

Publications

ERISA Group Health Plans – The New Target in Fee Cases

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Earlier this year, a Johnson & Johnson (“J&J”) employee brought a class action complaint (the “Complaint”) against J&J alleging fiduciary breaches under ERISA related to the prescription drug coverage under J&J’s self-funded group health plan (the “Plan”). *See Lewandowski v. Johnson and Johnson et al*, U.S. District Court, District of New Jersey, Case No. 3:24-CV-00671. Specifically, the Complaint alleges that the Plan’s fiduciaries, including individual members of the J&J benefits committee, breached their fiduciary duties by failing to exercise required prudence and overpaid for prescription drug benefits as a result. The Complaint presents novel claims under ERISA in the group health plan space. Below, we summarize the allegations of the Complaint and the current status of the litigation, including updates on the plaintiff’s recently-filed amended complaint.

Legal Background

ERISA requires that fiduciaries “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.” That requirement is commonly referred to as a duty of prudence. As discussed below, the Complaint’s allegations hinge on alleged violations of the duty of prudence.

Factual Background

The Complaint focuses on J&J’s practices in selecting its pharmacy benefits manager (“PBM”) and its contracting for, and monitoring of, such PBM services. The Complaint takes aim at certain fairly standard PBM practices, including the use of “spread” pricing, where a PBM retains the difference between what it pays a pharmacy and what the plan pays the PBM for any given drug. The Complaint

contrasts “spread” pricing with “pass-through” pricing, where a PBM is compensated via a flat administrative fee and charges the plan

the same price for any given drug that it pays to a pharmacy. The plaintiff alleges that “pass-through” pricing both keeps the PBM’s interests aligned with the plan’s and prevents PBMs from favoring the sale of any particular drug, which protects patients. The Complaint also focuses to some degree on the fact that the defendant’s plan is funded through a trust, funded by both employer and employee contributions.

The Complaint alleges that PBMs, in addition to brokers and consultants utilized by plans in contracting with PBMs, are incentivized to work against the interests of plans. With respect to brokers and consultants, the Complaint alleges that payments from PBMs to brokers and consultants for recommendations to use a particular PBM provide incentives that conflict with the plan’s interests. With respect to PBMs, the Complaint alleges they are incentivized to steer participants to drugs with the highest profit margin for the PBM, including by arbitrarily designating certain pharmaceuticals as “specialty” drugs—which potentially allows the PBM to charge higher prices—a designation that the Complaint alleges has no clear definition.

The Complaint’s Allegations Regarding J&J

The Complaint alleges three fiduciary breaches by J&J in managing the Plan: (1) J&J failed to adequately negotiate the contract with its PBM and failed to exercise its rights under the contract; (2) J&J failed to properly consider either contracting with a separate PBM or a PBM that uses a “pass-through” pricing model; and (3) J&J failed to consider carving out its specialty drug contract with its PBM.

The Complaint attempts to support these allegations by focusing on a specific and small subset of drugs covered by the Plan – specifically asserting that the Plan overpaid for 42 specialty generic drugs. For example, with respect to one of these drugs, teriflunomide (a generic drug used to treat Multiple Sclerosis), the Complaint alleges the following:

[S]omeone with a 90-pill prescription for the generic drug teriflunomide (the generic form of Aubagio, used to treat multiple sclerosis) could fill that prescription, without even using their insurance, at Wegmans for \$40.55, ShopRite for \$41.05, Walmart for \$76.41, Rite Aid for \$77.41, or from Cost Plus Drugs online pharmacy for \$28.40. Defendants, however, agreed to make their ERISA plans and their beneficiaries pay \$10,239.69—not a typo—for each 90-pill teriflunomide prescription.

The Complaint goes on to provide a number of other examples of specialty generic drugs that it alleges the Plan agreed to overpay as compared to the given drug’s cash cost at a retail pharmacy.

GROOM INSIGHT: Notably, there are many open legal questions regarding the allegations contained in the Complaint and the factual support being used to substantiate the allegations. The Complaint cherry-picks specific aspects of the PBM arrangements without looking at the arrangement in its totality. Established case law and DOL guidance supports a fiduciary prudence standard that looks at the overall economics of the service provider arrangement versus a more limited focus on any specific item or service. This is especially true with health and welfare plans where the number of covered items or services may be in the tens of thousands. Additionally, there are a host of arguments that suggest plaintiffs may lack Article III standing to bring litigation because of a failure to show the necessary “injury-in-fact” – especially where there is no allegation that participants did not receive all the benefits due under the plan or where the participants’ financial obligation to the plan is stated as a fixed premium (or equivalent), and cost sharing amounts are independent of the cost of the drug, item, or service. In those situations, the employer, not the plan or the participants, is responsible for funding all other plan costs and expenses from its general assets. Nonetheless, it will be very interesting to see how this court and other courts address these issues as part of current and future litigation.

Current Status of the Litigation

The litigation is still in its early days. J&J filed a motion to dismiss the Complaint making several arguments, including that the plaintiff:

- lacks standing because (1) she received all benefits to which she was entitled under the plan; and (2) she does not allege that she actually bought the drugs the Complaint highlights as too expensive.
- fails to state a plausible claim for relief because (1) J&J bears the cost of the drugs and so is incentivized to get the best deal, which J&J did on the overall program, not just the cherry-picked drugs listed in the Complaint; and (2) the proper comparison is not drug-by-drug, but rather the prescription drug program’s cost overall.

On May 10, 2024, the plaintiff filed an amended complaint that moots the defendants' motion to dismiss. As anticipated by the stipulation between the parties, the plaintiff removed the individual defendants previously included in the Complaint because J&J has agreed to be responsible for any liability for their individual actions.

The amended Complaint made a number of changes as compared to the initial Complaint, which largely appear driven by the defendant's arguments in its now-mooted motion to dismiss. The changes largely fall into the following categories:

- **The plaintiff's personal harms:** The plaintiff included additional allegations attempting to plead harm to her specifically.
- **Additional allegations attempting to link the Plan's practices to increased costs:** The plaintiff added language or made revisions in an apparent effort to link alleged fiduciary breaches to the Plan's overpayment and, the plaintiff argues, consequently the participants' overpayments.
- **Additional allegation about purported failures of oversight and contracting:** The plaintiff added language about the alleged need to: (1) conduct regular market surveys; and (2) compare contracts with other PBMs.

Also of note, the plaintiff dropped her allegation that drug price comparisons need to be done on a drug-by-drug basis, but retained the discussions of the alleged excessive pricing of individual drugs.

GROOM INSIGHT: This litigation warrants continued monitoring. The next anticipated step is that the defendants will file a motion to dismiss the plaintiff's amended complaint. The plaintiff is no longer permitted an amendment as a matter of right, so we anticipate that the plaintiff will respond to the motion and that eventually the court will issue a ruling on this important issue.