18-0346-cv

United States Court of Appeals

for the

Second Circuit

JOHN DOE 1, On behalf of themselves and all others similarly situated, JOHN DOE 2, On behalf of themselves and all others similarly situated, BRIAN CORRIGAN, STAMFORD HEALTH, INC., BROTHERS TRADING CO., INC.,

Plaintiffs-Appellants,

KAREN BURNETT, individually and on behalf of all others similarly situated, BRENDAN FARRELL, individually and on behalf of all others similarly situated, ROBERT SHULLICH, individually and on behalf of all others similarly situated,

Consolidated Plaintiffs-Appellants,

(For Continuation of Caption See Inside Cover)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

REDACTED BRIEF FOR DEFENDANT-APPELLEE EXPRESS SCRIPTS, INC.

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– v. –

EXPRESS SCRIPTS, INC., ANTHEM, INC.,

Defendants-Appellees,

1-10 INCLUSIVE DOES,

Defendant.

CORPORATE DISCLOSURE STATEMENT

Express Scripts, Inc., is a wholly owned subsidiary of Express Scripts Holding Company, which is a publicly held and traded corporation. No publicly held corporation owns more than 10% of the stock of Express Scripts Holding Company.

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INTRODUCTION

Plaintiffs-Appellants seek to stretch the scope of fiduciary liability under the Employee Retirement Income Security Act of 1974 ("**ERISA**") well beyond established law and, indeed, beyond any workable or principled limit. The theory of their claim against Defendant-Appellee Express Scripts, Inc. ("**Express Scripts**"), is that a pharmacy benefit manager ("**PBM**") becomes an ERISA fiduciary when it contracts with a health-benefits company that, in turn, contracts with health plans (only some of which are governed by ERISA), merely because its business arrangement with the health-benefits company may influence costs ultimately incurred downstream by ERISA plans. That unbounded theory threatens to eviscerate arm's-length negotiations between business counterparties and to ensnare doctors, hospitals, pharmacies and others in the healthcare chain as ERISA fiduciaries.

If accepted, Plaintiffs' theory would not only massively expand ERISA liability but preclude contractual counterparties from advancing their respective business interests when negotiating at arm's length—a result that the Ninth Circuit recently characterized as "absurd." *Santomenno v. Transamerica Life Ins. Co.*, 883 F.3d 833, 838 (9th Cir.

2018). Plaintiffs' overarching theory was rightly rejected on a motion to dismiss, and it should now be rejected by this Court, just as one court after another already has.

Nor do Plaintiffs' allegations meaningfully distinguish their claims from those rejected by courts. After the district court expressly invited Plaintiffs to attempt to amend, they bypassed that opportunity and instead appealed the dismissal without prejudice. The procedural upshot leaves numerous fatal gaps in Plaintiffs' allegations: Most fundamentally, Plaintiffs—who are sponsors, fiduciaries, or participants of health plans that contract with the health-benefits company Anthem, Inc. ("**Anthem**")—failed to plead that Express Scripts knew, or had any control over, the terms of the contracts between their health plans and Anthem. Express Scripts could not possess the requisite discretionary authority or control to be an ERISA fiduciary when it neither contracted directly with Plaintiffs' ERISA plans nor controlled the amounts that Anthem charged those plans under their contracts with Anthem.

Moreover, while purporting to piggyback on Anthem's allegations in a separate lawsuit that Express Scripts breached its contract with

Anthem by not charging "competitive benchmark pricing," Plaintiffs do not offer a coherent account of how that renders Express Scripts an ERISA fiduciary to the plans. They have *expressly disavowed* any notion that Express Scripts was a fiduciary in either its 2009 negotiations with Anthem over the initial contract (when the pricing was originally set), or its 2015 negotiations with Anthem (when Express Scripts did not accept Anthem's proposed new pricing terms), and they are *agnostic* as to whether Express Scripts ever actually breached its contract with Anthem. Such nebulous allegations cannot ground a valid legal claim.

Plaintiffs' allegations about Express Scripts' discretion over such matters as branded/generic classifications for certain drugs are similarly wayward. Express Scripts' decisions about such matters are a function of its across-the-board business policies and practices, and Plaintiffs have not pleaded contrary facts. Furthermore, the prices paid by Plaintiffs' plans are dictated by their individual contracts with Anthem. Nor have Plaintiffs even bothered to allege how any particular operational decision by Express Scripts was incorrect or damaged any particular Plaintiff, in any particular instance.

Finally, Plaintiffs have overreached still further by attempting to include claims under the Racketeer Influenced and Corrupt Organizations Act ("**RICO**"), the Affordable Care Act ("**ACA**"), and state law. Their grievances are, at best, contractual in nature, and do not translate to the far-flung theories Plaintiffs try to spin from them. Plaintiffs' sparse, oblique allegations fail to satisfy the established elements of the counts in their complaint. The district court was correct to dismiss each count and all of them together, while waiting to see if Plaintiffs could improve their allegations upon amending. Yet Plaintiffs have not amended, nor have they identified any valid basis to reverse the dismissal below.

COUNTER-STATEMENT OF JURISDICTION

Express Scripts agrees with Plaintiffs' jurisdictional statement, except with respect to this Court's appellate jurisdiction.

The district court dismissed Plaintiffs' second amended complaint without prejudice so that they could amend. *In re Express Scripts/Anthem ERISA Litigation*, 285 F. Supp. 3d 655, 690 (S.D.N.Y. 2018). "It is well established that a district court's order dismissing a complaint with leave to amend is not final and therefore not then

appealable." *Blanco v. United States*, 775 F.2d 53, 56 (2d Cir. 1985) (Friendly, J.). This Court therefore lacks jurisdiction under 28 U.S.C. § 1291, which permits appeal only from "final" decisions.

Express Scripts acknowledges that, under this Court's precedents, "an appellant can render such a non-final order 'final' and appealable by disclaiming any intent to amend," *Slayton v. American Express Co.*, 460 F.3d 215, 224 (2d Cir. 2006), and that Plaintiffs have disclaimed any intent to amend, Joint Appendix ("**JA**") 741.

But *Slayton* conflicts with decisions of the Supreme Court and other circuits, which reject the notion that disclaiming an intent to amend can transform a non-final order into a final decision; these decisions insist upon entry of a final order or judgment before jurisdiction arises under § 1291. *E.g.*, *Jung v. K. & D. Mining Co.*, 356 U.S. 335 (1958); *Sapp v. City of Brooklyn Park*, 825 F.3d 931, 935–36 (8th Cir. 2016) (dismissing for lack of jurisdiction despite disclaimer of intent to amend); *WMX Technologies, Inc. v. Miller*, 104 F.3d 1133, 1136 (9th Cir. 1997) (en banc) ("[A] plaintiff, who has been given leave to amend, may not file a notice of appeal simply because he does not choose to file an amended complaint. A further district court

determination must be obtained."). Express Scripts respectfully submits that the above-cited decisions are correct in their jurisdictional analysis and should be followed, with the instant appeal dismissed for lack of appellate jurisdiction. Alternatively, to the extent this Court finds jurisdiction where sister circuits would not, further review way be warranted to achieve consistency.

COUNTER-STATEMENT OF THE ISSUES

1. Whether the district court properly held that Express Scripts is not an ERISA fiduciary, particularly when (a) it negotiates the terms of an arm's-length contract with Anthem to provide PBM services for Anthem and Anthem's clients, only some of which are ERISA health plans; (b) it provides PBM services pursuant to the terms of that contract; (c) it does not agree to new pricing terms proposed by Anthem; and (d) it is not alleged to have engaged in any particular administrative misstep, relative to any particular plan, at the expense of any particular beneficiary?

2. Whether the district court properly held that ERISA's six-year statute of limitations was not tolled and therefore bars any ERISA

claims against Express Scripts for conduct in 2009, given that the initial complaint was not filed until May 6, 2016?

3. Whether the district court properly held that the complaint fails to plead a plausible RICO claim against Express Scripts?

4. Whether the district court properly held that the complaint fails to plead a plausible violation of the ACA's non-discrimination provision on the theory that prescription medication for HIV is costlier than prescription medication for other medical conditions?

COUNTER-STATEMENT OF THE CASE

A. Express Scripts and PBMs generally

Express Scripts is one of the largest PBMs in the United States. JA75 ¶ 109. PBMs "manage and administer prescription drug benefits on behalf of health plans subject to ERISA, as well as for non-ERISA plans." *Pharmaceutical Care Management Ass'n v. Gerhart*, 852 F.3d 722, 726 (8th Cir. 2017).

To carry out their responsibilities, PBMs perform an array of administrative tasks. For example, "[w]hen a plan participant fills a prescription at a pharmacy, the pharmacy checks with the PBM to determine coverage and obtain copayment information." *Id.*

The price paid for a prescription drug depends in part on the terms of separate contracts that PBMs negotiate at arm's length with pharmacies and with plan sponsors. After a pharmacy fills a prescription, "the PBM reimburses the pharmacy at a contractually agreed rate, minus the copay collected by the pharmacy from the plan participant. The PBM then separately bills the health plan at the rate negotiated between the PBM and the health plan." *Id.*

PBMs also negotiate separate contracts "with pharmaceutical manufacturers" for "rebates," JA74 ¶ 108, which the PBMs may pass through to their clients (such as health plans) according to the terms of the agreements between the PBMs and their clients. "Although plan sponsors often contract for a portion (or the entirety) of such amounts, rebates are owed, and directly paid, to the PBMs." *In re Express Scripts, Inc., PBM Litigation*, 2008 WL 2952787, at *5 (E.D. Mo. July 30, 2008).

PBMs pool together the purchasing power of all their clients to "get greater volume discounts from drug manufacturers and provide access to a larger network of pharmacies" than a single plan "could do on its own." *Pharmaceutical Care Management Ass'n v. District of*

Columbia, 613 F.3d 179, 182 (D.C. Cir. 2010). The rebate agreements that Express Scripts executes with drug manufacturers, and the network agreements that it executes with pharmacies, are "for its own account," spanning its entire book of business. JA77 ¶ 116; *see also* JA349 (Express Scripts "contracts for its own account with retail pharmacies . . . ."); JA350 (Express Scripts "contracts for its own account with manufacturers to obtain formulary rebates . . . ."). In other words, Express Scripts signs these agreements on its own behalf, not on behalf of any health plan.

B. Anthem and its PBM Agreement with Express Scripts

Anthem is "one of the nation's largest health benefits companies." JA73 ¶ 105. It insures or provides administrative services for a variety of health plans, including ERISA and non-ERISA plans. JA42 ¶ 3. Anthem also offers "Administrative Services Only" arrangements, in which employers that sponsor a self-funded plan pay Anthem for certain administrative services. JA42 ¶ 3.

In December 2009, Express Scripts and Anthem[1] executed a multi-hundred-page agreement ("**PBM Agreement**"), under which

[1] At the time, Anthem was called WellPoint, Inc. JA74 ¶ 106.

Express Scripts became the exclusive provider of PBM services to Anthem for 10 years. JA45 ¶ 12 & n.3; JA354–689. Simultaneously, Express Scripts purchased Anthem's in-house PBM, called NextRx. JA46 ¶ 15. During the negotiations leading up to these transactions, Express Scripts offered Anthem a spectrum of options for structuring the transaction: one such option included a $500 million upfront payment and lower prices for prescription drugs over the 10-year contract term; another included a $4.675 billion upfront payment and higher prices. Anthem chose the latter option. JA81 ¶¶ 127–28. A few years later, Anthem and Express Scripts executed an amended version of the PBM Agreement, dated January 1, 2012. JA45 n.3; JA324–52.

The PBM Agreement specifies the services that Express Scripts provides to Anthem. These include access to Express Scripts' network of pharmacies (§ 3.3, JA384–89) and processing of claims for prescription drugs (§ 3.7, JA334, JA393–95).

The PBM Agreement also specifies the prices that Anthem must pay to Express Scripts for prescription medications. *See* § 2.9, JA338, JA376 ("[Anthem] shall pay the administrative and other fees set forth in Section 5 and Exhibit A . . . ."). Section 5.4

. Special Appendix ("**SA**") 29.[2] Exhibit A

. SA30.

SA30.[3] Express Scripts has no discretion under these provisions to alter the price that Anthem pays.

Express Scripts' legal relationship extends no farther than Anthem; Anthem's client health plans, and persons enrolled in those plans, are neither parties to, nor third-party beneficiaries of, the PBM

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[2] .

[3] Unredacted versions of Section 5.4 and Exhibit A from the 2012 PBM Agreement are attached to Express Scripts' Motion To Supplement the Record, which is being filed simultaneously with this brief.

Agreement. PBM Agreement § 16.10, JA346, JA451 ("[Anthem] and [Express Scripts] specifically state, acknowledge and agree that this Agreement is intended solely for the benefit of each Party hereto . . . , and it is not the Parties' intent to confer any third party beneficiary rights hereunder and no such rights are conferred hereunder to any third party including, without limitation, Covered Individuals.").

Anthem's clients can elect to receive the PBM services that Express Scripts provides to Anthem, but to do so they must enter into separate agreements with Anthem. § 2.1(a), JA330, JA370 ("[*Anthem*] will offer to Plans the prescription drug benefits administered by [Express Scripts] pursuant to this Agreement. [*Anthem*] will be the entity that enters into the Coverage Documents with a Plan or sponsor(s) of such Plan . . . .") (emphasis added). Anthem's clients can also elect to refuse Anthem's offer of PBM services from Express Scripts and instead "enter[] into separate agreements for pharmacy benefit management services on their own behalf." § 12.1(a), JA343, JA436. At no point do Plaintiffs allege that Express Scripts knew or controlled the terms of any agreements between Anthem and its client plans.

Nor does Express Scripts control the price that Anthem charges to its client plans for any PBM services they receive from Express Scripts. Indeed, in Section 2.10 of the PBM Agreement, Anthem expressly "reserve[d] the right" to charge different prices to its client plans than what it pays Express Scripts and to pass on different amounts of rebates than what Express Scripts pays to Anthem. JA332, JA376.

C. Express Scripts' contract dispute with Anthem

Anthem and Express Scripts are currently involved in a separate commercial dispute over the prices that the PBM Agreement requires Anthem to pay. *See Anthem, Inc. v. Express Scripts, Inc.*, No. 16-cv-2048 (S.D.N.Y.). In that litigation, Anthem has not alleged that Express Scripts failed to abide by the current pricing terms of the PBM Agreement; rather, Anthem alleges that the PBM Agreement requires Express Scripts to accept *new* pricing terms that Anthem proposed.

Anthem relies on Section 5.6 of the PBM Agreement, which provides:

> **Periodic Pricing Review**. [Anthem] or a third party consultant retained by [Anthem] will conduct a market analysis every [redacted] during the Term of this Agreement to ensure that [Anthem] is receiving competitive benchmark pricing. In the event [Anthem] or its third party consultant determines that such pricing terms are not

> competitive, [Anthem] shall have the ability to propose renegotiated pricing terms to [Express Scripts] and [Anthem] and [Express Scripts] agrees to negotiate in good faith over the proposed new pricing terms. Notwithstanding the foregoing, to be effective any new pricing terms must be agreed to by [Express Scripts] in writing.

SA5, JA341, JA424.[4] As the text of Section 5.6 makes clear, Express Scripts' only obligation is to "negotiate in good faith" with Anthem over any new pricing terms that Anthem proposes under this provision (which Express Scripts has done). Express Scripts has no obligation to accept Anthem's proposed pricing terms or otherwise alter the pricing terms set in the PBM Agreement. To the contrary, Section 5.6 confirms that the parties are not required to reach agreement on new pricing terms by providing that, "[n]otwithstanding the foregoing, to be effective any new pricing terms must be agreed to by [Express Scripts] in writing."

Since the amended PBM Agreement was executed in 2012, Express Scripts has not agreed in writing to any new pricing terms proposed by Anthem under Section 5.6. *See Express Scripts/Anthem*,

[4] An unredacted copy of Section 5.6 of the 2012 PBM Agreement was filed under seal with the district court as Exhibit A to the Declaration of Angela Adler, ECF 99, *In re Express Scripts/Anthem ERISA Litigation*, No. 1:16-cv-03399-ER (S.D.N.Y. April 24, 2017).

285 F. Supp. 3d at 665–66 (summarizing the Complaint's allegations regarding pricing negotiations). Thus, the pricing terms from the 2012 PBM Agreement remain in effect.

D. Plaintiffs

Plaintiffs are six individuals enrolled in Anthem health plans and two fiduciaries of ERISA health plans that have Administrative Services Only contracts with Anthem. JA53–72 ¶¶ 35–100. Plaintiffs do not allege that they or their plans have any contracts with Express Scripts.

Lacking any contractual relationship with Express Scripts, Plaintiffs have instead attempted to piggyback on the separate contractual dispute between Anthem and Express Scripts. JA41 n.1. Plaintiffs' claims against Express Scripts are rooted primarily in (1) Anthem's allegation in the separate lawsuit that Express Scripts breached Section 5.6 by not agreeing to new pricing terms proposed by Anthem in 2015, and (2) Express Scripts' allegation that Anthem chose in 2009 to accept higher drug prices over the 10-year life of the PBM Agreement in exchange for more cash upfront from Express Scripts ($4.675 billion rather than $500 million). JA6–7 ¶¶ 13–17; JA81

¶¶ 127–130; JA90–102 ¶¶ 164–200. Based on these allegations, Plaintiffs claim that they have been overcharged for specific prescription medications ever since the PBM Agreement was executed in 2009, and that Anthem and Express Scripts are liable for those overcharges. JA82 ¶ 131; JA86–87 ¶¶ 146–47.

E. Procedural history

Plaintiffs John Doe One and John Doe Two—two individuals prescribed medication for the treatment of HIV—filed a complaint in the Southern District of New York on May 6, 2016. JA1. Plaintiffs Karen Burnett, Brendan Farrell, and Robert Shullich filed a separate complaint the next month (JA20). The cases were consolidated (JA5, JA24), and an amended complaint, adding Plaintiff Brian Corrigan, was filed shortly thereafter (JA5). After Express Scripts and Anthem moved to dismiss (JA8), a second amended complaint ("**Complaint**")—which is the operative complaint that added Plaintiffs Stamford Health, Inc., and Brothers Trading Co., Inc.—was filed on March 2, 2017 (JA10). The Complaint contains 17 separate claims for relief from violations of ERISA, RICO, the ACA, and New York law. JA 98–133 ¶¶ 313–467.

Express Scripts and Anthem again moved to dismiss. JA11. The motions were fully briefed, and the district court (Ramos, J.) granted the motions, dismissing the Complaint without prejudice on January 5, 2018. JA17. The sealed version of the opinion and order dismissing the complaint is available at SA1–50; the public redacted version is published as *In re Express Scripts/Anthem ERISA Litigation*, 285 F. Supp. 3d 655 (S.D.N.Y. 2018).

As an initial matter, the district court dismissed all claims of two individual plaintiffs (Burnett and Farrell) for lack of standing. *Id.* at 673. Plaintiffs have not challenged their dismissal in this appeal.

The court then held that any claims based on conduct before May 6, 2010—which was six years before the first complaint—are barred by ERISA's six-year statute of limitations and that the "Plaintiffs have not shown that they are entitled to equitable tolling under ERISA's 'fraud or concealment' exception." *Id.* at 676.

Substantively, the district court held that the Complaint failed to plausibly allege that either Express Scripts or Anthem was an ERISA fiduciary with respect to the actions occasioning complaint. For Express Scripts, the district could held, among other things, that (1)

Section 5.6 does not give Express Scripts sufficient discretion over pricing to be an ERISA fiduciary because "the prescription drug pricing at issue here was not subject only to the requirements of Section 5.6, but was also constrained by the more specific requirements of Section 5.4 and Exhibit A," *id.* at 679; and (2) other provisions of the PBM Agreement relied on by Plaintiffs—such as provisions concerning the amount of rebates Express Scripts pays to Anthem and provisions concerning the classification of drugs as branded or generic—also were insufficient to allege plausibly that Express Scripts was an ERISA fiduciary, *id.* at 680–81. For Anthem, the district court held that it was not acting as an ERISA fiduciary because "a health benefits company setting prices in its role as a health insurer is not acting as an ERISA fiduciary." *Id.* at 684.

Because Anthem and Express Scripts were not ERISA fiduciaries with regard to the challenged conduct, the district court also dismissed Plaintiffs' claims that Anthem and Express Scripts were liable under ERISA as co-fiduciaries or non-fiduciaries for participating in a prohibited transaction with a fiduciary. *Id.* at 681, 684.

The district court also dismissed Plaintiffs' non-ERISA claims. The RICO claim was dismissed "[b]ecause the predicate acts alleged in the [Complaint] are all connected to misrepresentations from [Express Scripts] to Anthem, and because those misrepresentations were plead[ed] with insufficient particularity, . . . Plaintiffs have failed to plead predicate acts as required under RICO." *Id.* at 686. The ACA claim was likewise dismissed because Plaintiffs failed to "plead facts sufficient to sustain a claim against [Express Scripts]." *Id.* at 688. Plaintiffs made no allegations, for instance, that the allegedly inflated co-insurance rates for Plaintiffs' HIV drugs were actually higher than the co-insurance rates for other prescription drugs that treat non-HIV related conditions. *Id.* With all the federal claims dismissed, the court declined to exercise jurisdiction over Plaintiffs claims under New York law. *Id.* at 689–90.

In dismissing without prejudice, the district court granted Plaintiffs' request for leave to further amend the Complaint. *Id.* at 690. It explained that there was "a possibility that the unredacted [2012] PBM Agreement [which Plaintiffs received after they filed the Complaint] provides Plaintiffs with newly available information that

enables them to raise colorable claims based on the Court's guidance in this opinion." *Id.*

Despite this invitation, Plaintiffs did not amend their complaint. Instead, on February 2, 2018, they filed this appeal without obtaining a final judgment from the district court. JA741.

SUMMARY OF ARGUMENT

Plaintiffs fundamentally err by basing their complaint on a dispute between Express Scripts and Anthem over the interpretation of a contract to which Plaintiffs are not a party. Plaintiffs have taken that dispute and tried to refashion it into claims under ERISA, RICO, and the ACA. In so doing, Plaintiffs have stretched those laws well beyond the pale of governing authority and any concrete facts set forth in their Complaint. Their Complaint does not plausibly allege a violation of any of these laws, and the district court's dismissal should be affirmed.

First, Plaintiffs assert that Express Scripts is an ERISA fiduciary because it has some discretion over prescription drug prices and its own compensation. Plaintiffs point to four sources of this alleged control: (1) Section 5.6, which permits Anthem to propose new pricing terms under certain circumstances; (2) Express Scripts' classification of

"brand" and "generic" drugs; (3) Express Scripts' determinations of the drugs and maximum prices that appear on its maximum allowable cost ("**MAC**") list; and (4) Express Scripts' payments to Anthem of amounts tied to rebates received from manufacturers.

As the district court correctly recognized, Express Scripts does not exercise discretionary control over pricing under the PBM Agreement. Rather, that pricing is fixed by Section 5.4 and Exhibit A. Express Scripts did not act as an ERISA fiduciary when it negotiated the PBM Agreement with Anthem at arm's length, nor did it become an ERISA fiduciary by simply adhering to the terms of that agreement. Because that same conduct did not transform Anthem, either, into an ERISA fiduciary, Express Scripts cannot be liable for any alleged fiduciary breach by Anthem, much less for *knowingly* contributing to any breach. As for determinations of drug classifications, MAC listings, and payment of amounts tied to rebates, those are a function of Express Scripts' across-the-board business policies that neither were made as a discretionary matter for any particular plan, nor were errant (even allegedly) for any particular drug or beneficiary. In sum, Plaintiffs have no coherent theory of a fiduciary duty, let alone a breach.

Next, Plaintiffs fail to plead a RICO violation. Plaintiffs' RICO claim is just another restatement of the contract dispute between Express Scripts and Anthem; courts refuse, however, to read RICO as covering run-of-the-mill contractual disputes. Even if Plaintiffs had a claim beyond that contract dispute, they did not plead it in the Complaint with requisite particularity. Plaintiffs do not offer any details about any allegedly fraudulent statements made by Express Scripts to Anthem, and they fail to plausibly allege that Express Scripts somehow defrauded Plaintiffs by charging the very drug prices dictated by the terms of the PBM Agreement.

Finally, Plaintiffs overreach by trying to transform the ACA's non-discrimination clause into a radical price-regulation scheme that mandates uniformity in out-of-pocket costs for all prescription medications. According to Plaintiffs' anomalous theory, Express Scripts should be liable under the ACA for neutrally charging—to all Anthem subscribers—the same price for the same drug, simply because payment of market prices has a "disparate impact" on Plaintiffs with HIV (whose HIV medications are more expensive and are attended by greater out-of-pocket costs than others pay for certain non-HIV medications). That

theory of discrimination is of Plaintiffs' own invention and is not properly grounded in the ACA.

Accordingly, this Court should affirm the district court's dismissal of the Complaint as to Express Scripts.

STANDARD OF REVIEW

This Court "review[s] the district court's grant of a motion to dismiss *de novo*, but may affirm on any basis supported by the record." *Coulter v. Morgan Stanley & Co.*, 753 F.3d 361, 366 (2d Cir. 2014).

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007)).

"And while a court must accept all of the allegations contained in a complaint as true, 'that tenet is inapplicable to legal conclusions, and threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.'" *Balintulo v. Ford Motor Co.*, 796 F.3d 160, 165 (2d Cir. 2015) (citation omitted). Nor should the Court credit any allegation that is "contradicted by more specific allegations or documentary evidence," including documents

incorporated by reference into the complaint—such as the PBM Agreement. *NECA-IBEW Health & Welfare Fund v. Goldman Sachs & Co.*, 693 F.3d 145, 149 n.1 (2d Cir. 2012); *see* JA45 ¶ 12 n.3 (incorporating PBM Agreement into the Complaint).

ARGUMENT

I. Express Scripts Is Not Liable Under ERISA

Plaintiffs' core contention against Express Scripts is that they pleaded a viable claim that Express Scripts breached a fiduciary duty, in violation of ERISA, by causing Plaintiffs' plans to pay too much for prescription drugs. Opening Brief 39–47. But the mere fact that a business upstream in the healthcare chain may make choices that somehow influence the ultimate price paid downstream by a plan and/or its participants does not give rise to fiduciary status under ERISA.

"In every case charging breach of ERISA fiduciary duty, . . . the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). The district

court correctly held that the "Plaintiffs have not alleged sufficient facts to support a finding that Express Scripts acted as a fiduciary in its relevant conduct." *Express Scripts/Anthem*, 285 F. Supp. 3d at 681. Various arguments that Plaintiffs advance have been rejected repeatedly over the past 15 years by courts, which uniformly hold that PBMs are not ERISA fiduciaries when providing services of the sort challenged here. *E.g.*, *Chicago District Council of Carpenters Welfare Fund v. Caremark, Inc.*, 474 F.3d 463 (7th Cir. 2007); *In re UnitedHealth Group PBM Litigation*, 2017 WL 6512222, at *8–10 (D. Minn. Dec. 19, 2017) (collecting cases); *In re Express Scripts, Inc., PBM Litigation*, 2008 WL 2952787, at *5 (E.D. Mo. July 30, 2008) (applying this case law to Express Scripts). Plaintiffs have not offered any persuasive reason to deviate from this consistent, well developed body of case law and to upset settled expectations across the healthcare industry.

A. The test for an ERISA fiduciary

There are two types of ERISA fiduciaries: named fiduciaries and *de facto* fiduciaries. A named fiduciary is a fiduciary named in the ERISA plan. 29 U.S.C. § 1102(a). Plaintiffs do not allege that either

Express Scripts or Anthem is a named fiduciary. Indeed, Section 9 of the PBM Agreement expressly disclaims that Express Scripts has a fiduciary relationship with Anthem or any of Anthem's plans. JA342, JA432 ("Nothing in this Agreement shall be deemed or construed to create a . . . fiduciary . . . relationship between the Parties, including, but not limited to, as between [Express Scripts] and any Plan.").

"Even if not a named fiduciary, a person is a *de facto* fiduciary under ERISA 'to the extent' she, *inter alia*, (a) '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 (b) 'has any discretionary authority or discretionary responsibility in the administration of such plan." *Coulter*, 753 F.3d at 366 (quoting 29 U.S.C. § 1002(21)(A)). "Under this definition, a person may be an ERISA fiduciary with respect to certain matters but not others, for he has that status only 'to the extent' that he has or exercises the described authority or responsibility." *F.H. Krear & Co. v. Nineteen Named Trustees*, 810 F.2d 1250, 1259 (2d Cir. 1987).

Notably, the "discretionary act" that gives rise to *de facto* fiduciary status "must be undertaken with respect to *plan management or administration*." *Coulter*, 753 F.3d at 367 (emphasis added). In contrast, a service provider "is not an ERISA fiduciary merely because it administers or exercises discretionary authority over its *own* . . . business." *Pegram*, 530 U.S. at 223 (emphasis added); *accord American Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352, 357 n.2 (2d Cir. 2016) ("'[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.'") (quoting *Flanigan v. General Electric Co.*, 242 F.3d 78, 88 (2d Cir. 2001)).

B. Express Scripts is not an ERISA fiduciary

Plaintiffs are wrong to assert that Express Scripts is an ERISA fiduciary because various provisions of the PBM Agreement—especially Section 5.6—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. Furthermore, case law forecloses any misconception that Express Scripts' 2009 negotiation of

the contractual pricing terms, its adherence to them in the years since, or its decision not to accept Anthem's proposed new pricing terms in 2015 rendered Express Scripts a fiduciary.

In any event, the prices that Express Scripts charges are to *Anthem*, and Section 2.10 makes clear that it is *Anthem*—not Express Scripts—that ultimately decides what to charge Plaintiffs' plans. In that fundamental respect, too, Express Scripts lacks discretion or control over what Anthem's client plans—*i.e.*, Plaintiffs' plans—pay for prescription drugs.

1. Fiduciary status is not triggered by negotiating and charging agreed pricing terms, or by declining to accept new pricing terms

Negotiating. Express Scripts and Anthem negotiated the PBM Agreement as non-ERISA commercial entities structuring their business relationship. They did not negotiate the arm's-length Agreement for the benefit of any other party. *See* PBM Agreement § 16.10, JA346, JA451.

It is well-settled that "a plan administrator is not an ERISA fiduciary when negotiating its compensation with a prospective customer." *Santomenno v. Transamerica Life Ins. Co.*, 883 F.3d 833,

837 (9th Cir. 2018) (collecting cases). "When a person who has no relationship to an ERISA plan is negotiating a contract with that plan," this Court has held that such a person "has no authority over or responsibility to the plan and presumably is unable to exercise any control over the trustees' decision whether or not, and on what terms, to enter into an agreement with him." *F.H. Krear*, 810 F.2d at 1259. Accordingly, "[s]uch a person is not an ERISA fiduciary with respect to the terms of the agreement for his compensation." *Id.*; *accord Harris Trust & Savings Bank v. John Hancock Mutual Life Ins. Co.*, 302 F.3d 18, 31 (2d Cir. 2002); *Santomenno ex rel. John Hancock Trust v. John Hancock Life Ins. Co. (U.S.A.)*, 768 F.3d 284, 293 (3d Cir. 2014) ("[W]hen a service provider and a plan trustee negotiate at arm's length over the terms of their agreement, discretionary control over plan management lies not with the service provider but with the trustee, who decides whether to agree to the service provider's terms."). "Succinctly put, contract negotiation is not discretionary plan administration." *Marks v. Independence Blue Cross*, 71 F. Supp. 2d 432, 436 (E.D. Pa. 1999).

What is true generally is true for PBMs specifically: PBMs are not ERISA fiduciaries when they negotiate arm's-length deals to provide PBM services to an ERISA plan. *Chicago District Council*, 474 F.3d at 477 (PBM "was not a fiduciary at the time it was engaged in arm's-length negotiations with [the plan sponsor], prior to entering into any of the agreements."); *Bickley v. Caremark Rx, Inc.*, 361 F. Supp. 2d 1317, 1332 (N.D. Ala. 2004) ("Making an advantageous contractual agreement with an ERISA plan does not make one an ERISA fiduciary."), *affirmed*, 461 F.3d 1325 (11th Cir. 2006).

Unlike discretionary plan administration, pre-contract negotiations about what prices to charge and what compensation to accept for services rendered to an ERISA plan qualify as "corporate business decisions," which do not trigger fiduciary status. *American Psychiatric Ass'n*, 821 F.3d at 357 n.2. Indeed, any contrary view would be unworkable—putting publicly traded service providers (with legal obligations to their shareholders) in the impossible predicament of having ***simultaneously*** to pursue their ***own*** business interests ***and*** those of plan beneficiaries that may arguably face downstream costs resulting from concessions won from the other side of the table.

Express Scripts was therefore not an ERISA fiduciary when it negotiated the arm's-length PBM Agreement with Anthem in 2009.[5] Indeed, Plaintiffs conceded this point below. In opposing Express Scripts' motion to dismiss, they expressly stated that it is "erroneous[]" to contend that "Plaintiffs' allegations regarding [Express Scripts'] fiduciary status are based on . . . [Express Scripts'] negotiation of the original terms of the PBM Agreement in 2009," and that, among the Complaint's 467 paragraphs, "*not one* alleges that [Express Scripts'] negotiation of the PBM Agreement . . . gives rise to [Express Scripts'] fiduciary status." Plaintiffs' Consolidated Memorandum of Law in Opposition to Defendants' Motions To Dismiss ("**MTD Opposition**") at 24 & n.11, ECF 109, *In re Express Scripts/Anthem ERISA Litigation*, No. 1:16-cv-03399-ER (S.D.N.Y. June 9, 2017).

Charging. Section 5.4 and Exhibit A specify the pricing that Express Scripts must charge to Anthem for prescription drugs—there is no discretion. *See* pages 10–11, above.

Service providers do not become ERISA fiduciaries when they charge prices specified in an arm's-length service contract. *See Harris*

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[5] Claims arising from 2009 are also untimely. *See* Section II, below.

Trust, 302 F.3d at 31 (service provider not an ERISA fiduciary when it collects 1% fee specified in arm's-length services contract). Otherwise, the settled rule discussed above—that corporate negotiations do not trigger fiduciary status—would be upended as soon as a plaintiff alleged that a service provider breached a fiduciary obligation by performing a contract per the negotiated terms. "Because [the service provider] did not owe plan participants a fiduciary duty while negotiating the fee terms with [the plan sponsor], [the service provider] could not have breached any such duty merely by charging the fees described in the contract that resulted from that bargaining process." *McCaffree Financial Corp. v. Principal Life Ins. Co.*, 811 F.3d 998, 1003 (8th Cir. 2016).

In a similar case, the Seventh Circuit held in *Chicago District Council* that a PBM "owed no fiduciary duties" when paying to a plan the rebates it received from pharmaceutical manufacturers "because the amount was fixed in the contract" and it "was the deal for which [the plan sponsor] bargained with [the PBM] at arm's length." 474 F.3d at 476. Paying rebates to a plan for a prescription drug is functionally equivalent to charging the plan a reduced price for that drug (a rebate

is simply a retroactive discount on the price of the drug); it follows that a PBM does not become a fiduciary when it charges a fixed price specified by a services agreement.

Declining to accept proposed new pricing terms. Nor does a service provider act as an ERISA fiduciary simply by not agreeing to alter the pricing terms in an arm's-length contract. Just as fiduciary duties do not arise from charging prices fixed by an arm's-length contract, so too they do not arise from "adhering to the bargained-for terms of the Contract" rather than renegotiating those terms. *Harris Trust*, 302 F.3d at 30. This too is a necessary corollary of the settled rule that arm's-length negotiations over an initial contract do not trigger fiduciary status. Otherwise, the rule would be upended as soon as a plaintiff alleged that a PBM breached its fiduciary status not through the initial contract negotiation, but one or two beats later, by declining to ***re***negotiate. Of course, contract terms are ***always*** open (explicitly or implicitly) to renegotiation; no clear line differentiates the dynamics, incentives, and prerogatives that business counterparties confront at one stage versus another of their contractual negotiations,

renegotiations, and renewals, which can be fluid and ongoing, especially in this context.

It follows that Express Scripts was not a fiduciary when, following extensive good-faith negotiations in 2015, it ultimately made the business decision to not accept Anthem's proposed new pricing terms offered under Section 5.6. Plaintiffs once again conceded this point below in opposing the motion to dismiss, when they stated that it is "erroneous[]" to contend that "Plaintiffs' allegations regarding [Express Scripts'] fiduciary status are based on . . . [Express Scripts'] refusal to agree to revised pricing terms proposed by Anthem in 2015," and that, among the Complaint's hundreds of allegations, "*not one* alleges that [Express Scripts'] . . . refusal to accept Anthem's pricing proposals in 2015 gives rise to [Express Scripts'] fiduciary status." MTD Opposition at 24 & n.11. That premise is shared and dispositive: Express Script's negotiations with Anthem in 2015 (which did not ultimately culminate in an agreement) did not give rise to fiduciary status any more than the initial 2009 contract negotiations did. Nothing intelligible remains of Plaintiffs' claim against Express Scripts based on its contractual dealings with Anthem.

2. Express Scripts is also not a fiduciary because it contracted with Anthem, not the ERISA plans

The flaws noted above would all be fatal even if Express Scripts had been negotiating ***directly*** with ERISA plans. They are all the more fatal, however, considering that Express Scripts was negotiating ***only*** with Anthem, a non-ERISA entity, and ***not*** with ERISA plans themselves. To be clear, courts have recognized that Express Scripts could not become a fiduciary by negotiating arm's-length contracts *directly* with ERISA plans, charging contractually fixed prices *directly* to ERISA plans, or not agreeing on revised pricing terms *directly* with ERISA plans. It follows that Express Scripts could not become a fiduciary to Plaintiffs or other ERISA plans *indirectly* by negotiating, charging, and not agreeing on revised pricing terms with Anthem, an entity that enters into separate agreements with ERISA and non-ERISA plans. *Cf. DeLuca v. Blue Cross Blue Shield of Michigan*, 628 F.3d 743, 747 (6th Cir. 2010) ("We conclude, as did the district court, 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." (emphasis added)).

Notably, if Anthem's clients disapprove of Express Scripts, nothing in the PBM Agreement obligates them to accept PBM services from Express Scripts. The plans can either choose to not contract with Anthem at all, or they can choose to contract with Anthem for everything except PBM services. Indeed, Section 12.1(a) of the PBM Agreement notes that Anthem's clients may sign their own separate agreements for PBM services. JA343, JA436 (Anthem's client plans are free to "enter[] into separate agreements for pharmacy benefit management services on their own behalf"). Because the plans "remained free to . . . contract with an alternative service provider offering more attractive pricing or superior . . . products," Express Scripts "could not have maintained or exercised any 'authority' over the plan and thus could not have owed a fiduciary duty under ERISA." *McCaffree*, 811 F.3d at 1003; *accord Santomenno*, 768 F.3d at 295 ("Nothing prevented the [plan's] trustees from rejecting [the provider's] product and selecting another service provider; the choice was theirs.").

3. None of Plaintiffs' other arguments that Express Scripts has discretion over pricing establish that Express Scripts is a fiduciary

In a faint effort to pin fiduciary status to some aspect of plan management or administration, Plaintiffs assert that Express Scripts assumed and breached fiduciary duties by exercising certain discretion in its operations. Specifically, Plaintiffs allege that Express Scripts has discretion over the prices that plans pay for prescription drugs by virtue of its purported discretion over (i) its negotiations with Anthem under Section 5.6; (ii) the classification of drugs as "brand" or "generic"; (iii) the determination of which drugs are included on a MAC list and (iv) whether to pass rebates on to plans. But none of these activities give Express Scripts the discretionary control over plan management or administration that would trigger fiduciary status under ERISA, and each fails for multiple reasons.

Section 5.6. Plaintiffs' claim that Section 5.6 of the PBM Agreement gives Express Scripts "substantial discretion" over the prices plans pay for prescription medication is belied by the plain terms of the Complaint and the PBM Agreement. It thus repeats the same

misconceived bid to inject fiduciary duties into arm's-length negotiations over contractual terms.

Pricing of prescription drugs is set by Section 5.4 and Exhibit A of the PBM Agreement. As the district court noted, Section 5.4 "contradicts Plaintiffs' allegations that [Express Scripts] had the discretion to set drug prices paid by Plaintiffs." *Express Scripts/Anthem*, 285 F. Supp. 3d at 678 n.34. And, as explained above, Express Scripts' implementation of the pricing terms set by the PBM Agreement is a ministerial task that does not render it a fiduciary. *See McCaffree*, 811 F.3d at 1003 ("[A] service provider's adherence to its agreement with a plan administrator does not implicate any fiduciary duty where the parties negotiated and agreed to the terms of that agreement in an arm's-length bargaining process.").

All Section 5.6 does is permit Anthem to conduct a "market analysis" at certain times. JA341, 424. If Anthem determines that the service fees and drug prices it pays are not competitive, then it has the limited ability "to propose renegotiated pricing terms to [Express Scripts]," after which Anthem and Express Scripts are required to "negotiate in good faith over the proposed new pricing terms." *Id.*

(emphasis added). To be effective, "any new pricing terms must be agreed to by [Express Scripts] in writing." *Id.*

Express Scripts is no more of a fiduciary when it negotiates and decides whether to accept new pricing under Section 5.6 than it was when it negotiated and decided whether to accept the original pricing. *See* Section I.B.1, above.

Moreover, a prerequisite to triggering Express Scripts' duties under Section 5.6 is that Anthem must first "propose renegotiated pricing terms." The only instance alleged in the Complaint where Anthem proposed and Express Scripts did not accept renegotiated pricing terms was in 2015. *See Express Scripts/Anthem*, 285 F. Supp. 3d at 665–66 (summarizing the Complaint's allegations regarding pricing negotiations). Yet, as also noted above, Plaintiffs expressly concede Express Scripts was not acting as a fiduciary when it declined to agree to new pricing terms Anthem proposed in 2015. *See* MTD Opposition at 24 & n.11. That alone refutes their claim.

Finally, Section 5.6 applies only to the prices that Express Scripts charges to *Anthem*. Even assuming *arguendo* that Section 5.6 somehow provides discretion to Express Scripts over drug pricing, that discretion

extends only to the prices charged to *Anthem*—not to Plaintiffs' plans. Again, plans remain free not only to contract with providers other than Anthem, but also to find PBMs other than Express Scripts even while contracting with Anthem. *See* Section I.B.2, above.

Brand-Generic classification. Plaintiffs assert that Express Scripts "has discretion to classify drugs as brand or generic pursuant to a proprietary algorithm." Opening Brief 10. But Express Scripts classifies drugs as brand or generic as part of the management of its business (PBM Agreement Exhibit N, JA349, JA680), and its decisions are not specific to Anthem plans—they apply across its entire book of business—so they do not give rise to fiduciary status. *See Moeckel v. Caremark, Inc.*, 622 F. Supp. 2d 663, 682 (M.D. Tenn. 2007) (PBM did not act as a fiduciary by using the same method "across its entire book of business for determining whether a drug is brand or generic.").[6]

More fundamentally, Plaintiffs ignore the fact that the prices their plans actually pay for prescription drugs are determined by plans'

[6] Plaintiffs also assert that Express Scripts does not disclose its classification algorithm (Opening Brief 42), but the assertion is irrelevant and, in any event, the algorithm and its results are in fact disclosed to Anthem on request, *see* 2012 PBM Agreement § 1.37, JA326; 2009 PBM Agreement § 1.26, JA360.

contracts with Anthem, not by Express Scripts (with which they do not contract). *See* PBM Agreement § 2.10, JA332, JA376. Express Scripts' classification of drugs as brand or generic therefore does not involve the exercise of any discretionary authority over *plan* assets that would give rise to ERISA fiduciary status; no matter what classification Express Scripts applies, Anthem has the ultimate authority as to how much to charge Plaintiffs' plans.

In any event, as the district court noted, Plaintiffs do not allege that any particular implementation of Express Scripts' brand-versus-generic-drug algorithm actually misclassified any drug or harmed any particular Plaintiff: "Plaintiffs offer no allegations of misconduct with respect to . . . the classification of drugs." *Express Scripts/Anthem*, 285 F. Supp. 3d at 681. The lack of connection between the conduct allegedly triggering fiduciary status and anything grounding complaint by a particular plaintiff is itself fatal. *See Santomenno*, 768 F.3d at 296–97 ("[I]t is clear that a complaint alleging breach of ERISA fiduciary duty must plead that the defendant was acting as a fiduciary '*when taking the action subject to complaint.*'") (emphasis added) (quoting *Pegram*, 530 U.S. at 226).

MAC list. Plaintiffs also contend that Express Scripts has discretion to "determine which drugs are included on its 'maximum allowable cost' (MAC) list, and determine for each of those drugs what the MAC price is." Opening Brief 42. But the MAC list reflects a business decision applicable to all of Express Scripts' clients. As such, Express Scripts' placement and cost of drugs on that list cannot give rise to fiduciary status. *See Express Scripts*, 2008 WL 2952787, at *9 (Express Scripts' "standard pricing policy, in retaining discretion over MRAs, is a business decision outside its relationships (fiduciary, or otherwise) with ERISA plans."); *Moeckel*, 622 F. Supp. 2d at 680, 682 (finding PBM did not act as a fiduciary by managing its own MAC list).

Additionally, the MAC list itself does not determine what prices *plans* pay for prescription drugs; at most it affects the pricing for *Anthem*. Anthem is left to determine for itself where to set its own pricing levels when contracting with its clients. *See* § 2.10, JA332, JA376 (Anthem "reserves the right" to charge different prices and pass on different amounts of rebates to its client plans than what Express Scripts provides to Anthem). Express Scripts therefore does not

exercise any discretionary authority in determining its MAC list that would give rise to ERISA fiduciary status relative to any plan.

Finally, as the district court rightly ruled, Plaintiffs fail to connect any issue with the MAC list to any particular drug, or price, or damage to any Plaintiff, leaving this sub-theory utterly beside the point and no basis for a plausible claim. *See Express Scripts/Anthem*, 285 F. Supp. 3d at 680–81.

Rebates. Plaintiffs also contend that Express Scripts "obtains rebates on prescription medications from drug manufacturers, and under the PBM Agreement has the ability to decide whether to pass the rebates through to the Plans or keep them for itself." Opening Brief 43. This claim is both factually and legally wrong.

As an initial matter, Plaintiffs' contention is again refuted by the PBM Agreement itself. Per those terms, Express Scripts shares rebates with Anthem, and not Anthem's clients (with whom Express Scripts has no contractual relationship). The PBM Agreement establishes a fixed percentage of rebates payable to Anthem. *See* § 5.3, JA339, JA418–22. The payment of rebates in an amount contractually prescribed is not a fiduciary task. *See Chicago District Council*, 474 F.3d at 475–76;

Express Scripts, 2008 WL 2952787, at *11 (Express Scripts is "not a fiduciary for the purpose of negotiating rebates," in part because the contract there called for payment of a fixed portion of rebates).

Additionally, Express Scripts negotiates rebates for its "own account" across its entire book of business (JA77 ¶ 116; *see also* JA350, JA682) and does not act in a fiduciary capacity for any particular ERISA plan in performing that function. *See Moeckel*, 622 F. Supp. 2d at 684 (PBM did not act as fiduciary in negotiating with drug manufacturers); *Mulder v. PCS Health Systems, Inc.,* 432 F. Supp. 2d 450, 458–60 (D.N.J. 2006) (same). Requiring Express Scripts to act as a fiduciary for a specific plan when negotiating rebates would be "self-defeating," as Express Scripts' "financial advantage" in these rebate negotiations "arises from the market power" that Express Scripts has as a large purchaser"; if it were "required to negotiate solely on a plan-by-plan basis, as a practical matter its economic advantage in the market would be destroyed, damaging its ability to do business on a system-wide basis, ultimately to the [plan] beneficiaries' disadvantage." *DeLuca*, 628 F.3d at 747.

Finally, the district court also correctly concluded that Plaintiffs' rebate theory should be dismissed for the additional reason that they "offer no allegations of misconduct with respect to the allocation of rebates." *Express Scripts/Anthem*, 285 F. Supp. 3d at 681.[7]

4. Express Scripts' alleged breach of the PBM Agreement does not make it an ERISA fiduciary

Plaintiffs further err in arguing that Express Scripts exercised discretion by violating its supposed "contractual obligation" under Section 5.6 of the PBM Agreement "to charge 'competitive benchmark pricing." Opening Brief 45. As explained above, Section 5.6 imposes no such obligation on Express Scripts. Express Scripts' only obligation is to negotiate in good faith when Anthem proposed new pricing terms under Section 5.6; it is not required to accept any new pricing proposal.

In any event, this argument merely reframes a breach-of-contract claim and should therefore be rejected as a matter of law. *See Sheet Metal Local 98 Pension Fund v. AirTab, Inc.*, 482 F. App'x 67, 69 (6th

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[7] An *amicus* brief by the AARP and the National Employment Lawyers Association repeats Plaintiffs' arguments regarding alleged fiduciary status and breach. Doc. 110 at 21–25. That brief evinces the same misconceptions Plaintiffs' does. What is more, it seems thoroughly out of touch with the actual allegations of the Complaint and largely unconcerned with any distinct role Express Scripts played as a PBM.

Cir. 2012) ("Their breach of fiduciary duty claim is therefore best characterized as a restatement of its other [contract] claims. In the past, we have disapproved of such restatements under ERISA.").

Plaintiffs' reliance on *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001), is misplaced. *Devlin* involved an alleged violation of *ERISA plan documents* by the *employer* that sponsored the plan, *id.* at 88—not an alleged breach by a *service provider* of a *service agreement* signed with a third party. Equally inapt is *Negron v. Cigna Health & Life Insurance*, 2018 WL 1258837 (D. Conn. Mar. 12, 2018), which also involved an alleged violation of "plan terms" when directly contracting (*id.* at *8) rather than of a service agreement relative to a third party.[8]

In contrast, under law this Court has cited with approval, a business counterparty does not become a fiduciary under ERISA simply because it breaches a contract with a plan. *See In re Luna*, 406 F.3d

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[8] To the extent *Negron* conflicts with the voluminous body of case law addressing the fiduciary status of PBMs under ERISA, including *Chicago District Council*, 474 F.3d 463; *UnitedHealth*, 2017 WL 6512222; *Express Scripts*, 2008 WL 2952787; *Moeckel*, 622 F. Supp. 2d 663; *Mulder,* 432 F. Supp. 2d 450; and *Bickley*, 361 F. Supp. 2d 1317, it was wrongly decided and should not be followed.

1192, 1203 (10th Cir. 2005) ("In our view, an employer cannot become an ERISA fiduciary merely because it breaches its contractual obligations to a fund. ERISA's text and purpose, the law of trusts, Department of Labor regulatory pronouncements, and case law all lend support to our conclusion."); *see also In re Halpin*, 566 F.3d 286, 289, 291–92 (2d Cir. 2009) (citing *Luna* with approval and holding an employer's failure to make contractually required contributions did not make the employer an ERISA fiduciary). Such reasoning applies with even greater force in this case, given that Express Scripts contracted only with Anthem, not with Plaintiffs or their plans, and that Plaintiffs are agnostic about whether Express Scripts even breached the PBM Agreement. *See* JA41 n.1 ("Plaintiffs reserve the right to amend this Complaint . . . once it becomes clear which of the conflicting allegations, Anthem's or Express Scripts', are correct . . . ."). This aspect of Plaintiffs' theory reduces to the premise that invoking the ***mere prospect*** of a contractual breach somewhere ***upstream*** from an ERISA plan translates to a claim for breach of fiduciary duty, which goes beyond the pale.

5. Adoption of Plaintiffs' theory of fiduciary status would lead to absurd consequences

Adoption of Plaintiffs' theory regarding what constitutes discretionary control over pricing would "lead to absurd results." *Santomenno*, 883 F.3d at 838. Express Scripts would be unable to negotiate service contracts at arm's length, as it would instead essentially "have to promise that its fees were no higher than those of any competitor." *Id.* Moreover, imposing fiduciary obligations on a PBM like Express Scripts—which does not contract directly with any of the ERISA plans but instead merely implements the terms of an arm's-length agreement with a third party—would expose to fiduciary liability countless other players in the chain of transactions for healthcare services, including doctors, hospitals, pharmacies, and drug manufacturers. All of these upstream entities would, under Plaintiffs' view, be similarly inhibited from entering any arm's-length agreements that could arguably increase the ultimate price that Plaintiffs' ERISA plans pay for medical services. No limiting principle is discernible that would prevent the entire healthcare industry from potentially becoming ERISA fiduciaries and being sued as such under this expansive theory. Such "absurd results" confirm Plaintiffs' folly. *Id.*

Furthermore, if Express Scripts' ability to renegotiate or breach its contract with Anthem constituted "discretion" of the type required by ERISA, virtually any party to a contract would have "discretion" over its terms, as there is always a chance that contracts may be amended, renegotiated, or breached. The upshot would be that every service provider that ultimately links—no matter how remotely—to an ERISA plan would become an ERISA fiduciary. That would wreak havoc on settled expectations of service providers, and it would greatly harm ERISA plans, as many providers would no longer want to have anything to do with ERISA plans for fear of facing fiduciary liability.

C. Express Scripts is not liable for Anthem's alleged breaches of fiduciary duty

Plaintiffs separately claim that Express Scripts is liable for Anthem's alleged breaches of fiduciary duty as a co-fiduciary or as a non-fiduciary who knowingly participated in Anthem's breach. Opening Brief 50 & n.8. Both claims fail because (1) Anthem was not a fiduciary, (2) Express Scripts was not a fiduciary, and (3) Express Scripts had no knowledge of any breach by Anthem.

1. Anthem is not an ERISA fiduciary

As the district court correctly held, Anthem was not a fiduciary when it engaged in the complained-of conduct. *Express Scripts/Anthem*, 285 F. Supp. 3d at 681–84. Anthem's actions were business-management decisions involving the structure of its business relationship with Express Scripts, not exercises of discretionary authority over plan management or administration. *See American Psychiatric Ass'n*, 821 F.3d at 357 n.2 (fiduciary duties are not triggered "when the decision is, at its core, a corporate business decision." (citations omitted)); *UnitedHealth*, 2017 WL 6512222, at *10 ("[N]egotiating prices with providers is also not a fiduciary function, but rather the administration of a network administrator's business."). Because Anthem was not a fiduciary, Express Scripts could not have participated in a breach of fiduciary duty by Anthem.

2. Express Scripts is not a co-fiduciary

Plaintiffs wander further astray by seeking to impose co-fiduciary liability on Express Scripts under ERISA § 405(a), 29 U.S.C. § 1105(a). A party can be a co-fiduciary only if is a fiduciary. As discussed above, the Complaint does not plausibly allege that Express Scripts is an

ERISA fiduciary of the Plaintiffs' plans. *See* Section I.B, above. Accordingly, co-fiduciary liability cannot attach to Express Scripts.

3. Express Scripts did not knowingly participate in, enable, or fail to make reasonable efforts to remedy Anthem's alleged breaches

Even assuming *arguendo* that both Express Scripts and Anthem were ERISA fiduciaries to Plaintiffs' plans, Express Scripts would still not be liable as a co-fiduciary for any fiduciary misconduct by Anthem because Plaintiffs fail to plausibly allege—as is required for co-fiduciary liability under ERISA § 405(a)—that Express Scripts knowingly participated in, enabled, or failed to make reasonable efforts to remedy any breach by Anthem. *See* 29 U.S.C. § 1105(a).

Despite insisting that Express Scripts "had knowledge of" Anthem's purported breaches and "failed to make reasonable efforts under the circumstances to remedy" them, Plaintiffs fail to specify any particular purported breaches that Express Scripts knew of and participated in. Such "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice" to state a viable claim. *Iqbal*, 556 U.S. at 678 (citing *Twombly*, 550 U.S. at 555). Express Scripts was not involved in Anthem's dealings with its own

plan clients, and the Complaint contains no allegations that Express Scripts actually knew Anthem was (as alleged) breaching its fiduciary duties to its plan clients. There is no co-fiduciary liability when—as here—plaintiffs fail to plead facts identifying how the defendants knowingly participated in the alleged underlying breach of fiduciary duty. *Smith v. Williams*, 819 F. Supp. 2d 1264, 1283 (M.D. Fla. 2011). Moreover, the district court's inability to discern any breach by Anthem confirms the implausibility of any theory positing that Express Scripts ***knew*** such a breach was occurring.

For the same reasons, Plaintiffs equally fail to state a claim that Express Scripts is liable as a non-fiduciary. *See* JA145–46 ¶¶ 344–49. The Complaint's assertions that Express Scripts is liable as a non-fiduciary participant "because it had actual or constructive knowledge of and participated in Anthem's violations of ERISA," JA145 ¶ 347, are too threadbare to satisfy the plausibility test of *Iqbal* and *Twombly*. There is no allegation that Express Scripts knew the details of Anthem's relationships with the relevant plans, let alone any allegation that Express Scripts knew of and participated in a fiduciary violation by Anthem. The dismissal should therefore be affirmed. *See Trustees of*

Upstate New York Engineers Pension Fund v. Ivy Asset Management, 131 F. Supp. 3d 103, 132 (S.D.N.Y. 2015).

D. Express Scripts is not liable for engaging in prohibited transactions

Plaintiffs imply (Opening Brief at 50–52) they pleaded a claim that Express Scripts engaged in prohibited transactions as a fiduciary in violation of ERISA § 406**(a)**, 29 U.S.C. § 1106(a). That is incorrect. The Complaint alleged that Express Scripts violated ERISA § 406**(b)** as a fiduciary (JA140–41) and ERISA § 406**(a)** as a party-in-interest or non-fiduciary (JA145–46). The district court properly dismissed these claims. *See Express Scripts/Anthem*, 285 F. Supp. 3d at 681, 684.

Express Scripts is not liable for violating ERISA § 406(b) because it was not acting as a fiduciary when engaged in any of the conduct at issue. *See* Section I.B, above. As the title of ERISA § 406(b) makes clear, it prohibits transactions only "between plan and ***fiduciary***." 29 U.S.C. § 1106(b) (emphasis added). Thus, "to establish a violation of ERISA Section 406(b), Plaintiffs must establish that these defendants engaged in a 'transaction' prohibited by that section while acting in a fiduciary capacity." *In re Honda of America Manufacturing, Inc., ERISA Fees Litigation*, 661 F. Supp. 2d 861, 868 (S.D. Ohio 2009).

Because Express Scripts was not a fiduciary, the district court properly dismissed this claim. *See Chicago District Council*, 474 F.3d at 472 n.4 (affirming dismissal of ERISA § 406(b) claims against PBM because it "was not a fiduciary when it engaged in any of the relevant transactions").

Nor is Express Scripts liable for violating ERISA § 406(a) as a party-in-interest. As Plaintiffs acknowledge, their § 406(a) claim should be reinstated only "if this Court holds that Plaintiffs have sufficiently alleged that Anthem is a fiduciary." Opening Brief 51. Anthem was not a fiduciary, so the claim should remain dismissed. *See* Section I.C.1, above.

Moreover, the remedy Plaintiffs seek for the violation of ERISA § 406(a) is unavailable. Plaintiffs pray under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), for the Court to "disgorge" from Express Scripts "co-insurance payments that Subscriber ERISA Plaintiffs . . . were forced to pay" and "payments for prescription medications the Plans were forced to pay." JA145–46 ¶¶ 346–49. The Supreme Court has made clear that, under ERISA § 502(a)(3), "[o]nly a transferee of ill-gotten *trust assets* [*i.e.*, plan assets] may be held liable." *Harris Trust & Savings*

Bank v. Salomon Smith Barney, Inc., 530 U.S. 238, 251 (2000) (emphasis added). What Plaintiffs seek to disgorge from Express Scripts are not *plan assets*. A plan asset is defined consistent with "ordinary notions of property rights." *Faber v. Metropolitan Life Ins. Co.*, 648 F.3d 98, 106 (2d Cir. 2011). Co-insurance payments are out-of-pocket payments by the *enrollees*, not by the *plan*; they are not *plan* assets because the *plans* have no property rights in them. *Negron*, 2018 WL 1258837, at *7; *UnitedHealth*, 2017 WL 6512222, at *10; *DeLuca v. Michigan*, 2007 WL 1500331, at *3 (E.D. Mich. May 23, 2007). And the plans themselves did not make *any* payments to Express Scripts; it is *Anthem* that pays Express Scripts for services provided under the PBM Agreement. *See* § 2.9, JA338, JA376 ("[Anthem] shall pay the administrative and other fees set forth in Section 5 and Exhibit A . . . ."). Because Plaintiffs do not seek disgorgement of plan assets, they are not entitled to relief under ERISA § 502(a)(3). Rather, Plaintiffs are seeking money damages from Express Scripts, which are plainly not available under ERISA § 502(a)(3). *See Mertens v. Hewitt Associates*, 508 U.S. 248, 255–62 (1993).

II. Plaintiffs Failed To Show That ERISA's Statute of Limitations Was Tolled for Fraud or Concealment

ERISA provides for a six-year statute of limitations that runs from the date of the last action constituting part of the breach of fiduciary duty. *See* 29 U.S.C. § 1113(1). In case of "fraud or concealment," the limitations period runs from "six years after the date of discovery of such breach or violation." *Id.* § 1113 hanging paragraph. To extend the limitations period, Plaintiffs must plead with the particularity required by Federal Rule of Civil Procedure 9(b) that Express Scripts, as a fiduciary, "(1) breached its duty by making a knowing misrepresentation or omission of a material fact to induce an employee/beneficiary to act to his detriment; *or* (2) engaged in acts to hinder the discovery of a breach of fiduciary duty." C*aputo v. Pfizer, Inc.*, 267 F.3d 181, 190 (2d Cir. 2001) (emphasis in original); *accord Janese v. Fay*, 692 F.3d 221, 228 (2d Cir. 2012).

Here, Plaintiffs filed their first complaint on May 6, 2016. JA1. Accordingly, unless the limitations period is tolled, any claims arising from conduct predating May 6, 2010—including all of the negotiations leading up to the 2009 PBM Agreement—are time-barred under ERISA.

Plaintiffs attempt to invoke the tolling provision for fraud or concealment by alleging that Express Scripts and Anthem "withheld and concealed both the details and nature of their negotiations regarding both the PBM Agreement and the NextRx Agreement" and "withheld material terms of the PBM Agreement itself." JA116–17 ¶ 243; *see also* Opening Brief 55–56.

These allegations fall well short of satisfying *Caputo* and Rule 9(b). They do not identify with particularity any affirmative duty to disclose contract negotiations and provisions that Express Scripts knowingly breached; they do not explain why any concealed details surrounding the PBM Agreement and NextRx Agreement are material; and they do not specify how an employee or beneficiary was detrimentally induced to act.

The district court correctly held that Plaintiffs failed to show they were entitled to equitable tolling of the statute of limitations under the "fraud or concealment" exception because, "even assuming at this stage of the analysis that Defendants were ERISA fiduciaries, this Court finds they did not have an affirmative duty to disclose the content of the PBM Agreement, [or] the connection between the PBM Agreement and

the NextRx Agreement." *Express Scripts/Anthem*, 285 F. Supp. 3d at 676. That decision was sound. Plaintiffs neither identify any contrary authority that places an affirmative duty on ERISA fiduciaries or non-fiduciaries to disclose contract negotiations or provisions, nor do they provide any persuasive reason to disturb the district court's enforcement of the time bar. Notably, it would follow from Plaintiffs' contrary contention that PBMs are routinely obliged to disclose the proprietary details of their contracts; neither precedent nor practice supports that remarkable proposition.

III. Express Scripts Is Not Liable Under RICO

Next, Plaintiffs allege that Express Scripts implemented a fraudulent scheme to exact excessive charges for prescription medications through a series of acts of wire and mail fraud, in violation of RICO. JA118 ¶ 249. With their RICO claim, Plaintiffs' attempt to bootstrap themselves to the contract dispute between Express Scripts and Anthem, by alleging that Express Scripts' conduct caused Plaintiffs to pay higher prices for their drugs (if Anthem is right), JA92 ¶ 169; JA102 ¶ 199, or that Anthem's conduct caused them to pay higher prices for their drugs (if Express Scripts is right), JA81 ¶ 130. As such,

"Plaintiffs in this case are simply 'attempting to dress a common law breach of contract . . . claim as a RICO claim,'" and Plaintiffs should not be permitted to transform such a case into "the litigation equivalent of a thermonuclear device." *Goldfine v. Sichenzia*, 118 F. Supp. 2d 392, 394, 405 (S.D.N.Y. 2000) (citations omitted).

Worse than trying to dress a standard contract claim up as RICO fraud, Plaintiffs here only half don even the contract garb—as noted, they are noncommittal at best about whether Express Scripts in fact breached Section 5.6 of its contract with Anthem. Even assuming *arguendo* Plaintiffs might somehow state a RICO claim, they certainly did not allege any such claim with the requisite particularity, nor did they try when given an another chance.

A. Plaintiffs failed to plead predicate acts of fraud with sufficient plausibility and particularity

To plead wire or mail fraud, a plaintiff must allege "(1) a scheme to defraud, (2) money or property as the object of the scheme, and (3) use of the mails or wires to further the scheme." *United States v. Binday*, 804 F.3d 558, 569 (2d Cir. 2015) (citation omitted). Rule 9(b) requires a plaintiff to plead with particularity that defendants knowingly participated in a scheme to defraud and used mail or wire

communication in interstate commerce in furtherance of the scheme. *See Chanyil v. Gulati*, 169 F.3d 168, 170–71 (2d Cir. 1999).

Generally, allegations of predicate mail and wire communication use should specify the asserted fraudulent statements, the identity of the speaker, the state where the statements were made and why the statements were fraudulent. *Id.* Extra scrutiny is warranted of such allegations. "Given the routine use of mail and wire communications in business operations, . . . 'RICO claims premised on mail or wire fraud must be particularly scrutinized because of the relative ease with which a plaintiff may mold a RICO pattern from allegations that, upon closer scrutiny, do not support it.'" *Crawford v. Franklin Credit Management*, 758 F.3d 473, 489 (2d Cir. 2014) (quoting *Efron v. Embassy Suites (Puerto Rico), Inc.*, 223 F.3d 12, 20 (1st Cir. 2000)).

1. Plaintiffs failed to plead with sufficient plausibility and particularity that Express Scripts made fraudulent statements to Anthem

Plaintiffs argue that Express Scripts fraudulently misrepresented to Anthem that Express Scripts would charge only competitive benchmark pricing for prescription medications for plans administered by Anthem and for Anthem subscribers and beneficiaries. JA119 ¶ 251.

But Plaintiffs did not make that allegation with the requisite particularity. As the district court correctly recognized, Plaintiffs "failed to plead predicate acts as required under RICO," and the Complaint "does not say *when* these alleged misrepresentations occurred, *where* they occurred, or *who* made the statements." *Express Scripts/Anthem*, 285 F. Supp. 3d at 686.

Instead, Plaintiffs relied on general allegations, such as: "Express Scripts represented that it would charge only competitive benchmark pricing for prescription medications for plans administered by Anthem and for Anthem subscribers and beneficiaries." JA119 ¶ 251. No further details of this supposed misrepresentation—the when, where, or who—are pleaded. The Complaint also states, without any specifics, that "Express Scripts knew these representations were false and that it would not in good faith attempt to do so." JA119 ¶ 252. These bare, conclusory statements are insufficient to satisfy either the plausibility standard of *Iqbal* and *Twombly*, much less the particularity standard of Rule 9(b).

2. Plaintiffs failed to plead with sufficient plausibility and particularity that Express Scripts made fraudulent statements to Plaintiffs

Plaintiffs' claims about purportedly fraudulent statements made by Express Scripts directly to Plaintiffs fare no better. The basis for these claims is Plaintiffs' contention that Express Scripts fraudulently overbilled Plaintiffs for PBM services. *See* Opening Brief at 58–59 ("ESI uniformly misrepresented to Plaintiffs and Class members that it was entitled to the amounts charged, thus defrauding them by charging and collecting more than ESI was entitled to collect pursuant to its agreement with Anthem."). But Plaintiffs do not contend that Express Scripts ever charged prices above those specified in the PBM Agreement in Section 5.4 and Exhibit A. Instead, they maintain that Express Scripts committed fraud by billing the exact prices specified in the PBM Agreement rather than billing an amount *less* than what the contract specifies. In other words, Plaintiffs' premise is that Express Scripts needed to charge hypothetical prices that Plaintiffs desire and contend could have been (but never were) agreed to by Anthem and Express Scripts under Section 5.6.

At the risk of understating things, it is implausible that Express Scripts was committing billing fraud when it sent bills that matched the pricing terms specified in the governing contract. Acts amounting to *breach* of a contract—much less *performance* of a contract—"do not amount to a separate claim of fraud" when "[t]he defendants did not owe the plaintiffs some legal duty beyond the obligations contained within the contracts, and the defendants made no misrepresentation 'collateral or extraneous to the contract.'" *Bigsby v. Barclays Capital Real Estate, Inc.*, 170 F. Supp. 3d 568, 576 (S.D.N.Y. 2016) (citation omitted); *accord, e.g.*, *New York State Catholic Health Plan, Inc. v. Academy O & P Associates*, 312 F.R.D. 278, 303 (E.D.N.Y. 2015) (whether a party's conduct was in accordance with a contract is "a garden-variety question of contract interpretation" that cannot support a claim of wire fraud). That point is all the more salient here, where Express Scripts does not have a contract with or owe any contractual duties to Plaintiffs or their plans.

3. Plaintiffs failed to plead that Express Scripts made fraudulent statements with the intent to defraud Plaintiffs

Plaintiffs must also allege that Express Scripts made such statements with the "specific intent" to defraud Plaintiffs. *Ritchie v. Taylor*, 701 F. App'x 45, 47–48 (2d Cir. 2017) (citing *United States v. Regan*, 937 F.2d 823, 827 (2d Cir. 1991), *amended*, 946 F.2d 188 (2d Cir. 1991)). Plaintiffs have not only failed to plausibly allege that Express Scripts did so, but they have effectively conceded that Express Scripts did not.

Plaintiffs acknowledge that Express Scripts may prevail in its contract dispute with Anthem. *See, e.g.*, JA41 n.1 ("Plaintiffs reserve the right to amend this Complaint . . . once it becomes clear which of the conflicting allegations, Anthem's or Express Scripts', are correct . . . ."). This acknowledgement is fatal. Once it is accepted that that Express Scripts' understanding of the PBM Agreement is at least reasonable, it follows that Express Scripts was not defrauding or deceiving when it followed the pricing terms specified by Section 5.4 and Exhibit A, per its understanding of the PBM Agreement. Because

they do not allege Express Scripts was knowingly breaching its agreement with Anthem, Plaintiffs have no plausible claim of fraud.

B. Plaintiffs failed to plead that Express Scripts had control over an "enterprise"

Nor can Plaintiffs make out a RICO claim without pleading the existence of an "enterprise" that Express Scripts had "some part in directing," *Reves v. Ernst & Young*, 507 U.S. 170, 179 (1993), or that Express Scripts "participated in the operation or management of the enterprise itself," *id.* at 183. Plaintiffs allege in the Complaint that this enterprise is *Anthem itself*, but they fail to allege any facts to support their assertion that Express Scripts "acquired and maintained control" of the Anthem Enterprise. JA121–23 ¶¶ 268, 273–74. The Complaint contains no allegations that Express Scripts actually directs, operates, or manages Anthem, let alone has authority to require Anthem to provide particular pricing to its clients. For this reason, too, the dismissal of the RICO claim should be affirmed.

IV. Express Scripts Is Not Liable Under the ACA's Non-Discrimination Provision

Finally, Plaintiffs allege that Express Scripts discriminated against two individual plaintiffs who have HIV (John Does 1 and 2) in

violation of Section 1557 of the ACA, 42 U.S.C. § 18116, because these Plaintiffs paid more out of pocket for HIV medications than other persons pay for non-HIV medications. JA170–71 ¶ 459. In Plaintiffs' view, a person with a disability is discriminated against if the medication for that disability is more expensive than medication for a different medical condition. Of course, there is nothing discriminatory about charging different prices for different goods.

For claims of disability discrimination, Section 1557 incorporates the "enforcement mechanisms" available under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, so a court must "look[] to Section 504 to determine the pleading requirements for a disability discrimination claim under the ACA," *Express Scripts/Anthem*, 285 F. Supp. 3d at 687; *accord Southeastern Pennsylvania Transportation Authority v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688, 698–99 (E.D. Pa. 2015). To state a claim under Section 504, a plaintiff must allege that "(1) he is a '[disabled] person' under the Rehabilitation Act; (2) he is 'otherwise qualified' for the program; (3) he is excluded from benefits solely because of his [disability]; and (4) the program or special service

receives federal funding." *C.L. v. Scarsdale Union Free School District*, 744 F.3d 826, 840–41 (2d Cir. 2014) (citation omitted).

Plaintiffs have not pleaded that they pay more out of pocket for HIV medication "solely because" they have HIV. They do not (and could not) contend, for example, that Express Scripts discriminates by charging persons with HIV one price for a medication and charging persons without HIV a *different* price for the *same* medication. Instead, Plaintiffs argue that Express Scripts engaged in a facially neutral practice—allegedly charging excessive pricing to all Anthem subscribers—and that this facially neutral conduct has a disparate impact on Plaintiffs with HIV. By Plaintiffs' theory, because their medications are more expensive, the alleged overcharging of all Anthem subscribers results in the HIV patients paying more out-of-pocket than persons without HIV, who fill prescriptions for different medications that treat different medical conditions. Opening Brief 71–72.

Such a theory does not translate to unlawful disability discrimination. A person with HIV may pay more out of pocket for expensive HIV medication than a person without HIV pays for cheap non-HIV medication, but that is only because the HIV medication is

expensive *for everyone*. There is, accordingly, no *disparate* impact. *See Gilead Sciences*, 102 F. Supp. 3d at 700 (rejecting disparate-impact claim under the ACA based on drug pricing by a drug manufacturer because "[t]here are no allegations that Gilead changes the prices of its drugs depending upon whether the potential consumer has Hepatitis C."). Because all persons with or without disabilities have equal access to a particular drug at a given price, there is no disability discrimination. *See EEOC v. Staten Island Savings Bank*, 207 F.3d 144, 148–150 (2d Cir. 2000) (insurance plans that equally provide all covered persons with different benefits for different types of disabilities do not discriminate in violation of Title I of the ADA); *Modderno v. King*, 82 F.3d 1059, 1061–62 (D.C. Cir. 1996) (same under Section 504).

In effect, Plaintiffs seek to transform the ACA's non-discrimination clause into a radical price-regulation scheme that requires uniformity in out-of-pocket costs for all prescription medications. Yet nothing in Section 1557 says that it is imposing such a massive overhaul of the prescription-drug market, nor is there reason to think that Congress intended such an outcome by enacting a statute that says no such thing. *See Whitman v. American Trucking Ass'ns,*

Inc., 531 U.S. 457, 468 (2001) ("Congress . . . does not, one might say, hide elephants in mouseholes."); *Staten Island Savings Bank*, 207 F.3d at 149 (refusing to treat the ADA as requiring disability plans to provide equal benefits to all persons with disabilities, which "would require far-reaching changes in the way the insurance industry does business," absent a clearer legislative command from Congress). To the contrary, Section 504—and the ACA's non-discrimination provision—do not "guarantee the handicapped equal results." *Alexander v. Choate*, 469 U.S. 287, 304 (1985) (holding that a claim of disability discrimination against Tennessee for reducing the number of days of inpatient hospital care covered by its state Medicaid program is not cognizable, even if the reduction has a disparate impact on the disabled). Indeed, it follows *a fortiori* from the inability to hold a ***drug manufacturer*** liable for the higher prices it charges for more expensive drugs, *see Gilead Sciences*, 102 F. Supp. 3d at 698–99, that a ***PBM*** like Express Scripts is not unlawfully discriminating under the ACA simply by accounting for the higher prices prevailing on the market.

Moreover, as the district court ruled, the Complaint also fails to allege that the named plaintiffs here paid more for their HIV medication than their non-HIV medication. *Express Scripts/Anthem*, 285 F. Supp. 3d at 688–89. Even under a disparate-impact theory, therefore, they have failed to state a plausible claim. *Id.* This Court should affirm the district court's dismissal of Plaintiffs' ACA claim along with the others.

CONCLUSION

For the reasons above, this appeal should be dismissed for lack of appellate jurisdiction or the order of dismissal should be affirmed.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitations in Federal Rule of Appellate Procedure 32(a)(7)(B), as modified by Local Rule 32.1(a)(4)(A), because, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f), it contains 13,430 words (based on the Microsoft Word word-count function).

This brief complies with the typeface requirement of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirement of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionately spaced typeface using Microsoft Word in Century Schoolbook, 14-point type.

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CERTIFICATE OF SERVICE

I hereby certify that on May 30, 2018, the foregoing brief was served on all parties or their counsel of record through the CM/ECF system.

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