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THE COST OF DRUGS: Johnson & Johnson Lawsuit Could Signal the Opening of a New Area of ERISA Class Action Litigation Against Health Plan Fiduciaries

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Over the past two decades, fiduciaries of health plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) have largely avoided involvement in the increasingly active area of "excessive fee" fiduciary breach litigation, which has mainly targeted fiduciaries of defined contribution retirement plans. That may have changed when a class action lawsuit was filed recently against Johnson & Johnson ("J&J") and the fiduciaries of two J&J-sponsored health plans: *Lewandowski v. Johnson and Johnson, et al.*, Case No. 3:24-cv-00671-ZNQ-RLS (D. N.J., Feb. 5, 2024). If successful, this case could signal the opening of a new area of ERISA class action litigation aimed at health plan fiduciaries, who have largely

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stayed under the radar of the ERISA plaintiffs' bar up to this point.

In this article, we will address the claims and allegations in the J&J case and the impact the case might have on the ERISA health plan industry. But to provide context for our discussion, we will first address some of the key components of ERISA health plans and the players involved in their operation.

Health Plans and Fiduciaries

Employer-sponsored health plans can take different forms, including fully insured (where the employer pays premiums to an insurance company and the insurer pays claims) and self-funded (where the claims are paid by the plan sponsor). Fiduciaries that oversee ERISA health plans are judged by the same strict standards as other ERISA fiduciaries, which are commonly referred to in case law as the "highest duties known to the law."[1] ERISA requires, among other responsibilities, that fiduciaries exercise their duties prudently, which is measured by a comparison to how other prudent fiduciaries would carry out their duties under the same circumstances. Like other ERISA fiduciaries, health plan fiduciaries must prudently select and monitor plan service providers and, in particular, the fees that the providers receive in exchange for their services — and also oversee the operation of benefit programs.

One such benefit is a prescription drug program. Under prescription drug programs, plans pay a certain amount for prescription drugs that are covered under the plan's terms. The list of drugs that are covered under the plan is referred to as a "formulary." The price of the drugs included in a plan's formulary may impact the amount plan participants pay in premiums, co-payments, and co-insurance, all of which are out-of-pocket costs to the participant. Prescription drug benefits for self-funded group health plans are usually managed and administered by a Pharmacy Benefits Manager (PBM).

PBMs and Drug Pricing

PBMs negotiate pricing with drug manufacturers and pharmacies, which makes them central to determining the price of drugs paid by these group health plans. Traditional PBMs commonly receive revenue in various forms, such as "spread compensation" or "rebate" income. For spread compensation, traditional PBMs keep the difference between what the plan pays the PBM for a drug and what the PBM pays the pharmacy for dispensing the drug. This amount may not be disclosed to plan sponsors. Separately, PBMs may negotiate "rebates" from drug manufacturers that are paid directly to the PBM — commonly as incentives to the PBM to include that drug on the plan's formulary or provide more prominent placement for the drug on the plan's formulary. Critics argue that both spread and rebate compensation misalign the incentives between the PBM and the group health plan, as the PBM may be motivated by the amount received in spread or rebate compensation when determining the plan's formulary as opposed to the actual effectiveness or cost to the plan of the drug.

A different model that some PBMs follow is referred to as "pass-through." Under a pass-through model, the PBM bills a health plan for drugs in the same (or very similar) amount that the pharmacy is paid for that drug, which, arguably, eliminates the spread. Pass-through PBMs also agree to pass on any rebates that they may receive from drug manufacturers back to the plan. Revenue under this model is based on a flat administrative fee that the PBM charges to the plan.

The pricing negotiated by PBMs not only affects health plans but the prescription drug industry as a whole. Drug manufacturers have argued that the increasing amount of rebates being paid to PBMs has forced them to increase the cost of their drugs. Notably, PBMs keep their drug pricing, including information about rebates, a closely guarded secret — claiming their pricing models are proprietary. That secrecy may create difficulties for plan fiduciaries who are tasked with overseeing the reasonableness of drug pricing.

Increased Transparency Regarding Health Plan Costs

In recent years, new laws and regulations have required an unprecedented level of transparency regarding the costs of medical services paid by group health plans, and the cost-sharing amount borne by participants. Under

the "Transparency in Coverage" rule issued in 2020, group health plans are required to disclose cost-sharing information upon request to participants, including an estimate of the individual's cost-sharing liability for covered items or services furnished by a particular provider. Additionally, the Transparency in Coverage rule requires group health plans to publish machine readable files containing amounts paid to in-network providers and out-of-network providers, as well as drug pricing information.[2]

The Consolidated Appropriations Act of 2021 (CAA) also included many provisions that require a new level of transparency on pricing and fees charged to health plans. Notably, the CAA amended ERISA §408(b)(2) — which greatly expanded fee disclosure responsibilities for retirement plan providers — such that ERISA §408(b)(2) disclosure requirements now apply to health plans for certain service providers. Under the CAA, a "responsible plan fiduciary" is required to review the compensation disclosures provided by a plan's brokers and consultants to ensure that they are only paid reasonable compensation. And it requires brokers and consultants, which arguably can include PBMs (depending on the services provided), to disclose "direct" and "indirect" compensation received during the term of the contract. ERISA §408(b)(2) is an exemption to ERISA's prohibited transaction rules, which allows fiduciaries to limit liability where a party-in-interest (such as a consultant) receives compensation, at least in part, from plan assets, so long as the compensation is reasonable. In order to fall within the exemption, fiduciaries must receive disclosures about the PBM's compensation in order to properly review them to make sure the compensation is reasonable.

This brings us to our discussion of the lawsuit filed earlier this year against J&J and its health plan fiduciaries.

Lewandowski v. Johnson & Johnson

On February 5, 2024, plaintiff Ann Lewandowski filed a class action lawsuit against J&J and the fiduciaries of J&J's prescription drug benefits program ("J&J Defendants") in the District of New Jersey. Lewandowski's claims are premised on an alleged violation of ERISA's duty of prudence under ERISA § 404(a)(1)(B), 29 U.S.C. §1104(a)(1)(B). At a high level, she claims that the J&J Defendants breached their fiduciary duty of prudence by failing to manage drug costs of two J&J-sponsored health plans — the Salaried Medical Plan and Salaried Retiree Medical Plan ("the Plans") — and adequately monitor the Plans' PBM, Express Scripts.

The Complaint claims that the J&J Defendants' alleged mismanagement cost the Plans and participants millions of dollars in the form of higher drug costs, premiums, deductibles, co-payments, and co-insurance, and lower wages for employees (as a result of money allegedly being diverted from wages to prescription drug expenses). It identifies several examples of prescription drugs that Lewandowski claims were available at lower retail prices, but for which the Plans allegedly paid significantly higher prices.[3] She claims that the Plans' PBM, Express Scripts, received unreasonable spread income that was paid from the Plans' assets and by the participants, who paid out-of-pocket amounts based on the allegedly inflated prices. Among other alleged failures, Lewandowski claims the fiduciaries breached their duties in selecting the Plans' PBM, agreeing to the pricing formulary for the prescription drug program, allowing the PBM to enrich itself at the expense of the Plans and its participants, and not taking steps to "rein in" its PBM's profit-driven motivations to protect plan assets and the participants' interests.

In an effort to establish alternative (i.e., allegedly prudent) actions that the J&J Defendants could have taken, Lewandowski claims the J&J fiduciaries could have negotiated better rates from the Plans' PBM or another traditional PBM, steered beneficiaries toward more cost-effective pharmacy options, or moved J&J's prescription drug program to PBMs that operate under the "pass-through" model described above. Without those protections, Lewandowski alleges, the Plans' PBM was incentivized to include high-cost drugs in the Plans.

The Complaint alleges that, as a result of the J&J Defendants' alleged fiduciary breaches, the Plans and participants suffered losses totaling millions of dollars.

Looking Forward

The J&J Defendants have not yet responded to Lewandowski's Complaint, and we will continue to monitor this case to determine whether the claims gain any traction.

A fundamental question that will likely be answered early in this case is whether Lewandowski has Constitutional standing to assert claims on her own behalf and on behalf of the putative class. Article III of the U.S. Constitution requires that plaintiffs establish that they have sustained a concrete injury to bring a lawsuit in federal court. In a recent case titled *Knudsen v. MetLife* (Case No. 23-cv-00426; D. N.J. July 18, 2023), the plaintiffs sued MetLife and its ERISA group health plan on grounds that MetLife improperly kept rebates it received through its PBM instead of using the rebates to reduce copays and coinsurance or distribute the rebates directly to the participants. The court dismissed the plaintiffs' claims on grounds that the plaintiffs lacked standing because they received all the benefits that were owed to them, and they were not entitled to the drug rebates under the group health plan's governing documents.

Notably, *Knudsen* relied heavily on the recent Supreme Court decision in *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615 (2020). *Thole* held that participants suing a defined benefit pension plan lacked Constitutional standing because they failed to plausibly allege that they suffered any injury. Defined benefit plans pay out a predetermined amount to participants at the time of retirement. *Thole* reasoned that allegations that the plan suffered losses were insufficient to establish that the participants, themselves, suffered any injury because there were no allegations that the participants' individual benefit payments would be impacted as a result of the alleged misconduct. Adopting this reasoning, *Knudsen* concluded that the MetLife health plan was analogous to a defined benefit plan and the same interpretation of the Constitutional standing requirements should apply to ERISA health plans. If other courts follow this logic, plaintiffs will have an uphill battle in establishing standing in fiduciary breach cases involving health plans, as we have seen in the context of defined benefit plans governed by ERISA post-*Thole*.

If *Lewandowski* or other cases like it progress past the pleading stage, the defenses asserted by the J&J Defendants will be based on the *processes* that the fiduciaries followed in selecting and monitoring the Plans' service providers, the income those providers received, and benefits paid under the Plans. *Lewandowski* reinforces how important it is for health plan fiduciaries to pay close attention to their plans' costs and fees, which could include actions like issuing requests for proposals for service providers at a regular cadence, pressing consultants and brokers for information about drug pricing and formularies, developing internal processes and procedures for selecting and monitoring service providers, and maintaining steadfast oversight of compensation paid to service providers.

Retirement plan "excessive fee" litigation has plagued fiduciaries of defined contribution plans over the past two decades and reshaped the entire retirement industry — from the pricing of investments to compensation paid to service providers to insurance and legal costs. If *Lewandowski* gains any traction and paves a new path of ERISA fiduciary litigation, we could see the same seismic disruption in the health plan industry.

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1 See *Johnson v. Couturier*, 572 F.3d 1067, 1077 (9th Cir. 2009) (citing *Howard v. Shay*, 100 F.3d 1484, 1488 (9th Cir.1996)).

2 The requirement regarding the publishing of drug pricing information has been delayed.

3 The Complaint identifies drugs covered under the Plans that Lewandowki claims were available for much lower prices on the retail market, and several employers that Lewandowski claims negotiated better overall rates and/or pricing structures for their plans.

FIRM NEWS

Katuri Kaye was recently appointed to the Board of Directors of the California Minority Counsel Program (CMCP), a California non-profit dedicated to promoting diversity in the legal profession by providing attorneys of color with access and opportunity for business and professional development. CMCP is the only state-wide organization that brings business lawyers of all races together as members and colleagues, regardless of the type of organization in which they practice — for the purpose of achieving diversity and inclusion within law firms and in-house law departments, and in the outside counsel spend of corporations and government agencies. As the Firm's Diversity, Equity and Inclusion (DEI) Director, Katuri also chairs the Firm's DEI Committee.

We are pleased to announce that **Brian Murray** has been elevated to the position of Counsel, effective January 1, 2024. This promotion recognizes Brian's years of experience as an ERISA litigator, as well as his in-depth knowledge of the law and demonstrated ability to successfully represent clients at a senior level with respect to complex matters. Congratulations, Brian!

We are pleased to announce that **Stephanie Platenkamp** recently joined the Firm, and her practice focuses on both single employer and multiemployer tax-qualified retirement plans. Stephanie is active in the American Bar Association's Joint Committee on Employee Benefits (JCEB), and she is an editor of Chapter 10, *Fiduciary Responsibility,* of the JCEB's *Employee Benefits Law Treatise*. Stephanie has presented on seminar panels for the JCEB and other industry organizations, and she served as the 2020 Chair of the Executive Committee of the Labor & Employment Law Section of the Sacramento County Bar Association.

Stephanie graduated from University of California Davis School of Law, and prior to joining Trucker Huss she primarily advised multiemployer retirement and health and welfare plans, and public and private sector labor organizations. Welcome to the Firm, Stephanie!

On February 20, 2024, **Angel Garrett** and **Brian Murray** presented a webinar hosted by Strafford: *ERISA Arbitration and Class Action Waivers: Drafting Arbitration Provisions, Minimizing Risks and Class Actions*. The webinar provided an in-depth analysis of key issues and drafting considerations for the inclusion of ERISA arbitration and class action waivers in ERISA plans.

In January, **Robert Gower** presented on the new proposed fiduciary rule for ABA's Joint Committee on Employee Benefits (JCEB).

On January 31 and February 2, Robert participated in the 2024 FIS Advanced Pension Conference, held virtually. He presented on: *2023 Changes to Form 5500; The New Proposed Fiduciary Rule;* and *Cybersecurity Compliance.*

In February, Robert presented on Fiduciary Best Practices at the Institutional Investor Retirement Plan Investor Conference in Orlando, Florida.

On March 21, Robert will be speaking about fiduciary compliance at the 2024 Bay Area Healthcare & Retirement Plan Summit. The summit will discuss key topics and best practices including: *What Every Fiduciary Needs to Know for 2024; Convergence of Healthcare & Retirement;* and *Preserving & Enhancing the Value of Your Total Rewards Strategy.*

On February 21, **Mary Powell** moderated the Healthcare Compliance panel at the Joint TE/GE Council Annual Meeting. The panel discussed updates on health benefits, plan design compliance, fertility benefits, mental health parity, IDR and more.

On March 5, Mary presented a Trucker Huss Webinar: *Pharmacy Benefit Managers (PBMs) — What ERISA Fiduciary Obligations and Duties Relate to Prescription Drug Plans?* Topics for discussion included an explanation of PBMs and how PBMs fit into the drug pricing puzzle.

On March 20, **Dylan Rudolph** was a panelist for the Strafford Webinar: *401k & 403b Retirement Benefit Plan Litigation: Recent Cases and Issues for Plan Sponsors and Fiduciaries — Causes of Action, Defenses, Dismissals and Settlements, Best Practices for Avoiding and Managing Claims*.

On May 8, Dylan will join a panel on *The Next Frontiers of Plan Fee Litigation,* at the ABA Joint Committee on Employee Benefits virtual program, *ERISA: Beyond the Basics*.

Dylan will also speak on *Preparing for DOL & IRS Aduits* at the ESOP Association's TEA National Conference to be held May 7–9 in Washington DC. More information at:

www.esopassociation.org/events.

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In February, **Angel Garrett, Clarissa Kang, Brian Murray and Dylan Rudolph** presented at the 48th Annual American Bar Association (ABA) TIPS Midwinter Symposium on Employee Benefits, ERISA, Life, Health & Disability Insurance, and Insurance Regulation, held in in La Jolla, CA. The Trucker team had the opportunity to present on a variety of topics, including:

- ERISA Civil Procedure Updates
- Mediating Employee Benefits Cases
- Artificial Intelligence in Insurance

On January 31 through February 3, 2024, **Trucker Huss** participated in the ABA Labor and Employment Law Section Employee Benefits Committee Midwinter Meeting, which took place in San Diego, CA. The Firm supported the event as a Platinum sponsor and co-sponsored the Diversity, Equity and Inclusion Luncheon.

Director **Clarissa Kang** held a key leadership role as Co-Chair of the 2024 Midwinter Meeting. She is serving as the Employer/Management Co-Chair for the Employee Benefits Committee for the next two years.

Brad Huss spoke on the panel, *The Next Frontier(s) of Defined Contribution Plan Litigation.*

The Trucker ✦ Huss Benefits Report is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of Benefits Report are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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