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Courts Keep Upping Standing Ante In ERISA Healthcare Suits

By **Samuel Ruddy and Andrew Holmer** (September 24, 2025, 11:48 AM EDT)


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Article III standing under the Constitution has recently become an increasingly important issue in litigation brought by, or on behalf of, employer-sponsored health plan members against sponsors and fiduciaries under the Employee Retirement Income Security Act.

Several cases in the past year suggest that courts are taking a more scrutinizing approach to the standing inquiry in both class actions and individual matters.

The Article III Standing Trend In Excessive Fee Class Actions

The renewed focus on standing has largely grown out of the 2020 decision in Thole v. U.S. Bank NA, where the U.S. Supreme Court stated that "[t]here is no ERISA exception to Article III," and that ERISA pension plan plaintiffs lacked standing where they "would still receive the exact same monthly benefits" if they won their lawsuit.[1]

Following this decision, both litigants and courts began paying increasing attention to standing arguments.

The trend in increasing standing scrutiny can perhaps be best seen in a recent spate of 401(k)-style, fee-related test cases against health plans and related entities.

These cases have often focused on relationships between health plans and the pharmacy benefit managers, or PBMs, that negotiate discounted rates for health plans with pharmacies and drug manufacturers and serve as third-party claims administrators.

But courts have found that plaintiffs' claims of injury related to these arrangements are either speculative or not redressable by a judicial decision.

The leading case in this series is the U.S. Court of Appeals for the Third Circuit's September 2024 decision in Knudsen v. MetLife Group Inc.[2]

In Knudsen, the putative class plaintiffs alleged that MetLife used $65 million in PBM-obtained rebated discounts for itself, as opposed to putting that money into its self-funded health plan.

Although the relevant plan documents explicitly stated that these rebates would not be utilized to determine out-of-pocket costs, the plaintiffs hypothesized that putting these drug rebates back into the

health plan might still have lowered their individual out-of-pocket costs.

The Third Circuit affirmed dismissal of the lawsuit on standing grounds, finding that the plaintiffs failed to identify any actual or imminent concrete financial harm that could satisfy the injury-in-fact requirement for Article III standing.

Although the Third Circuit did not completely rule out the theoretical possibility of standing in such cases, the court held that the alleged impact of MetLife's choice on out-of-pocket costs was too speculative to satisfy the injury-in-fact requirement for Article III standing.

Following the Third Circuit's decision, the U.S. District Court for the District of New Jersey applied Knudsen in January when dismissing a claim focused on drug pricing in Lewandowski v. Johnson & Johnson.[3] However, the Lewandowski court's standing decision ultimately rested on different grounds.

In Lewandowski, the named plaintiff, a Johnson & Johnson employee, argued that the plan sponsor and benefits committee breached their alleged fiduciary duties by failing to demand lower drug prices from the plan's PBM, allegedly causing participants to pay higher premiums and to overpay for covered drugs.

The case was the first of its kind to attempt to address the underlying costs associated with an employer's self-insured prescription drug benefit.

On a motion to dismiss, the district court applied Knudsen, but ultimately found that standing was not satisfied based on the redressability requirement, not injury in fact.

Under Knudsen, the court found that the plaintiff's allegations of injury through higher premiums were "at best ... speculative and hypothetical," but the court nevertheless found that injury in fact was satisfied by the plaintiff's assertion that allegedly higher drug prices "caus[ed] her to pay more out-of-pocket."

Even so, the court noted that the plaintiff met her prescription drug out-of-pocket cap each year at issue in her complaint. It consequently found that "a favorable decision would not be able to compensate Plaintiff for the money she already paid," and that any proceeds from the case "would be owed to her insurance carrier to reimburse it for its expenditures on other drugs that same year."

This decision likely is not the end of the standing decisions in Lewandowski. The plaintiff has attempted to amend her complaint, and a motion to dismiss the amended complaint is currently pending.

Standing in Individual Cases

Outside the class action context, courts also have taken a skeptical view of novel ERISA standing theories that have been asserted by healthcare providers in individual ERISA litigation.

Traditionally, courts have held that healthcare providers lack statutory standing under ERISA to assert benefit claims against health plans for services rendered by the provider to an ERISA plan member.[4]

To get around this rule, many healthcare providers routinely require their patients to assign their right to ERISA plan benefits to the provider, so that the provider can seek those plan benefits by standing in the shoes of the ERISA plan member as an assignee.

However, many ERISA plans, including many ERISA health plans, include antiassignment provisions that either prohibit provider assignments or require written consent from the plan for the assignment to be effective, and courts have generally enforced such plan antiassignment provisions.[5]

In what appears to be an effort to avoid such standing and antiassignment issues, some providers have begun to take power of attorney designations from their patients, purporting to grant the provider power to bring a lawsuit for benefits on the patient's behalf, rather than on the provider's behalf as an assignee.

But in a decision earlier this year, the U.S. Court of Appeals for the Second Circuit **rejected** this novel approach and held that a provider with power of attorney lacked Article III standing to bring an ERISA claim for benefits on behalf of the nonparty patient.

On June 9, in Karkare v. International Association of Bridge, Structural, Ornamental & Reinforcing Iron Workers Local 580, a doctor affiliated with an out-of-network medical practice attempted to bring an ERISA claim under Title 29 of the U.S. Code, Section 1132(a)(1)(B), seeking payment of the full billed charges for a knee surgery that he performed on a patient plan member.[6]

The plaintiff doctor, however, had not obtained any assignment of benefits from the patient. Instead, the doctor argued that no assignment of benefits was necessary because he had obtained power of attorney from the patient.

The Second Circuit affirmed the dismissal of the doctor's complaint, holding that power of attorney did not confer Article III standing on the doctor, who did not suffer any injury in fact.

The Second Circuit explained that power of attorney does not transfer ownership interest in a claim, so the plaintiff could not rely on the patient for Article III standing.

Additionally, after engaging in a close reading of the complaint and considering the specific relief sought, the Second Circuit determined that the doctor was bringing a claim in his own individual capacity, rather than on behalf of the patient.

To support this finding, the Second Circuit noted that the complaint identified the doctor "as the named plaintiff in this action," and that the complaint referred to the named plaintiff and his affiliated medical group interchangeably.

And more fundamentally, the Second Circuit found that the specific relief sought — payment of the full billed charges — would benefit the doctor and his medical practice, not "the patient and party for whom [the doctor] purports to act."

Nevertheless, because the patient would likely have standing to sue under ERISA, pursuant to Title 29 of the U.S. Code, Section 1132(a)(1)(B), the court held that dismissal without leave to amend was inappropriate, and remanded to the district court to permit amended claims to be brought on behalf of the patient directly.

Takeaways

Across both class action and individual litigation, courts appear to be ratcheting up scrutiny on the specifics of ERISA plaintiffs' pleadings to ensure that Article III's standing requirements are met.

Key in these courts' analyses are (1) whether there is a clear factual chain from the complained-of conduct to the plaintiffs' alleged injury, (2) whether the plaintiffs would actually benefit from their requested relief, and (3) for nonmember plaintiffs, whether they actually have a proprietary interest in a claim or are otherwise actually attempting to represent the plan member.

These standing decisions also continue to show the central relevance of plan design to ERISA cases, particularly in relation to the use of cost-sharing terms and antiassignment clauses.

Cost-Sharing Terms

Plan language related to cost-sharing could play a role in determining whether a plaintiff has Article III standing.

For example, the plan documents in Knudsen explicitly stated that drug rebates would not be considered when determining coinsurance or copayment amounts. Given this express term, it is difficult to see how the Knudsen plaintiffs could have shown an impact on their out-of-pocket costs.

Moreover, a fixed copayment for prescriptions could prophylactically address issues like those raised in Lewandowski, as cost-sharing amounts would not depend on the price of the drug.

Antiassignment Clauses

While it was not a main focus of the parties' arguments in the Karkare litigation, discussions at the oral argument suggest that the plaintiff's power of attorney standing theory was developed as an end run around the ERISA plan's antiassignment clause.

Given the result in Karkare, it appears likely that antiassignment clauses — and potential legal theories to avoid the impact of such clauses — will continue to play a significant role in determining whether a provider has standing to assert ERISA claims.

Beyond standing, and just like traditional 401(k) excessive fee cases, plans and fiduciaries can further mitigate risk by utilizing and documenting a prudent process for selecting the plan's PBM or administrator that takes into account, among other things, administrative fees, cost savings and qualitative benefits to plan members.

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[1] Thole v. U.S. Bank N.A., 590 U.S. 538 (2020).

[2] Knudsen et al. v. MetLife Group, 117 F.4th 570 (3d Cir. 2024).

[3] Lewandowski v. Johnson & Johnson, No. 3:24-cv-671, 2025 WL288230 (D.N.J. Jan. 24, 2025).

[4] See, e.g., Griffin v. Coca-Cola Refreshments USA Inc., 989 F.3d 923, 932 (11th Cir. 2021); Denver Health & Hosp. Auth. v. Beverage Distribs. Co., 546 F. App'x 742, 745 (10th Cir. 2013).

[5] See, e.g., Dialysis Newco Inc. v. Cmty. Health Sys. Grp. Health Plan, 938 F.3d 246, 251 (5th Cir. 2019); Eden Surgical Ctr. v. B. Braun Medical Inc., 420 F. App'x 696, 697 (9th Cir. 2011); Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes Inc., 371 F.3d 1291, 1295 (11th Cir. 2004) (collecting cases).

[6] Karkare ex rel. JN v. International Association of Bridge, Structural, Ornamental & Reinforcing Iron Workers Local 580, 140 F.4th 60 (2d Cir. 2025).