

*Memorandum and Order*

In Re: MEDCO HEALTH SOLUTIONS, INC.,  
PHARMACY BENEFITS MANAGEMENT  
LITIGATION

MDL - 1508 (CLB)

Applies to:  
97 Civ. 9167 (CLB)  
98 Civ. 0847 (CLB)  
98 Civ. 4763 (CLB)  
99 Civ. 4067 (CLB)  
01 Civ. 3805 (CLB)

Briant, J.

Familiarity of the reader with all prior proceedings in this multi-district Employee Retirement Income Security Act of 1974 ("ERISA") class action litigation is presumed, and the history of this litigation will be summarized only to the extent necessary for clarity. By Memorandum and Order dated May 25, 2004, this Court certified a class action and approved an Amended Proposed Settlement Agreement ("Settlement") in five consolidated actions. Several appeals ensued and our Court of Appeals rendered a decision on December 8, 2005, followed by a mandate.<sup>1</sup> On February 24, 2006, counsel for the parties convened before this Court to discuss compliance with the mandate, and final submissions on the relevant issues were received on June 5, 2006. No evidentiary hearing was requested or held, but additional discovery has been taken and filed with the Court.

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<sup>1</sup> *Central States Southeast & Southwest Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 433 F.3d 181 (2d Cir. 2005).

In this litigation, Plaintiffs claim that Medco Health Solutions (“Medco”)<sup>2</sup> held itself out as an independent pharmacy benefits management company (“PBM”) that could control the rising costs of prescription drugs to employee benefit plans, by aggregating the purchasing power of employee benefit plans and other techniques, thereby negotiating favorable purchasing terms with drug manufacturers. In reliance on Medco’s promise of cost containment, certain Plan sponsors entrusted Medco with varying degrees of discretionary authority over certain aspects of managing their pharmacy benefit plans. Plaintiffs claim that Medco thereby became a fiduciary and then systematically misused its fiduciary authority, and its management of formularies and drug-switching programs to increase the market share in specific drugs of its then parent company, Merck, and others, and to divert rebates from drug manufacturers to itself, in violation of ERISA.

The Class consists solely of Plans. The Class, as defined by the Proposed Settlement Agreement, consists of all employee welfare benefit Plans that have and have had contracts with Medco, whether directly or indirectly (including through third party administrators, HMOs, insurance companies, Blue Cross Blue Shield entities, or other intermediaries (collectively, “TPAs”)), where the contracts between such plans and Medco were both (a) in force at any time between December 17, 1994, to the date of the final approval of the Settlement contemplated by this Settlement Agreement, and (b) subject to ERISA. *See Memorandum and Order, May 25, 2004.*

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<sup>2</sup> Formerly known as Merck-Medco Managed Care, L.L.C.

The parties in good faith engaged in protracted arms length negotiations, assisted and supervised by this Court and a Special Master, and arrived at what this Court found after a hearing, to be a fair, reasonable and adequate settlement amount of \$42.5 million.

On appeal from the order approving the Settlement, our Court of Appeals concluded that the question of Article III standing of the settling Class Plaintiffs<sup>3</sup> was insufficiently established, and remanded the case for determination of that single issue. It held that “we do not have the benefit of the District Judge’s views as to whether the Plaintiffs have demonstrated the requisite injury-in-fact for supporting a finding of constitutional standing[.]” *Central States*, 433 F.3d at 200, and that

serious questions remain as to whether the Individual Plaintiffs have demonstrated how Medco’s alleged wrongdoings caused any injury to any individual or entity other than the Plans that Medco contracted with, and provided prescription benefit coverage to, during the class period. [] It is especially unclear whether any evidence supports the claim that Medco’s drug-switching programs and formulary caused the Individual Plaintiffs - as opposed to the Plans to which they belong - any injury (either by paying more for prescription drugs or by having to take different prescription drugs), given that Plan participants generally pay a flat co-pay for a drug regardless of the cost of the drug. *Seemingly, only plan participants who paid percentage coinsurance would incur injury if Medco favored the higher-cost drugs.* In regard to Medco’s drug-switching programs, the only injury that the Individual Plaintiffs appeared to have alleged was an increase in the cost of the drugs to the employer Plans in which they participated, but in which they serve no fiduciary role in administering. Moreover, *such an increase in cost would in all probability not affect the Individual Plaintiffs absent a demonstration of individualized harm.* Similarly, the Individual Plaintiffs appear to have failed to demonstrate (i) that they incurred an injury resulting from Medco’s failure to pass along formulary rebates to the Plans; or (ii) that they have been impacted by defendants’ allegedly wrongful disclosures or misstatements.

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<sup>3</sup> The Individual Class Plaintiffs are plan beneficiaries Genia Gruer, Walter Green, Mildred Bellow and Elizabeth O’Hare. The Plan Trustee Class Plaintiff is Ms. Marissa Janazzo, now Marissa Salisbury (“Janazzo”).

*Id.* at 202-203 (emphasis added).

With regard to Plan Trustee Janazzo (now Salsbury), the Court held:

The parties also have raised a considerable question regarding whether the fifth settling plaintiff, Janazzo, a Plan trustee, represents a Plan with Article III standing, given that Janazzo failed to produce a signed, executed contract between the Plan and either Medco or a TPA that contracted with Medco. ... *In the absence of evidence of a contractual relationship with Medco, Janazzo is precluded from demonstrating any injury resulting from Medco's alleged wrongdoings.*

*Id.* at 203 (emphasis added). “Accordingly, we will remand to the District Court for that purpose, leaving the District Court free to resolve the Article III standing question identified in this Opinion in any way it deems proper.” *Id.*

This case is before the Court, *inter alia*, for approval or rejection of a proposed class action settlement, negotiated at arm's length by sophisticated lawyers. The law favors the settlement of litigation. *See e.g. In re: Tamoxifen Citrate Antitrust - Litigation*, 429 F.3d 370, 386-387 (2d Cir. 2005); *In Re: Paine Webber Limited Partnership Litigation*, 147 F.3d 132, 138 (2d Cir. 1998) (strong judicial policy in favor of settlements particularly in the class action context). The negotiated settlement in this case factors in numerous differences of opinion as to liability and damages, including whether following a plenary trial plaintiffs, or at least one of them, can demonstrate Constitutional standing. Whether a plaintiff has standing would seem to go to the merits of the claim asserted, rather than jurisdiction. It is basic that “when the provision of the Constitution or federal statute affords a remedy which may in some circumstances be availed of by a plaintiff, the fact that his pleading does not bring him within that class as one entitled to the remedy, goes to the sufficiency of the pleading and not to the jurisdiction.” *Bell v. Hood*, 327 U.S. 678, 685 (1946); *The Fair v. Kohler Die Co.*, 228 U.S. 22, 25; *Sarhank Group v.*

*Oracle Corp.*, 404 F.3d 657, 660 (2d Cir. 2005) (“When a party challenges the court’s subject matter jurisdiction based upon the merits of the case, that party is merely arguing that the adversary has failed to state a claim. The court has and must assume subject matter jurisdiction and hear the merits of the case.”); *Miller v. Am. Stock Exch. (in Re Stock Exchs. Options Trading Antitrust Litig.)*, 317 F.3d 134, 150 (2d Cir. 2003).

Since the district court has jurisdiction of a case such as this, which presents non-frivolous but disputed allegations of entitlement to a remedy, and thus may try the merits and decide all issues presented including the issue of Constitutional standing, it would seem reasonable to conclude that the Court’s jurisdiction over the case extends also to approval of a good faith settlement, negotiated with due regard to the difficulties of proof and any problems relating to “standing.”

Standing has been described as “not a term used for its precision.” *Graddick v. Newman*, 453 U.S. 928, 938 (1981) quoted with approval in *Thompson v. County of Franklin*, 15 F.3d 245, 247 (2d Cir. 1994), which also describes the doctrine as “unsettled.” The function of the court-supervised settlement of cases is to settle the unsettled. Jurisdiction to decide the merits, including standing, must, of necessity, include jurisdiction to approve or reject a proposed settlement.

Subsequent to the mandate in this action, our Court of Appeals held that the Supreme Court case of *Bennett v. Spear*, 520 U.S. 154 (1997), “may mean no more than that a court may

adjudicate a statutory standing issue so long as Article III standing is adequately pleaded, even though Article III standing might turn out to be absent upon subsequent fact-finding.” *Alliance for Env’tl. Renewal, Inc. v. Pyramid Crossgates Co.*, 436 F.3d 82, 86 (2d Cir. 2006). The Court also said that the “message of *Steel Co. [v. Citizens for a Better Env’t, 523 U.S. 83 (U.S. 1998)]* that Article III standing must be decided before the merits ... does not inevitably mean that a district court must make a definitive ruling on Article III standing before giving any consideration to the merits.” *Id.* at 87. *Steel Co.* “seeks to guard only against a definitive ruling on the merits by a court that lacks jurisdiction because of the absence of an Article III requirement, such as Article III standing.” *Id.*

In this case, prior to any trial or definitive ruling on the merits, several parties opted to settle, as is favored by the law. In light of the procedural history and the jurisprudence just cited, it seems to this Court that a prior definitive ruling as to Article III standing was not required, and in any case, as discussed *infra*, the Court relied on the adequacy of representational standing of the Individual Plaintiffs to support ratification of a settlement.

In its opinion remanding this case, our Court of Appeals impliedly criticized the District Court for failing to rule definitively on Constitutional standing prior to entertaining the settlement, observing: “Despite the issue of constitutional standing having been brought to the attention of the district judge by various parties on numerous occasions throughout the Litigation. . .the district judge repeatedly failed to rule on whether any of the Plaintiffs had Article III standing to bring the class action.” *Id.* at 200.

This failure to rule prior to the exhaustion of settlement negotiations was not inadvertent, nor the result of neglect. It was based instead on this Court's understanding that non-frivolous allegations of constitutional standing are sufficient to allow the court to try a case in which the merits and standing are intertwined, and to effect settlement if a consensus could be reached; and also based on this Court's unexpressed view that both the majority and concurring opinions in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) which construe § 502(a)(2) of ERISA, assume Article III standing of a plan beneficiary to sue in the right of the plan for breach of fiduciary duty.<sup>4</sup>

To have decided the issue before settlement had been exhausted would have materially altered the settlement dynamic. The ultimate issue is of course one of law, reviewable *de novo* in the Court of Appeals, but only after entry of a final judgment. So long as this Court appeared uncommitted, the uncertainty on the point was part of the negotiations. Had the Court ruled in favor of Plaintiffs, their greed would have grown proportionately with their optimism, and settlement would have become impossible. Defendants would have been unlikely persuaded, but unable to obtain appellate review until a final judgment. Had the Court ruled in favor of Defendants, the case would have been dismissed in the district court and gone directly to the

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<sup>4</sup>Justice Stevens wrote for the majority:

There can be no disagreement...that § 502(a)(2) authorizes a beneficiary to bring an action against a fiduciary who has violated § 409. Petitioner contends, however, that recovery for a violation of § 409 inures to the benefit of the plan as a whole. We find this contention supported by the text of § 409, by the statutory provisions defining the duties of a fiduciary, and by the provisions defining the rights of a beneficiary.

Court of Appeals, probably on an incomplete record, and again settlement would have become impossible. The participants were at all times free to break off the settlement negotiations. They did not.

The Court responds herein to the Mandate of the Court of Appeals.

**County Line Plan and Marissa Janazzo as Plan Fiduciary**

Class Plaintiffs assert that during the Class Period, which began December 17, 1994 (and continued to the date of final approval of the settlement), the County Line Buick Plan (“County Line Buick” or “County Line Plan”) had a contractual relationship with M.D. Health Plan, which in turn contracted for pharmacy benefit management services with Merck-Medco. They assert that for a portion of the Class Period, the County Line Plan was self-funded with M.D. Health Plan operating as a third-party administrator (“TPA”), and that during a subsequent portion of the Class Period, the County Line Plan was insured through M.D. Health Plan. They assert that throughout both of these periods, M.D. Health Plan used Medco for its pharmacy services, and was therefore in an indirect contractual relationship with Medco.

Objectors contend that Class Plaintiffs have failed to produce sufficient evidence to support the Medco-County Line relationship. They note that during depositions, Ms. Janazzo could not recall anything linking County Line to Medco, and that Mr. Lynch, who formerly served as County Line’s health insurance broker, based his assertion of a contract between Medco and County Line on his belief, rather than on recent review of an executed contract.

While their deposition testimony reveals imperfect memory, neither Ms. Janazzo's nor Mr. Lynch's imperfect recall necessarily answers in the negative the question of whether a contract existed. There is no basis for this Court to believe, in the absence of an adverse credibility finding, which the Court is not prepared to make, that these individuals are lying. Understandably, memories would fade in the six to ten years since these events occurred. Were there no documentary evidence proffered to support the existence of a contract, the Court would find the weaknesses in their testimony of greater concern. However, the Court concludes on balance that Plaintiffs have adequately proved the existence of such an indirect contractual relationship.

Attached to Plaintiff's submissions is a "Third Party Administrative Services Agreement" between County Line Motors and M.D. Health Plan. *See Normand February 2006 Decl., Ex. A.* The effective date of the Agreement is June 1, 1995. Although the exhibit copy of the Agreement is signed by only one party, namely, a representative of County Line, it still has evidentiary value of both an intent to execute the Agreement, and progress toward such execution. The existence of a contractual relationship between County Line and M.D. Health Plan is further supported by two "Application[s] for Excess Loss Indemnity Coverage" from Continental Assurance Company, in which "M.D. Employee Benefit Services" is listed as the full legal name of "Plan Supervisor." *See Normand February 2006 Decl., Exs. B and C.* These two documents appear to be fully executed, having been signed by Miss Janazzo as Executive Vice President of County Line on January 4, 1996 and June 24, 1996, and by Zaven Kazazian as Vice President of Continental Assurance on January 16, 1996 and November 14, 1996, respectively.

Also submitted is a letter dated April 29, 1997, from M.D. Health Plan to Brian Lynch of Benefit Resource Group, which references Countyline Motors and its transfer from a self-funding to fully insured status to be effective on June 1, 1997. *See Normand February 2006 Decl., Ex. E.* This document shows that M.D. Health Plan treated County Line as a client. Also submitted is a January 3, 1997, letter from M.D. Health Plan to its Agents, which informs them that their clients would be notified that effective February 1, 1997, M.D. Health Plan would consolidate all of its pharmaceutical services under "Merck-Medco Managed Care, Inc." *See Normand February 2006 Decl., Ex. D.* This document shows that M.D. Health Plan was entering into an exclusive contractual relationship between itself and Medco.

Also attached to Plaintiff's submissions is a contract between M.D. Health Plan and Merck-Medco which is entitled "Integrated Prescription Drug Program Master Agreement" and made effective February 1, 1997. *See Normand Supp. Decl., Ex. B.* It provided, *inter alia*, that Medco would be the exclusive providers of prescription drug benefits to M.D. Health while the Agreement was in effect. The Agreement was executed by signature of Vincent Catrini, the Chief Medical Officer of M.D. Health Plan, dated April 15, 1997, and by signature of James Cooper, the Vice President of Contracts for Merck-Medco Managed Care, on what appears to be May 5, 1997.

Mr. Lynch's unsupported and concededly incorrect statement that when Physicians Health Services of Connecticut acquired M.D. Health Plan in the beginning of 1998, it continued to use Medco, does not change the evidence that during the Class Period, as confirmed by the

paper trail analyzed above, the County Line Plan was in relationship with M.D. Health Plan, a third party administrator, which contracted on behalf of the County Line Plan with Medco at least from February 1, 1997 through July 1, 1998.

Medco concedes that during the class period, it provided prescription benefits to Marissa Janazzo through her employer's plan, and has produced spreadsheet excerpts, which reflect that Ms. Janazzo had prescriptions filled through Medco in 1997 and 1998. In addition, Ms. Janazzo's 2001 Declaration and submission of copies of Rite Aid pharmacy prescriptions for herself and her father, confirm that Ms. Janazzo and her father were beneficiaries of County Line Plan for whom Medco administered prescriptions under contract with the M.D. Health Plan. *See Normand February 2006 Decl., Exs. H, I and J.*

This Court finds the existence of the contractual relationship as claimed by Plaintiffs.

#### *Injury to the County Line Plan*

Objectors argue that Class Plaintiffs have not shown how Medco's conduct caused injury to the County Line plan, as Ms. Janazzo testified that she does not now know whether the alleged conduct caused an increase in the payments by County Line Buick, does not now know what kind of formulary County Line adopted, nor whether M.D. Health received rebates from Medco, or whether County Line received rebates passed through M.D. Health. Plaintiffs appear to rely on the common and largely undisputed business practices of Medco and may do so. There is no reason to suppose that County Line was treated any differently than any other Plan served by

Medco during the class period. The proof developed in pretrial discovery shows that Medco had a general practice of collecting rebates and not passing the entire amount through to the plans, keeping significant portions of them under claim of right for its own benefit. This is the typicality of the claims that makes this case a class action. In the absence of evidence to the contrary, there is no reason to think that Medco acted with respect to County Line otherwise than it is understood to have acted under this system-wide general practice with respect to other Plans, including the Blumenthal Plan (*see infra*), which the Court of Appeals found to have constitutional standing. *Central States*, 433 F.3d at 203.

#### *Kaiser Reports and Fleischacker Declaration*

The Reports offered by Plaintiffs of the Kaiser Family Foundation and the Health Research and Educational Trust show that insurance premiums and co-payments have been on the rise, in part due to higher spending for prescription drugs. They show that employers have looked to higher cost-sharing through various means, such as increased deductibles and increased co-payments. *See Normand Supp. Decl. Exs. M and N*. The Fleischacker Declaration explains that Medco's failure to pass rebates on to the Plans would or did require those plans which were insured to pay higher insurance premiums than they would have paid had the rebates been passed through to them. *See Normand Supp. Decl. Ex. F*. Self-funded plans, which County Line was during part of the class period, also paid more for their beneficiaries' drugs.

Objectors and Carefirst object to any consideration of these documents offered by Class Plaintiffs, in part because they do not deal with the specific facts of this case. While these

unsworn articles probably would not be admissible at trial, the Court concludes that they support a claim of financial impact on the Plan. Generally, the authors who might be able to testify as expert economists, are setting forth information, which they have compiled from data in the public domain. There is no reason to believe that such information cannot form a partial support for the allegations of injury in this case, the full extent and nature of which could only be determined with the benefit of a plenary trial record.

Even without the Kaiser Reports and Fleischacker Declaration, the record supports a finding that Medco received considerable money in vendor rebates, which according to the legal theory on which these lawsuits are based, should have been received by this and the other ERISA plans. While the legal theory underlying this litigation has not been endorsed by any Court, the non-frivolous claims asserted are sufficient to support a claim of financial injury or loss to the Plans, including County Line Buick's Plan, and thereby to establish Constitutional standing.

**Individual Class Plaintiffs:**

In its decision resulting in the remand, the Court of Appeals held the following:

Assuming, without deciding, that Plaintiffs have demonstrated statutory standing, such standing "does not necessarily provide constitutional standing." *Bollig v. Christian Comm. Homes and Servs., Inc.*, 2003 U.S. Dist. LEXIS 24715, 2003 WL 23200362, at \*2 (W.D. Wis. July 10, 2003), amended by 2003 WL 23211142 (W.D. Wis. Oct. 27, 2003), (alteration in original) (quoting *Carducci v. Aetna U.S. Healthcare*, 247 F. Supp. 2d 596, 621 (D. N.J. 2003)). Courts have, however, recognized that a plan participant may have Article III standing to obtain injunctive relief related to ERISA's disclosure and fiduciary duty requirements without a showing of individual harm to the participant.

*Central States*, 433 F.3d at 199. It also held:

Requests for restitution or disgorgement under ERISA are different from requests for injunctive relief. Obtaining restitution or disgorgement under ERISA requires that a plaintiff satisfy the strictures of constitutional standing by "demonstrating individual loss," [*Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450, 456 (3d Cir. 2003)] (citing *In re Unisys Sav. Plan Litig.*, 173 F.3d 145, 159 (3d Cir. 1999)); see also *Bollig*, 2003 U.S. Dist. LEXIS 24715, 2003 WL 23200362, at \*2; to wit, that they have suffered an injury-in-fact. In *Horvath*, the Third Circuit held that while the plaintiff had standing under ERISA to seek injunctive relief, the class representative lacked Article III standing to assert claims for restitution or disgorgement because she did not allege that she was personally affected by the alleged breach. 333 F.3d at 456. Statutes do not abdicate the standing requirements of the Constitution.

*Id.* at 200. The Court also looked to the Eighth Circuit's reasoning and stated:

The Eighth Circuit has also held that an ERISA Plan participant or beneficiary must plead a direct injury in order to assert claims on behalf of a Plan. See *Harley v. Minn. Mining and Manufacturing Co.*, 284 F.3d 901, 906-07 (8th Cir. 2002) (determining that there was no constitutional standing because the "loss did not cause actual injury to plaintiff's interests in the plan" and determining that the "limits on judicial power imposed by Article III counsel against permitting participants or beneficiaries who have suffered no injury in fact from suing to enforce ERISA fiduciary duties on behalf of the Plan").

*Id.* at 200 (some citations omitted).

The Individual Plaintiffs have alleged that Medco breached its fiduciary duties and thereby violated Plaintiffs' legally protected interest to have their employee benefit plan served and administered by fiduciaries who are loyal and do not engage in self-dealing or prohibited transactions. "Under ERISA, trustees have a fiduciary duty to act to ensure that a plan receives all funds to which it is entitled, so that those funds can be used on behalf of participants and beneficiaries." *Diduck v. Kaszycki & Sons Contractors, Inc.*, 874 F.2d 912, 916 (2d Cir.

1989)(citations and quotations omitted).<sup>5</sup> The Supreme Court noted that the common interest shared by those enabled to sue under ERISA is the financial integrity of the plan:

Consistent with this objective, § 502(a)(2), the enforcement provision for § 409, authorizes suits by four classes of party-plaintiffs: the Secretary of Labor, participants, beneficiaries, and fiduciaries. Inclusion of the Secretary of Labor is indicative of Congress' intent that actions for breach of fiduciary duty be brought in a representative capacity on behalf of the plan as a whole. Indeed, the common interest shared by all four classes is in the financial integrity of the plan.

*Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 n.9 (1985). See also *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, (U.S. 1989) (“Unlike the LMRA, ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans. See 29 U.S.C. §§ 1132(a), 1132(f)”).

In light of these jurisprudential observations, it would appear to this Court that the Individual Plaintiffs have standing on the basis that their “common interest” shared with that of the fiduciaries and others eligible to bring suit, is in the financial integrity of the plan, which has

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<sup>5</sup> Section 1002(21)(A) of the ERISA statute provides:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 USCS § 1105(c)(1)(B)].

allegedly been compromised by self-dealing conducted by Medco.<sup>6</sup> Nevertheless, the Court proceeds here below as instructed by the Court of Appeals, to evaluate the Individuals' asserted Article III bases for standing.

*Mr. Green*

Class Plaintiffs have submitted to the Court Mr. Green's record of his personal prescriptions from January 27, 1996 through March 13, 2006, and confirmed thereby Plaintiff's allegation that Mr. Green was at least on one occasion switched from a less expensive drug to a more expensive drug manufactured by Merck. The evidence shows that on January 27, 1996, Mr. Green received a prescription for the less expensive drug and paid a co-pay of \$5.00, and that on January 18, 1997, he received a prescription for the more expensive drug and paid a co-pay of \$10.00. Mr. Green's allegations are fairly read to assert a claim that Medco switched prescriptions of Plan beneficiaries to maximize its own profits, rather than for therapeutic reasons. Carefirst argues that the evidence submitted by Mr. Green doesn't answer the questions

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<sup>6</sup> See 65 Ohio St. L.J. 199, 209 (Muir, Dana):

The Eighth Circuit's decision in *Harley* dramatically undercuts ERISA's protection of DB [defined benefit] plan assets from fiduciary breach. Under the *Harley* court's logic, the only plaintiffs that could seek redress for breach of fiduciary duty owed to an overfunded DB plan are the Secretary of Labor and plan fiduciaries. The DOL successfully pursues numerous cases of fiduciary malfeasance each year, but like all government agencies, it operates with severely constrained resources. DOL cannot possibly police the more than three million plan sponsors and other members of the benefits plan community that provide benefits to more than 200 million plan participants and beneficiaries across a broad range of pension, health care, life insurance, and other types of employee benefit plans without the possibility of suits by private parties to enforce ERISA's standards.

of whether Medco *improperly* switched Mr. Green's prescription from one drug to another, whether "Mr. Green paid more than he should have for the drugs," or whether he, (as opposed to his Plan), was injured by the switch.

Carefirst's arguments go to the merits of Mr. Green's case. This Court does not understand the Court of Appeals, for purposes of the present remand, to have directed this Court to ascertain whether any Plaintiff would or should prevail at trial. A Court could not make such a comprehensive determination on less than a plenary trial record, and a jury has been demanded in the case. Rather, the purpose of the remand is to determine whether at least one of the Class Representatives presents non-frivolous allegations of an injury, sufficient to satisfy what the Court of Appeals has adopted as an Article III standing requirement for these ERISA Plaintiffs, who assert claims on behalf of their plans. The Court of Appeals also appears to hold in its decision accompanying the remand, that evidence supporting a claim that Medco's drug-switching programs caused the Individual Plaintiffs any injury, "either by paying more for prescription drugs *or* by having to take different prescription drugs," would be sufficient to show an injury. *Central States*, 433 F.3d at 202 (emphasis added).

That these issues are in dispute does not affect Article III standing. The allegations of injury are non-frivolous and Mr. Green need not win his lawsuit in order to prove that he has the right to bring it. Mr. Green has Article III standing.

*Ms. Bellow*

Carefirst argues that the documents produced by Class Plaintiffs cannot be a basis for establishing standing for Ms. Bellow, because although represented to be hers, they do not include Ms. Bellow's name, and even if related to Ms. Bellow, they do not support proof of injury in fact. The documentation illustrates a prescription switch from Zestril (marketed by Astra) to Prinivil (marketed by Merck), but that the pharmacy charged the same co-pay as it did for Zestril. Carefirst argues that Ms. Bellow was not harmed by the switch because the drugs are identical forms of lisinopril and that the cost to Ms. Bellow was the same before and after the switch, due to a flat co-pay. As noted *supra*, the Court of Appeals appears to consider "having to take different prescription drugs" to be an adequate basis of alleged injury. Ms. Bellow at least can claim her rights and expectations were violated, and contractual and fiduciary duties which her Plan owed to her were violated with notice by Medco, for its own financial benefit, when she was "required to take a different [brand] of prescription drug. Loss or damage does not have to be economic in order to support standing. *See Firestone Tire, supra*. Ms. Bellow has Article III standing.

*Ms. O'Hare & Ms. Gruer*

Ms. O'Hare and Ms. Gruer submitted no evidence in response to the mandate. As discussed below, this Court's view is that they, as well as Mr. Green and Ms. Bellow have representational standing under the ERISA statute, which also satisfies Article III standing in the factual context of this case.

### *Representational or Statutory Standing*

Class Plaintiffs stand by their argument that the individual Plaintiffs have established representational standing under Section 502(a) of ERISA, 29 U.S.C. §1132(a)(2), to bring claims on behalf of their Plans. The Court of Appeals quoted this Court's statement during a conference with counsel that: "I think that if Congress tells me I can sue, it takes a certain amount of temerity for the Eighth Circuit to tell me I can't." *Transcript, December 11, 2003*, at 38. The Court stands by this statement, nevertheless acknowledging the Supreme Court's holding:

It is settled that Congress cannot erase Article III's standing requirements by statutorily granting the right to sue to a plaintiff who would not otherwise have standing. *Gladstone, Realtors v. Village of Bellwood*, 441 U.S. 91, 100, 60 L. Ed. 2d 66, 99 S. Ct. 1601 (1979). We acknowledge, though, that Congress' decision to grant a particular plaintiff the right to challenge an act's constitutionality [] eliminates any prudential standing limitations and significantly lessens the risk of unwanted conflict with the Legislative Branch when that plaintiff brings suit.

*Raines v. Byrd*, 521 U.S. 811, 820 n.3 (U.S. 1997).

The Supreme Court has acknowledged representational standing of beneficiaries suing on behalf of their plans under the ERISA statute, as noted *supra*. ("Inclusion of the Secretary of Labor is indicative of Congress' intent that actions for breach of fiduciary duty be brought in a representative capacity on behalf of the plan as a whole." *Russell*, 473 U.S. at 142, n.9.) The Court in *Russell* also assumed Article III standing when it held that "[t]here can be no disagreement with the Court of Appeals' conclusion that § 502(a)(2) authorizes a beneficiary to bring an action against a fiduciary who has violated § 409" and that any restoration of profits inures to the plan. *Id.* at 140. While not expressly mentioned in the opinion, we may not lightly conclude that all nine Justices overlooked the hot issue of Constitutional standing.

Clearly, a Plan fiduciary has standing, both by statute and under Article III.<sup>7</sup> Congress also authorized Plan beneficiaries to sue derivatively in the right of their Plans for all relief permitted by the statute, including disgorgement. *See* 29 U.S.C. §1132(a). Notwithstanding the requirement of injury to establish constitutional standing, there is a long unquestioned history of practice in the federal district courts where a Plaintiff may sue derivatively in the right of another who was in fact injured. A voluntary organization has standing to sue in the right of its members whose rights have been adversely affected by governmental action or inaction. *Sierra Club v. Morton*, 405 U.S. 727 (1972); *Andrus v. Sierra Club*, 442 U.S. 347, 353 (1979); *Schweiker v. Gray Panthers*, 453 U.S. 34, 40 (1981). An ordinary citizen sues in the name of the United States as a *qui tam* relator for injury to the United States. *See Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 787 (2000) (“We hold that a private individual has standing to bring suit in federal court on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733”). Shareholders of a corporation sue defalcating officers and directors derivatively in the right of the injured corporation. Persons having remote or contingent interests in a trust sue trustees derivatively for injury to the trust *res*. A guardian sues in the right of his ward and the parent or foster parent in the right of his child. *Smith v. Organization of Foster Families*, 431 U.S. 816, 840-42 (1977). This is as a result of a juridical relationship which gives standing without any requirement of the derivative Plaintiff to show

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<sup>7</sup> No party has questioned the standing of the Blumenthal Plan, which opted out of the Settlement, and will, when these appellate proceedings are concluded, go to trial on the merits, with or without these plaintiffs, depending on the ultimate resolution of the other issues on appeal. Indeed, the Court of Appeals noted that it “seems clear that the trustees of the Blumenthal Plan had constitutional standing and were proper named plaintiffs ... [and] qualified to serve as class representatives.” *Central States*, 433 F.3d at 203.

actual personal harm. Just as the common law and equity grant standing to the parent, the guardian and to *cestuis qui trustent*, the statute in this case grants standing to the plan beneficiary to sue for disgorgement by wrongdoers to the Plan, and to the extent that the Eighth Circuit's decision in *Harley* is read to hold by implication such provision in the statute to be unconstitutional or void, it is respectfully submitted that *Harley* is wrong, inapplicable or distinguishable on its facts.

The Court of Appeals also referenced *O'Shea v. Littleton*, 414 U.S. 488, 494 (1974), which held that "if none of the named plaintiffs purporting to represent a class establishes the requisite of a case or controversy with the defendant[], none may seek relief on behalf of himself or any other member of the class." It also referenced *Warth v. Seldin*, 422 U.S. 490, 502 (1975), which held, in part, that class plaintiffs "must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent." The controversy in this case is between the Plans and Medco Health Solutions, Inc., and the Settlement Fund is to be paid entirely to the Plans. The Class consists of the Plans, not the plan beneficiaries. The settlement fund goes to the Plans, not to the plan beneficiaries who are Plaintiffs. The Plans cannot sue as entities, but only by the Plan Fiduciaries, as in the case of *Janazzo*, or by Plan beneficiaries suing derivatively in the right of the Plans, as they are permitted to do under Section 502(a)(2), where the Plan fiduciaries decline to sue.

### Conclusion

In compliance with the Mandate, this Court concludes that (1) Plaintiff Marissa Janazzo, as the Plan fiduciary of County Line Buick has demonstrated that she has Article III standing to maintain the litigation, and therefore to submit the proposed settlement to the Court for approval. Walter Green and Mildred Bellow have Article III standing. It is also the view of this Court under *Russell* and the ERISA statute, that all of the Individual Plaintiffs have representational standing in the right of their Plains, which have Article III standing. *See Central States, supra* at 203.

Parties desiring to proceed further in the Court of Appeals as to this issue or the remaining undecided issues of the appeal, shall write the Clerk of the Court of Appeals within thirty (30) days , with informational copy to this Court, seeking such review. Further proceedings in the District Court in these cases and all the related actions continue stayed for thirty (30) days, and if the appeal is reactivated, stayed thereafter until it is decided, or further order of the Court.

X

X

SO ORDERED.

Dated: White Plains, New York  
August 10, 2006

**CHARLES L. BRIEANT**

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Charles L. Brieant, U.S.D.J.