca*, 628 F.3d at 747; see Pet. App. 10a (quoting this language). No conflict exists on that case-specific issue.

Most of the decisions that petitioners cite (Pet. 20-22) are inapposite because they address contexts involving only one ERISA plan under circumstances entirely dissimilar to those here.[5] One decision does not address

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[5] See *Peters* v. *Aetna Inc.*, 2 F.4th 199, 210, 231-232 (4th Cir. 2021) (holding that Aetna was a fiduciary where it exercised its discretion over plan administration to use a "dummy code" to surreptitiously bill the plan for Aetna's payments to its subcontractor in violation of Aetna's contract with the plan), cert. denied, 142 S. Ct. 1227 (2022); *Patelco Credit Union* v. *Sahni*, 262 F.3d 897, 909 (9th Cir. 2001) (holding that an insurance broker who exercised "significant, and in most respects exclusive, control over the Plan's assets" by exercising direct control over its bank account was a plan fiduciary); *Health Cost Controls of Ill., Inc.* v. *Washington*, 187 F.3d 703, 709 (7th Cir. 1999) (holding that the entity to which an ERISA plan had assigned a reimbursement claim against a participant and that exercised full discretion to pursue that claim was a fiduciary when doing so), cert. denied, 528 U.S. 1136 (2000); *Reich* v. *Lancaster*, 55 F.3d 1034, 1048-1049 (5th Cir. 1995) (holding that a plan's consultant was a fiduciary because he "effectively exercised authority and control over management and administration of the plan" by "usurp[ing]" the "independent discretion" of plan trustees through "misleading information" that led to their approval of "[e]very recommendation" he made).

the question of fiduciary status. See *Mitchell* v. *Blue Cross Blue Shield*, 953 F.3d 529, 537, 539-540 (8th Cir. 2020). And the only decision that petitioners cite concerning prescription-drug pricing held that a company that provided pharmacy benefits services to a self-funded plan pursuant to contract was *not* a fiduciary with respect to drug pricing. See *Chicago Dist. Council of Carpenters Welfare Fund* v. *Caremark, Inc.*, 474 F.3d 463, 472-475 (7th Cir. 2007) (*Caremark*).

Finally, shortcomings in the record would make this case a poor vehicle for the Court's review, as the Seventh Circuit's analysis in *Caremark* illustrates. The court in *Caremark* concluded that a company administering a self-insured ERISA plan's prescription-drug benefits (Caremark) was not a fiduciary with respect to its pricing of drug benefits for the plan, even though Caremark had the ability to negotiate with providers the prices that Caremark paid for the prescription drugs that it arranged to be provided to the plan's participants. 474 F.3d at 472-475. The court explained that the plan had "agreed to pay set prices for the drugs" that were "negotiated with Caremark at arm's length" as part of the plan's administrative services agreement, and that the negotiated prices based on AWP, MAC, or a pharmacy's usual-and-customary charges did not leave Caremark discretionary authority over drug pricing for the plan. *Id*. at 472-473. The court explained that "Caremark owed no fiduciary duty in this regard" —and had no obligation to "pass along all of the savings" that "Caremark could negotiate with retailers"— under the pricing arrangement established by the plan's contract with Caremark because that "was the very deal for which [the plan] bargained at arms' length." *Id*. at 473-474.

In this case, the record contains only very limited excerpts of the relevant plan sponsors' ASO agreements with Anthem. Those excerpts include no or minimal provisions relevant to drug pricing. See pp. 5-6 & n.3, *supra*. Pricing provisions based on benchmarks such as AWP, MAC, and other price metrics are typical, see pp. 4-5, *supra*, and one would anticipate at least some contracts governing Anthem's relationships with ERISA plans would contain provisions addressing that issue.[6] Any meaningful analysis of whether Anthem was a fiduciary under the plans here with respect to drug pricing would need to consider all the terms of the governing contracts. For instance, any drug-pricing provisions in the agreements in which plans contracted to pay Anthem for drug costs under negotiated pricing guarantees would be central to the analysis. Moreover, although ERISA's functional definition of fiduciary cannot be displaced by contracts disclaiming fiduciary status, the provisions of the ASO agreements in the record that limit Anthem's fiduciary responsibilities to the administration of the processing of benefits claims and appeals, p. 6, *supra*, could be relevant to whether the plan sponsors agreed at arms-length to particular pricing terms, not prices that Anthem would, as a fiduciary, negotiate on the plans' behalf. Given the highly complicated nature of pricing in this prescription-drug-benefits context, it would be appropriate for this Court to consider the fiduciary status of entities providing administrative services to self-funded ERISA plans only

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[6] Although petitioners Stamford and Brothers were parties to their ASO agreements with Anthem, C.A. App. 199, 213, petitioners have failed to identify, reproduce, or explain any relevant terms of those contracts. See pp. 5-6 & nn.2-3, *supra*.

in a case in which the Court would be able to consider all the contract terms central to that question.

2. The court of appeals appears to have determined that petitioners failed to establish that ESI was a fiduciary on two grounds. First, the court "agree[d] with the district court" that a "PBM does not exercise discretion in setting prices when [the] prices are set according to contractual terms." Pet. App. 11a. Second, the court stated that "[e]ven fully crediting petitioners' allegations that the PBM Agreement provided [ESI] with extraordinarily broad discretion in setting prescription drug prices, at bottom the ability to set such prices is a contractual term, not an ability to exercise authority over plan assets." *Id.* at 11a-12a. That determination does not warrant review for several reasons. Cf. Pet. 37-40.

First, the court of appeals may have based its decision on the ground that it agreed with the district court that the PBM Agreement's pricing terms did not give ESI meaningful pricing discretion. Pet. App. 11a. The district court's conclusion, in turn, was based on its analysis of Section 5.4 of, and Exhibit A to, that Agreement, which are filed under seal. *Id.* at 50a-54a; see pp. 7, 9-10, *supra*. Petitioners do not seek this Court's review of that factbound issue.

Second, the court of appeals' statement that ESI's assertedly "broad discretion" to set drug pricing was a "contractual term" and not an ability to "exercise authority over plan assets," Pet. App. 11a-12a, is itself unclear. ESI has no direct contractual relationship with petitioners' plans. The court of appeals appeared to conclude that even though ESI's implementation of the pricing provisions of its PBM Agreement with Anthem may in turn have affected the costs to the plans (and

their participants) under Anthem's contracts with the plans, that did not render those actions by ESI fiduciary acts on behalf of the plans. That case-case specific determination does not warrant review by this Court.

Moreover, to the extent petitioners read the court of appeals' brief statement to suggest that discretion conferred by contract can never support fiduciary status because it will not confer discretionary authority or control over the "administration" or "management" of the plan, 29 U.S.C. 1002(21)(A), that reading (as petitioners acknowledge, Pet. 39) would be in significant tension with the Second Circuit's prior recognition that authority granted under a contract with a plan *can* confer discretion supporting fiduciary status. See *F.H. Krear & Co.* v. *Nineteen Named Trs.*, 810 F.2d 1250, 1259 (2d Cir. 1987). Moreover, no other court of appeals apparently takes the view that contract-based discretion is irrelevant to ERISA's fiduciary test. And regardless how one interprets the summary order in this case, the Second Circuit will not be bound by that nonprecedential decision in the future.

3. Finally, this Court's review is unwarranted for the additional reason that this case presents a threshold jurisdictional question that would need to be resolved before the Court could address the merits. The district court dismissed petitioners' complaint without prejudice and directed them to file any amended complaint by a deadline that was later extended. See Pet. App. 79a-80a; 1/25/2018 D. Ct. Order. ESI suggests (Br. in Opp. 23-24) that that order may not be a "final decision" under 28 U.S.C. 1291 in light of *Jung* v. *K. & D. Mining Co.*, 356 U.S. 335 (1958) (per curiam).

Jung did not expressly address 28 U.S.C. 1291's "final decision" requirement. And the courts of appeals

have since divided over whether, in the absence of a further order dismissing the action, an order dismissing a complaint but granting leave to amend will itself be transformed into a final decision where, as here (see 2/5/2018 Notice of Appeal 1), the plaintiff disclaims its intent to file an amended complaint. See *North Am. Butterfly Ass'n* v. *Wolf*, 977 F.3d 1244, 1256 (D.C. Cir. 2020); *id.* at 1271-1272 & n.3 (Millett, J., dissenting) (discussing the "longstanding circuit split"). Compare, *e.g.*, *WMX Techs., Inc.* v. *Miller*, 104 F.3d 1133, 1136 (9th Cir. 1997) (en banc) (holding that a "further district court determination must be obtained" before an appeal is filed), with *Slayton* v. *American Express Co.*, 460 F.3d 215, 224 (2d Cir. 2006) (concluding that a plaintiff "can render such a non-final order 'final' and appealable by disclaiming any intent to amend") (citing cases).

If the Court concludes that appellate jurisdiction is wanting, the Court would be unable to address the only questions that petitioners present for review. The need to address that threshold question additionally weighs against review by this Court.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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