No. 26-1107

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

ANN LEWANDOWSKI, on her own behalf and on behalf of all others similarly situated; ROBERT GREGORY

v.

JOHNSON & JOHNSON;
THE PENSION AND BENEFITS COMMITTEE OF JOHNSON & JOHNSON; PETER FASOLO;
WARREN LUTHER; LISA BLAIR DAVIS; DOES 1-20

ANN LEWANDOWSKI,
Appellant

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

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INTRODUCTION

Appellant Lewandowski alleges that Johnson & Johnson ("J&J") imprudently agreed to exorbitant prices for its employees' prescription drugs. Notwithstanding J&J's protests and merits arguments, these allegations must be taken as true when assessing standing. *E.g.*, *Cottrell v. Alcon Lab'ys*, 874 F.3d 154, 162 (3d Cir. 2017). For standing purposes, the only question is whether Lewandowski plausibly alleges she was injured by the alleged imprudence, as opposed to being unaffected by it.

With respect to Lewandowski's payments for her own drugs, the analysis is simple: J&J agreed to high prices and Lewandowski paid them. Recognizing this does not "assume that [Lewandowski] suffered a traceable injury," as J&J argues. Answering Br. 28. It properly assumes that J&J agreed to unreasonably high prices (the violation) and then concludes that Lewandowski adequately pleaded how those high prices harmed her personally, *i.e.*, because she paid them directly. J&J's analogies to cases with convoluted links between other misconduct (not directly related to pricing) and allegedly inflated prices are inapposite: Lewandowski directly paid the price to which J&J agreed.

With respect to increased premiums, the causal chain is slightly longer, but just as clear. Unlike plans where the employer pays for everything or participants pay the same amount regardless of overall spending, Lewandowski's premiums were set as a percentage of Plan spending. As a result—and regardless of the specific percentage J&J chose—Lewandowski's premiums were affected by the Plan's

overspending. J&J's simplistic reading of *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570 (3d Cir. 2024) ignores determinative differences between that case and the allegations here. J&J's other arguments—that it cannot be held liable because of its "discretion" and because factors other than drug prices affect premiums—have no legal support or limiting principle, and would improperly immunize fiduciaries even where (as here) their imprudence costs participants money.

Finally, J&J's redressability arguments were neither pressed nor passed on below. This Court should not consider them. Regardless, J&J did not make these arguments beforehand for good reason: the Supreme Court and several appellate courts have rejected its § 1132(a)(3) argument, and at least four courts of appeals have rejected its § 1132(a)(2) argument. Congress did not (and this Court should not) "immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy." *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996). The decision below should be reversed.

ARGUMENT

I. Lewandowski Alleged an Article III Injury.

J&J concedes that "the complaint's allegations must be accepted as true" and "this Court may assume plaintiff's claimed breach of J&J's duty of prudence under ERISA for purposes of [the] standing inquiry." Answering Br. 23, 29; *see Cottrell*, 874 F.3d at 162. J&J likewise concedes that "monetary harms" are Article III

injuries. Answering Br. 27. Thus, the only question left is whether it is "plausible"—not certain or even probable—that J&J's failure to ensure drug prices were reasonable resulted in monetary harm to Lewandowski. *See Mator v. Wesco Distrib., Inc.*, 102 F.4th 172, 189 (3d Cir. 2024) (district court erred in applying probability requirement). Properly applying this standard, the answer is "yes"; she directly paid the high drug prices. *See Boley v. Universal Health Servs., Inc.*, 36 F.4th 124, 131 (3d Cir. 2022) (payment of excessive fees resulting from fiduciary imprudence is Article III injury).

A. Lewandowski Plausibly Alleges She Was Injured When She Overpaid for Prescription Drugs.

1. An Overpayment Is a Recognized Injury.

An overpayment is a recognized injury that supports standing. *See* Opening Br. 26-27; *In re Warfarin Sodium Antitrust Litig.*, 391 F.3d 516, 531 (3d Cir. 2004) (plaintiffs "suffered direct economic harm when … they paid supracompetitive prices for Coumadin"). J&J does not dispute this. *See* Answering Br. 26 ("A plaintiff might … 'plead an economic injury by alleging that, absent the defendant's conduct, she would have purchased [a] product that was less expensive'" or that the defendant caused her to "pay[] an unfair 'premium' for the product."). Instead, it argues the overpayment allegations are inadequately pled. But it is wrong.

2. Lewandowski's Overpayment Allegations Are Not Speculative.

Lewandowski's injuries from overpaying for her own drugs are "concrete and particularized" and "not conjectural or hypothetical." *See Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016). The Second Amended Complaint ("SAC") identifies specific purchases Lewandowski made out of her own pocket, which involved specific drugs (tizanidine and valacyclovir) at specific times (January and February 2023) at specific prices ($18.72 and $303.68) that exceeded pricing benchmarks by specific amounts. Appx137-38. The amount she paid for these drugs was the price J&J agreed to make Plan participants pay, and Lewandowski directly paid the "entire amount." *Id.* Accepting these allegations as true, there is nothing speculative about her overpayment—J&J agreed to high prices and Lewandowski paid them. *See In re Avandia Mktg., Sales Pracs. & Prod. Liab. Litig.*, 804 F.3d 633, 641 (3d Cir. 2015) ("*Avandia*") ("[I]f we accept [plaintiffs'] plausible allegations as true—as we are required to do at this stage—then no speculation is required to determine whether they suffered an injury" from drug overcharges).

The cases J&J cites are distinguishable because they required multi-step causal chains to connect the alleged misconduct to the overcharge. *See* Answering Br. 25-27 (citing, *e.g.*, *Finkelman v. NFL*, 810 F.3d 187 (3d Cir. 2016)). In *Finkelman*, for example, the misconduct related to sales channels (not price setting) and the multi-step chain meant there was "no way of knowing whether the

[misconduct] would have had the effect of increasing or decreasing prices." *Id.* at 200. Here, in contrast, there is no multi-step chain between the fiduciary misconduct (agreeing to high prices) and Lewandowski's financial harm (directly paying those high prices).

3. The Fact that J&J Negotiated the Inflated Prices with a Third Party Does Not Diminish Lewandowski's Injury.

J&J emphasizes that it negotiated the inflated prices with a third party PBM. Answering Br. 50-54. But that is true in all contracts with outside service providers, and does not diminish a plan participant's injury where fiduciaries imprudently agree to unreasonable prices.

For example, in *Sweda v. Univ. of Pa.*, 923 F.3d 320 (3d Cir. 2019), third parties "TIAA-CREF and Vanguard charge[d] investment and administrative (recordkeeping) fees," *id.* at 324, which the plaintiffs alleged were excessive and not properly monitored or negotiated by the plan sponsor, *id.* at 330-31. The involvement of these third parties did not defeat injury-in-fact, traceability, or the merits. If it did, no plan participant could ever bring suit against a plan sponsor for failing to monitor compensation paid to a third-party service provider—but such claims are common. *See* Opening Br. 7-8, 27 (citing cases).

A key allegation in *Sweda* was that the plan sponsor "failed to leverage the Plan's size to obtain lower fees." *Sweda,* 923 F.3d at 330. Lewandowski similarly alleges that "Fortune 50 companies like Johnson and Johnson … have the bargaining

power to obtain the most favorable terms from third-party vendors," Appx79, but "Defendants squandered their bargaining power," Appx89. The SAC specifically alleges that tizanidine and valacyclovir are two drugs where "Defendants—despite all their bargaining power—negotiated a price … that was higher than the price available to any person with no insurance and no bargaining power, and Lewandowski was required to pay that inflated amount out-of-pocket." Appx137-38. These allegations suffice: "[P]lan participants can state an ERISA claim if the fiduciary … fails to use its market power to bargain [with third parties] for lower fees." *Kruchten v. Ricoh USA, Inc.*, 2024 WL 3518308, at *3 (3d Cir. July 24, 2024).

The SAC not only alleges that J&J had sufficient "market power to bargain for lower fees," *id.*, it also alleges *how* J&J could have done so—and how prudent fiduciaries *have* done so. It could have stuck with Express Scripts but used its bargaining power to negotiate lower prices or a better fee structure, Appx111-12, as others have done or recommend, Appx115-17, 119-26; *cf. Sweda*, 923 F.3d at 330 (allegations that defendant "could have negotiated for a cap on fees or renegotiated the fee structure" were sufficient). Or, if Express Scripts was unwilling to lower its prices, J&J could have contracted with a lower-cost PBM, Appx68-76, 112-15, as others have done or recommend, Appx115-17, 126-29; *cf. Johnson v. Parker-Hannifin Corp.*, 122 F.4th 205, 222 (6th Cir. 2024) (allegations that defendant

"failed to pay close enough attention to available lower-cost alternatives" were sufficient). The cases cited by J&J (Answering Br. 51) are not on point.[1]

4. J&J's Merits-Based Challenges to the Overcharge Allegations Are Inappropriate at This Stage, and Fail.

J&J challenges the merits of Lewandowski's overcharge allegations, Answering Br. 54-58, but these arguments did not form the basis for the District Court's standing decision and instead relate to Rule 12(b)(6) issues it expressly did "not reach." Appx33. Accordingly, such arguments are not properly considered on appeal. *See Cottrell*, 874 F.3d at 170. Regardless, J&J's arguments are meritless.

a. Challenge to Price Comparators

J&J concedes that "price comparators may sometimes support an overcharge standing theory." Answering Br. 54. However, it quibbles with Lewandowski's specific pricing comparisons. This is precisely the sort of merits argument clothed as a standing challenge that is impermissible. *See Cottrell*, 874 F.3d at 162 & 170 n.11. In any event, the SAC offers multiple well-pled comparisons.

NADAC Comparisons. The SAC alleges that J&J agreed to massive markups from NADAC, *see* Opening Br. 13-15, and shows that Lewandowski paid 271% and

[1] Neither *FDA v. All. for Hippocratic Med.*, 602 U.S. 367 (2024) nor *Clapper v. Amnesty Int'l USA*, 568 U.S. 398 (2013) dealt with past overcharges. *FDA* dealt with a challenge to regulatory action by unregulated parties, and *Clapper* involved a speculative *future* injury involving government surveillance of persons that had not yet occurred.

267% markups for tizanidine and valacyclovir. *See* Appx137-38. J&J acknowledges that "plan sponsors and PBMs … use [NADAC] as a basis for prescription-drug pricing." Answering Br. 12. While J&J contends that a reasonable markup from NADAC is appropriate, Answering Br. 56, these markups—and others ranging up to 13,225%, Appx100-01—were manifestly ***un***reasonable. Other plans have only a "small markup above NADAC prices," Appx90, and no prudent fiduciary would agree to the inflated markups Lewandowski was forced to pay. Appx55, 104.

Retail Price Comparisons. The SAC also compares J&J's prices to retail pharmacy prices. *See* Appx91-102, 137-38. These retail prices are substantially lower than the J&J price, and in some cases, lower than NADAC. *Id.* This was true for both tizanidine and valacyclovir. Appx137-38. J&J notes that retail price comparisons involve "persons paying without insurance," Answering Br. 55, and not participants in a company plan. But that only makes the price differences worse, given J&J's substantial bargaining power.[2]

Comparison to Similar Plan. J&J argues that "Lewandowski does not identify … a similarly situated plan under which the prices for tizanidine and valacyclovir are lower than they are on J&J's Plan." Answering Br. 55. But Lewandowski *does* provide such a comparison. The SAC alleges that, "For the generic drugs in the table

[2] J&J's excuses for its prices exceeding retail prices (Answering Br. 56) are unsupported (and inaccurate), do not appear in the Complaint, and cannot be considered at this stage.

at paragraph 126 [], Defendants agreed to make ... participants/beneficiaries pay, on average, *four times* as much as PepsiCo's plan … for the same drugs." Appx125. And the referenced table includes both tizanidine and valacyclovir. Appx103-04.[3]

In summary, the SAC offers not just one, but three sets of price comparisons that support the overcharge allegations. Even if the merits were at issue here, Lewandowski's allegations are adequately pled. *See Sweda*, 923 F.3d at 332 ("Sweda's factual allegations are not merely 'unadorned, the-defendant-unlawfully-harmed-me accusation[s].' … Sweda offered specific comparisons[.]"); *Avandia*, 804 F.3d at 645 ("It is sufficient that a plaintiff identify in the pleadings a specific [comparator] drug … that would have cost less."). While J&J argues that the price comparisons are imperfect, "[t]he implication is that the Plan overpaid, even if the comparisons are imperfect." *Mator*, 102 F.4th at 181. J&J does not cite a single case rejecting pricing comparisons like those here.[4]

[3] Regardless, plan comparisons are not required. *See Mator*, 102 F.4th at 185 ("Sweda did not support [excess fee] allegation with any comparisons to other plans").

[4] J&J leans into *In re Johnson & Johnson Talcum Powder Prods. Mktg., Sales Pracs. & Liab. Litig.*, 903 F.3d 278 (3d Cir. 2018), but that case involved an allegation that the plaintiff paid too much because the product was unsafe, not because it was priced or marked up higher than identical or comparable products. *Id*. at 289.

b. Challenge to Individual Price Comparisons

J&J and its amici object that Lewandowski's overpayment allegations are about specific drugs rather than all drugs in the aggregate. *See* Answering Br. 51-52; Washington Legal Foundation ("WLF") Br. 3-4, 7. This argument also fails.

First, J&J and its amici confuse standing with the merits. At this stage, what matters is whether Lewandowski was overcharged for the drugs *she* purchased, not whether the Plan's aggregate pricing was reasonable (which it wasn't). If Lewandowski had paid prices *below* NADAC, *below* retail, and *below* the price charged to other large employer plans for her own drugs, J&J undoubtedly would argue that she had no stake in the controversy because she was not personally injured by the overall pricing arrangement, even if many other drugs were overpriced. Indeed, J&J *did* argue that the District Court should only consider the drugs she actually purchased. *See* Dkt. 75-1 at PageID 919-20.

Second, even as to the merits, J&J's argument fails. In the analogous context of overpriced investments on a retirement plan's investment menu, it is no defense that the investment menu as a whole was reasonably priced. *See* Opening Br. 51; *accord Hughes v. Nw. Univ.*, 595 U.S. 170, 176 (2022). J&J does not address this authority. Moreover, in this specific context, "the general fiduciary obligations under ERISA" require plan fiduciaries to monitor pricing on a drug-by-drug basis. *See Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure*, 91 Fed.

Reg. 4348, at 4364-65, 4368, 4371, 4379 (Jan. 30, 2026) (proposing disclosure of PBM "spread compensation," "drug pricing methodology," and net cost information for "each drug," so fiduciaries can "assess … the reasonableness of the compensation" for each drug).

Third, even if plan-wide overpricing allegations were required, the SAC alleges overcharges totaling "millions of dollars per year on prescription drug costs across the Plan[] as a whole, after accounting for all charges for all drugs." Appx115. These allegations are supported by comprehensive comparisons of every generic specialty drug on the Plan's formulary for which NADAC information is available, Appx100-01, and comprehensive comparisons for every generic non-specialty drug that Lewandowski purchased since April 2022, Appx103-04. Lewandowski can hardly be accused of "cherry pick[ing]." *See* WLF Br. 2; Chamber of Comm. Br. 6.

Finally, J&J's argument rests on a speculative assertion: that it "may well have" obtained savings for other drugs. Answering Br. 52. J&J is not entitled to this inference.[5] "At this stage, [Lewandowski's] factual allegations must be taken as true, and every reasonable inference from them must be drawn in her favor." *Sweda*, 923 F.3d at 331. She is not required to "rule out every possible lawful explanation"

[5] The declaration that J&J submitted from its Head of Global Compensation and Benefits says nothing about the PBM contract it negotiated or the terms of that contract. *See* Appx216-27. Nor did J&J produce a copy of the PBM contract, despite Lewandowski's request under ERISA § 104(b). *See* Appx145, 154.

advanced by J&J. *Mator*, 102 F.4th at 184; *Sweda*, 923 F.3d at 326. Regardless, the SAC alleges that "[t]he Plans' extraordinarily high prices for generic drugs are not offset by special discounts from Express Scripts for other kinds of drugs." Appx104.

5. Lewandowski's Injury Was Not Negated by the Plan's Out-of-Pocket Maximum.

J&J's final argument is that even if Lewandowski was overcharged, she was not harmed because her out-of-pocket costs were capped at $3,500. The District Court did not dismiss the SAC on this basis, Appx20 n.7, nor could it have done so. As the SAC details, Lewandowski's *actual* out-of-pocket payments in 2023 were $979.57, and if she had not been overcharged for prescription drugs, those payments would have been $210 less, or $769.57. Appx139. That is because after overpaying for tizanidine and valacyclovir, she used a copayment assistance card to pay for an expensive infusion treatment, which counted toward her $3,500 maximum. Appx138-40. If Lewandowski had paid $210 less for tizanidine and valacyclovir, her copay card would have paid $210 more toward her infusion (and deductible), resulting in a net out-of-pocket savings of $210. Appx139-40.

J&J recognizes the "bottom line" with respect to the math. Answering Br. 16. Nevertheless, it argues that Lewandowski's injury was "wholly unrelated to J&J's challenged conduct." Answering Br. 48-49. Not so. But for the drug overcharges, Lewandowski would have paid less out of her pocket. While the copay card is part

of the story,[6] J&J does not dispute that there may be more than one but-for cause of a loss. *See* Opening Br. 48; *Edmonson v. Lincoln Nat'l Life Ins. Co.*, 725 F.3d 406, 418 (3d Cir. 2013) ("We have described this requirement as akin to 'but for' causation and found the traceability requirement met even where the conduct in question might not have been a proximate cause of the harm, due to intervening events.").

Even if the out-of-pocket maximum mattered, Lewandowski was harmed because she was forced to pay up to that maximum sooner. Appx141. The fact that her yearly out-of-pocket costs were capped does not alter the fact that she had less money than she otherwise would have had in the first quarter of 2023. *Id.* This is an independent injury that additionally supports standing because "the temporary loss of use of one's money constitutes an injury in fact for purposes of Article III." *Van v. LLR, Inc.*, 962 F.3d 1160, 1164 (9th Cir. 2020); *see also MSPA Claims 1, LLC v. Tenet Fla., Inc.*, 918 F.3d 1312, 1318 (11th Cir. 2019); *Dieffenbach v. Barnes & Noble, Inc.*, 887 F.3d 826, 828 (7th Cir. 2018).

[6] J&J did not have discretion as to the accounting; federal law requires that funds from copay assistance cards count toward participants' out-of-pocket maximums (at least under the circumstances here, where there is no generic alternative). Appx139. The contrary rule J&J cites (Answering Br. 48 n.10) was vacated. *See HIV & Hepatitis Pol'y Inst. v. U.S. Dep't of Health & Hum. Servs.*, 728 F. Supp. 3d 1, 15 (D.D.C. 2023), *clarified*, 2023 WL 10669681 (D.D.C. Dec. 22, 2023).

B. Lewandowski Plausibly Alleges an Injury from Increased Premiums.

J&J's fiduciary breaches also inflated the amounts the Plan paid to provide prescription-drug coverage, and Lewandowski plausibly alleges those inflated amounts were passed on to her and other participants as increased premiums. Opening Br. 35-55.

1. *Knudsen* Supports Standing.

J&J principally argues that this case is just a repeat of *Knudsen*. That simplistic argument overreads *Knudsen*'s holding and ignores key differences between the *Knudsen* complaint and Lewandowski's SAC. Here, unlike in *Knudsen*, Lewandowski plausibly alleges that the fiduciary misconduct increased her premiums.

The *Knudsen* plaintiffs alleged that MetLife improperly kept $65 million in "rebate" revenue for itself instead of giving those funds to the plan. To plead an Article III injury, they needed to plausibly allege that the $65 million, had it been given to the plan, would have been used to reduce their premiums. 117 F.4th at 580-82. They failed to plead that in a non-speculative way. They did not allege that rebate revenue was part of the formula used to calculate premiums. *Id.* at 582. Nor did they allege historical precedent of the plan receiving an asset windfall, let alone using such a windfall to reduce premiums. While they noted that plan *expenses* were split 30/70 between participants and MetLife, *id.* at 574, they did not allege facts about

how an infusion of assets from *rebates* had affected or would affect premiums. Instead, they made explicitly speculative allegations, stating only that "it may have been consistent with [MetLife's] fiduciary duties … to reduce ongoing contributions on account of the rebates," *id.* at 582, without providing any basis to infer MetLife would actually do that.

Lewandowski's SAC fills those gaps. She expressly alleges that prescription-drug spending is an input for calculating premiums: "when Defendants expect higher healthcare costs (including on prescription drugs), they require higher employee contributions to the [] Trust." Appx129; *see also* Appx129-31, 133-34 (additional allegations on this point). And unlike in *Knudsen*, J&J admits it. J&J's declaration in the District Court stated that "when establishing contribution levels, the Committee considers ... the costs of [] prescription drugs." Appx217. J&J's brief in this Court "does not dispute that drug costs may be one consideration" in setting premiums. Answering Br. 36. And J&J told employees it "need[ed] to increase employee premiums … to cover costs." Appx143.

The SAC also provides historical precedent: the data show that when J&J's spending was lower, it charged lower premiums. *See* Appx130. By contrast, the *Knudsen* plaintiffs had no historical evidence and could only speculate about how rebate revenue would affect premiums.

Finally, Lewandowski cites extensive research linking plan spending to participant premiums. *See* Appx131-33. The *Knudsen* plaintiffs did not allege any studies linking rebates to premium reductions. J&J claims the cited studies are irrelevant because they do not "relate to J&J's Plan," Answering Br. 38, but the caselaw says otherwise. Where, as here, defendants cite nothing to "suggest [they] established premiums in a way inconsistent with the [] industry's conventional ratemaking procedures," a court at the pleading stage "must infer that [Defendants] do charge premiums established in that conventional manner," and thus "adjusted their premiums upward to reflect the projected value of claims for these prescriptions." *Ironworkers Local Union 68 v. AstraZeneca Pharms., LP*, 634 F.3d 1352, 1368 (11th Cir. 2011).

2. J&J's Arguments About Fiduciary Discretion, "Other Factors," and Non-Fiduciary Functions Fail.

A. J&J invokes its "discretion" in setting premiums, but fails to respond to the arguments in Lewandowski's Opening Brief showing this doesn't matter. *See* Opening Br. 45-47. That J&J *could have* made different choices in the past doesn't mean it gets a do-over on the choice it actually made, *i.e.*, to set premiums as a percentage of Plan spending. *See* Opening Br. 41-43.

Plaintiffs have standing to pursue plan overpayments if they allege they "paid percentage contributions." *Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 608 (6th Cir. 2007); *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th

517, 524 (9th Cir. 2023) (standing satisfied if "employee contribution rates are tied to overall [expenses]"). J&J notes that *Loren* and *Winsor* "reject[ed] standing" on their specific facts, Answering Br. 34 n.4, but they did not establish a "plaintiffs always lose" rule. Instead, they held that plaintiffs have standing if they plausibly allege that "employee contributions are calculated as a *pro rata* share of the total benefits cost." *Winsor*, 62 F.4th at 525. That is precisely what Lewandowski alleges, supported by facts and data analysis; J&J has no response to these cases' holdings.

J&J cites *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450 (3d Cir. 2003), *see* Answering Br. 25, 32, but the plaintiff there did not pay a *pro rata* share. She paid nothing; the employer covered all costs itself. 333 F.3d at 452. The employer's real-world choice foreclosed her speculation that savings from reduced costs would have benefitted her. *Id.* at 457. Here, J&J exercised its discretion differently and made employees cover a percentage of the Plan's costs. That real-world choice controls. J&J cannot strip Lewandowski of standing by inventing alternative realities.

J&J fixates on the precise percentage charged to participants each year, Answering Br. 35-37, but it does not matter whether J&J chose 15.4% one year or 17.5% in another. What matters is that Lewandowski plausibly alleges that J&J charged participants *some* percentage of Plan spending. Unlike plans where the employer covers everything, *see Horvath*, 333 F.3d at 452, or where participants pay

the same "flat-rate" regardless of overall spending, *Loren*, 505 F.3d at 608, participants in the J&J Plan paid a percentage of overall spending—and as a result, their premiums were affected by the overcharges.

J&J does not deny that treating its "discretion" as determinative would be inconsistent with *Sweda*, 923 F.3d 320, where the plaintiffs had standing even though their employer had discretion to reduce its retirement contributions. *See* Opening Br. 46-47. This non-denial is telling. J&J's rule also would be inconsistent with other cases. In *Cottrell*, for example, the defendant had discretion to raise the price of a redesigned eyedrop bottle, but that did not give it a free pass where it unlawfully caused the plaintiffs to pay too much for their eyedrops; to the contrary, this Court reversed the district court for relying on just such speculation about what the defendant could have or would have done. 874 F.3d at 168-69.

J&J is wrong that Article III injury can exist only if "J&J was obligated by law or Plan documents to set employee contributions" as a percentage of Plan spending. Answering Br. 31-32, 35. *Knudsen* expressly rejected this argument: "[Article III injury] is ***not*** dependent on whether the alleged conduct violates a statute or breaches a contract." 117 F.4th at 580 n.65 (emphasis added).[7]

[7] The Chamber of Commerce's arguments regarding employer "discretion" (Chamber Br. 7, 9) and purportedly "baseless" lawsuits (*id.* at 3, 7, 22) just repeat arguments this Court rejected in *Sweda*, 923 F.3d at 333-34 & n.9 (noting that "discretion is bounded by the prudent man standard" and rejecting concerns about "frivolous litigation").

B. J&J also argues that the link between Plan spending and participant premiums is speculative because "other factors" go into setting premiums. Answering Br. 36. But J&J fails to address Lewandowski's cases saying this doesn't matter. *See* Opening Br. 48; *Wilson v. Centene Mgmt. Co., L.L.C.*, 168 F.4th 217, 224 (5th Cir. 2026) (rejecting district court's reasoning regarding "other factors which impact … premiums"). J&J does not dispute that employee premiums are based on Plan expenses. *See supra* at 15. That other factors may impact premiums does not change the basic relationship. If premiums (P) are a function of expenses (E), and other factors (O), *i.e.*,

$$E + O \rightarrow P,$$

any increase in E will cause P to increase relative to what it otherwise would have been.[8]

C. J&J argues that setting premiums is a "non-fiduciary" act that cannot form the basis of a breach-of-fiduciary duty claim. Answering Br. 32-33. This is a straw man. Lewandowski does not challenge J&J's decision to set employee contributions as a percentage of total Plan spending, or the percentage it chose. Lewandowski challenges J&J's failure to monitor Express Scripts and ensure that costs were reasonable, which is unquestionably fiduciary. *See, e.g.*, *Hughes v. Nw. Univ.*, 63

[8] J&J is not entitled to an inference that an increase in E would have been offset by decreases in O based on unspecified adjustments it would have made in its "discretion."

F.4th 615, 631 (7th Cir. 2023) ("[A] fiduciary who fails to monitor the reasonableness of plan fees and fails to take action to mitigate excessive fees may violate the duty of prudence."); Restatement (Third) of Trusts § 88 cmt. a (2007) ("Implicit in a trustee's fiduciary duties is a duty to be cost conscious."). Taking J&J's chosen *pro rata* contribution structure as given, its fiduciary failure to control costs increased participant premiums.

3. The Link Between Excess Costs and Excess COBRA Premiums Is Irrefutable.

While Lewandowski was enrolled in COBRA, she paid 102% of her *pro rata* share of the Plan's spending, making any question about the employer/employee split irrelevant. Opening Br. 53-55. J&J's counterarguments fail.

First, J&J repeats its arguments about "independent actors," Answering Br. 43, which fail for the reasons above. *See supra* at 5-7.

Second, J&J notes that COBRA does not *require* employers to pass through the full cost of coverage—*i.e.*, employers may foot some of the bill themselves. Answering Br. 43-44. But Lewandowski alleges, and J&J does not dispute, that it made her pay the full 102%. *See* Appx58, 134-35

Third, J&J says that Lewandowski was required to allege that "J&J's conduct increased costs for those under *Lewandowski's* plan of choice (the Premier HSA Individual Plan)." Answering Br. 44-45. She did: Lewandowski alleges that J&J's

conduct increased her premiums, *see* Appx129, 135, and she was on the Premier HSA Individual Plan.

II. J&J Cannot Rehabilitate the District Court's Redressability Analysis on Alternative Grounds.

J&J does not defend the District Court's reasoning on redressability, instead offering new arguments it did not make below and that the District Court did not address. Neither argument should be considered and both fail regardless.

A. Surcharge Is a Recognized Equitable Remedy Against Breaching Fiduciaries under 29 U.S.C. § 1132(a)(3).

For the first time, J&J argues that surcharge can never be "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3). Answering Br. 63-66. It never raised this argument below despite two rounds of briefing and despite Lewandowski requesting surcharge in both the SAC (Appx65, 151, 153, 155) and her briefing (Dkt. 77 at PageID 1045). This Court is "reluctant to consider an issue not argued to and passed upon by the district court," even as an alternative ground for affirmance. *Quinn v. Stone*, 978 F.2d 126, 137 (3d Cir. 1992); *see also Cross v. Buschman*, 2024 WL 3292756, at *2 (3d Cir. July 3, 2024). J&J offers no reason to depart from that practice. Indeed, in *Watson v. EMC Corp*., the Tenth Circuit declined to address the same argument "without the benefit of full briefing (here or in district court) and district court analysis." 2024 WL 501610, at *1 n.5 (10th Cir. Feb. 9, 2024).

J&J's argument fails anyway. The term "appropriate equitable relief" in § 1132(a)(3) refers to "those categories of relief that, traditionally speaking (*i.e.*, prior

to the merger of law and equity), were *typically* available in equity." *CIGNA Corp. v. Amara*, 563 U.S. 421, 439 (2011) (internal quotation marks omitted). The Supreme Court in *Amara* explained that surcharge is one such type of relief; it is a "monetary remedy" for a "breach of trust committed by a fiduciary." *Id.* at 442. Pre-merger, surcharge was "exclusively equitable" and "[e]quity courts possessed the power to provide relief in the form of monetary 'compensation' for a loss resulting from a trustee's breach of duty." *Id*. at 441-42. That "this relief takes the form of a money payment does not remove it from the category of traditionally equitable relief." *Id*. at 441.

Since *Amara*, the majority of circuits have recognized surcharge as available under § 1132(a)(3). The Eleventh Circuit's decision in *Gimeno v. NCHMD, Inc*., 38 F.4th 910 (11th Cir. 2022), is instructive. There, the court explained that "[c]ourts in equity could … impose equitable surcharge—an order that a trustee compensate a trust beneficiary for a loss due to a breach of fiduciary duty." *Id.* at 914 (citing Samuel Bray, *Fiduciary Remedies*, THE OXFORD HANDBOOK OF FIDUCIARY LAW 449, 456–58 (2019)). The Eleventh Circuit stressed "that the defendant's status as a fiduciary made a 'critical difference' in differentiating a surcharge from the kind of

compensatory damages that were not typically available in courts of equity." *Id.* (quoting *Amara*, 563 U.S. at 442).[9]

Other circuits have held the same. *See New York State Psychiatric Ass'n, Inc. v. UnitedHealth Group*, 798 F.3d 125, 134-35 (2d Cir. 2015); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 721-22 (8th Cir. 2014); *Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 957-58 (9th Cir. 2014); *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 880-82 (7th Cir. 2013). Although this Court has not squarely addressed the question, it specifically noted in *Menkes v. Prudential Ins. Co. of Am.*, 762 F.3d 285, 296 n.11 (3d Cir. 2014) that a claim for the return of premiums paid under an ERISA plan "may well be available under ERISA 502(a)," explaining that *Amara* "held … that 'other appropriate equitable relief' in § 502(a)(3) may consist of monetary compensation for a loss resulting from a trustee's breach of duty." *Id.*

J&J claims that *Montanile v. Bd. of Trustees of Nat. Elevator Industry Health Benefit Plan*, 577 U.S. 136 (2016), "disavowed" *Amara's* holding, Answering Br. 64, but overstates the footnote on which it relies. *Montanile* addressed an equitable lien involving a non-fiduciary defendant. Surcharge was never discussed because

[9] *See also* 4 John Pomeroy, Equity Jurisprudence § 1080, p. 229 (5th ed. 1941) ("The trustee's personal liability to make compensation for the loss occasioned by a breach of trust … may be enforced by a suit in equity against the trustee himself."); Restatement (Third) of Trusts § 95 (2012) (surcharge is "equitable in character and enforceable against [a] trustee[] in a court exercising equity powers.").

surcharge is a remedy against a fiduciary, and the *Montanile* defendant was not a fiduciary.

The *Montanile* footnote rejected the respondent's overbroad reading of *Amara*, not *Amara* itself. 577 U.S. at 148 n.3. The *Montanile* respondent wrongly claimed that *Amara* endorsed a new "interpretation of 'equitable relief'" and "all but overrul[ed]" *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) and *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993). The Court rejected that overreading, stating that its interpretation of "equitable relief" in those cases remained "unchanged." 577 U.S. at 148 n.3. That only confirms *Amara*'s recognition of the surcharge remedy, as *Amara* applied the pre-existing interpretation of "equitable relief." *See* 563 U.S. at 439, 442 (citing *Mertens* and *Great-West* for the standard and concluding that surcharge against a trustee "was 'exclusively equitable'"). Even after *Montanile*, the Supreme Court has cited *Amara*, *Great-West*, and *Mertens* together. *See Liu v. SEC*, 591 U.S. 71, 79 (2020).

J&J argues (based on the same footnote) that *Amara's* lengthy reasoning was dictum. Answering Br. 64. But well-reasoned dictum from the Supreme Court should not be viewed "lightly," *Galli v. New Jersey Meadowlands Comm'n*, 490 F.3d 265, 274 (3d Cir. 2007), and regardless, *Amara*'s reading of historical equity practice was correct.

Since *Montanile*, only two circuit courts have read that decision's footnote as foreclosing surcharge. *See Rose v. PSA Airlines, Inc*., 80 F.4th 488, 504 (4th Cir. 2023); *Aldridge v. Regions Bank*, 144 F.4th 828, 849 (6th Cir. 2025), petition for cert. filed, No. 25-590 (U.S. Nov. 14, 2025).[10] That departure is the exception, not the rule. Other courts continue to recognize surcharge as available relief. *See, e.g*., *Powell v. Minn. Life Ins. Co.*, 60 F.4th 1119, 1123 (8th Cir. 2023); *Gimeno*, 38 F.4th at 915; *Sullivan-Mestecky v. Verizon Comms., Inc*., 961 F.3d 91, 102-03 (2d Cir. 2020); *Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 960 (9th Cir. 2016).

In *Carr v. Jefferson Defined Benefit Plan*, the unpublished post-*Montanile* decision on which J&J and its amici rely, this Court expressly declined to reach "whether [] a surcharge may be an appropriate equitable remedy" since the plaintiff sought benefits due under the plan, not surcharge. 2025 WL 2888014, at *2 (3d Cir. Oct. 10, 2025). That case hardly marks the sort of dramatic departure from *Amara* and the weight of other caselaw that J&J advocates here (for the first time).

[10] Professor Samuel Bray's amicus brief supporting certiorari in *Aldridge* shows that these decisions were wrong, explains that surcharge was typically available in equity, and provides historical context this Court may find helpful. *See* https://tinyurl.com/2rsvh9yw.

B. The Loss Remedy under 29 U.S.C. § 1132(a)(2) Inures to the Benefit of Participants Who Were Harmed by the Plan's Loss.

J&J takes the extreme position—also not pressed or passed on below—that claims involving a healthcare plan can never be redressable under § 1132(a)(2). Answering Br. 59-63. This argument is meritless.

First, the fact that a loss remedy under § 1132(a)(2) will first be paid to the Plan does not make Lewandowski's injury non-redressable. When both a plan and its participants suffer financial harm, "the plan takes legal title to any recovery" under § 1109(a), but the recovery "then inures to the benefit of its participants and beneficiaries." *Graden v. Conexant Sys., Inc.*, 496 F.3d 291, 295 (3d Cir. 2007). Accordingly, "there is no lack of redressability merely because a plaintiff's recovery under Section [1132(a)(2)] might first go to the [] plan rather than directly to plaintiff." *Harris v. Amgen, Inc.*, 573 F.3d 728, 736 (9th Cir. 2009) (noting that "the First, Fourth, and Seventh Circuits" agree).

It may be true that § 1132(a)(2) claims are not redressable when "the fiduciaries are not before the courts and they have discretion that cannot be controlled or predicted." *In re Mut. Funds Inv. Litig.*, 529 F.3d 207, 217 (4th Cir. 2008). But here, "the fiduciaries *are* in fact before the court … and can respond to court orders to redress wrongs." *Id.* at 217 (quoting 29 U.S.C. § 1109(a)). Accordingly, the court can prohibit the fiduciaries from pocketing the losses they are ordered to restore to the Plan and order them to instead "allocat[e] any recovery

to the affected participants." *Evans v. Akers*, 534 F.3d 65, 74 (1st Cir. 2008) (expressing doubt that fiduciaries taking recovered losses for themselves "would be consistent with the fiduciaries' duty to act in the interests of participants"). "[T]o hold otherwise would be to allow employers to claw back with their fiduciary hands" compensation intended to remedy their own breach. *See Brotherston v. Putnam Invs., LLC*, 907 F.3d 17, 29 (1st Cir. 2018).

Second, it is irrelevant whether a plaintiff has a "corresponding individual right to plan assets" or "interest in future changes to plan assets." Answering Br. 60-61. *Graden* involved a former plan participant lacking any present or future right to plan assets, but this Court still held that "any recovery made 'on behalf of the plan' must be paid out to the injured participant[s]" including the plaintiff. 496 F.3d at 296 n.6; *see also In re Mut. Funds Inv. Litig.*, 529 F.3d at 210, 217 (injuries redressable even though plaintiffs were "former employees" who had already "cashed out" their 401(k) accounts). J&J identifies no cases holding otherwise.

J&J relies on *Thole* and other cases to blur the line between injury-in-fact and redressability. Answering Br. 60-63. "*Thole* held that, *in the absence of a personal loss* … an abstract breach of fiduciary duty or a diminishment in a plan's assets is insufficient to confer standing." *Boley*, 36 F.4th at 132-33 (emphasis added). But here, Lewandowski "alleged the kind of concrete, personalized injuries traceable to the challenged conduct" that *Thole* lacked. *Id.* Similarly, "[t]he *Horvath* plaintiff

never contended she suffered a financial loss" because her employer paid all plan costs. *Edmonson*, 725 F.3d at 416-17 (citing *Horvath*, 333 F.3d at 452). Finally, the plaintiff in *Smith* "identified no injury to the plan" that would implicate § 1132(a)(2). *Smith v. Med. Benefit Adm'rs Grp., Inc.*, 639 F.3d 277, 283 (7th Cir. 2011). None of these cases suggest that Lewandowski's § 1132(a)(2) claim is not redressable.

CONCLUSION

For these reasons and those previously stated, this Court should reverse.

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CERTIFICATES OF COMPLIANCE

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Dated: August 14, 2026

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The undersigned certifies that on this 14th day of August 2026, I electronically filed the foregoing reply brief with the Clerk of the Court for the United States Court of Appeals for the Third Circuit by 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.

Dated: August 14, 2026

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