NO. 26-1107

IN THE 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
(No. 3:24-cv-00671) (Hon. Zahid N. Quraishi)

BRIEF OF WASHINGTON LEGAL FOUNDATION AND THE NATIONAL ASSOCIATION OF MANUFACTURERS AS AMICI CURIAE SUPPORTING DEFENDANTS-APPELLEES AND AFFIRMANCE

Erica Klenicki
Caroline McAuliffe
NATIONAL ASSOCIATION OF MANUFACTURERS
733 10th Street, NW, Ste. 700
Washington, DC 20001

Cory L. Andrews
WASHINGTON LEGAL FOUNDATION
2009 Massachusetts Ave. NW
Washington, DC 20036
(202) 588-0302
candrews@wlf.org

Counsel for Amici Curiae

July 17, 2026

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases:

TABLE OF AUTHORITIES
(*continued*)

Page(s)

Statutes:

TABLE OF AUTHORITIES
(*continued*)

Page(s)

Miscellaneous Sources:

INTERESTS OF AMICI CURIAE*

Washington Legal Foundation is a nonprofit, public-interest law firm and policy center with supporters nationwide. WLF promotes free markets, individual rights, limited government, and the rule of law. It appears often as amicus curiae in Employee Retirement Income Security Act cases that test the bounds of fiduciary liability. *See, e.g., Thole v. U.S. Bank, N.A.*, 590 U.S. 538 (2020); *Amgen Inc. v. Harris*, 577 U.S. 308 (2016).

The National Association of Manufacturers is the largest manufacturing association in the United States, representing small and large manufacturers in all fifty states and in every industrial sector. Manufacturing employs nearly 13 million people, contributes $2.96 trillion to the economy annually, has the largest economic impact of any major sector, and accounts for over half of all private-sector research and development in the nation, fostering the innovation that is vital for this economic ecosystem to thrive. The NAM is the voice of the manufacturing

* No party's counsel authored any part of this brief. No one, apart from amici and their counsel, contributed money intended to fund the brief's preparation or submission. All parties consent to the filing of this brief.

community and leading advocate for a policy agenda that helps manufacturers compete in the global economy and create jobs across the United States.

ERISA was written to encourage employers to offer benefits, not to punish them when they do. Plaintiff's theory here turns that logic inside out. It stretches Article III to reach a plan participant who received everything her plan promised, and it invites a wave of class actions over the price of cherry-picked prescription drugs. If that theory succeeds, amici worry that the cost will land not only on plan sponsors but on the very employees ERISA seeks to protect.

INTRODUCTION & SUMMARY OF ARGUMENT

Sooner or later, every buyer decides she paid too much: the air traveler who spots a cheaper fare the day after booking; the clothes shopper who finds the same designer coat on sale a week later; the driver who passes a station selling gas a dime cheaper down the road. Second-guessing a price is a national pastime. It has never been a federal case. Now the plaintiffs' bar wants to make it one.

Ann Lewandowski belonged to Johnson & Johnson's self-funded health plan. App. 221. In a single year, the Plan paid roughly $200,000

toward her medical and prescription care. App. 19. Yet she complains that, on two generic drugs, she paid about $210 more than a better-run plan would have charged. App. 103–04, 135–40 (SAC ¶¶ 126–27, 213–29). From that $210 she would build a nationwide class and, if her theory holds, expose every American employer that offers health coverage to liability over the price of any drug on any formulary.

Article III does not stretch that far. Start with the injury. A participant who received every benefit her plan promised is not harmed because she wishes a benefit had cost less. A bare preference to pay less is not the "invasion of a legally protected interest" that standing demands. *Spokeo, Inc. v. Robins*, 578 U.S. 330, 340 (2016). Lewandowski says she paid too much for two drugs in a year the Plan spent more than $200,000 on her. App. 19. That is buyer's remorse, not injury in fact.

Lewandowski answers that the overcharge is a "pocketbook injury" like any other, and that the price she paid at the pharmacy counter is concrete and complete. But her own framing gives away the problem. She did not buy two drugs; she bought Plan coverage, and she got it. A single line item, plucked from a bundle she received in full, is not a stand-alone transaction. It is one entry on a receipt the Plan paid many times over.

ERISA's duty of prudence governs the management of the whole Plan, not the price of each pill measured against a cash-pay coupon.

Causation and redressability fail too, and for the same reason. Between any pricing decision J&J made and any dollar in Lewandowski's pocket stands a wall of discretion. App. 19–20. So even a courtroom victory could not put money back in her pocket. Any recovery that ran to the Plan would not benefit her, because the Plan gives J&J discretion about how, if at all, to apply those funds to participant contributions. Besides, Lewandowski no longer participates in the Plan, so no payment to the Plan could benefit her.

A theory that depends on guessing how a sponsor would have exercised discretion it was never required to exercise in her favor is the definition of speculation. *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 582 (3d Cir. 2024). And a remedy that runs to a Plan in which she no longer participates is not redressing an "actual" and "concrete" legal interest. *Campbell-Ewald Co. v. Gomez*, 577 U.S. 153, 160–61 (2016).

The stakes reach far past this plaintiff. More than 100 million Americans get coverage through self-funded plans. The employers who run them already pay the lion's share of every claim, so they already have

every reason to bargain hard with their pharmacy benefit managers. Lewandowski's rule would punish them for offering coverage at all, turning ERISA from an invitation into a trap. The Court should affirm.

ARGUMENT

I. LEWANDOWSKI RECEIVED EVERYTHING HER PLAN PROMISED, SO HER PAYMENT IS NOT A COGNIZABLE INJURY.

"No concrete harm, no standing." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 417 (2021). Article III is not a pleading technicality. It marks the line between a court and a complaint department. It demands a plaintiff with a real stake: an injury that is concrete and particularized, traceable to the defendant, and redressable by a judgment. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992); *Spokeo*, 578 U.S. at 338. Lewandowski clears none of those bars. "Those who do not possess Article III standing may not litigate as suitors in the courts of the United States." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State*, 454 U.S. 464, 475–76 (1982).

A. A line item inside a bundle she fully received is not a stand-alone injury.

Lewandowski leads with what she calls a textbook pocketbook injury: she paid $303.68 for an antiviral drug that, she says, sold

elsewhere for about $100, and roughly $210 too much across two prescriptions. App. 137 (SAC ¶ 221); App. 103–04, 136–37 (SAC ¶¶ 126–27, 218–21). Paying money one would rather keep, she insists, is the classic injury in fact. *See Danvers Motor Co. v. Ford Motor Co.*, 432 F.3d 286, 293 (3d Cir. 2005).

That principle is sound, but it does not fit her case. In *Danvers*, the dealers were unfairly forced to bear the costs of the Ford program whether or not they participated in it. *Id.* at 291–93. That's not true for Lewandowski. She chose to participate in the J&J Plan, voluntarily chose her specific health coverage, and could have purchased the prescriptions without using her insurance were she convinced that would have been cheaper.

The fee cases Lewandowski invokes are no more convincing. The recordkeeping plaintiffs in *Boley* and *Sweda* paid a discrete fee—a charge that bought them nothing beyond the service whose price they disputed. *See Boley v. Universal Health Services*, 36 F.4th 124, 131–32 (3d Cir. 2022); *Sweda v. University of Pennsylvania*, 923 F.3d 320, 334 n.10 (3d Cir. 2019). In each, the disputed charge was the whole transaction.

Lewandowski's drug payments are not. She did not contract to buy two drugs at a market price. She enrolled in a health plan that promised to cover a defined suite of benefits—medical, pharmacy, dental, and vision—and the Plan delivered as promised. The price of any one prescription is a single entry inside that bundle. To call that entry a free-standing pocketbook injury is to pretend the bundle does not exist. It does, and she received all of it.

The point is not that $210 is too small to matter. Article III sets no minimum dollar figure. *See Czyzewski v. Jevic Holding Corp.*, 580 U.S. 451, 464 (2017). The point is that that delta is not an injury at all when it is part of a package the participant received in full. A diner who orders the prix fixe and eats every course has not been injured if she later decides the fish was overpriced. She got what she paid for. So did Lewandowski.

B. Receiving the full bundle does not "offset" an injury; it shows there was none.

Lewandowski tries to head off this reasoning by attacking what she calls the district court's "offset" theory. She says the court wrongly let the $200,000 in benefits she received cancel out her $210 overpayment, and she points to an out-of-circuit district court that recently declined to

follow that approach. *See Stern v. JPMorgan Chase & Co.*, 2026 WL 654714, at *9 (S.D.N.Y. Mar. 9, 2026). She also invokes an airline analogy: a passenger overcharged for a checked bag is harmed even if her flight, snacks, and wi-fi all arrive as promised.

The analogy defeats her point. A checked-bag fee *is* a separate transaction—a discrete charge for a discrete service, billed and paid on its own. A drug's price inside a pooled health plan is not. It is absorbed into a single, blended product: a year of coverage, bought with premiums and cost-sharing, that pays out across thousands of claims. The passenger can isolate the bag fee because the airline itemizes and charges it alone. Lewandowski cannot isolate her drug price, because the Plan never sold it to her. It sold her the whole Plan.

Lewandowski borrows the logic of 401(k) cases and drops it into a self-funded health plan. The two are not cousins; they are opposites. Force one into the other and the result is incoherent. No amount of grousing over line-item pricing can state a plausible claim.

A 401(k) is an "individual account plan" whose participant balances rise and fall with their own investments and the fees charged against them. *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 250 n.1,

256 (2008). An imprudent fee directly reduces that balance because, unlike in a defined-benefit plan, fiduciary breaches in defined-contribution plans reduce benefits below the amount participants would otherwise receive by diminishing assets allocated to "particular individual accounts." *Id.* at 256; *see also id*. at 260 (Thomas, J., concurring in the judgment). As the Supreme Court has emphasized, in a 401(k) plan "the retirees' benefits are typically tied to the value of their accounts." *Thole*, 590 U.S. at 540. The harm is personal, measurable, and curable by crediting the account.

A self-funded health plan is the opposite. It is a shared pool that buys a defined suite of benefits—medical, pharmacy, dental, vision—where the employer bears the financial risk. No participant owns a slice of the pool. *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 439–40 (1999); *Navarro v. Wells Fargo & Co.*, 2026 WL 591454, at *6 (D. Minn. Mar. 3, 2026) (treating a self-funded health plan as closely analogous to a defined-benefit pension). The value lies in the coverage received, not in any abstract surplus. Under ERISA, "no plan member has a claim to any particular asset that composes a part of the plan's general asset pool." *Hughes*, 525 U.S. at 440.

That reframes the so-called offset. The district court did not hold that good benefits wash out a real injury. It held there was no concrete injury to wash out, because the thing Lewandowski paid for was the whole package, and she got it. App. 19–20 & n.7. The 57 drug comparisons in her complaint—drawn against cash-pay or pharmacy-acquisition prices—are 57 lines out of a formulary of thousands. App. 18. Pulling a handful of entries from a bundle and benchmarking them against a different kind of purchase does not show that the bundle, taken as a whole, shorted her anything.

This Court's decision in *Knudsen* confirms the distinction. There, participants in a self-funded plan complained that the sponsor pocketed tens of millions in rebates and pushed the cost onto them. 117 F.4th at 573–74. Not enough, the Court held: participants must plead "concrete facts establishing that" the challenged conduct "caused [their] increased costs"—not rank speculation that better stewardship "may have" helped. *Id.* at 582.

Knudsen's logic means that a health-plan participant is injured when she pays "more . . . than is allowed under Plan documents," *id.* at 580—not when she pays exactly what the plan charged and later finds a

cheaper price somewhere else. Here Lewandowski paid what the Plan charged. App. 136 (SAC ¶ 218). She alleges no overcharge against the Plan's own terms, only against a benchmark of her own choosing.

But health care is consumed in real time and across a pool. One member's costly year is carried by everyone's premiums. A high price on one drug may be offset by a low price on the next—by rebates or by network deals. A plan that overpaid here may well have saved there. ERISA does not judge prudence one drug at a time. Neither should this Court.

II. NO JUDGMENT CAN REDRESS HER, BECAUSE THE PLAN GIVES J&J SOLE DISCRETION OVER WHAT PARTICIPANTS PAY.

Even if Lewandowski had alleged an injury, her case would fail at causation and redressability. Both collapse on a single fact: J&J, not any pricing formula, decides what participants pay. App. 19–20. That discretion severs the chain between the PBM decisions she attacks and any dollar she spent, and it means no judgment could put a dollar back in her pocket.

A. Her costs are not traceable to the PBM decisions she attacks.

Trace Lewandowski's theory and it collapses under the slightest scrutiny. Harder bargaining *might* have produced savings of some unspecified size. Those savings *might* have stayed in the Plan rather than reduced J&J's own contributions. And the Plan *might* have routed them to her—on her particular Plan option, on her two particular drugs—rather than anywhere else. Each link is a guess. Stacked together, they are speculation cubed. Participant contributions turn on claims experience, utilization, non-drug medical costs, geography, stop-loss coverage, and J&J's own design choices. App. 18–19. The district court called the connection "tenuous at best," and even that was generous. App. 17, 19.

Lewandowski's response is that she does not need a formula—she has one. She alleges that her premiums were set as a percentage of overall Plan spending, so that every dollar the Plan overpaid raised her share in lockstep. On that basis she enlists *Winsor v. Sequoia Benefits & Insurance Services, LLC*, which suggested that participants might have standing if their "contributions [were] calculated as a pro rata share of

the total benefits cost." 62 F.4th 517, 525 (9th Cir. 2023); *see also Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598, 608 (6th Cir. 2007).

That pro-rata theory cannot bear the weight she puts on it. A percentage may describe how J&J divided last year's costs, but it does not bind how J&J must divide next year's, or guarantee that any savings would have flowed to her rather than to the employer's share. Besides, *Winsor* ultimately *denied* standing because the employer set rates with "broad discretion," with no guarantee that plan savings were tied to reducing participant costs. 62 F.4th at 524–25. So too here.

The complaint identifies no Plan term obliging J&J to pass any drug savings to help offset Lewandowski's contributions, and J&J—which already foots roughly 85 cents of every Plan dollar (App. 185)—had every right to allocate any savings as it saw fit. A theory that depends on assuming J&J would have handed her the savings, when nothing required it to do so, does not establish traceability. *Knudsen*, 117 F.4th at 582; *see also Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 456–57 (3d Cir. 2003).

B. No remedy reaches her, because J&J alone decides what she pays.

Redressability fails for the same reason, and independently. Below, Lewandowski sought forward-looking changes to Plan oversight, a monetary award to the Plan, and an equitable "surcharge" under ERISA § 502(a)(3). On appeal, she seeks only retrospective monetary relief. No longer a Plan participant, she concedes she has no personal stake in prospective relief and has abandoned it. What is left cannot put a dollar in her pocket. A payment to the Plan, even if won, would run to the Plan, not to her. *Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS Inc.*, 465 F.3d 1123, 1125 (9th Cir. 2006).

From there, J&J's discretion finishes the job. Acting as settlor rather than fiduciary, J&J alone sets contribution rates and decides where any Plan savings go. App. 19–20. Nothing in the Plan or the statute would compel it to share a recovered dollar with Lewandowski. It could offset any Plan-level recovery by trimming its own future contributions and leave her precisely where she began. *Glanton*, 465 F.3d at 1125. As the district court put it, even if Lewandowski "received every bit of the relief [she] request[s]," J&J "could still increase Plan

participants' contribution amounts under the Plan['s] terms without any violation of ERISA having occurred." App. 20.

What's more, because Lewandowski is no longer a Plan participant, her interests now diverge from those of current and former J&J employees who continue to participate in the Plan. She wants to take money out of the Plan. But her interest in draining the Plan runs counter to the interests of those who are counting on it to fund their healthcare going forward.

Nor can the existence of any "surcharge" remedy be assumed. Lewandowski treats the availability of a § 502(a)(3) "surcharge"—in the form of a retroactive damages payment to a former participant—as a given. But no such non-equitable relief is available against a fiduciary. *Carr v. Jefferson Defined Benefit Plan*, No. 24-2574, 2025 WL 2888014, at *2 (3d Cir. Oct. 10, 2025); *see also 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).

Each path thus dead-ends. A recovery to the Plan would bypass her wallet and remain subject to the sponsor's unfettered discretion to claw it back; a surcharge payable to her personally is a remedy that § 502(a)(3)

does not supply. A redressability theory built from those "remedies" redresses nothing at all. The district court held Lewandowski to that line. So should this Court.

III. ADOPTING PLAINTIFF'S VIEW WOULD DETER PLAN SPONSORSHIP AND UNDERMINE ERISA'S PURPOSE.

ERISA does not command employers to offer benefits; it cajoles them into doing so. Congress built the statute so that the burdens of sponsorship would not "unduly discourage employers from offering [ERISA] plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 517 (2010). Embracing Lewandowski's theory would do exactly that.

Turn every PBM price into a potential class action, and you hand the plaintiffs' bar an easy roadmap: find one drug, anywhere on the formulary, that costs more than some benchmark and sue. That litigation tax would land on the employers best placed to hold costs down—and hardest on those who self-insure, who already absorb the very risk Lewandowski says they ignore.

This is not speculation. Cost, complexity, and litigation risk are the leading reasons employers hesitate to sponsor plans. *See* U.S. Gov't Accountability Office, GAO-12-326, *Private Pensions: Better Agency Coordination Could Help Small Employers Address Challenges to Plan*

Sponsorship, at 20 (2012), https://perma.cc/KZK3-FVAD; The Aspen Inst. Fin. Sec. Program, *Rapid Change, Real Momentum*, at 16 (May 22, 2023), https://perma.cc/7DMQ-TV68. As one study put it, it "makes little sense" for many employers to shoulder full fiduciary exposure when the burdens already deter sponsorship—an effect that compounds as competitors abandon offering ERISA benefits. John N. Friedman, *Building on What Works: A Proposal to Modernize Retirement Savings*, The Hamilton Project, Discussion Paper No. 2015-05, at 9 (June 2015), https://perma.cc/R2BA-D9N5.

Add liability for conduct that ERISA and the plan expressly permit, and many employers will do the rational thing: stop offering plans, or strip them down to the studs. And who could blame them? The losers would be employees—the very people Lewandowski claims to speak for. And while ERISA protects employees, it does not punish employers. "The interests of employers were considered and protected by Congress when it enacted ERISA." *Associated Bldrs. & Contrs., Saginaw Valley Area Chapter v. Perry,* 115 F.3d 386, 389 (6th Cir. 1997). That balance—strong protection for participants, predictability for sponsors—keeps coverage flowing.

Courts should not read ERISA to "discourage employers from offering [ERISA] plans." *Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 108 (2013). More than 100 million Americans rely on self-funded employer plans. Kaiser Family Foundation, *2025 Employer Health Benefits Survey* 10, https://perma.cc/SBU6-PGBB. Expand litigation exposure to every pricing decision and costs will rise, options will shrink, and coverage will contract—for the same workforce ERISA was written to help.

This is the rare case where the parade of horribles has already begun to march. Near-identical suits, filed by the same plaintiffs' bar against major employers, have so far failed largely for the same want of standing. *See, e.g., Navarro*, 2026 WL 591454, *6. Article III has been the bulwark. This Court should hold the line.

CONCLUSION

Lewandowski's only quarrel is that a sliver of her Plan cost more than she preferred to pay. That is buyer's remorse, not a federal case. The judgment should be affirmed.

Respectfully submitted,

July 17, 2026

/s/ Cory L. Andrews
Cory L. Andrews
WASHINGTON LEGAL FOUNDATION
2009 Massachusetts Ave. NW
Washington, DC 20036
(202) 588-0302

Counsel for Amici Curiae

COMBINED CERTIFICATIONS

1. Service: I certify that I filed this brief electronically with the Clerk of Court using the Court's CM/ECF system. I also certify that all parties required to be served have been served.

2. Type Volume, Typeface & Typestyle: This brief complies with the type-volume limit of Fed. R. App. P. 29(a)(5) because it contains 3,617 words. This brief also complies with the typeface and typestyle requirements of Fed. R. App. P. 32(a) because it was prepared in 14-point font using a proportionally spaced typeface, Century Schoolbook.

3. Bar Membership: This brief complies with Local Rule 46.1(e) because Cory L. Andrews is a member of the bar of this Court.

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/s/ Cory L. Andrews
CORY L. ANDREWS

July 17, 2026