No. _____

In The Supreme Court of the United States

JOHN DOE 1, ET AL.,

Petitioners,

KAREN BURNETT, ET AL.,

Consolidated Plaintiffs-Petitioners,

v.

EXPRESS SCRIPTS INC., ANTHEM, INC.,

Respondents.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

ERISA imposes fiduciary duties to the extent that an actor performs a function enumerated in 29 U.S.C. § 1002(21)(A) (defining fiduciary status in terms of the administration or management of a plan or its assets).

Until 2010, no circuit disputed that a party hired by an ERISA plan is a fiduciary when it controls the prices paid by the plan or its participants. Then, a split Sixth Circuit panel created an extra-textual exception for third-party administrators whose "business" is to control prices. *See DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 747 (6th Cir. 2010). Judge Kethledge dissented.

In this case, the Second Circuit joined the Sixth Circuit on the wrong side of a lopsided circuit split. It then extended that error on a second important issue.

The Questions Presented are:

1. Does an administrator hired by an ERISA plan act as a fiduciary when it controls prices paid by the plan or its participants (as the Fourth, Fifth, Seventh, Eighth, and Ninth Circuits hold) or is control over pricing exempt from the definition of "fiduciary" (the *DeLuca* exception) if the administrator is in the "business" of setting prices for its clients (as the Second and Sixth Circuits maintain)?

QUESTIONS PRESENTED—Continued

2. If the *DeLuca* exception is, in fact, a proper gloss on ERISA based on this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), does it exempt from fiduciary status a third-party benefit manager that exercises ongoing discretion over the actual prices charged to the plans pursuant to a contract with the plan administrator?

PARTIES TO THE PROCEEDING BELOW

Petitioners are John Doe 1, John Doe 2, Brian Corrigan, Stamford Health, Inc., and Brothers Trading Co., Inc., and Consolidated Plaintiffs-Petitioners are Karen Burnett, Brendan Farrell, and Robert Shullich.

Respondents are Express Scripts, Inc. and Anthem, Inc.

CORPORATE DISCLOSURE STATEMENT

1. Petitioner Stamford Health, Inc. does not have a parent corporation and no publicly held corporation owns 10% or more of its stock.

2. Petitioner Brothers Trading Co., Inc. does not have a parent corporation and no other publicly held corporation owns 10% or more of its stock.

RELATED CASES

In re Express Scripts/Anthem ERISA Litig., No. 1:16-cv-03399-ER, U.S. District Court for the Southern District of New York. Judgment entered Jan. 5, 2018.

John Doe I, et al. v. Express Scripts, Inc., Anthem, Inc., No. 18-346, U.S. Court of Appeals for the Second Circuit. Judgment entered Dec. 7, 2020.

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Plaintiffs respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The order denying panel rehearing and rehearing en banc (App., *infra*, 81a-82a) is unreported. The opinion of the court of appeals (App., *infra*, 1a-12a) is unreported but is available at 837 F. App'x 44 (2d Cir.

2020). The district court's order (App., *infra*, 13a-80a) is reported at 285 F. Supp. 3d 655 (S.D.N.Y. 2018).

JURISDICTION

The judgment of the court of appeals was entered on December 7, 2020. App., *infra*, 13a-80a. The court of appeals denied a petition for panel rehearing and rehearing en banc on January 26, 2021. App., *infra*, 81a-82a. The Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 3(21)(A) of the Employee Retirement Income Security Act of 1974 ("ERISA") provides:

> [A] person is a fiduciary with respect to a plan to the extent (i) 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 (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). Other relevant provisions of ERISA are reproduced in the appendix to this petition. App., *infra*, 83a-85a.

INTRODUCTION

The Second Circuit joined the Sixth Circuit in adopting an extra-statutory exemption from ERISA's definition of "fiduciary" that has created a clear circuit conflict regarding an issue of exceptional importance: the fiduciary status of third-party administrators who control the prices plans and participants pay for benefits. If this exemption is allowed to stand, Anthem will avoid all responsibility for brazen self-dealing that has already cost employers and employees more than $13 billion in above-market prescription drug costs. Worse, it will continue to foster confusion among service providers, plans, participants, and lower courts, undermining Congress's interest in establishing predictable, uniform standards of conduct applicable to those who serve benefit plans. This Court's review is urgently needed.

Anthem was hired to administer numerous self-insured ERISA health plans. Pursuant to these arrangements, Anthem has discretion to set the prices of prescription drug benefits. But Anthem does not provide insurance or otherwise incur the cost of these benefits. Those costs are incurred by the Petitioners in this case, the plan participants and the employers who sponsor the plans.

Anthem exploited this arrangement for its own benefit. Anthem was looking to both outsource the pharmacy benefit management services it provided to these plans and to sell its in-house pharmacy benefit management business, NextRx. Express Scripts, the

largest pharmacy benefit manager ("PBM") in the country, presented Anthem with two options: (i) it would pay Anthem $500 million for NextRx in exchange for executing a PBM agreement requiring Express Scripts to charge industry-standard drug prices; or (ii) it would pay Anthem $4.675 billion for NextRx in exchange for a PBM agreement allowing Express Scripts to charge plans and participants drug prices that far exceeded industry standards. Anthem accepted the $4.675 billion payment for itself and allowed Express Scripts to charge the plans and participants prices that, by Anthem's own analysis, exceeded industry standards by more than $13 billion.

The first question presented easily satisfies the Court's traditional criteria for plenary review. *First*, there is a clear conflict among the circuits. It is undisputed that when Anthem executed and subsequently renewed the PBM Agreement with Express Scripts, it exercised discretion over the costs Petitioners paid for drug benefits. Under the precedent of the Fourth, Fifth, Seventh, Eighth, and Ninth Circuits, exercise of discretion over the prices plans and participants pay for benefits constitutes discretion over the "administration" or "management" of a plan or its assets, satisfying ERISA's definition of "fiduciary." 29 U.S.C. § 1002(21)(A). But the Second Circuit, following the lead of the Sixth Circuit's outlier opinion in *DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 747 (6th Cir. 2010), adopted a contrary position: the exercise of discretion over prices is exempt from ERISA's fiduciary definition where a service provider is in the "business"

of controlling the prices paid by its clients. Because all third-party service providers act as "businesses" when they serve ERISA plans, the position of the Second and Sixth Circuits is irreconcilable with the precedent of the Fourth, Fifth, Seventh, Eighth, and Ninth Circuits.

Second, the circuit conflict will not be difficult for the Court to resolve. The Second and Sixth Circuit opinions are outliers for good reason. They contradict the statutory text, which, without exception, defines fiduciary functions to include any exercise of discretion over the "administration" or "management" of a plan or its assets. 29 U.S.C. § 1002(21)(A). The Second and Sixth Circuits based their conclusions on gross distortions of the so-called "two hats" doctrine and this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211, 211 (2000). Although *Pegram* and the "two hats" doctrine recognize that a single entity may serve both fiduciary and non-fiduciary functions, whether particular conduct is a fiduciary function turns only on whether the conduct satisfies ERISA's definition of "fiduciary." Neither the "two hats" doctrine nor *Pegram* provide any basis for exempting "business" activities from fiduciary status where, as here, those activities entail discretion over the administration and management of ERISA plans and assets.

Finally, this conflict concerns an issue of great importance. Plan service providers, many of which operate nationwide, face inconsistent standards regarding whether ERISA's fiduciary duties apply to their discretionary pricing decisions. Health plans and participants are unable to predict whether the

administrators and other service providers they hire to help navigate complex aspects of the U.S. health care system are acting in their best interests.

The "business" exception rule adopted by the Second and Sixth Circuits is pernicious. If such an exception exists, service providers with unfettered discretion over prices would have carte blanche to charge ERISA plans and participants exorbitant prices. Third-party administrators could rely on the exceedingly complex and opaque pricing mechanisms that are characteristic of the U.S. health care system to secretly markup prices charged to plan participants. Or, as specifically alleged here, a service provider could engage in a quid pro quo that expressly trades the exercise of discretion over plan administration in exchange for pecuniary benefits to itself.

Review is therefore warranted to restore uniformity regarding the circumstances under which third-party service providers hired by ERISA plans are subject to ERISA fiduciary duties.

The second question presented follows from the first. Until the decision below, every circuit agreed that the exercise of discretion over plan administration satisfies ERISA's definition of "fiduciary" even if the discretion was authorized by contract. The Second Circuit compounded its first error by concluding that *Pegram* and the "business" exception required it to disregard this consensus. Thus, although Express Scripts exercised ongoing discretion over the cost of drug benefits paid by the plaintiff plans and

participants, the panel concluded it was exempt from ERISA's fiduciary definition because it contracted to perform these business services. This conclusion warrants plenary review, if not summary reversal.

STATEMENT

A. Statutory Background

ERISA is a landmark federal statute enacted "to protect * * * the interests of participants in employee benefit plans * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries[.]" 29 U.S.C. § 1001(b).

Congress believed that "a fiduciary standard embodied in Federal legislation is * * * desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state." H.R. Rep. No. 93-533, p. 12 (1973). This "uniformity of decision * * * will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." *Ibid. Accord Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

To this end, Congress included a definition of "fiduciary" in ERISA. 29 U.S.C. § 1002(21)(A). As relevant here, that statutory definition provides that a person is a fiduciary of a plan to the extent (i) "he exercises any discretionary authority or discretionary control respecting management of such plan" or its

assets; or (ii) "he has any discretionary authority or discretionary responsibility in the administration of such plan." *Id.*

Every fiduciary under ERISA is subject to express statutory obligations and prohibitions. *See, e.g.*, 29 U.S.C. § 1104 (entitled "Fiduciary duties"); § 1106 (entitled "Prohibited transactions"). As this Court has observed, the Congressional sponsors of ERISA believed these "fiduciary standards 'will prevent abuses of the special responsibilities borne by those dealing with plans'" and "would safeguard employees from 'such abuses as self-dealing * * * and misappropriation of plan funds.'" *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 15 (1987) (quoting 120 Cong. Rec. 29197, 29932 (1974)).

B. Factual Background

This is a proposed class action filed against Anthem, Inc. ("Anthem") and Express Scripts, Inc. ("Express Scripts" or "ESI") alleging that each Defendant violated its fiduciary obligations under ERISA.

1. Anthem is a health benefits company that enters into "Administrative Services Only" ("ASO") contracts with "self-funded" or "self-insured" ERISA plans ("ASO Plans"). "ASO plans account for sixty percent of Anthem's business." App., *infra*, 14a.

When dealing with ASO Plans, Anthem does not provide insurance or otherwise cover the cost of benefit claims. Instead, the ASO Plan "reimburses the health

care costs of the plan [participants and] beneficiaries, but pays Anthem * * * to administer the plan (and to negotiate on its behalf for lower rates with health care providers)." *Ibid.*

The contracts between ASO Plans and Anthem do not specify the prices that participants and plans will pay for prescription drugs. Instead, these contracts grant Anthem broad discretion to determine drug pricing, including the discretion to negotiate and execute a contract permitting a pharmacy benefits manager ("PBM") to determine drug prices on behalf of plans and participants. Complaint ¶¶ 88, 207(a)-(b), 222, C.A. App. 70, 105, 110.

As the district court explained: "PBMs generally contract with pharmacies, negotiate discounts and rebates with drug manufacturers, review drug utilization, manage drug formularies, and process and pay prescription drug claims" on behalf of health plans. App., *infra*, 14a-15a. And "ESI [Express Scripts] is the largest PBM operating in the United States." App., *infra*, 15a.

2. In 2009, Anthem and Express Scripts completed a deal that gave ESI a decade-long right to provide prescription medicine to Anthem customers (including ASO Plans and participants). Specifically:

> On December 1, 2009, Anthem and ESI entered into a ten year agreement (the "PBM Agreement"). Under the PBM Agreement, ESI either processes claims of Anthem participants [including those in ASO Plans] who fill

> prescriptions at retail pharmacies or fills the prescriptions of Anthem participants directly through its mail-order pharmacies. ESI also provides administrative services relating to prescription drugs for Anthem, Anthem's health plans [including ASO plans], and Anthem participants.

App., *infra*, 15a (citations omitted).

In the PBM Agreement, Anthem delegated extraordinary discretion to Express Scripts regarding its ability to set the drug prices that would be charged to Anthem customers. *E.g.*, Complaint ¶¶ 18-20, 112, 116-19, 206(f)-(h), C.A. App. 47-48, 75-78, 104 (detailing how the PBM Agreement granted ESI broad discretion over drug prices, including by failing to utilize industry-standard pricing benchmarks and by granting ESI discretion over drug ingredient costs, maximum reimbursement amounts, maximum allowable cost lists, the classification of drugs as brand or generic, and rebates (revenue from drug manufacturers) that can be shared with plans to reduce costs). Anthem did so in exchange for an immediate payment of more than $4.6 billion as part of a broader deal described by the district court:

> On the same day, Anthem and ESI entered into an agreement by which Anthem sold three [Anthem] PBM companies * * * (collectively, the "NextRx companies") to ESI (the "NextRx Agreement"). The execution of the PBM Agreement was a condition precedent to the signing of the NextRx Agreement. * * * ESI offered to pay $500 million to Anthem

> * * * in exchange for providing prescription medications to Anthem subscribers at a lower price throughout the ten year PBM Agreement. Conversely, ESI offered to pay a much greater amount for the NextRx companies—$4.675 billion—but allegedly made clear that prescription medication pricing would be higher over the life of the Agreement. Ultimately, Anthem opted for the greater upfront payment of $4.675 billion.

App., *infra*, 15a-16a (citations omitted).

3. Several years into the contract, Anthem discovered that ESI had been overcharging its customers *by billions of dollars*. As the district court explained:

> [I]n late 2014, Anthem engaged third-party Health Strategy, LLC to conduct a market analysis[.] * * * Health Strategy reported * * * that [ESI's] prescription drug pricing exceeding "competitive benchmark pricing" by more than $3 billion annually. Anthem estimated that pricing under the PBM agreement would therefore cost $13 billion more than "competitive benchmark pricing" over the remaining life of the Agreement[.]

App., *infra*, 20a (citations omitted).

After months of communication between Anthem and ESI, Anthem wrote in January of 2016 that "'Express Scripts' excessive pricing is harming Anthem and its customers.'" App., *infra*, 21a (citation omitted). Anthem reiterated that it was "'prepared to accept something less than competitive benchmark

pricing,'" as it had done in striking the original bargain with Express Scripts, but emphasized that it "'obviously will not accept Express Scripts' grossly inflated pricing proposal.'" App., *infra*, 21a-22a (citation omitted).

Express Scripts denied any wrongdoing and, to this day, the ASO Plans and their participants have not received any reimbursement for the excessive costs they incurred for prescription drug benefits. Although Anthem sued Express Scripts in 2016 for breaching even the extremely lenient pricing terms in the PBM Agreement, that litigation will not make ASO plans and participants whole for the fact that Anthem agreed to allow Express Scripts to grossly overcharge plans and participants. In any event, that litigation remains pending in the Southern District of New York, with motions for summary judgment due August 27, 2021. *See Anthem, Inc. v. Express Scripts, Inc.*, No. 1:16-cv-02048-ER (S.D.N.Y.).

C. Proceedings Below

1. "On March 21, 2016, Anthem sued ESI over its pricing dispute, making Anthem's allegations of price inflation public." App., *infra*, 22a. In May and June of 2016, class action complaints were filed against both Anthem and Express Scripts, which were subsequently consolidated. Dist. Ct. Dkt. ## 1, 39.

As the court of appeals explained: "Plaintiffs in this case are six individuals ('Subscriber Plaintiffs') and two fiduciaries of ERISA health plans ('Plan Plaintiffs')." App., *infra*, 22a. "Plaintiffs all argue that

* * * ESI has been setting prescription drug pricing at inflated rates." App., *infra*, 23a.

"The Subscriber Plaintiffs allege * * * they are responsible for payment of co-insurance charges," which "are a percentage share of the costs of a prescription." *Ibid.* Thus, "inflated prescription drug prices set by ESI would inflate the co-insurance amount Subscriber Plaintiffs are required to pay." App., *infra*, 24a.

"The Plan Plaintiffs are health plans that are self-funded by employers but operated under ASO agreements with Anthem. They alleged that with respect to their plans, Anthem absorbed none of the costs of inflated prescription pricing[.]" *Ibid.* (citation omitted).

2. Petitioners maintain that Anthem and ESI are both fiduciaries who violated ERISA. Specifically, the complaint alleges the following:

Anthem was a fiduciary to every ASO Plan because its contract with each gave it discretion to negotiate and agree to all drug prices and because Anthem exercised that discretion by negotiating the PBM Agreement with ESI. Complaint ¶¶ 12, 88, 207(a)-(b), 208, 221, C.A. App. 45-46, 70, 105, 109-10. Anthem violated ERISA by allowing ESI to charge ASO plans and participants grossly excessive prices, partly in exchange for a multi-billion payment. Complaint ¶¶ 328-35, C.A. App. 141-43 (violations of 29 U.S.C. § 1104); *id.* ¶¶ 336-43, C.A. App. 143-44 (violations of 29 U.S.C. § 1106).

Express Scripts was a fiduciary to every ASO Plan because, pursuant to its contract with Anthem, ESI exercised complete discretion in setting all drug prices paid by the plans and participants. Complaint ¶¶ 18-20, 112, 116-19, 206(f)-(h), C.A. App. 47-48, 75-78, 104. Express Scripts violated ERISA by charging the plans and participants excessive drug prices and retaining those excess payments for its own benefit. Complaint ¶¶ 313-20, C.A. App. 138-40 (violations of 29 U.S.C. § 1104); *id.* ¶¶ 321-327, C.A. App. 140-41 (violations of 29 U.S.C. § 1106).

3. Both Anthem and Express Scripts filed motions to dismiss all ERISA claims for lack of fiduciary status. Dist. Ct. Dkt. ## 63, 68. The district court agreed that Defendants lacked fiduciary status and granted their motions. App., *infra*, 13a-80a.

Petitioners appealed. C.A. App. 741-43. Before the Second Circuit, petitioners explained why the district court erred in granting motions to dismiss both Anthem and Express Scripts on grounds of fiduciary status.

a. Anthem. Petitioners argued in detail that "[t]he complaint plausibly alleges that Anthem is a fiduciary because it has discretionary authority over the prices the plans paid for prescription drugs and exercises control over plan assets." Br. of Pls.-Appellants at 20-35, C.A. Dkt. # 94; *see also id.* at 18-20 (explaining the statutory definition of fiduciary).

In response, Anthem insisted that the pricing terms it negotiated with ESI were non-fiduciary

"business decisions" because they were matters of plan design. *See*, *e.g.*, Br. of Def-Appellee Anthem at 18-23, C.A. Dkt. # 129 ("Anthem was not acting as an ERISA fiduciary in determining the content of its plan offerings."); *id.* at 18 ("Insurers * * * are entitled to determine the terms of their offerings, including pricing[.]").[1]

Anthem did not (and cannot) dispute that this case involves ASO Plans, which are not Anthem's insurance offerings, and that those ASO Plans hired Anthem to negotiate drug prices for the plans. Nonetheless, Anthem insists the negotiation of those prices constituted a "business decision" because its singular PBM Agreement with ESI applies to *all* Anthem customers. In making that argument, Anthem relied—and urged the Second Circuit to adopt—the mistaken position of the Sixth Circuit panel majority in *DeLuca*. In the words of Anthem:

> *DeLuca* * * * is instructive. There, the Sixth Circuit held that a health insurer was not acting as an ERISA fiduciary where negotiating rates * * * [because] the "conduct at issue" was a "business decisions that has an effect on an ERISA plan not subject to fiduciary standards." Here the spin-off and the PBM Agreements apply not merely to a broad range of healthcare consumers, but to all customers and to Anthem itself.

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[1] Anthem's brief included numerous other arguments. But none is responsive to petitioners' position on fiduciary status and none was adopted or even addressed by the Second Circuit.

Id. at 20-21 (quoting *DeLuca*, 628 F.3d at 747); *see also id.* at 36 (relying entirely on *DeLuca* in disputing "plan asset" theory of fiduciary status).

b. Express Scripts. Petitioners argued at length that "[t]he complaint plausibly alleges that ESI is a fiduciary because of its discretionary control in determining prescription drug prices, its breaches of the PBM Agreement, and its setting of its own compensation." Br. of Pls.-Appellants at 39-44, C.A. Dkt. # 94.

In response, ESI took the following position:

> Plaintiffs are wrong to assert that Express Scripts is an ERISA fiduciary because various provisions of the PBM Agreement * * * supposedly grant Express Scripts "considerable discretion" and "control" over how much Plaintiffs' plans pay for prescription drugs. Express Scripts has no discretion over prices, which are fixed by Section 5.4 and Exhibit A of the PBM Agreement.

Br. of Def.-Appellee ESI at 27, C.A. Dkt. # 157. *See generally id.* at 27-49 ("Express Scripts is not an ERISA fiduciary").[2]

4. The Second Circuit affirmed the dismissal of all claims against Anthem and ESI entirely on the

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[2] ESI's brief includes numerous other arguments. But, again, none is responsive to petitioners' position on fiduciary status and none was adopted or even addressed by the Second Circuit.

basis that neither were acting as fiduciaries under ERISA.[3]

a. Anthem. In concluding that Anthem was not an ERISA fiduciary, the panel held as follows:

> 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. *See, e.g., DeLuca v. Blue Cross Blue Shield of Mich.*, 628 F.3d 743, 747 (6th Cir. 2010) (insurer did "not act[] as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefits plan at issue but were generally applicable to a broad range of healthcare consumers.").

App., *infra*, 10a.

As explained below (*infra* pp. 20-32), the panel's endorsement of the *DeLuca* exception puts the Second Circuit on the wrong side of a circuit split, misreading ERISA's text based on a fundamental misinterpretation of this Court's *Pegram* decision.

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[3] The decision was issued by Circuit Judges Winter and Pooler. The third member of the panel, Judge Robert Sweet, sitting by designation, passed away between oral argument and the issuance of the decision. *See* App., *infra*, 1a & n.1. Judge Winter passed away the day after the decision was filed. Clay Risen, *Ralph K. Winter Jr., a Top Conservative Judicial Mind, Dies at 85*, N.Y. Times (Dec. 18, 2020), https://www.nytimes.com/2020/12/18/us/ralph-k-winter-jr-dead.html.

b. Express Scripts. In concluding that ESI was not an ERISA fiduciary, the panel held as follows:

> Even fully crediting plaintiffs' allegations that the PBM Agreement provided Express Scripts 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.

App., *infra*, 11a-12a.

In other words, the panel did *not* adopt ESI's factual position (i.e., that it did *not* have sufficient discretion under the PBM Agreement to confer fiduciary status). That is hardly surprising because ESI's position is not only wrong but, more importantly, improper at the pleading stage. Instead, it merely extended the *DeLuca* exception to a third-party that contracts with the administrator to exercise ongoing discretion over the actual prices charged to the plans. As explained below (*infra* pp. 37-40), that holding is indefensible and warrants summary reversal.

5. This petition followed.

REASONS FOR GRANTING THE PETITION

The Second Circuit adopted the *DeLuca* majority's ill-conceived, extra-statutory "business" exception to excuse two different plan service providers from all ERISA liability despite the fact that both entities

exercised discretion over prescription drug prices to benefit themselves at the expense of the plans and participants they served. The first question warrants review because in applying *DeLuca*'s business exception to Anthem, the Second Circuit deepened a circuit conflict on an issue of exceptional importance based on a fundamental misunderstanding of this Court's *Pegram* decision. The second question warrants plenary review, if not summary reversal, because in extending the *DeLuca* exception to Express Scripts, the Second Circuit further misconstrued *Pegram*, blatantly ignored the statutory text, and defied the unanimous view of every circuit regarding contractually granted discretion.

I. The First Question Warrants Review

The decision below exacerbates a circuit conflict as to whether administrators hired by ERISA plans are fiduciaries when they control prices paid by the plans or participants they serve. The Second and Sixth Circuits' position contradicts the statute and is based on gross distortions of the "two hats" doctrine and this Court's *Pegram* decision. Their pernicious "business" exception has harmed employers and employees and has created growing confusion among service providers, plans, and participants, undermining Congress's intent in establishing predictable, uniform standards of conduct. Further review is warranted.

A. The Decision Below Exacerbates a Circuit Conflict First Created by the Sixth Circuit's *DeLuca* Decision

1. Most circuits recognize that third-party service providers hired by ERISA plans act as fiduciaries when they control the prices plans or participants pay for benefits or services. The reason is simple. The ability to set the prices paid by a plan surely constitutes the exercise of "discretionary control or authority" over the "management" or "administration" of a plan or its assets, thus satisfying the uniform, statutory definition of "fiduciary" adopted by Congress in ERISA. 29 U.S.C. § 1002(21)(A).

For example, in *Reich v. Lancaster*, 55 F.3d 1034 (5th Cir. 1995), the Fifth Circuit held that a third-party insurance agent qualified as a fiduciary to a union health and welfare fund because the agent was the "decision maker when it came to [health and life] insurance purchases and the payment of compensation to those who procured [insurance] on behalf of the Fund." *Id.* at 1049. Among other things, the third-party agent "handle[d] all the Fund's health, medical, and life insurance needs," including by causing the Fund "'to spend, in a little over two years, nearly $1,000,000.00 in premiums on life insurance when the Fund only had $750,000.00 in assets.'" *Id.* at 1046, 1048 (citation omitted). The court concluded that the agent "effectively exercised discretionary authority or control over the management of the plan's insurance assets, and exercised discretionary authority

or responsibility in the plan's administration," and thus qualified as an ERISA fiduciary. *Id.* at 1049.

The Ninth Circuit reached a similar conclusion in *Patelco Credit Union v. Sahni*, 262 F.3d 897 (9th Cir. 2001), when it held that a third-party manager of a self-funded health plan was a fiduciary because it set the monthly payments the plan sponsor was required to pay to cover medical costs, insurance premiums for a stop-loss policy, and the manager's administrative fee. *Id.* at 901-02, 909. *See also Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1124 (9th Cir. 2006) (third-party pharmacy benefit manager exercised fiduciary discretion by determining whether plan would pay for prescribed drug or alternative drug).

The Fourth Circuit recently held that an administrator for self-funded ERISA health plans (Aetna) was a functional fiduciary because it manipulated the prices plans paid for health care. *See Peters v. Aetna Inc.*, ___ F.3d ___, No. 19-2085, 2021 WL 2546412, at *17-20 (4th Cir. June 22, 2021). Aetna contracted with a third-party benefit manager (Optum) to provide services to the plans. But Aetna wanted "'to ensure'" that it "'didn't have to pay [Optum's fee] out of [its] own bank account.'" *Id.* at *19 (citation omitted). Aetna thus conspired with Optum to use a "dummy code" to secretly "bury" Optum's fee within the health care costs paid by the plans. *Id.* at *17-20. The Fourth Circuit concluded that a reasonable fact finder could conclude that Aetna exercised discretion over plan

management and assets, satisfying ERISA's definition of "fiduciary." *Ibid.*

The Seventh and Eighth Circuits also recognize that third-party service providers are fiduciaries when they exercise discretion over the amounts plans pay for medical claims. *See, e.g.*, *Health Cost Controls of Ill., Inc. v. Washington*, 187 F.3d 703, 706 (7th Cir. 1999) (third-party service provider hired by plan administrator was ERISA fiduciary because it had "sole discretion" over whether and how the plan would seek reimbursement for medical claims paid on behalf of participants who subsequently received payments from other insurance policies); *Mitchell v. Blue Cross Blue Shield of N.D.*, 953 F.3d 529, 539-40 (8th Cir. 2020) (recognizing breach of fiduciary duty claim could be based on control over amounts plan was charged for medical costs); *see also Chi. Dist. Council of Carpenters Welfare Fund v. Caremark, Inc.*, 474 F.3d 463, 472-75 (7th Cir. 2007) (fiduciary status of pharmacy benefit manager turned on whether it exercised discretion over the prices the plan paid for prescription drugs).

2. A divided Sixth Circuit panel disrupted this consensus in 2010; over a sharp dissent from Judge Kethledge, the panel majority held that an administrator of self-funded health plans did not act as a fiduciary when it exercised discretion over the rates ERISA plans and participants paid for health benefits. *See DeLuca*, 628 F.3d 743.

DeLuca addressed the fiduciary status of Blue Cross Blue Shield of Michigan ("BCBSM"), which

contracted with self-insured ERISA plans to provide plan administration and other services. Plaintiff's claims required the court to consider whether BCBSM was acting as an ERISA fiduciary when it negotiated with health care providers to set the rates that BCBSM's ERISA plan clients—and the participants of those plans—would pay for health care services.

The panel majority affirmed the entry of summary judgment, holding "that BCBSM was not acting as a fiduciary when it negotiated the challenged rate changes, principally because those business dealings were not directly associated with the benefits plan at issue here but were generally applicable to a broad range of health-care consumers." *Id.* at 747. In other words, the panel majority found dispositive the fact that BCBSM was generally in the "business" of negotiating rates for clients: *See, e.g.*, *id.* ("In this case, the 'conduct at issue' clearly falls into the latter category, 'a business decision that has an effect on an ERISA plan not subject to fiduciary standards.'").

3. Judge Kethledge dissented, taking issue with the majority's conclusion and its reasoning. As an initial matter, he made two important observations:

First, "no one disagrees * * * that the function of negotiating rates with provider hospitals surely would have been fiduciary in nature had the Plan's trustees kept that function in-house." *Id.* at 749. And second, the provision of services by a third-party to an ERISA plan "quite frequently" creates fiduciary duties under

ERISA, which "is especially true for discretionary services that directly impact a plan's finances." *Ibid.*

In light of those (uncontroversial) premises, Judge Kethledge recognized that whether BCBSM was exercising discretion over plan administration, management, or assets was a *factual* question that should not have been resolved on a motion for summary judgment. *Ibid.* And he concluded that "[t]he record here would allow a jury to find that [BCBSM] agreed to provide services * * * [that] are highly discretionary and have a direct impact on the Plan's bottom line. Thus, if [BCBSM] indeed provided those services, it was an ERISA fiduciary when it did so." *Id.* at 751.

As Judge Kethledge explained, the fact that a service provider acts on behalf of many plans simultaneously has no bearing on fiduciary status:

> The Contract nowhere prohibits [BCBSM] from negotiating on behalf of all of its client plans at once. So far as the Contract is concerned, [BCBSM]'s obligation was simply to establish, arrange, and maintain provider networks; and if [BCBSM] discharged that obligation at the same time it discharged the same obligation to other plans, the terms of the Contract afforded Flagstar no reason to complain. So the possibility remains that Blue Cross agreed to provide what the Contract says it agreed to provide: services.

Id. at 750; *see also id.* ("I reject the unspoken premise * * * that we should be acutely concerned about Blue Cross's business model in the first place.").

Ultimately, the dispositive question for Judge Kethledge, consistent with the holdings of every other circuit to consider the issue, was whether BCBSM was engaged in discretionary services that had "a direct impact on the Plan's bottom line." Such discretionary control over the prices paid by ERISA plans and participants would make a third-party service provider an ERISA fiduciary.

4. The decision below undeniably exacerbates the circuit conflict. The panel expressly concluded *on a motion to dismiss* that Anthem was not a fiduciary even though the operative complaint alleges that (1) Anthem's contracts with self-funded ERISA plans gave it discretion over the cost of prescription drug benefits and (2) Anthem exercised that discretion by negotiating an agreement permitting Express Scripts to charge plans and participants prices that grossly exceeded market rates. Complaint ¶¶ 12, 88, 207(a)-(b), 208, 221, C.A. App. 45-46, 70, 105, 109-10.

In reaching its holding, the panel failed entirely to assess whether Anthem's control over drug prices (as alleged here) met the standard enumerated in 29 U.S.C. § 1002(21)(A). Instead, the court merely adopted the *DeLuca* "business decision" exception—as urged by Anthem. Specifically, the panel noted that "'[g]eneral fiduciary duties under ERISA [are] not triggered' * * * when the decision at issue is, 'at its core, a corporate business decision,'" App., *infra*, 9a-10a (citation omitted), and the panel cited *DeLuca*'s holding that a third-party service provider's negotiation of health care rates paid by ERISA plans constituted non-fiduciary "business

dealings." App., *infra*, 10a (quoting *DeLuca*, 628 F.3d at 747). Indeed, *DeLuca* was the only authority the panel cited in support of its conclusion that "Anthem did not act as an ERISA fiduciary when it entered into the * * * PBM Agreement[], even though its decisions may ultimately affect how much plan participants pay for drug prices." *Ibid.*

B. The Second and Sixth Circuits Grossly Misapplied the "Two Hats" Doctrine And this Court's *Pegram* Decision

1. The Second Circuit decided to adopt *DeLuca*'s categorical "business" exception based on its misunderstanding of the "two hats" doctrine and this Court's *Pegram* decision. The panel began with *Pegram*'s observation that a "'trustee under ERISA may wear different hats.'" App., *infra*, 9a (quoting *Pegram*, 530 U.S. at 225). It then quoted *Pegram*'s summary of the basic distinction between the fiduciary and non-fiduciary actions of an employer, noting that employers do not act as fiduciaries, and thus can "'take actions to the disadvantage of employee beneficiaries, when they act as employers (e.g., firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (e.g., modifying the terms of a plan as allowed by ERISA to provide less generous benefits).'" *Ibid.* (quoting *Pegram*, 530 U.S. at 225).

Because Anthem is neither the employer of the plan participants nor the sponsor of their plans, the panel relied on *Pegram*'s further assertion that there

is no "'apparent reason in the ERISA provisions to conclude * * * that this tension is permissible only for the employer or plan sponsor, to the exclusion of persons who provide services to an ERISA plan.'" *Ibid.* (quoting *Pegram*, 530 U.S. at 225).

The panel appears to have construed this language as creating a general exception from fiduciary status for "business decisions," as the panel's very next assertion was that "'[g]eneral fiduciary duties under ERISA [are] not triggered' * * * when the decision at issue is, 'at its core, a corporate business decision, and not one of a plan administrator.'" App., *infra*, 9a-10a (citing dicta from *Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 357 n.2 (2d Cir. 2016). The panel then summarily concluded that Anthem was not a fiduciary. It did not conduct *any* analysis of whether Anthem's control over drug prices through the PBM Agreement constituted plan "administration" or "management." App., *infra*, 10a. Instead it merely cited *DeLuca*'s holding that the negotiation of health care "rate changes" were non-fiduciary "business dealings." *Ibid.* (quoting *DeLuca*, 628 F.3d at 747).

2. Nothing in *Pegram* supports this amorphous, extra-statutory "business" exception. *Pegram* explained that the applicability of the "two hats" doctrine was not limited to "the employer or plan sponsor, to the exclusion of persons who provide services to an ERISA plan," 530 U.S. at 225. But this clarified the scope of entities to which the "two hats" doctrine applied; it did not alter the meaning of the doctrine, which is clearly explained in the very next paragraph:

> [T]he statute does not describe fiduciaries simply as administrators of the plan, or managers or advisers. Instead it defines an administrator, for example, as a fiduciary only "to the extent" that he acts in such a capacity in relation to a plan.

Id. at 225-26 (quoting 29 U.S.C. § 1002(21)(A)).

Because an entity may be a fiduciary for some, but not all, purposes, *Pegram* explained that "[i]n every case charging breach of ERISA fiduciary duty, * * * the threshold question is * * * whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Id.* at 226.

This discussion cannot be interpreted as categorically excluding "business decisions" from ERISA's fiduciary duties. Indeed, the *Pegram* opinion makes clear that fiduciary status turns *only* on an analysis of whether the conduct "subject to the complaint" constituted a "fiduciary function" withing the meaning of the statute, *ibid.*, which defines fiduciary status based on whether an entity is engaged in discretionary control over the "management" or "administration" of a plan or its assets. 29 U.S.C. § 1002(21)(A). The Second and Sixth Circuits' belief that courts were relieved of the obligation to evaluate whether the "business" conduct of service providers constituted plan "administration" or "management" directly contradicts this Court's discussion in *Pegram*.

Pegram ultimately held that a health maintenance organization ("HMO") was not engaged in fiduciary conduct when it made "mixed eligibility and treatment decisions * * * acting through its physicians." 530 U.S. at 229-31. Critically, in sharp contrast to the approach of the Second and Sixth Circuits, this Court reached this conclusion only after evaluating whether these "mixed" decisions constituted acts of plan "administration." The decisions in question were treatment decisions made by physicians exercising their medical judgment, such as decisions "about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition." *Ibid.* The Court noted that such decisions made by physicians bore little resemblance to traditional acts of plan administration, and expressed doubt that Congress intended to federalize medical malpractice claims. *Id.* at 231-37. The Court concluded that such mixed eligibility and treatment decisions made by physicians did not qualify as acts of plan "administration" within the meaning of ERISA's definition of "fiduciary." *Ibid.*

This Court subsequently confirmed the narrow nature of *Pegram*'s holding:

> Since administrators making benefits determinations, even determinations based extensively on medical judgments, are ordinarily acting as plan fiduciaries, it was essential to *Pegram*'s conclusion that the decisions challenged there were truly "mixed eligibility

> and treatment decisions," 530 U.S. at 229, i.e., medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* "only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer."

Aetna Health Inc. v. Davila, 542 U.S. 200, 220-21 (2004) (citation omitted).

Pegram's narrow holding provides no basis to conclude that any activity, business or otherwise, is categorically excluded from ERISA's statutory definition of "fiduciary." In all contexts, including with respect to the "mixed" decisions addressed in *Pegram*, fiduciary status must be determined based on whether the conduct in question constitutes a discretionary act of "administration" or "management" of a plan or its assets. 29 U.S.C. § 1002(21)(A). Indeed, this Court subsequently confirmed that other discretionary acts performed by HMOs—*in the course of their business*—qualify as fiduciary acts of plan administration: "When administering employee benefit plans, HMOs must make discretionary decisions regarding eligibility for plan benefits, and, in this regard, must be treated as plan fiduciaries." *Davila*, 542 U.S. at 220.

3. A similar misunderstanding of the "two hats" doctrine caused the *DeLuca* majority to originally adopt its "business decision" exception. The majority

relied on discussions of the "two hats" doctrine in two prior Sixth Circuit opinions, which directed courts to "'examine the conduct at issue to determine whether it constitutes "management" or "administration" of the plan, giving rise to fiduciary concerns, or merely a business decision that has an effect on an ERISA plan not subject to fiduciary standards.'" 628 F.3d at 747 (citing *Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 718 (6th Cir. 2000); *Sengpiel v. B.F. Goodrich Co.*, 156 F.3d 660, 665 (6th Cir. 1998)). The *DeLuca* majority interpreted this as an instruction to evaluate whether an entity was engaged in "business decisions" and that, if they were, courts were not required to further evaluate whether that business conduct constituted plan "administration" or "management." 628 F.3d at 747.

That is not what *Hunter* and *Sengpiel* said and that is not what the "two hats" doctrine means. *Hunter* and *Sengpeil* used the phrase "business decision" as a shorthand reference to an employer's performance of "settlor functions such as establishing, funding, amending, and terminating the trust." *Hunter*, 220 F.3d at 718; *Accord Sengpiel*, 156 F.3d at 665. These settlor functions are qualitatively different than acts of plan "administration" or "management" and thus do not qualify as fiduciary conduct within the meaning of the statute. But consistent with *Pegram*, *Hunter* and *Sengpiel* were clear that the language of the statute still governed: fiduciary status turned on whether the conduct at issue constituted "discretionary acts of plan management or administration." *Hunter*, 220 F.3d at

718 (citation omitted); *accord Sengpiel*, 156 F.3d at 666. Neither case held that fiduciary status turns on an amorphous evaluation of whether an entity is engaged in "business decisions."

Because the *DeLuca* majority misunderstood the "two hats" doctrine, it did not even consider whether BCBSM engaged in plan management or administration. It concluded that a third-party service provider (which was not the settlor of the plans) could not be a fiduciary if it was engaged in a "business decision," even if that business conduct fell squarely within the scope of ERISA's definition of "fiduciary."

4. Properly applied, the "two hats" doctrine and *Pegram* compel the conclusion that third parties who contract with ERISA plans to provide services are engaged in fiduciary acts of plan administration when, in their business or otherwise, they exercise discretionary control over the costs the plans and participants incur for health care. Indeed, *Pegram* itself recognized, consistent with the opinions of most circuits, *see supra* pp. 20-23, that decisions about "paying out money to buy medical care" were traditionally the sort of administrative decisions that were fiduciary in nature. 530 U.S. at 231-32. The Second and Sixth Circuits' contrary conclusions were based on a fundamental misunderstanding of *Pegram* and the "two hats" doctrine.

C. The First Question is Exceptionally Important and Recurring

1. There is growing confusion among service providers and ERISA plans alike regarding whether, and under what circumstances, ERISA's fiduciary duties apply to third parties who are in the business of providing services to ERISA plans.

Many service providers operate nationwide. These entities face considerable uncertainty regarding the standards that will apply to their conduct, as different circuits and lower courts have adopted inconsistent standards regarding whether the fiduciary duties of loyalty and prudence apply to discretionary control over benefit costs.

ERISA plans and participants face similar uncertainty. It is difficult to predict whether plan administrators, PBMs, or other third-party service providers they hire to navigate complex areas of the U.S. health care system—areas far beyond the knowledge or expertise of most plan sponsors, much less plan participants—will protect their interests or, conversely, engage in transactions that benefit themselves at the expensive of plans and participants.

The circuit conflict, and the confusion caused by *DeLuca*'s "business decision" exception, undermines "ERISA's policy of * * * assuring a predictable set of liabilities, under uniform standards of primary conduct." *Moran*, 536 U.S. at 379.

2. This confusion is playing out in district court litigation addressing the roles of administrators like Anthem and PBMs like Express Scripts. For example, one district court relied on *Pegram* and *DeLuca* in concluding, without analysis, that "negotiating prices with [healthcare] providers is * * * not a fiduciary function, but rather the administration of a network administrator's business." *In re UnitedHealth Grp. PBM Litig.*, No. 16-CV-3352 (JNE/BRT), 2017 WL 6512222, at *10 (D. Minn. Dec. 19, 2017). Another court, seemingly influenced by defendants' repeated discussion of *DeLuca* in their briefing, cited cases applying the "two hats" doctrine in concluding, without analysis, that Defendants' "setting of reimbursement rates * * * are business decisions" not subject to ERISA's fiduciary duties. *Am. Psychiatric Ass'n v. Anthem Health Plans*, 50 F. Supp. 3d 157, 169-70 (D. Conn. 2014).

3. The "business" exception adopted by these courts has had, and will continue to have, pernicious effects. *DeLuca* has already caused several district courts to conclude that pharmacy benefit managers—entities hired by ERISA plans specifically to *manage* pharmaceutical benefits—do not need to act "solely in the interest" of plan participants, even when their exercise of discretion directly increases the costs participants pay for prescription drug benefits. If this "business" exception is allowed to stand, its impacts will not be constrained to entities controlling prescription drug prices.

Every third-party that provides services to every type of ERISA plan does so in a business capacity. On its face, the rule adopted by the Second and Sixth Circuits would exempt vast swaths of discretionary conduct from the fundamental fiduciary protections Congress enacted. Financial services corporations in the business of providing administrative, investment management, or recordkeeping services to 401(k) plans could unilaterally extract fees from accounts without any concern for whether those fees are reasonable or solely in the interest of plan participants. Health insurers could secretly base participant coinsurance obligations on inflated amounts, lowering the insurer's share of the actual cost owed to health care providers. And administrators to pension, disability, and health plans alike could follow the lead of Anthem by trading the interests of the participants they serve in exchange for financial windfalls to themselves.

Paradoxically, the "business" exception would exclude from ERISA's fiduciary protections the entities that have the most influence over the security of the nation's employee benefit plans—health care companies and financial services institutions in the business of serving employee benefit plans—leaving only employers and their human resources personnel subject to the fiduciary duties of prudence and loyalty. This bifurcation of standards applicable to those who exercise discretion over employee benefit plans cannot be reconciled with Congress's interest in adopting

uniform standards of conduct or its decision to adopt a single, functional definition of "fiduciary."

4. This Court has granted certiorari several times to ensure that lower courts apply uniform standards in construing ERISA's definition of "fiduciary." *See, e.g.*, *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 94-106 (1993) (addressing the meaning of "plan assets" in ERISA's definition of "fiduciary"); *Varity Corp. v. Howe*, 516 U.S. 489, 502-03 (1996) (addressing the meaning of "administration" in ERISA's definition of "fiduciary"). In *Pegram*, this Court granted certiorari in the absence of any circuit conflict because the extent to which fiduciary duties applied to HMO's was a question of exceptional importance. *See* 530 U.S. at 231-37.

The Court should grant certiorari now to clear up the confusion that has persisted regarding the meaning of *Pegram* and the "two hats" doctrine. *Cf. DeLuca*, 628 F.3d at 752 (Kethledge, J., dissenting) ("the problem is compounded here because the Supreme Court's dicta in *Pegram* is likely causing all the circuit courts to break one way. Perhaps eventually the Court will take a [29 U.S.C.] § 1106(b)(2) case and decide whether the subsection means what it seems clearly to say."). The "business decision" exception adopted by the Second and Sixth Circuits contradicts the statutory text, undermines ERISA's general policy of establishing predictable and uniform standards of conduct, and has led to egregious conduct that has harmed both employers and employees who count on the expertise of entities like Anthem to navigate an

exceedingly complex and opaque health care system. This Court should affirm that fiduciary status *in all instances* turns on the application of ERISA's statutory definition, 29 U.S.C. § 1002(21)(A), and resolve the conflict among the circuits regarding whether fiduciary duties apply to discretionary control over the costs plans and participants pay for benefits.

II. The Second Question Also Warrants Review, if Not Summary Reversal

The Second Circuit's misunderstanding of *Pegram* and adoption of the "business" exception caused it to further err by dismissing all ERISA claims against Express Scripts, the entity that contracted with the plan administrator to exercise ongoing discretion over the above-market drug prices paid by the plaintiff plans and participants.

The court of appeals' resolution of the Second Question in this case would justify summary reversal. If certiorari is granted on the First Question, however, plenary review of the related Second Question would also be appropriate.

The panel did not question Petitioners' allegations that Express Scripts exercised discretion, noting several ways in which Express Scripts controlled the prices Petitioners paid for prescription drug benefits. App., *infra*, 11a. Instead, the panel held that Express Scripts lacked fiduciary status because its contract allowed it to set prices:

> Even fully crediting plaintiffs' allegations that the PBM Agreement provided Express Scripts 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.

App., *infra*, 11a-12a. In short, the panel concluded that discretionary conduct is not fiduciary conduct if the authority to exercise discretion is granted by contract.

This conclusion contradicts both the plain language of the statute and the precedent of every circuit to consider such questions. ERISA's definition of "fiduciary" imposes fiduciary status on those who "exercise" discretion, 29 U.S.C. § 1002(21)(A)(i), and on those who have been granted discretion, *id.* § 1002(21)(A)(iii). Because fiduciary status can be based on *either* the exercise or granting of fiduciary authority, one is undoubtedly a fiduciary where *both* have occurred.

Every circuit to consider the issue has recognized that when a service provider to an ERISA plan acts in accordance with a contractual term, fiduciary status turns on whether that contractual term grants discretion or removes discretion. *See, e.g., Ed Miniat, Inc. v. Globe Life Ins. Grp., Inc.*, 805 F.2d 732, 737 (7th Cir. 1986) ("No discretion is exercised when an insurer merely adheres to a specific contract term. When a contract, however, grants an insurer discretionary authority, * * * the insurer may be a fiduciary.");

Pipefitters Local 636 Ins. Fund v. Blue Cross & Blue Shield of Mich., 722 F.3d 861, 866-67 (6th Cir. 2013); *Rozo v. Principal Life Ins. Co.*, 949 F.3d 1071, 1074 (8th Cir. 2020) ("A service provider may be a fiduciary when it exercises discretionary authority, even if the contract authorizes it to take the discretionary act.").

The Second Circuit itself has recognized this principle when addressing an insurer's discretionary control over its own compensation: an "agreement may give [a person] such control over factors that determine the actual amount of its compensation that the person thereby becomes an ERISA fiduciary with respect to that compensation." *F.H. Krear & Co. v. Nineteen Named Trs.*, 810 F.2d 1250, 1259 (2d Cir. 1987).

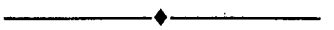
The panel disregarded this precedent. The only case the panel cited in support of its decision was *Pegram*, which the panel believed established a rule that an "insurer does not act in a fiduciary capacity under ERISA when it 'mak[es] decisions * * * influenced by the terms' of the agreement between the insurer and employer." App., *infra*, 11a (quoting *Pegram*, 530 U.S. at 226). That is not what *Pegram* said. The language the panel quoted was from this Court's characterization of the plaintiff's claim, which alleged that Carle, an HMO, breached its fiduciary duty of loyalty "by making decisions affecting medical treatment while influenced by the terms of the Carle HMO scheme, under which the physician owners ultimately profit from their own choices to minimize the medical services provided." 530 U.S. at 226. *Pegram* did not address whether a discretionary act was exempt from

ERISA's definition of "fiduciary" if it was authorized or otherwise "influenced" by the terms of a contract.

As detailed above, *Pegram*'s holding was that HMO physicians were not acting as plan fiduciaries when they made mixed eligibility and treatment decisions. *Id.* at 228-37. Express Scripts does not act through physicians and does not make treatment decisions. Thus, *Pegram*'s holding has nothing to do with whether Express Scripts' discretionary control over the pricing of drug benefits is exempt from fiduciary status, whether or not it was authorized or "influenced" by a contract.

The panel's tortured reading of *Pegram*'s "influenced by the terms" language makes sense only in the context of the panel's erroneous belief that *Pegram* exempted all "corporate business decisions" from ERISA's definition of "fiduciary." *See supra* pp. 26-30. If *Pegram* had exempted "business decisions" from fiduciary status, then an entity might not be a fiduciary if it contracted to perform functions that could be characterized as business decisions. But *Pegram* created no such exception, and the panel's confusion on this point caused it to adopt a rule that defies both the plain statutory text and the precedent of every circuit to address contractual grants of discretionary authority.

The Court should summarily reverse the panel's holding with respect to Express Scripts.



CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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