No. 21-16992

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Winsor, *et al.*,

Plaintiffs-Appellants,

v.

Sequoia Benefits and Insurance Services, LLC, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court for the
Northern District of California
No. 3:21-cv-00227-JSC
Hon. Jacqueline Scott Corley

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES

Paul Lettow
Janet Galeria
U.S. Chamber Litigation Center
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

Meaghan VerGow
Alexander Reed
O'Melveny & Myers LLP
1625 Eye St., N.W.
Washington, D.C. 20006
(202) 383-5300

Counsel for Amicus Curiae

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 29(a)(4)(A) and 26.1, undersigned counsel states the following: the Chamber of Commerce of the United States of America is a non-profit corporation organized under the laws of the District of Columbia. The Chamber has no parent corporation, and no publicly held corporation owns ten percent or more of its stock.

Dated: May 16, 2022

O'MELVENY & MYERS LLP

By: */s/ Meaghan VerGow*
Meaghan VerGow

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STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE[1]

The Chamber of Commerce of the United States of America ("Chamber") is the world's largest business federation. The Chamber represents approximately 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. Among the Chamber's many important functions is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. The Chamber regularly files *amicus* briefs in cases that raise issues of concern to the nation's business community.

In particular, the Chamber frequently participates in cases that bear on the ability of private employers to provide benefits to millions of American workers and their families. This is such a case. The district court correctly determined that plaintiffs could not bring suit against the insurance broker their employer used to obtain benefit options for its employees. The decisions plaintiffs seek to challenge

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[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(D) and Circuit Rule 29-3, counsel for *amicus curiae* states that all parties have consented to the filing of this brief. In addition, pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), counsel for *amicus curiae* states that no counsel for a party authored this brief in whole or in part, no party or party counsel made a monetary contribution intended to fund the preparation or submission of this brief, and no person—other than *amicus curiae*, its members, or its counsel—contributed money intended to fund the preparation or submission of this brief.

were made by their employers. The defendants here had no authority or ability to influence the contributions (if any) plaintiffs made toward their employer-sponsored benefits. Further, a holding that the broker was not entitled to payment would not accrue to plaintiffs' benefit, meaning a favorable decision would not redress alleged harm to plaintiffs. Under these circumstances, plaintiffs clearly lack Article III standing to challenge the broker's compensation. Plaintiffs' (and their *amicus*'s) arguments to the contrary defy Supreme Court precedent and would launch a new genre of litigation under the Employee Retirement Income Security Act of 1974 ("ERISA") in which plaintiffs have no personal stake.

Employers—particularly small ones—commonly use brokers and multiple employer welfare arrangements to provide their employees with a complete array of benefit options at competitive rates. This model has worked effectively for years to deliver benefits to workers that employers could otherwise obtain only at greater cost, or not at all. Plaintiffs' effort to cast defendants as fiduciaries with respect to decisions ultimately made by plan sponsors is fatally at odds with long-settled ERISA principles. But more fundamentally, this lawsuit attacks a longstanding and useful service that facilitates access to benefits for millions of American workers, and the availability of that service would be imperiled if the law functioned as plaintiffs wrongly claim. The Chamber urges the Court to follow established Article III and ERISA precedents in this case, as the district

court did, and reject plaintiffs' novel attempt to disable this important tool for employers to provide benefits to their employees.

SUMMARY OF ARGUMENT

At its core, the case presents a straightforward standing question: Can health and welfare plan participants sue their employer's health insurance broker for its receipt of commissions from third-party insurers where the *employer* determined its plan's insurance premiums and participant contribution levels? The district court correctly answered no. Plaintiffs undisputedly received every benefit due to them under their employer-sponsored plan. They cannot demonstrate that defendants caused them any injury by offering to the market insurance products that their employer independently selected as appropriate for its plan. When an employer uses a broker and multiple employer welfare arrangement to provide employee benefits, the *employer* decides what benefits to offer, what premiums it will pay for those benefits, and what (if any) contributions it will require of employees. Even if plaintiffs could show that defendants were forbidden to accept commissions from the insurers whose products they include on their platform—itself a meritless legal theory—plaintiffs could not establish that their employer would then be obliged to reduce the employee contribution levels adopted in its own plan design.

The critical role of employers in designing their own plans also establishes why plaintiffs' claims fail on the merits. A broker does not act as a fiduciary when it receives commissions out of premiums independently selected and approved by the employer. Indeed, the *employer* does not even act as a fiduciary when deciding what benefits to offer employees and what their contributions will be—those are settlor decisions. When an employer agrees to the all-in premium for an insurance product it selects for its plan, the premium includes both the insurance *and* the broker's service *to the employer*. And when the employer decides what participant contribution levels will be, it is making an independent plan-design decision. The employer's *broker* certainly has no fiduciary obligation to the employer's plan participants in any of these decisions.

If allowed to proceed, plaintiffs' lawsuit would disrupt a beneficial service enabling small businesses to enhance their employee benefit offerings, and it would dismantle settled Article III and ERISA principles to that end. The district court correctly held that the lawsuit must be dismissed.

ARGUMENT

I. BROKERS PROVIDE A CRUCIAL NON-FIDUCIARY SERVICE TO EMPLOYERS, FACILITATING THE PROVISION OF ROBUST, AFFORDABLE EMPLOYEE BENEFITS

This appeal threatens to upend an established service that has for years helped small businesses provide a full complement of healthcare and other benefits

to American workers. Employers use brokers and multiple employer welfare arrangements (MEWAs) to offer benefits that would be costly or infeasible to procure and provide on their own. Brokers and MEWA administrators do not act as fiduciaries in bringing products to the market for independent selection by plan sponsors, and plaintiffs' fiduciary breach and prohibited transaction theories are therefore unsustainable.

Over half of all Americans receive health insurance through their employer.[2] Insurance brokers play a significant role in helping those employers navigate the complex healthcare market to identify appropriate coverage options for their employees at competitive prices. In 2007, it was estimated that 71% of small businesses that offered insurance to their employees purchased their plans from an insurance broker[3]; nearly a decade later, 80% of small businesses planned to do the same.[4] In a 2019 poll, 92% of small business owners reported that they viewed

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[2] Kaiser Family Foundation, Health Insurance Coverage of the Total Population (CPS) (2020), https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/.

[3] William J. Dennis, NFIB National Small Business Poll, Purchasing Health Insurance, NFIB Research Foundation Series 7, no.3, at 1 (2007).

[4] *See* National Small Business Association, 2015 Small Business Health Care Survey, at 9 (2015), https://www.nsba.biz/wp-content/uploads/2015/11/Health-Care-Survey-2015.pdf.

healthcare brokers as "helpful."[5] Brokers are generally able to leverage economies of scale in gathering information to help buyers match with sellers, reducing information-gathering and transaction costs for employers and providing them with access to lower premiums than they could obtain going into the marketplace alone.[6] It is no surprise, then, that the federal government has itself recommended that business and individuals alike turn to a licensed insurance agent or broker for assistance in finding the right healthcare coverage.[7]

A MEWA is one way in which small businesses may get a broker's assistance in obtaining health and welfare products for their employees. A MEWA is defined as an arrangement established or maintained for the purpose of offering

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[5] The Commonwealth Fund, Small-Business Owners' Views on Health Coverage and Costs (2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/small-business-owners-views-health-coverage-costs.

[6] Pinar Karaca-Mandic, Roger Feldman, & Peter Graven, *The Role of Agents and Brokers in the Market for Health Insurance*, J. of Risk and Ins., at 2 (2016) (collecting research).

[7] *See, e.g.*, HealthCare.gov, Health insurance for businesses, https://www.healthcare.gov/small-businesses/learn-more/explore-coverage/ ("You can also contact a licensed agent or broker for more help."); Healthcare.gov, Health coverage for self-employed, https://www.healthcare.gov/small-businesses/learn-more/self-employed/ ("Agents and brokers are experts in health insurance and can help you find the coverage you need ...."); Centers for Medicare & Medicaid Services, Resources for Agents and Brokers in the Health Insurance Marketplaces, https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources ("Agents and brokers play a crucial role in educating consumers about the Health Insurance Marketplace ... [and] may also help employers understand their options ....").

or providing benefits to employees of two or more employers, with certain exceptions (*e.g.*, arrangements that are collectively bargained). 29 U.S.C. § 1002(40); *see* ER-31 (Am. Compl. ¶ 3). Participating in a MEWA can be particularly beneficial for small businesses. According to the Department of Labor, "MEWAs are often able to market insurance coverage at rates substantially below those of regulated insurance companies, thus, in concept, making the MEWA an attractive alternative for those small businesses finding it difficult to obtain affordable health care coverage for their employees."[8] By pooling with other companies, employers participating in a MEWA are able to access a broader range of health plan options for their employees, at rates that might otherwise be unavailable to a small business on its own.[9]

In a MEWA like the Tech Benefits Program that Sequoia offers to eligible employers, the broker-administrator makes decisions about the design of the product and the options it will offer, which employers are then free to elect (or to reject) in whole or in part. The program may include a variety of types of coverages (*e.g.*, health, dental, vision), available from an array of insurers at quoted

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[8] U.S. Dep't of Labor, Employee Benefits Security Administration, Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation 3 (rev. Apr. 2022).
[9] *See* Association Health Plans, What Is a MEWA? A Brief Introduction to Key Concepts, https://www.associationhealthplans.com/employer/mewa/.

premium rates. Employers decide whether to participate in the program at all, and when they do, they select which benefits to offer and at which rates. The employer provides the benefits through an employee welfare benefit plan that it sponsors and administers for its employees, and it decides for its own plan what its employees' contribution amounts will be.

For their services, it is customary for brokers to receive commissions from insurance providers.[10] The employer appoints the broker, and the employer agrees that the broker will receive commissions out of the approved premiums. The commissions are "built into the insurer's rates," and are thus accounted for in the premiums the employer elects.[11] The employer could certainly consider the premiums in deciding what employee contributions will be, but it does not have to. Employee contributions are a settlor matter—a part of the plan design itself. *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996) (explaining that adopting, modifying, or terminating a welfare plan is a settlor function, not a fiduciary one); *see, e.g.*, *Hartline v. Sheet Metal Workers' Nat'l Pension Fund*, 134 F. Supp. 2d 1,

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[10] Karaca-Mandic, *et al.*, *supra* note 6, at 3; *see also* Healthcare.gov, Glossary: Broker, https://www.healthcare.gov/glossary/broker/ (brokers "typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans."); Healthcare.gov, Glossary: Agent and Broker (Health Insurance), https://www.healthcare.gov/glossary/agent/ ("Agents and brokers often get payments ('commissions') from insurance companies for selling plans.").

[11] Health Coverage Guide, Part Two: Getting Covered, Step 3: Find a Broker, https://healthcoverageguide.org/part-two-getting-covered/step-3-find-a-broker/.

16 (D.D.C. 2000) ("This court holds that setting the contribution rate was a settlor, not fiduciary, function because it was a matter of plan design."), *aff'd*, 286 F.3d 598 (D.C. Cir. 2002).

In an arrangement like this, the broker-administrator does not act as a fiduciary when it makes insurance options available for selection by employers; when it collects premiums (including administrative fees) approved by the employer and remits them to insurers; or when it accepts commissions from insurers. "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) (emphasis added). A service provider does not perform a fiduciary function when it brings a product to market. *See Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 655 (9th Cir. 2019) (quoting *Cotton v. Mass. Mut. Life Ins. Co.*, 402 F.3d 1267, 1278–79 (11th Cir. 2005) ("Simply urging the purchase of its products does not make an insurance company an ERISA fiduciary with respect to those products.")). A service provider is also not considered a fiduciary with respect to compensation that is independently approved by a plan fiduciary, because "discretionary control over plan management lies ... with the

trustee, who decides whether to agree to the service provider's terms." *Santomenno v. Transamerica Life Ins. Co.*, 883 F.3d 833, 838 (9th Cir. 2018) (internal quotation omitted). And a service provider's receipt of compensation *from third-party insurers* does not confer fiduciary status—the premium payments to the insurers secure the agreed-upon coverage, and how the insurers allocate those premiums to their own expenses does not implicate plan assets at all. *See Depot*, 915 F.3d at 657 ("Premiums paid to an insurance company in return for coverage under a fully insured insurance policy are not 'plan assets.'"); *see also, e.g.*, *In re Fidelity ERISA Fee Litig.*, 990 F.3d 50, 59 (1st Cir. 2021) (holding Fidelity's receipt of infrastructure fees from mutual funds in which its plan customers invested was not an exercise of authority or control over any plan assets, management, or administration).

To the extent these decisions implicate fiduciary functions at all, they are the employer's, because the employer has the "final say" over the benefits and rates that it will offer to its plan participants. *Hecker v. Deere Co.*, 556 F.3d 575, 583–84 (7th Cir. 2009) (finding recordkeeper that merely "played a role" in retirement plan's development of investment menu did not act as fiduciary because plan sponsor had "final say on which investment options [would] be included"); *see also, e.g.*, *Mahoney v. J.J. Weiser & Co.*, 564 F. Supp. 2d 248, 257 (S.D.N.Y. 2008) (finding plan's insurance broker "did not have the discretion or authority to

purchase the insurance policies or to approve the payment of premiums," and thus was not an ERISA fiduciary in connection with those acts), *aff'd*, 339 F. App'x 46 (2d Cir. 2009). Any compensation ultimately received by the broker-administrator results from "numerous intervening and independent decisions" by other actors, *In re Fidelity ERISA Fee Litig.*, 990 F.3d at 56–58, precluding a finding that it was controlled by the broker-administrator itself.

Plaintiffs' effort to cast the defendants here as fiduciaries runs counter to long-settled ERISA principles, and adhering to those principles matters—not just to avoid extending fiduciary liability where the law does not support it, but to ensure that all actors in relation with an ERISA plan clearly understand their respective roles and fulfill them accordingly. Plaintiffs are attempting to assign to defendants a responsibility that belongs to the employer that sponsored their plan. The request should be rejected.

II. PLAINTIFFS LACK ARTICLE III STANDING TO SUE THEIR EMPLOYER'S HEALTH INSURANCE BROKER ABOUT COMMISSIONS IT RECEIVES FROM THIRD-PARTY INSURERS

The district court correctly held that plaintiffs established none of the elements required for standing: injury in fact; traceability; and redressability. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992).

A. Plaintiffs Cannot Establish Article III Injury Without a Concrete Personal Stake in the Outcome of the Lawsuit

Plaintiffs contend that defendants' retention of commissions paid by third-party insurers caused financial injury to plan participants. But plaintiffs indisputably received the benefits due to them under the terms of the plan, in accordance with the plan (including their contribution obligations, if any). Consistent with the Supreme Court's decision in *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020), they cannot show that they suffered any injury in fact when they received exactly what was promised them in the plan.[12]

In *Thole*, the Court held that ERISA plan participants lacked standing to challenge plan fiduciaries' alleged mismanagement of plan assets because they could not show any impact on the benefits that participants received. *Id.* at 1619. As the Court recognized, there is no "ERISA exception to Article III," *id.*, at 1622,

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[12] Outside the ERISA context, courts have similarly recognized that plaintiffs suffer no Article III injury in how insurers spend premiums the plaintiffs have agreed to pay for coverage received. *See, e.g.*, *Krukas v. AARP, Inc.*, No. 18-cv-1124, 2021 WL 5083443, at *11 (D.D.C. Nov. 2, 2021) ("Plaintiffs suffer no harm, however, simply because they object to the ultimate recipient of a portion of their premium ...."), *appeal docketed*, No. 21-7136 (D.C. Cir. Nov. 30, 2021); *In re Sci. Applications Int'l Corp. (SAIC) Backup Tape Data Theft Litig.*, 45 F. Supp. 3d 14, 30 (D.D.C. 2014) ("[A]s to the value of their insurance premiums, Plaintiffs do not plausibly allege any actual loss.... [T]hey do not claim that they were denied coverage or services in any way whatsoever. To the extent that Plaintiffs claim that some indeterminate part of their premiums went toward paying for security measures, such a claim is too flimsy to support standing." (internal citation omitted)).

and plaintiffs lacked a concrete personal stake in the outcome of the case because—win or lose—they would receive "the exact same monthly benefits that they [were] already slated to receive, not a penny less" and "not a penny more," *id.* at 1619. When it comes to ERISA plans, a participant who receives (and will receive) every benefit promised does not suffer a cognizable injury by complaining about *how* their employer delivered those benefits.

Plaintiffs, and the Department of Labor as *amicus curiae*, now contend that the district court erred in applying *Thole* because the RingCentral plan is not a defined benefit plan. Pls.' Br. (Dkt. 15) at 36–42; DOL Amicus Br. (Dkt. 22) at 4–15. Of course it is not a defined *pension* benefit plan. But as a health and welfare plan, it operates in exactly the same way as the plan in *Thole*—participants are promised benefits set forth in the plan according to the plan terms. *See LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 250, 255 (2008) (analogizing disability plan that paid "fixed level of benefits" to "defined benefit" plan). *Thole* is squarely on point, as other courts have correctly recognized in applying it in the health and welfare benefit plan context. *See, e.g.*, *Scott v. UnitedHealth Group, Inc.*, 540 F. Supp. 3d 857, 862–65 (D. Minn. 2021) (finding no standing under *Thole* in participant action to recover alleged overpayments to healthcare providers by employee-sponsored healthcare plans, which are "closely analogous to the defined-*benefit* plan at issue in *Thole*, as participants are entitled to their

contractually defined benefits regardless of the value of the plans' assets"); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, No. 18-cv-06749, 2020 WL 5994957, at *1, *3 (E.D.N.Y. Oct. 9, 2020) (finding no standing under *Thole* in challenge to alleged "captive insurance scheme" by participants of welfare benefit plan, which is "a form of defined benefit plan" in that "participants are guaranteed certain health benefits, regardless of the Plan's funding").[13]

To the extent plaintiffs made any contributions to their premiums at all, they received exactly what the plan promised they would receive in exchange—the benefits they elected. Their preference for lower contribution obligations under the plan is not a cognizable injury in fact.

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[13] Plaintiffs point to *Peters v. Aetna Inc.*, 2 F.4th 199 (4th Cir. 2021), in support of their argument that they can establish standing through allegations of breach of fiduciary duty to pursue equitable relief, even in the absence of a tangible financial injury. Pls.' Br. (Dkt. 15) at 41–42. But plaintiffs don't *allege* any non-financial injury. *See* SER-32–33. Moreover, in *Peters*, the Fourth Circuit relied on precedents that pre-dated the Supreme Court's unambiguous holding in *Thole* that plaintiffs must *themselves* allege an injury in fact to establish Article III standing. *Thole*, 140 S. Ct. at 1619; *see Peters*, 2 F.4th at 220–21 (finding no personal financial loss necessary to establish standing to request disgorgement of improper gains (relying on *Pender v. Bank of Am. Corp.*, 788 F.3d 354, 365–66 (4th Cir. 2015))). The Supreme Court's *TransUnion* opinion, handed down just three days after *Peters*, confirms that non-financial injury does not suffice for standing. *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2206 (2021) (lawsuit may not proceed where "plaintiff has not suffered any physical, monetary, or cognizable intangible harm traditionally recognized as providing a basis for a lawsuit in American courts"—*i.e.*, where uninjured plaintiff is "merely seeking to ensure a defendant's compliance with regulatory law." (quotation omitted)).

B. Plaintiffs Cannot Establish Causation or Redressability Where Their Claims and Remedies Depend on the Exercise of Discretion by Independent Decisionmakers Not Before the Court

Plaintiffs also cannot trace their premium contributions to any decision by defendants, nor can they establish that a judicial decision requiring defendants to disgorge commissions received from third-party payers would result in a reduction of their contribution obligations. They accordingly cannot satisfy the traceability or redressability elements of standing, as the district court also correctly held.

A broker-administrator does not "cause" an employer's selection of insurance products by simply making them available for purchase, nor does it cause the employer's determination of employee contribution levels. The independent decisions of the third-party employer interrupt any causal connection between the broker-administrator's offering of products to the market and the premium contribution amounts (if any) paid by plaintiffs. *See, e.g.*, *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 413 (2013) (rejecting "standing theories that require guesswork as to how independent decisionmakers will exercise their judgment").

The employer's independent decisionmaking authority similarly stands in the way of redressability: Plaintiffs cannot establish that their employer would be obliged to apply any reduction of premiums to a reduction of participant contributions. This Court's decision in *Glanton ex rel. ALCOA Prescription Drug*

Plan v. AdvancePCS Inc., 465 F.3d 1123 (9th Cir. 2006), is directly on point. There, participants in employer-sponsored welfare benefit plans alleged that a pharmacy benefit manager overcharged their plans for prescription drugs, which caused the plans to increase participant co-payment and contribution requirements. *Id.* at 1125. This Court found the plaintiffs' claim that a successful suit *might* reduce their drug costs too speculative under Article III:

> Nothing would force [their employers] to do this, nor would any one-time award to the plans for past overpayments inure to the benefit of participants. [The employers] would be free to reduce their contributions or cease funding the plans altogether until any such funds were exhausted. There is no redressability, and thus no standing, where (as is the case here) any prospective benefits depend on an independent actor who retains "broad and legitimate discretion the courts cannot presume either to control or to predict."

Id. (quoting *ASARCO, Inc. v. Kadish*, 490 U.S. 605, 615 (1989)). So it is here. Any money returned by defendants would not necessarily accrue to the benefit of participants, as it would have to for plaintiffs to establish that they can redress their alleged injury through this lawsuit.

To the extent that plaintiffs and their *amicus* contend that an employer would have a fiduciary obligation to route any premium savings to participants, their argument rests on a flawed premise. An employer's decision about how much their employees will contribute to health insurance premiums is a decision about how to *design* its plan—a settlor function, not a fiduciary one. *See Wright v. Or. Metallurgical Corp.*, 360 F.3d 1090, 1102 (9th Cir. 2004) (quoting *Lockheed*,

517 U.S. at 890 ("[B]ecause [the] defined functions [in the definition of fiduciary] do not include plan design, an employer may decide to amend the employee benefit plan without being subject to fiduciary review." (alterations in original; quotation omitted))). The commissions do not come from plan assets, *see, e.g.*, *Santomenno*, 883 F.3d at 838–39 (service provider's receipt of third-party payments did "not come from plan assets"), and the employer could equally apply any savings to its own premium contributions. Like the employers in *Glanton*, an employer in receipt of a return of premiums would retain "broad and legitimate discretion" as to its treatment of any one-time award for past overpayments. *Glanton*, 465 F.3d at 1125.[14] This is particularly the case where, as here, the plaintiffs do not allege any facts to plausibly suggest that *their* premium contributions—as opposed to their employer's—funded any of the commissions paid by the insurers. And even if employers did have a fiduciary responsibility to pass on premium savings to plan participants, that theory of standing *still* would hinge on independent

[14] Contrary to plaintiffs' assertion, *Glanton* is consistent with this Court's prior decision in *Graham v. FEMA*, 149 F.3d 997 (9th Cir. 1998). Critical to *Graham* was the Court's recognition that the facts of the case were *distinguishable* from situations in which redressability "depend[ed] on the unfettered choices made by independent actors not before the courts and whose exercise of broad and legitimate discretion the courts cannot presume either to control or predict." *Id.* at 1003 (quoting *ASARCO*, 490 U.S. at 615). That, too, was the guiding principle of the *Glanton* decision. *Glanton*, 465 F.3d at 1125 (quoting *ASARCO*, 490 U.S. at 615).

decisionmaking that precludes it. Plaintiffs cannot show that their own healthcare premium contributions would necessarily change at all.

The standing principles implicated in this appeal are well-settled, and they have only been reinforced by recent decisions of this Court and the Supreme Court. This case presents no new or difficult questions. Plaintiffs and their *amicus* ask the Court to create standing where none exists, with arguments the Court has already rejected. The decision below should be affirmed.

CONCLUSION

For the foregoing reasons and those stated in the defendants-appellees' opposition brief, this Court should affirm the district court's dismissal decision.

Dated: May 16, 2022

O'MELVENY & MYERS LLP

By: /s/ *Meaghan VerGow*

Meaghan VerGow
Alexander Reed
O'Melveny & Myers LLP
1625 Eye Street, N.W.
Washington, D.C. 20006-4001
Tel: (202) 383-5300
Fax: (202) 383-5414

Paul Lettow
Janet Galeria
U.S. Chamber Litigation Center
1615 H Street, N.W.
Washington, D.C. 20062
Tel: (202) 463-5337

Attorneys for Amicus Curiae

CERTIFICATE OF COMPLIANCE

9th Cir. Case Number: 21-16992

I am the attorney or self-represented party.

This brief contains 4,308 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

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Respectfully submitted,

/s/ Meaghan VerGow
Meaghan VerGow

CERTIFICATE OF SERVICE

I hereby certify that on May 16, 2022, I electronically filed the foregoing brief with the Clerk of this Court using the CM/ECF system, through which counsel for all parties will be served.

/s/ Meaghan VerGow
Meaghan VerGow