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Publications

Federal District Court Dismisses Another Case Regarding the Cost of Prescription Drug Coverage

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On January 24, 2025, the United States District Court for the District of New Jersey dismissed a putative ERISA class action lawsuit in a much-followed case involving Johnson & Johnson ("J&J") in which the plaintiff alleged that the plan fiduciaries for J&J's group health plan violated ERISA by mismanaging its self-funded health plan's prescription drug benefit. See our prior alert here.

In welcome news for the employer community, as well as for health plan service providers, the district court dismissed the plaintiff's ERISA fiduciary breach claims for lack of Article III standing, finding that the plaintiff's allegations that she paid too much in premiums, copays, and coinsurance and that her wages were adversely impacted by prescription drug costs were speculative "at best" and that her allegations regarding higher out-of-pocket costs for prescription drugs were not redressable.

The decision in this case, *Lewandowski v. Johnson & Johnson,* is a major victory for employers and a significant setback to plaintiffs attempting to assert ERISA claims predicated on allegedly excessive health plan fees.

Background – Plaintiff's Allegations

The plaintiff's complaint was rooted in allegations the plan fiduciaries mismanaged the company's employer-sponsored health plan's prescription drug benefit, costing the plan and company employees millions of dollars in the form of higher payments for prescriptions drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth. The plaintiff alleged that the plan fiduciaries failed to satisfy their fiduciary obligations in multiple ways, including, among other things, failing to act in the interest of participants and beneficiaries in selecting a pharmacy benefit manager (PBM), not negotiating better prescription drug pricing, not obtaining sufficient competitive bids from other prescription drug service

providers, not monitoring the PBM and the prices charged for prescription drugs, and requiring participants to use a PBM-affiliated specialty pharmacy. As a result, the plaintiff alleged that she paid too much for two categories of prescription drugs: (1) generic specialty drugs, which typically are only available at hospitals or doctor's offices or through a specialty pharmacy, and (2) generic non-specialty drugs and identified specific generic drugs that were available at cheaper prices at certain pharmacies, even to individuals without insurance.

The complaint also challenged common plan design features such as spread pricing, usage of mail order and specialty pharmacies, and steerage to PBM-owned pharmacies. The amended complaint also asserted a claim for statutory penalties due to the employer's alleged failure to produce documents pursuant to ERISA Sections 104(b)(4) and 502(c).

The District Court's Holding – Plaintiff Failed to Allege Article III Standing

In response to J&J's motion for dismissal of the litigation, the district court dismissed the plaintiff's ERISA breach of fiduciary duty claims due to the plaintiff's failure to adequately allege Article III standing. Generally, to establish Article III standing to pursue litigation in federal district court, the plaintiff must be able to show that (1) the plaintiff suffered an injury-in-fact, (2) the injury was likely caused by the defendants' alleged ERISA violations, and (3) the injury would likely be redressed by judicial relief. In the case at hand, the district court concluded that the plaintiff was unable to meet the criteria to establish Article III standing to bring her ERISA fiduciary breach claims.

Plaintiff's Alleged Injury Due to the Payment of Higher Premiums, Higher Deductibles, Higher Coinsurance, and Lower Wages is Speculative and Hypothetical

The district court found that the plaintiff's alleged injury due to the payment of higher premiums, higher deductibles, higher coinsurance, and lower wages or limited wage growth was "at best" speculative and hypothetical. In reaching this conclusion, the district court heavily relied on a decision by the Third Circuit's in a case called *Knudsen v. MetLife Group, Inc.*, which the district court held was "both controlling and dispositive" in determining the plaintiff's standing to bring her class-based claims against J&J.

In *Knudsen*, the Third Circuit held that the plaintiffs failed to allege Article III standing to assert claims that they incurred higher out-of-pocket costs for their prescription drug coverage due to their employer's retention of prescription drug rebates. The Third Circuit held, among other things, that the plaintiffs failed to allege concrete facts demonstrating that the employer's retention of prescription drug rebates impacted their out-of-pocket costs and failed to allege that they had an individual right to the rebates under the governing plan documents.

Relying heavily on the Third Circuit's decision in *Knudsen*, the district court in *Lewandowski* found that the plaintiff's purported injury due to the payment of higher premiums was based on speculation. Specifically, the plaintiff failed to allege that the employer's "specific conduct" resulted in the plaintiff's payment of higher premiums. Further, the plaintiff failed to assert allegations comparing the premiums charged by the plan to those charged by other plans. Instead, the plaintiff merely asserted conclusory allegations that she "paid more," which the district court found were insufficient to allege Article III standing.

Plaintiff's Alleged Injury Due to Higher Out-of-Pocket Costs is Not Redressable

Although the plaintiff's allegations regarding higher premiums, higher deductibles, higher coinsurance, and lower wages were too speculative to allege a cognizable injury-in-fact, her allegations regarding higher out-of-pocket costs for prescription drugs were sufficiently concrete to meet the pleading requirements of Article III. The district court held that the plaintiff's allegations that she paid higher prices for specific drugs as a result of the employer's alleged fiduciary breaches was a concrete injury-in-fact that was traceable to the employer's alleged ERISA violations. The complaint identified specific prescription drugs that were available at lower costs than the amount charged to the plaintiff. The complaint also alleged that the plaintiff received prescriptions for certain drugs that were marked up by more than 200% over the pharmacy acquisition cost.

The district court, however, held that the plaintiff failed to demonstrate that her injury was redressable. The employer came forward with facts demonstrating that the plaintiff incurred a significant amount of medical expenses (*i.e.*, expenses entirely unrelated to the plan's prescription drug benefit) such that she would have hit the plan's cap on out-of-pocket expenses based on her medical expenses alone for each of the years at issue. Once a participant hit the plan's out-of-pocket maximum, the plan was financially responsible for all other covered medical and prescription drug benefits. As a result, the employer argued that the cost of prescription drugs under the plan had no impact on the plaintiff's total out-of-pocket expenses. Stated differently, even if the plaintiff paid less for the drugs identified in the complaint, her total out-of-pocket costs still would have been the same—*i.e.*, she still would have paid the plan's out-

of-pocket maximum. The district court agreed, holding that there is nothing that it could do to redress the plaintiff's alleged injury. Significantly, the district court "expressed no opinion" as to whether another plaintiff, who did not reach the plan's out-of-pocket maximum, could allege Article III standing.

Plaintiff Stated a Claim for Failure to Produce Plan Documents

Finally, the district court held that the plaintiff sufficiently alleged a claim for statutory penalties due to the employer's failure to timely produce plan documents as required under ERISA section 104(b)(4). The plaintiff alleged that she submitted written requests for "all" plan documents and "all" documents falling within the terms of ERISA section 104(b)(4), but the employer failed to timely and fully respond to those requests, and so the employer's motion to dismiss that claim was denied.

GROOM INSIGHT: The court's holding on this claim is a reminder to plan fiduciaries and third-party administrators to be vigilant in establishing policies and procedures to ensure timely and fulsome responses to requests for plan documents as required by ERISA section 104(b).

Key Takeaways

The *Lewandowski* decision is another major victory for employers. The *Lewandowski* complaint was among the first filed in a possible wave of similar litigation against employers alleging ERISA violations because the self-funded ERISA health plan overpaid for benefits and services. The plaintiffs' bar has attempted to translate excessive fee theories developed in the context of defined contribution retirement plans to self-funded health plans, but thus far has not been able to plead facts sufficient to withstand a motion to dismiss for lack of Article III standing.

The *Lewandowski* decision follows similar decisions dismissing health plan fee claims due to lack of Article III standing, including the Third Circuit's decision in *Knudsen* and the Ninth Circuit's decision in *Winsor v. Sequoia Benefits & Insurance Services, LLC*. Collectively, these decisions hold that a bare allegation that a plaintiff "paid too much" for health benefits and services is not enough to adequately allege Article III standing and proceed to discovery.

The *Lewandowski* decision will likely impact the disposition of pending cases with similar allegations related to the mismanagement of prescription drug benefits. It is notable that the *Lewandowski* court did not entirely close the door on the ERISA fiduciary breach claims. The *Lewandowski* court left open the possibility for a new plaintiff to come forward to establish Article III standing to the extent she has a redressable injury, in this case or another case going forward. The *Knudsen* court similarly left open the possibility for a plaintiff to assert a claim to the extent an employer's action violated plan documents. The plaintiffs' bar may attempt to find a way to exploit these narrow openings to attempt to establish Article III standing in a case predicated on allegedly excessive health plan fees.

GROOM INSIGHT*:* To the extent a plaintiff ultimately is able to plead Article III standing in a health plan fee case, it remains to be seen whether such a plaintiff can also plead a plausible claim for relief as no court has yet weighed in on the pleading standard for an excessive fee claim in the context of a health plan. The court's holding, particularly with respect to the redressability of the plaintiff's claim, highlights the individualized nature of these types of complaints for plaintiffs. In the context of purported class action litigation, this ruling could present challenges to plaintiffs in seeking class certification where the harm alleged is individualized to the claims experience of each individual class member.

In the final analysis, *Lewandowski* is indeed a positive ruling for employers. Nonetheless, the best defense of these types of complaints is to ensure that plan fiduciaries have undertaken and documented a prudent process in the selection of service providers, the negotiation of the service provider contract, and the ongoing monitoring of the service provider.

Groom attorneys are closely monitoring this evolving area in ERISA litigation.