

No. 26-1107

**THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

ANN LEWANDOWSKI and ROBERT GREGORY,
on their own behalf, on behalf of all others similarly situated, and on
behalf of
the Johnson & Johnson Group Health Plan and its component plans,

Plaintiffs-Appellants

v.

JOHNSON & JOHNSON, et al.,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of New Jersey
No. 3:24-cv-00671 (ZNQ) (RLS)

**BRIEF OF *AMICUS CURIAE* CHRIS DEACON
IN SUPPORT OF APPELLANTS AND REVERSAL**

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TABLE OF CONTENTS

TABLE OF AUTHORITIES..... ii

STATEMENT OF INTEREST OF AMICUS CURIAE 1

PRELIMINARY STATEMENT 3

I. How Self-Funded Plans Work 4

 A. Employers typically outsource management of their plan
 to third-party providers..... 5

 B. Self-funded plans expose participants to pricing decisions.
 7

II. Plan Participants May be Injured by Imprudent Management
of Self-Funded Health Plans..... 8

III. The District Court’s Misunderstanding of Self-Funded Plans
Affected its Analysis..... 10

IV. The Alleged Overcharges Are Sufficient to Establish Article III
Injury..... 14

CONCLUSION..... 15

CERTIFICATE OF COMPLIANCE 17

TABLE OF AUTHORITIES

Other Authorities

Fed. Trade Comm’n, <i>Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies</i> (2024)	8
Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4,348 (proposed Jan. 30, 2026)	5
KFF, <i>2025 Employer Health Benefits Survey: Summary of Findings</i> (2025)	4, 7
Meredith Freed, <i>What to Know About Pharmacy Benefit Managers (PBMs) and Federal Efforts at Regulation</i> , KFF (Feb. 9, 2026).....	6
U.S. Dep’t of Labor, <i>Report to Congress: Annual Report on Self-Insured Group Health Plans</i> (2025).....	7
Laura Wadsten & Nathaniel Horwitz, “ <i>Bullshit</i> ” — <i>The New Way Health Giants Hide Billions</i> , Hunterbrook (Jan. 6, 2026)	7

STATEMENT OF INTEREST OF AMICUS CURIAE

Amicus Christin Deacon is a healthcare policy expert. She previously served as Assistant Director of the Division of Pensions and Benefits, Department of Treasury, in charge of State Employee and School Employee Health Benefits Programs for the State of New Jersey, where she was responsible for coverage for more than 820,000 public employees, retirees, and their families. In that role, she oversaw large-scale contracting with third party administrators and pharmacy benefit managers and was directly responsible for stewarding public plan assets in the employer-sponsored market.

Ms. Deacon now advises labor-management health funds, state and municipal governments, non-profit policy organizations and large self-funded employers across the country. She has testified before the United States Senate Committee on Health, Education, Labor, and Pensions, United States House Committee on Aging, and the *United States House of Representatives Committee on Education and Workforce, Subcommittee on Health, Employment, Labor* on the subject of healthcare affordability and the structural opacity that impairs employer oversight.

Drawing on her experience administering and advising large self-funded plans, Ms. Deacon submits this brief to assist this Court in understanding how self-funded plans operate, and in particular how a plan's pricing decisions impact plan participants.¹

¹ All parties have consented to the filing of this brief. Fed. R. App. P. 29(a)(2). No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund preparing or submitting this brief; and no person other than amicus curiae or her counsel contributed money intended to fund preparing or submitting this brief. Fed. R. App. P. 29(a)(4)(E).

PRELIMINARY STATEMENT

This case asks a question that should be easy: when a self-funded plan participant pays more than she should have for a prescription drug, did that plan participant suffer an injury? The district court effectively answered no. Faced with the Plaintiffs' allegations that they paid too much for a variety of charges, the district court dismissed their allegations as too speculative or too conceptually entangled with other plan features to constitute a concrete injury.

The district court's analysis is unmoored from how self-funded plans operate and how their pricing decisions affect plan participants. In a self-funded health plan, participants and employers jointly pay for benefits through premiums, deductibles, and variable-cost sharing imposed at the point-of-sale. This makes self-funded plans unlike defined-benefit plans, where participants generally receive a fixed benefit and are ordinarily insulated from transaction-level fluctuations in plan spending.

That distinction matters here. The district court analyzed the alleged injury as though participant costs could be understood only by looking at the plan as a whole or by comparing a challenged overcharge

to other benefits paid during the same year. But in a self-funded health plan, participant-level costs arise transaction by transaction, under the plan's pricing and cost-sharing rules. Understanding that feature of self-funded plans helps explain why allegations of overpayment in this setting do not fit neatly within frameworks developed for plans in which participants receive fixed benefits largely unaffected by the pricing of individual claims.

The district court's analysis rests on a conceptual error: it treats a self-funded health plan as if participant injury can only be understood at the level of aggregate plan spending, rather than at the level where participants actually experience cost—the transaction.

I. How Self-Funded Plans Work

A self-funded health plan is not an insurance product in which an employer simply pays a fixed premium to an insurer and transfers the risk away. Instead, in a self-funded plan, expenses are shared between the employer and participants, who pay premiums, deductibles, and copayments. Self-funded health plans are common. KFF, a widely respected non-profit that focuses on health policy, reported that in 2025, 67% of covered workers were enrolled in self-funded plans. KFF, 2025

Employer Health Benefits Survey: Summary of Findings, at 11. At firms with two hundred or more workers, more than 80% of covered workers are enrolled in self-funded plans. *Id.* Thus, the legal regime governing self-funded plans affects large swaths of Americans.

- a. Employers typically outsource management of their plan to third-party providers.

Employers tend not to run self-funded plans themselves. Rather, employers typically retain service providers to administer the plan and its benefits to plan participants. These third parties may be contracted to perform any number of services, including, for example, paying claims, resolving disputes, and negotiating payment rates. Although these third parties manage the plan, it is the duty of the fiduciary to ensure that they are doing so responsibly.

Pharmacy benefit managers (“PBMs”) are a category of service providers that are pertinent to this dispute. “PBMs are described as the ‘middlemen’ in the pharmaceutical supply chain. For ERISA-covered self-insured group health plans, PBMs perform a wide range of services including, but not limited to, organizing pharmacy networks, negotiating pharmacy reimbursement amounts and drug rebates, establishing drug formularies, and processing claims.” Improving Transparency Into

Pharmacy Benefit Manager Fee Disclosure, 91 Fed. Reg. 4,348, 4,348 (proposed Jan. 30, 2026). These middlemen have been the subject of much scrutiny for playing a role in increasing drug prices. Meredith Freed, *What to Know About Pharmacy Benefit Managers (PBMs) and Federal Efforts at Regulation*, KFF (Feb. 9, 2026), available at <https://www.kff.org/other-health/what-to-know-about-pharmacy-benefit-managers-pbms-and-federal-efforts-at-regulation/>.

PBMs are not merely neutral claims processors. Modern pharmacy-benefit arrangements often operate within vertically integrated structures in which what appears to be a negotiation between separate actors may in fact involve affiliated payers, PBMs, pharmacies, and rebate-aggregation entities. Recent investigative reporting has described similar structures involving affiliated PBM entities that reportedly aggregate rebate negotiations and route rebate-related revenue through subsidiaries, making it difficult for plan sponsors to audit or even identify them. Laura Wadsten & Nathaniel Horwitz, *“Bullshit” — The New Way Health Giants Hide Billions*, Hunterbrook (Jan. 6, 2026). Yet it remains a fiduciary’s obligation to ensure that the PBMs they contract with are benefiting plan participants.

b. Self-funded plans expose participants to pricing decisions.

Unlike a defined-benefit pension, where the participant's entitlement is ordinarily fixed and does not rise or fall with each plan expenditure, a self-funded health plan exposes participants to transaction-level pricing decisions throughout the year. See U.S. Dep't of Labor, *Report to Congress: Annual Report on Self-Insured Group Health Plans* at 4–5 (2025) (explaining that, in self-insured plans, the employer or plan pays covered health expenses directly as claims are incurred, rather than shifting that risk to an outside insurer). In employer health coverage, participants commonly bear deductibles, copayments, and coinsurance in real time; KFF reports that 88% of covered workers with single coverage are in plans with a general annual deductible, and hospital coinsurance requirements remain common as well. KFF, *2025 Employer Health Benefits Survey: Summary of Findings*, at 11–12 (2025). Those features mean that participants are not economically insulated from the plan's pricing structure; they are charged under it, often at the moment they obtain care.

That is particularly true on the pharmacy side. PBMs often design pharmacy networks, manage formularies, and adjudicate prescription

claims electronically at the point of sale. The Federal Trade Commission explains that PBMs create pharmacy networks through their contracts with pharmacies and may use network design, including narrow or preferred networks, to steer patients toward particular pharmacies, including affiliated ones. Fed. Trade Comm’n, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies* at 10–13 (2024). The FTC further explains that, “[a]t the point of sale,” the pharmacy submits the claim through the PBM’s adjudication engine, and “the health plan’s design determines the amounts charged to the patient and plan sponsor.” *Id.* at 55.

II. Plan Participants May be Injured by Imprudent Management of Self-Funded Health Plans

In a self-funded health plan, participants incur financial obligations in discrete transactions. A participant is required to pay premiums at set intervals and, when seeking care, pays deductibles, copayments, or coinsurance calculated under the plan’s pricing rules. When those pricing rules require a participant to pay more than she otherwise would have paid under a prudent arrangement, the participant

experiences an economic loss at that moment. That loss is concrete, individualized, and complete when the payment is made.

The existence of other plan payments does not alter that conclusion. Self-funded plans do not operate on a netting principle across unrelated claims. A participant's obligation to pay an inflated price for a prescription drug is not reduced or offset because the plan later pays for unrelated medical services.

An analogy illustrates the point. If a customer is charged \$10 for an item that should have cost \$5, the customer has suffered an economic injury at the point of purchase. That injury is not undone because the customer later buys other items at a discount or receives value elsewhere in the store. Each transaction is separate, and the overcharge remains.

The same is true here. Prescription drug claims are adjudicated in real time under the plan's pricing structure. If that structure requires a participant to pay more than she otherwise would have paid, that overcharge constitutes a concrete injury, regardless of other benefits the plan may provide in the same year. The presence of unrelated plan payments does not transform a discrete overcharge into a non-injury.

III. The District Court's Misunderstanding of Self-Funded Plans Affected its Analysis

The district court did not reject Plaintiffs' allegations on the merits. It did not hold that the prices alleged in the Complaint were reasonable, that the PBM arrangement was prudent, or that the challenged plan design benefited participants. Instead, it held that Plaintiffs, despite alleging that they overpaid for prescription drugs, Second Amended Complaint ¶¶ 219–221, 234–240, did not adequately allege an injury. Op. at 8–11.

The district court's analysis departs from the basic framework of self-funded plans, described above. It evaluates Plaintiffs' alleged harm primarily by reference to aggregate plan features, including total benefits paid in a given year and the multiple factors that may influence premiums. *Id.* at 10. In doing so, the court treated this self-funded health plan too much like a pension or generalized pool of assets and not what it actually is: a benefits arrangement in which participants experience pricing decisions in real time through premiums, deductibles,

coinsurance, copays, formularies, network requirements, and point-of-sale claim adjudication.²

That approach does not reflect how self-funded plans operate. As described above, participants in such plans are not insulated from pricing decisions. As explained earlier, participants in self-funded health plans bear cost-sharing directly and continuously—they pay premiums, deductibles before plan sharing begins, and coinsurance calculated as a percentage of plan prices. Those amounts are determined by the plan’s pricing structure, including its arrangements with service providers such as PBMs, and are affected by formulary placement, dispensing channels, PBM pricing, and network rules.

² The Complaint itself alleges exactly that structure. It alleges a self-funded plan in which expenses are shared by J&J and participants, with claims paid from plan assets rather than by a third-party insurer; it further explains that a prescription claim is adjudicated while the participant is at the pharmacy counter, at which point the participant may be required to pay the full plan price, a copay, or coinsurance based on the plan’s design. Second Amended Complaint ¶¶ 16, 32–34. The court nevertheless concluded that it was “too speculative” to connect the alleged PBM overpayments to Plaintiffs’ premium and out-of-pocket harms and held that even prospective relief would not necessarily reduce participant costs because J&J retained discretion over contribution levels. Op. 9–12.

The Complaint alleges that Plaintiffs paid more than they otherwise would have paid for certain prescription drugs because of the plan's pricing design and PBM arrangements. Second Amended Complaint ¶¶ 219–221, 234–240. Those allegations describe transaction-level overcharges—specifically, discrete financial obligations incurred at the point of sale. The district court discounted those allegations by comparing the asserted overcharges to the total amount of benefits paid on behalf of each Plaintiff in the same year. Op. at 11. In effect, the court treated unrelated plan expenditures as bearing on whether the alleged overcharges constituted an injury.

That reasoning is inconsistent with how self-funded plans function. A participant's obligation to pay a particular amount for a prescription drug arises at the moment the claim is adjudicated under the plan's pricing rules. That obligation is not altered or offset because the plan later pays for unrelated medical services. Each claim gives rise to a discrete financial obligation governed by the plan's terms.

The district court's analysis also produces a framework under which plan participants cannot establish injury under any common set of circumstances. If a participant incurs significant medical expenses in a

given year, the court's reasoning treats any alleged overcharge as insignificant relative to the total benefits paid. Under that approach, a participant who pays more than required for a prescription drug cannot demonstrate injury because the plan paid substantial unrelated claims in the same year. But, if a participant incurs minimal medical expenses, the court's separate analysis treats any premium-based injury as too attenuated, because contribution levels are influenced by multiple factors and remain within the employer's discretion. And if a participant incurs no medical expenses? Then there is no claim at all.

Taken together, this framework leaves no practical path for a participant to establish injury. The existence of high claims forecloses transaction-level harm; the absence of claims forecloses premium-based harm. Consider a plan participant who, in one year, incurs significant medical expenses and also pays more than required for a prescription drug because of the plan's pricing structure. Under the district court's reasoning, the participant's overcharge is not a cognizable injury because it is viewed as insignificant relative to the total benefits paid that year.

In a different year, the same participant incurs little or no medical expense but continues to pay premiums and remains subject to the same

pricing structure. Under the district court's reasoning, any injury reflected in premiums or cost-sharing is too speculative because contribution levels are influenced by multiple factors. In neither circumstance can the participant establish injury, even though the participant was subject to the same allegedly imprudent pricing arrangement in both years.

IV. The Alleged Overcharges Are Sufficient to Establish Article III Injury

Viewing self-funded plans correctly, it is clear that the allegations in the Complaint are sufficient to establish Article III injury. Plaintiffs allege that they paid more than required for specific prescription drugs as a result of the plan's pricing structure and PBM arrangements. Second Amended Complaint ¶¶ 219–221, 234–240. Those allegations describe concrete, out-of-pocket payments made by identified participants in discrete transactions. As explained above, in a self-funded health plan, such payments constitute economic injury at the moment they are incurred. That injury does not depend on aggregate plan performance, the total value of benefits received in a given year, or whether other factors also influence participant costs.

At the pleading stage, Plaintiffs are not required to isolate the precise contribution of each pricing component or to demonstrate that no other factors affected their costs. It is sufficient to allege that the challenged arrangements required them to pay more than they otherwise would have paid. Whether Plaintiffs can ultimately prove those allegations, and whether the challenged arrangements were imprudent, are questions for the merits. But the allegations themselves describe a concrete and particularized injury sufficient to satisfy Article III.

Whether Plaintiffs' allegations can ultimately be proved is a merits question. But the court's decision to discount those allegations by reference to unrelated annual plan spending reflects a misunderstanding of how premiums, cost sharing, deductibles, and point-of-sale pricing interact in the real world of employer-sponsored health coverage.

CONCLUSION

For the foregoing reasons, the Court should hold that, at the very least, Plaintiffs' complaint adequately alleges that they were injured by Defendants' imprudent management of Plaintiffs' self-funded health plans. Anything less would imperil the statutory protection for the many Americans who have self-funded health plans.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), counsel certifies that this brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because it contains 2,642 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Century Schoolbook.

This brief complies with Local Appellate Rule 31.1(c) because the text of the electronic brief is identical to the text in the paper copies and because a virus check was performed using current Microsoft Defender and no virus was detected.

Pursuant to Third Circuit L.A.R. 28.3(d), the attorney who signed this motion is a member in good standing of the Bar of this Court.

DATED: May 6, 2026

/s/ Jeremy Shur

CERTIFICATE OF SERVICE

I certify that on May 6, 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Third Circuit using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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