Lewandowski v. Johnson and Johnson—Unable to Pursue Fiduciary Breach Claims for High Costs of Drugs

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Lewandowski v. Johnson & Johnson—Unable in First Try to Pursue Fiduciary Breach Claims for High Costs of Drugs

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The United States District Court for the District of New Jersey dismissed without prejudice, and with leave to amend, Ann Lewandowski's breach of fiduciary duty claims against Johnson & Johnson and its Pension & Benefits Committee (the "Health Plan Fiduciaries"), stating that she lacked Article III standing. (Lewandowski v. Johnson & Johnson, *et al* (https://www.bloomberglaw.com/public/document/LEWANDOWSKIvJOHNSONANDJOHNSONetalDocketNo324cv00671DNJFeb052024Co/3?doc_id=X6QK7S118S487KBFG5ITDUDK288)., D.N.J., No 3:24-cv-00671) (The "J&J Case"). The focus of the lawsuit was the allegation that the Health Plan Fiduciaries entered into an agreement with the pharmacy benefit manager (PBM) for the health plans that required the health plans and the participants to overpay for the costs of prescription drugs.

The Complaint in the J&J Case. The First Amended Complaint alleged the following breaches of fiduciary duties by the Health Plan Fiduciaries:

- Failure to adequately negotiate the PBM agreement;
- Failure to monitor the PBM (such as conducting a market check on drug prices); and
- Failure to consider alternative PBM pricing models (such as a pass-through model that does not include spread pricing).

The allegations are based on the ERISA requirement that fiduciaries must "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries and…with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." (ERISA §404(a)(1)(B)).

In the J&J Case, the plaintiff focused on the "spread compensation" paid to the PBM. Spread compensation occurs when a PBM enters into a contract with a health plan sponsor (such as the employer) stating that the plan sponsor will pay a certain amount to the PBM for a drug when it is dispensed by the pharmacy to a plan participant. The PBM has a separate contract with the pharmacy that sets the amount the PBM will pay the pharmacy when the drug is dispensed to a participant. For example, the PBM has a contract with the pharmacy to reimburse the pharmacy for a drug that it dispenses at the price of $300. However, the PBM separately charges the health plan $2,000 when that drug is dispensed. The $1,700 differential is referred to as the "spread compensation," which the PBM retains as a profit from the transaction.

In the J&J Case, the plaintiff alleged numerous examples of "excessive" spread pricing under the PBM agreement, including the following with regard to a generic HIV antiviral drug:

- The National Average Drug Acquisition Cost (NADAC) had the acquisition cost of that drug at about $181 dollars for a 90-day supply[1];

- The cash price for someone who is not insured—based on the information listed on the websites for CostPlus, Rite Aid, etc.—for that 90-day supply was about $200; and
- The complaint alleges that the plan paid the PBM $1,629 for the same 90-day supply—a mark-up of over $1,400 on one prescription.

The complaint alleges that no fiduciary, properly exercising their fiduciary duties, would agree to such inflated and excessive pricing. The plaintiff alleged that agreeing to pay such excessive prices for the drugs caused participants to pay inflated premiums for health plan coverage and forced participants to pay more out-of-pocket costs at the pharmacy counter than she would have paid absent defendants' fiduciary breaches.

Defenses Raised by the Health Plan Fiduciaries in the J&J Case. In the defendants' reply in support of their motion to dismiss, they raised several defenses. With regard to the plaintiff's allegation that if the overall costs being paid to the PBM had been lower, the defendants might have made a different decision each year about how much of the premium to pass on to the participants, the defendants stated this was speculative. With regard to the allegation that plaintiff incurred greater out-of-pocket expenses for her prescription drugs as a result of the alleged fiduciary breaches, the defendants noted that the plaintiff would have met the "cap" for prescription drug costs in the plan regardless of the "excessive" pricing. The defendants stated that the plaintiff did not dispute that she would have reached her $3,500 total maximum out-of-pocket amount under the plan each year, but rather due to these allegedly excessive costs for certain drugs, she reached her $3,500 maximum out-of-pocket amount a few months earlier each year than she would have otherwise. The defendants claimed that "the lost time value of money" was not enough to show standing.

Court Decision in the J&J Case. In order for a plaintiff to show Article III standing, she must establish that she has: (1) sustained a concrete injury, (2) the injury was caused by the defendant and (3) the injury could be redressed by a court order.

With regard to the plaintiff's allegation that the defendants' fiduciary breach caused her to pay higher premiums for the health plan, the court stated that the injury was "speculative and hypothetical" and was a conclusory allegation that did not meet the requirements for standing.

With regard to her claim that paying higher prices for drugs caused her to pay more out-of-pocket costs, the court stated that although she established an injury-in-fact, she nevertheless could not show standing because her injury was not redressable by an order from the court: "Even if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug—that is, the higher amount of money she spent as a result of Defendants' breaches—that money would be owed to her insurance carrier to reimburse it for its expenditures on other drugs for the same year. In short, there is nothing the Court can do to redress Plaintiff's alleged injury." Based on information submitted by the plaintiff, it appears she received infusions each year that cost well over the plan's out-of-pocket maximum —so she would have hit the plan's "cap" based on other treatments she received.

Difference from the Wells Fargo Case. Very similar allegations were claimed by plaintiffs in *Sergio Navarro, et al. v. Wells Fargo & Co.*, Case No. 0:24-cv-3043 (D. Minn., July 30, 2024). Like the plaintiff in the J&J Case, the *Wells Fargo* plaintiffs are alleging that the fiduciaries breached their duties by not taking proper measures to ensure plan costs for prescription drugs were reasonable. However, one significant difference between the two cases is that the Wells Fargo plaintiffs' suit also includes a claim of a prohibited transaction. In general, ERISA prohibits transactions between a health plan and its service providers unless no more than reasonable compensation is paid for the services.

Based on information in the plan sponsor's Form 5500, the plaintiffs claimed that Wells Fargo paid incredibly high administrative fees (over $25 million) to the PBM, Express Scripts. The plaintiffs claimed further that the amount of the administrative fees greatly exceeded the fees paid to Express Scripts by plans comparable in size to (or smaller than) Wells Fargo's plan; therefore, the compensation was "excessive" and resulted in a prohibited transaction.

As of the time of this article's publication, there have not been any decisions in the *Wells Fargo* case.

Possible Issues with Different Plan Design. One thing to note is that not all health plans have a maximum out-of-pocket limit for drugs that the plan does not consider to be "essential health benefits" under the Affordable Care Act (ACA). Some plan designs require participants to pay a large coinsurance amount—such as 50%—for the cost of a drug categorized as a non-essential health benefit and those amounts paid by the participant never accrue to the out-of-pocket maximum. That type of plan design was not present in either of the cases discussed above.

ERISA Documents Request in the J&J Case. The one claim in the J&J Case that was not dismissed was a claim under ERISA Section 104(b)(2)—the right to receive certain documents within 30 days of a written request by a participant or beneficiary. The plaintiff requested access to documents regarding the plan's prescription drug formulary and a copy of the agreement between the employer

and the PBM—all of which were allegedly not provided.

The court provided the plaintiff with time to file an amended complaint to address the deficiencies in her claims.

The Future. The decision in the J&J Case is a win for plan sponsors. However, we assume the plaintiffs' bar will continue to bring "excessive" fee cases against the fiduciaries of employer-sponsored health plans. If they are able to establish standing and survive a motion to dismiss —such as on the claim of a prohibited transaction in the Wells Fargo Case —the flood gates could open. Even if plaintiffs are not successful with a prohibited transaction claim, we assume they will continue to bring lawsuits against employer-sponsored health plans under different theories.

Now is a good time for plan sponsors to evaluate their procedures for reviewing PBM contracts and monitoring PBMs. In addition, plan sponsors should confirm that they have adequate fiduciary liability insurance in place with an experienced, reputable insurer.

[1] NADAC was developed by the Centers for Medicare and Medicaid Services (CMS). It represents the average price that retail community pharmacies pay to acquire prescription drugs, including both brand and generic drugs, from wholesalers. NADAC pricing is calculated by collecting data from participating pharmacies across the country and aggregating it to determine the average acquisition cost for each drug.

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