UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

SETH STERN, ANGELA BINDNER, and MARIANNE SCHMITT, on their own behalf, on behalf of all others similarly situated, and on behalf of the JPMorgan Chase Health Care and Insurance Program for Active Employees and its component Medical Plan, Plaintiffs, v. JPMORGAN CHASE & CO., JPMORGAN CHASE BANK N.A., JPMORGAN CHASE U.S. BENEFITS EXECUTIVE, and JPMORGAN CHASE COMPENSATION & MANAGEMENT DEVELOPMENT COMMITTEE, Defendants.	Case No. 1:25-cv-02097 (JLR)

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

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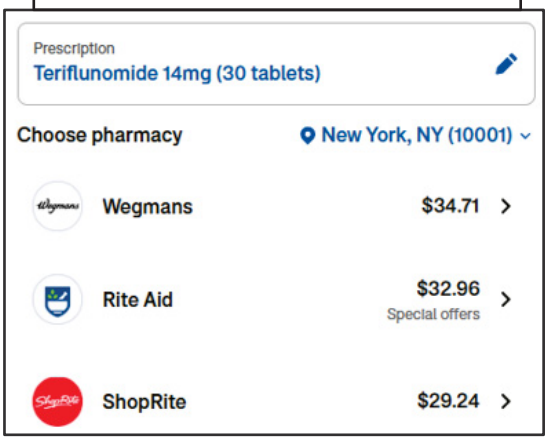
INTRODUCTION

JPMorgan[1] established a health plan for its employees. It then proceeded to waste millions of dollars of the Plan's money, and millions more of participants' money, by failing to monitor the Plan's pharmacy benefits manager ("PBM") and control the Plan's prescription-drug costs. The proof is in the prices: Across 366 generic drugs on the Plan's formularies for which public data is available, JPMorgan allowed the Plan's PBM to charge an average ***211.1% markup***. ECF 1 ("Compl.") ¶¶ 6, 109-28. The markups are even more eye-popping for certain drugs: for example, one drug available at Rite Aid for just $32.96 costs the Plan and its participants ***$6,229.23***. *Id.* ¶¶ 4-5.

Cash Price Using No Insurance



Price Using JPMorgan Plan

Allegations of excessive costs like these state a claim under ERISA. *See, e.g., Hughes v. Nw. Univ.*, 595 U.S. 170, 174 (2022); *Sacerdote v. New York Univ.*, 9 F.4th 95, 107-10 (2d Cir. 2021). Congress enacted ERISA to protect hard-earned employee benefits from erosion through fiduciary misconduct and imprudence, and provides relief when money is wasted.

[1] "JPMorgan" refers collectively to JPMorgan Chase & Co., JPMorgan Chase Bank, N.A., and any "administrator or fiduciary … of the JPMorgan Chase Health Care and Insurance Program for Active Employees and its component Medical Plan (the "Plan") who is or was affiliated with JPMorgan." *See* ECF 32. The company has assumed responsibility for such administrators and fiduciaries. *Id.*

JPMorgan does not deny that it allowed its PBM to charge the prices alleged in the Complaint. Instead, it deflects from the facts by insisting that it "had every incentive to keep prescription-drug costs low." ECF 30 ("MTD") at 3. But ERISA exists precisely because plan sponsors—none of whom have "incentives" to waste money or harm employees—nevertheless sometimes do. Under ERISA, "a pure heart and an empty head are not enough." *Reich v. Valley Nat'l Bank of Ariz.*, 837 F.Supp. 1259, 1281 (S.D.N.Y. 1993) (Motley, J.). Moreover, "the [Complaint] here suggests that [JPMorgan] lacked even a pure heart." *Id.* The pharmaceutical industry is a major source of investment banking revenue for JPMorgan, and the Complaint alleges that JPMorgan abandoned cost-saving efforts amid pressure from its banking clients, including its PBM's parent company. *See* Compl. ¶¶ 147-69.

JPMorgan contests Plaintiffs' Article III standing, but the alleged ERISA violations cost Plaintiffs money—the "prototypical form of injury in fact." *Collins v. Yellen*, 594 U.S. 220, 222 (2021). First, Plaintiffs paid inflated costs for their own prescriptions because they were responsible for a portion of the charges, or in some cases all the charges, before Plan coverage kicked in. *See* Compl. ¶¶ 245-49. Second, JPMorgan required Plan participants like Plaintiffs to cover 30% of the Plan's expenses through monthly premium contributions, so Plaintiffs always bore a portion of the Plan's overpayments. *Id.* ¶¶ 224-44. Thus, Plaintiffs have standing to bring suit. JPMorgan's contention that Plaintiffs "receive[d] all the benefits they were promised," MTD at 1, is irrelevant because Plaintiffs do not bring a benefits claim and are harmed from excessive costs.

Plaintiffs also state plausible claims on the merits. JPMorgan's arguments regarding the prohibited transaction claims are foreclosed by *Cunningham v. Cornell Univ.*, 145 S.Ct. 1020 (2025), which held that plaintiffs need not plead anything more than a transaction with a service provider. Plaintiffs' breach of fiduciary duty claims also stand on solid footing. Monitoring plan

expenses and service providers is a fundamental fiduciary function, and Plaintiffs plausibly allege that JPMorgan failed that duty. Rather than engage with the pleaded facts, JPMorgan once again deflects. It mischaracterizes Plaintiffs' theory of the case, fails to accept Plaintiffs' allegations as true, and relies on factual assertions that appear nowhere in the Complaint. In the end, this is a straightforward case: JPMorgan failed to monitor its service provider, causing participants to overpay for essential medications and wasting the Plan's money. JPMorgan's motion should be denied.

BACKGROUND

Plaintiffs are current and former JPMorgan employees who received prescription-drug benefits through the Plan. Compl. ¶¶ 13-15. JPMorgan is the Plan sponsor, a participating Plan employer, and a Plan fiduciary. *Id.* ¶ 18-19. The Plan's prescription drug program is self-funded, which means that the Plan (not a third-party insurance company) pays all covered expenses. Compl. ¶ 224. The Plan pays these expenses from a trust account funded by a combination of employer and participant contributions. *Id.* ¶¶ 27, 224. During the relevant period, JPMorgan set required participant contributions at amounts it projected would result in participants covering 30% of Plan expenses annually. *Id.* ¶¶ 228-32.

Plan participants, in addition to making contributions into the trust to cover a portion of overall Plan expenses, also directly paid some or all of the costs for their own prescriptions. *Id.* ¶¶ 86-87, 221-23, 247-49. Thus, participants are affected by drug prices in two separate ways: (1) directly through the amounts they pay out-of-pocket, and (2) indirectly through their premium contributions that help underwrite the Plan's expenses.

JPMorgan contracted with CVS Caremark ("Caremark") to serve as the Plan's PBM. *Id.* ¶¶ 17, 104. Plaintiffs allege that instead of prudently managing the Plan's prescription-drug program and carefully monitoring drug costs, JPMorgan gave Caremark free rein, *id.* ¶¶ 267, 274,

allowing it to charge unreasonable prices for prescription drugs, *see id.* ¶¶ 7, 107-08. Caremark's prices are inflated compared to numerous benchmarks, including (1) National Average Drug Acquisition Cost ("NADAC"), *id.* ¶¶ 109-20, 127; (2) retail prices at multiple pharmacies, *id.* ¶¶ 114-25; (3) prices charged by other PBMs, *id.* ¶¶ 175-77; and (4) prices charged to a similar plan by Caremark, *id.* ¶ 207.

The results of these comparisons are staggering: Across 366 generic drugs on the Plan's public formularies for which NADAC data is available, the Plan's prices reflect an average markup of ***211.1%***, meaning that JPMorgan allowed Caremark to charge ***more than three times*** what those drugs actually cost. *Id.* ¶ 112. For 38 generic drugs for which NADAC data is *not* available, the prices are no better: those drugs are widely available at retail pharmacies for tens, hundreds, or thousands less than through the Plan. *Id.* ¶¶ 121-126. And for generic drugs prescribed specifically to the named Plaintiffs, the Plan's prices reflect an even higher markup of ***275.24%***. *Id.* ¶ 127. Contrary to JPMorgan's repeated attempts to downplay the scope of Plaintiffs' pricing analysis, the analysis encompasses all three types of drugs—generic, specialty, and brand—across two separate JPMorgan formularies. *Id.* ¶¶ 112-25 (generics and generic-specialty); ¶ 127 (Plaintiffs' prescriptions); ¶ 128 (brand).

JPMorgan knew better. For over a decade, media and research organizations warned about unmonitored PBMs and detailed the ways they enrich themselves at plan participants' expense. *Id.* ¶¶ 179-200. JPMorgan's own industry trade groups offered recommendations about how to save on drug costs, but JPMorgan failed to take heed. *Id.* ¶¶ 136-46. Indeed, JPMorgan initially formed a venture that was designed to reduce costs and eliminate PBM abuses. *Id.* ¶¶ 148-49, 203. But under pressure from industry stakeholders, including CVS (Caremark's parent company), JPMorgan dissolved the venture, *id.* at ¶¶ 150-57, and failed to take other measures to protect the Plan and its participants. *Id.* ¶ 170. As a result, JPMorgan maintained lucrative financial ties with

CVS and Caremark, *id.* ¶¶ 165–66, and other major industry players, *id.* ¶¶ 160–64, 167-68, but the Plan and its participants kept paying excessive drug costs.

Plaintiffs allege that JPMorgan breached its fiduciary duties under 29 U.S.C. § 1104 and engaged in prohibited transactions with Caremark in violation of 29 U.S.C. §1106(a). Plaintiffs seek both plan-wide relief under 29 U.S.C. §1132(a)(2) and individual relief under § 1132(a)(3).

ARGUMENT

I. PLAINTIFFS HAVE STANDING TO PURSUE THEIR CLAIMS

To satisfy Article III standing, Plaintiffs must allege: (1) an injury in fact; (2) traceable to defendant's conduct; (3) that would likely be redressed by judicial relief. *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021). JPMorgan does not dispute the traceability and redressability requirements, arguing only that Plaintiffs did not plausibly allege injury in fact. *See* MTD at 7. "Injury in fact is a low threshold," *Ross v. Bank of Am., N.A.*, 524 F.3d 217, 222 (2d Cir. 2008), satisfied by any "nontrivial economic injury," *John v. Whole Foods Mkt. Grp., Inc.*, 858 F.3d 732, 737 (2d Cir. 2017). Both types of alleged injuries here satisfy this requirement: "Overpaying for a product results in a financial loss constituting a particularized and concrete injury in fact," *id.* at 736, and "[a]n increase in premiums would certainly constitute an injury," *AARP v. EEOC*, 226 F.Supp.3d 7, 18 (D.D.C. 2016).

When assessing standing, courts must accept "plaintiffs' allegations as true and assum[e] they would be successful on the merits." *Dubuisson v. Stonebridge Life Ins. Co.*, 887 F.3d 567, 574 (2d Cir. 2018). Courts must also "draw from the pleadings all reasonable inferences in the plaintiff's favor and … presume that general allegations embrace those specific facts that are necessary to support the claim." *John*, 858 F.3d at 737 (alterations omitted). Thus, accepting as true that JPMorgan agreed to unreasonable drug prices, the only question is whether it is plausible—not certain, but plausible—that the overcharges harmed Plaintiffs. The answer is "yes."

A. The Allegations of Higher Out-of-Pocket Costs Support Standing Under 29 U.S.C. § 1132(a)(3)

Plaintiffs have standing to pursue their claims under § 1132(a)(3) based on their out-of-pocket overpayments for prescription drugs—*i.e.*, the specific amounts they allege they were overcharged for their prescriptions. Plaintiffs allege that the amounts they paid were higher than they would have been if JPMorgan had prudently monitored Plan expenses and loyally administered the Plan. *See* Compl. ¶¶ 245-49. For example:

- Stern paid $8.25 of his own money for a drug that cost $2.01. *Id.* ¶ 247.
- Bindner paid $30.00 of her own money for a drug that cost $5.69. *Id.* ¶ 248.
- Schmitt paid $18.34 of her own money for drug that cost $4.30. *Id.* ¶ 249.

Contrary to JPMorgan's arguments, there is nothing "speculative" about these allegations. These are completed financial transactions in documented amounts. Plaintiffs used their own money to make these purchases and specifically identify the amounts they were overcharged. *See id.* ¶¶ 247-49. As in any case alleging that a defendant caused the plaintiff to overpay for goods, these allegations satisfy the injury-in-fact requirement. *See Lewandowski v. Johnson & Johnson*, 2025 WL 288230, at *5 (D.N.J. Jan. 24, 2025) ("It is clear to the Court based on these allegations that Plaintiff has suffered an injury-in-fact that is traceable to Defendants' alleged ERISA violations.");[2] *John*, 858 F.3d at 736.

[2] JPMorgan falsely asserts that the *Lewandowski* court "assumed" injury in fact. MTD at 11 n.13. The court squarely ruled that "[w]hen Plaintiff spent more money on drugs at the pharmacy, which was allegedly the result of Defendants' breach of fiduciary duties, Plaintiff suffered a cognizable injury." *Lewandowski*, 2025 WL 288230, at *5. While the court held that the plaintiff's injuries were not redressable because she hit her out-of-pocket maximum, *id.*, JPMorgan makes no such argument here—nor could it. Plaintiffs did not hit their out-of-pocket maximums. Compl. ¶¶ 250-52.

JPMorgan's other arguments go to the merits and are fully addressed in Part II, *infra*. For example, JPMorgan argues that Plaintiffs did not plausibly allege overpayments. *See* MTD at 12 (arguing Plaintiffs did not plausibly allege "prices were excessive"); *id.* at 13 (disputing whether "drugs purchased by Plaintiffs … would have been … cheaper" absent alleged conduct). For standing purposes, the Court must "accept[] plaintiffs' allegations as true and assum[e] they would be successful on the merits." *Dubuisson*, 887 F.3d at 574. The only question is whether, assuming the existence of the alleged overpayments, Plaintiffs were harmed. They were, as the alleged overpayments came right out of their wallets.

JPMorgan argues that prescription drug pricing is "incredibly complicated," MTD at 12, but that has nothing to do with standing. Even on the merits, plan fiduciaries do not get a free pass just because their job is sometimes challenging. *See Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982) (noting that ERISA's fiduciary obligations are "the highest known to the law"). The facts relevant to Article III injury could not be more straightforward: Plaintiffs purchased prescription drugs under the Plan and allege that they paid more than they would have if JPMorgan had prudently monitored Caremark's prices and acted loyally in administering the Plan. "Plaintiffs (obviously) plead an injury in fact" when they "allege that they were overcharged" for prescription drugs. *Blue Cross & Blue Shield of N.C. v. Rite Aid Corp.*, 519 F.Supp.3d 522, 532 (D. Minn. 2021).

B. The Allegations of Higher Premiums Support Standing Under 29 U.S.C. §§ 1132(a)(2) and (a)(3)

Plaintiffs also have standing based on inflated premium contributions resulting from JPMorgan's fiduciary breaches and prohibited transactions. The mechanics are simple: JPMorgan set employee premium contributions each year as a percentage of overall Plan spending, so when the Plan overpaid for prescription drugs by millions of dollars each year, participants necessarily

overpaid too. Compl. ¶¶ 103-35, 227-32. That concrete financial harm gives Plaintiffs standing to seek relief on behalf of the Plan under 29 U.S.C. § 1132(a)(2) and on their own behalf under 29 U.S.C. § 1132(a)(3).

JPMorgan contends that the link between Plan spending and participant premiums is "speculative." MTD at 10. This ignores the Complaint's allegations, JPMorgan's own tax filings, the historical record, and a wealth of empirical research.

The Plan is self-funded, which means that the Plan (not a third-party insurer) paid all covered expenses, including prescription-drug costs. Compl. ¶¶ 224. The fact that ***the Plan*** was responsible for all covered expenses, however, does not mean that ***JPMorgan*** footed the entire bill. Rather, the Plan paid its bills through a trust that was funded by a combination of employer and participant contributions. *Id.* ¶¶ 27, 226. Critically, JPMorgan set participant contributions as a fixed percentage of the Plan's projected expenses. Specifically, JPMorgan "intentionally set employee contributions at amounts they projected would result in employees contributing premiums equal to 30% of overall Plan healthcare costs, with JPMorgan contributing the remaining 70%." *Id.* ¶ 228; *see id.* ¶¶ 227-33. Accordingly, the higher the projected Plan costs, the more participants had to pay to cover their share. *Id.* ¶ 227.

JPMorgan does not dispute that it set participant premiums in a way that left participants partially on the hook for Plan overpayments. Indeed, its own tax filing confirms that "Participant contributions … are determined based on the projected total annual Plan costs." *Id.* ¶ 227. In any event, the Complaint includes historical data showing that participant contributions were almost exactly 30% each year, reflecting JPMorgan's use of a percentage-based methodology and 30%

target, with any "minor variation [] due to forecasting error." *Id.* ¶ 228; *see id.* ¶ 229 (listing percentages each year).[3]

In 2021, for example, JPMorgan required participants to pay 30% of total Plan expenses, with JPMorgan covering the remaining 70%. *Id*. ¶ 229. If JPMorgan had acted prudently and reduced prescription drug costs by $100 million, participants' 30% share would have been $30 million less, or $222 less per participant. Plaintiffs have therefore plausibly alleged Article III injury. *See, e.g., In re Ins. Brokerage Antitrust Litig.*, 579 F.3d 241, 275 (3d Cir. 2009) ("Because the plaintiffs … suffered economic harm in the form of higher premiums …, [they] have standing."); *City of Columbus v. Trump*, 453 F.Supp.3d 770, 787 (D. Md. 2020) (an "increase in premiums constitutes economic harm and is therefore 'a classic and paradigmatic form of injury in fact.'"); *AARP*, 226 F.Supp.3d at 18.[4]

Indeed, the Complaint cites government studies and independent research confirming the link between higher drug costs and higher employee premiums.

- The Federal Trade Commission found that inflated drug costs "result in higher premiums" for recipients of employer-provided insurance. Compl. ¶ 235.
- The Center for American Progress found that inflated drug prices "ultimately raise[] costs for consumers through higher cost sharing and premiums." *Id*. ¶ 236.
- The Peterson Center on Healthcare states that "Prescription drugs are one of the leading contributors to health spending growth," and that "growth in prescription drug spending may have a relatively large effect on employer-sponsored health insurance premiums." *Id*. ¶ 239.

[3] The participant contribution percentage was slightly higher in 2020, reflecting the COVID-19 pandemic's unanticipated effects on healthcare spending, as JPMorgan's own analysis confirms. *Id.* ¶ 230. Omitting the 2020 COVID year, the average employee contribution was 30.75%, with a standard deviation of just 0.87%. *Id.* ¶ 231.

[4] Even cases dismissing complaints on standing grounds have acknowledged that plaintiffs would satisfy injury-in-fact if they plausibly alleged (like Plaintiffs here) that "employee contributions are calculated as a *pro rata* share of the total benefits cost." *Winsor v. Sequoia Benefits & Ins. Servs., LLC*, 62 F.4th 517, 525 (9th Cir. 2023).

- RAND Corporation found that "[h]igher drug spending will, holding all else constant, lead to higher premiums." *Id*. ¶ 240.

RAND also found that "[t]he employer share of the premium remained steady at 82-83 percent per year" even as healthcare expenses increased. *Id.* This aligns with JPMorgan's practice of maintaining employee contributions steady at approximately 30% per year. The only difference is that JPMorgan required its employees to pay a *greater* share of total premiums (30%) than the average employer (17-18%).

JPMorgan claims that "[c]ourts have repeatedly held that these types of cost-saving assertions are far too speculative to satisfy this requirement," MTD at 10, but its cases are distinguishable. In two cases, the plaintiffs did not allege they paid *any* premiums, much less premiums tied to plan spending. *See Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450, 452 (3d Cir. 2003) ("The [employer] pays all premiums … and does not make any specific healthcare deductions from employees' paychecks."); *Gonzalez de Fuente v. Preferred Home Care of N.Y. LLC*, 2020 WL 5994957 (E.D.N.Y. Oct. 9, 2020) (no allegation that employees paid premiums). In *Glanton v. AdvancePCS, Inc.*, 465 F.3d 1123 (9th Cir. 2006), the problem was redressability rather than injury, as the plaintiffs sued a third-party service provider rather than the plan sponsor. *Id.* at 1125. And JPMorgan's citation to *Loren v. Blue Cross & Blue Shield of Mich.*, 505 F.3d 598 (6th Cir. 2007), supports *Plaintiffs'* position because the court acknowledged that the plaintiffs would have alleged injury-in-fact if—like Plaintiffs here—they "paid percentage contributions." *Id.* at 608.

The *Knudsen* case is distinguishable for similar reasons. That case involved windfall income to the plan in form of "rebates." *Knudsen v. MetLife Grp., Inc.*, 117 F.4th 570, 574-75 (3d Cir. 2024). The plaintiffs did not allege that "rebate" money had *ever* been used in setting participant premiums, so they could only speculate about how the plan would have used such

funds. *Knudsen*, 117 F.4th at 581-82 & n.91. Here, in contrast, Plaintiffs plausibly allege that JPMorgan consistently set participant contributions as a percentage of Plan expenses.[5]

Unable to deny that participant contributions rose and fell in lockstep with overall Plan spending, JPMorgan resorts to speculation. Citing its discretion over participant contribution levels, JPMorgan contends that in a counterfactual world in which it acted prudently and reduced the Plan's drug spending, it might have *changed* the annual participant contribution percentage from its real-world level, leaving the dollar amount of Plaintiffs' annual contributions the same despite overall Plan savings. MTD at 10-11 (speculating that "savings could have been used for any number of things").

This self-serving speculation is irrelevant to the injury-in-fact analysis. While JPMorgan is right that it "can set the contribution levels wherever it wishes before each plan year begins," MTD at 11 n.12, that doesn't mean it gets a do-over on the choices it actually made. In assessing the "but-for" world in which a defendant did not engage in unlawful conduct, "the but-for scenario differs from what actually happened *only with respect to the harmful act*." Fed. Judicial Center, Reference Guide on Estimation of Econ. Damages, REFERENCE MANUAL ON SCIENTIFIC EVID. 432 (3d ed. 2011) (emphasis added). The "actual real world conditions during the entire damages period" are held constant, "with the only fantastical element being that the unlawful conduct did not occur." *ICTSI Or., Inc. v. Int'l Longshore & Warehouse Union*, 2022 WL 16924139, at *9 (D.

[5] In the portion of the *Lewandowski* decision regarding increased premiums, the court failed to fully credit the plaintiff's allegations linking overall plan spending to employee contributions. 2025 WL 288230, at *4 (citing paragraphs 190 and 194 of the operative complaint but not addressing paragraphs 191-93, which contained the key factual allegations regarding the employer's contribution methodology). Regardless, no final judgment was entered in *Lewandowski*, the plaintiffs recently filed a Second Amended Complaint, and the defendant's renewed motion to dismiss remains unresolved.

Or. Nov. 14, 2022). Thus, the real-world contribution percentage that JPMorgan selected remains the same.

This is a well-established principle under ERISA. For example, when a fiduciary imprudently invests plan assets, the measure of loss is the difference between "what the Plan actually earned on the [imprudent] investment [and] what the Plan would have earned had the funds been available for other Plan purposes." *Donovan v. Bierwirth*, 754 F.2d 1049, 1056 (2d Cir. 1985). In determining "what the Plan would have earned," courts do not speculate but instead "presume that the funds would have been treated like other funds being invested during the same period." *Id.* If the rule were different, every ERISA defendant could speculate away its liability by asserting that it would have spent the savings on something else, depriving harmed plan participants of ERISA's protections. JPMorgan cannot escape its real-world decision about contribution percentages, especially at the pleading stage, where the Court must "draw all reasonable inferences in [Plaintiffs'] favor." *John*, 858 F.3d at 737.

In all events, even if Plaintiffs needed to rebut JPMorgan's speculation, the Complaint does so. Plaintiffs allege that JPMorgan "would have maintained the same static split of employee and employer contributions" even "[i]f the Plan's costs were higher or lower in any given year." Compl. ¶ 228. This allegation is supported by specific facts showing JPMorgan's 70-30 contribution split was not dependent on the overall level of Plan spending. In 2015, when Plan spending was $12,311 per-participant, JPMorgan required participants to pay 30.93%. *Id.* ¶ 229. In 2022, when spending was substantially higher—$15,685 per participant—JPMorgan made participants pay essentially the same percentage, 30.85%. *Id.* We therefore already know whether JPMorgan would have kept the same split if overall spending were substantially lower, because overall spending ***was*** substantially lower several years ago, and JPMorgan had the same split. At

the pleading stage, with all inferences drawn in Plaintiffs' favor, there is no reason to indulge JPMorgan's self-serving speculation to the contrary.

C. JPMorgan Mischaracterizes Plaintiffs' Claims in Arguing that Plaintiffs Are Not Entitled to Additional "Benefits"

JPMorgan argues that Plaintiffs "receive[d] all benefits they were promised." MTD at 8. This is irrelevant. Plaintiffs are not bringing an action under 29 U.S.C. § 1132(a)(1)(B) "to recover benefits due to [plaintiffs] under the terms of [the] plan." Rather, Plaintiffs bring claims under 29 U.S.C. §§ 1132(a)(2) and (a)(3) seeking to address fiduciary breaches and prohibited transactions.

Even when a plan provides all promised benefits, ERISA requires fiduciaries to monitor expenses and not waste money in providing those benefits. *See id.* § 1104(a)(1)(A)(ii); *infra* at § II.B.1. In *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585 (8th Cir. 2009), for example, Wal-Mart promised its 401(k) plan participants an assortment of investment options. Even though the plaintiff received access to those investment options, he stated a claim by alleging that the plan fiduciaries agreed to "significantly higher fees" on those investments than necessary. *Id.* at 595; *accord Sacerdote*, 9 F.4th at 109 (plaintiffs stated claim by alleging that "63 of the funds included in the 103-fund and 84-fund Plans charged excessive [] fees"); *Hughes*, 595 U.S. at 176 (plaintiff stated claim where available funds were allegedly overpriced). This case is no different: Plaintiffs received access to promised prescription drugs, but JPMorgan imprudently made Plaintiffs pay "substantially more" for them than necessary. Compl. ¶ 170.

This case is nothing like *Thole v. U.S. Bank N.A.*, 590 U.S. 538 (2020). The plaintiffs in *Thole* paid no monthly premium or out-of-pocket costs and received "a fixed payment each month" that did "not fluctuate with the value of the plan or because of the plan fiduciaries' good or bad investment decisions." *Id.* at 540. They *conceded* that they did not allege "any monetary injury." *Id.* The Supreme Court straightforwardly held that "[t]here is no ERISA exception to Article III"

and that plaintiffs failed to allege a personal stake in the lawsuit. *Id.* at 547. Here, in contrast, Plaintiffs allege specific monetary injuries—they paid inflated premiums and inflated out-of-pocket costs for prescription drugs. Courts routinely recognize such monetary harms as sufficient for Article III standing and reject similar "attempts to fit these facts to *Thole*." *Acosta v. Bd. of Trs. of Unite Here Health*, 2023 WL 2744556, at *3 (N.D. Ill. Mar. 31, 2023). As JPMorgan acknowledges, MTD at 9 n.11, its own authorities reject the argument that *Thole* precludes "a participant in a self-funded healthcare plan [from] bring[ing] an ERISA suit alleging that mismanagement of plan assets increased his/her out-of-pocket expenses." *Knudsen*, 117 F.4th at 579.

II. PLAINTIFFS STATE PLAUSIBLE CLAIMS UNDER ERISA

Plaintiffs' extensive allegations are more than sufficient to state plausible ERISA claims.

A. Plaintiffs Assert Plausible Prohibited Transaction Claims

JPMorgan's argument that Plaintiffs' prohibited transaction claims under 29 U.S.C. § 1106(a) are "conclusory" (MTD at 26) is foreclosed by the plain text of the statute and the Supreme Court's recent decision in *Cunningham*.

Section 1106 flatly "prohibits ERISA plan fiduciaries from causing a plan to enter into certain transactions with parties in interest," *Cunningham*, 145 S.Ct. at 1024, which include any entity "providing services to [the] plan," *id.* at 1025 (citing 29 U.S.C. § 1002(14)). In *Cunningham*, the Court held that a plaintiff need only plead the bare fact of such a transaction; it is not necessary to plead the absence of affirmative defenses to a prohibited-transaction claim. *Id.* at 1024.[6] As the

[6] For example, § 1106 claims are subject to a defense under § 1108 that "no more than reasonable compensation is paid," *id*. at 1025, but "Plaintiffs are not required to plead … that the … § 1108 exemption[] pose[s] no barrier to ultimate relief." *Id.* at 1032. In any event, Plaintiffs allege that "[t]he compensation that [JPMorgan] agreed to pay Caremark was not reasonable." Compl. ¶ 290; *see id.* ¶¶ 282-83, 291.

Court explained, "Section 1106(a)(1)(C) contains [just] three elements … (1) 'caus[ing a] plan to engage in a transaction' (2) that the fiduciary 'knows or should know ... constitutes a direct or indirect ... furnishing of goods, services, or facilities' (3) 'between the plan and a party in interest.'" *Cunningham*, 145 S.Ct. at 1027.

Plaintiffs allege all three elements: (1) JPMorgan "entered into and/or renewed a contract with Caremark," Compl ¶ 104, and "repeatedly ma[d]e excessive payments to Caremark," *id.* ¶ 280; (2) JPMorgan "caused the Plan to engage in transactions that [it] knew or should have known constituted … a furnishing of services between the Plan and Caremark prohibited by 29 U.S.C. § 1106(a)(1)(C)," *id.* ¶¶ 280, 288; and (3) "[a]s a service provider to the Plan, Caremark is a party in interest." id. ¶¶ 279, 287 (citing 29 U.S.C. § 1002(14)(B)).[7] Nothing more is required. *Cunningham*, 145 S.Ct. at 1027-28.

JPMorgan's argument (MTD at 26-27) that Plaintiffs did not sufficiently plead these elements is meritless. JPMorgan argues that Plaintiffs did not allege under § 1106(a)(1)(C) that Caremark "engage[d] in the 'furnishing of goods, services, or facilities'" to the Plan. MTD at 27. But the Complaint extensively alleges that Caremark furnished PBM services to the Plan, *see, e.g.*, Compl. ¶¶ 5, 17, 50, 279-81, 287-89, and the Plan's Form 5500 filings expressly identify Caremark as a "service provider." Declaration of Kai Richter, Ex. 1 at 2. JPMorgan also argues that Plaintiffs did not allege that Plan "assets" were "transferred" to Caremark under § 1106(a)(1)(D), but all funds held by the Trust are "assets of the Plan," Compl. ¶ 27, and the Complaint plainly alleges that Trust funds were transferred to Caremark in exchange for goods and services, *see e.g.*, *id.*

[7] The services provided by Caremark include negotiating with pharmacies to establish pharmacy networks where plan participants can obtain prescription drugs; helping manage plans' formularies; processing participants' claims in real-time; and contracting with drug manufacturers. *Id.* ¶ 50.

¶¶ 17, 27.[8] Finally, JPMorgan implies that § 1106(a)(1)(A) covers only "real property or stock," MTD at 26, but the text says "*any* property," 29 U.S.C. § 1106(a)(1)(A) (emphasis added), and "[m]oney is certainly property," *Pirie v. Chicago Title & Tr. Co.*, 182 U.S. 438, 443 (1901).

B. Plaintiffs Assert Plausible Breach of Fiduciary Duty Claims

Plaintiffs also plead plausible breach of fiduciary duty claims. Their allegations go far beyond the "short and plain statement" required to state a claim. *See* Fed. R. Civ. P. 8(a)(2).

1. Monitoring Plan Expenses and Service Providers Is a Fundamental Fiduciary Role

ERISA requires that fiduciaries act "solely in the interest of the participants and beneficiaries … for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying ***reasonable*** expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A) (emphasis added). In addition, fiduciaries must act "with the care, skill, prudence, and diligence" that a prudent person would exercise in similar circumstances. 29 U.S.C. § 1104(a)(1)(B). These duties are considered "the highest known to the law." *Donovan*, 680 F.2d 263 at 272 n.8.

In carrying out these duties, it is essential to prudently select and monitor plan service providers and ensure that expenses are reasonable. As the Department of Labor's Fiduciary Handbook makes clear, "[h]iring a service provider … is a fiduciary function," and "the plan's fees and expenses should be monitored to determine whether they continue to be reasonable." U.S. Dep't of Labor, MEETING YOUR FIDUCIARY RESPONSIBILITIES at 5-6 (Sept. 2021).[9] Courts have consistently recognized these responsibilities. *See, e.g., Beck v. PACE Int'l Union*, 551 U.S. 96,

[8] Although JPMorgan asserts (wrongly) that Caremark provides services to the company instead of the Plan, it does not dispute that payment for those services comes from trust (i.e., Plan) assets.

[9] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/meeting-your-fiduciary-responsibilities-booklet-2021.pdf.

102 (2007) ("ERISA imposed on [defendant] a fiduciary obligation in its selection of an appropriate [service] provider."); *Hughes v. Nw. Univ.,* 63 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."); *Tibble v. Edison Int'l*, 843 F.3d 1187, 1198 (9th Cir. 2016) (en banc) ("Wasting beneficiaries' money is imprudent …. trustees are obliged to minimize costs."); *Carrigan v. Xerox Corp.,* 2022 WL 1137230, *5 (D. Conn. Apr. 18, 2022) ("[A] plan fiduciary's duty of prudence incorporates an ongoing duty to monitor ... fees, in order to be cost-conscious."); *Liss v. Smith*, 991 F.Supp.278, 300 (S.D.N.Y. 1998) ("Failure to utilize due care in selecting and monitoring a fund's service providers constitutes a breach of a trustee's fiduciary duty."); *accord* Restatement (Third) of Trusts § 88 cmt. a (2007) ("Implicit in a trustee's fiduciary duties is a duty to be cost conscious."); 29 C.F.R. § 2550.404c-1(d)(2)(iv) (noting fiduciary "duty to prudently select and monitor any service provider").

Mahoney v. J.J. Weiser & Co., Inc., 564 F.Supp.2d 248 (S.D.N.Y. 2008), is instructive. There, the court ruled that "a fiduciary has 'an ongoing obligation to monitor the ... services provided by service providers with whom [it has] an agreement, to ensure that renewal of such agreements is in the best interest' of the plan." *Id*. at 255-56. Thus, while "[t]he decision of the [defendant] to offer supplemental health insurance was a settlor function," "the determinations to retain [the service providers], and the subsequent decisions to maintain and renew those relationships, were subject to ERISA fiduciary oversight." *Id*. at 256; *accord Bowers v. Russell*, 2025 WL 1474307, at *6 (D. Mass. Mar. 26, 2025); *Rodriguez v. Intuit, Inc*., 744 F.Supp.3d 935, 943 (N.D. Cal. 2024); *Abraha v. Colonial Parking, Inc.*, 243 F.Supp.3d 179, 187 (D.D.C. 2017); *Perez v. Chimes Dist. Of Columbia, Inc.*, 2016 WL 5815443, at *10-11 (D. Md. Oct. 5, 2016) (all recognizing distinction between "settlor" functions and fiduciary functions relating to monitoring service providers and fees). The same logic applies here.

JPMorgan attempts to sidestep these well-established duties by contending that "the choice of a formulary" and "the terms … at which benefits were offered" are "not fiduciary in nature." MTD at 13-14. This argument is a straw man. Plaintiffs do not allege that JPMorgan breached its fiduciary duties by adopting the Plan's formulary, setting employee contributions at 30% of total Plan spending, or requiring employee cost-sharing for drugs. (Compl. ¶¶ 30, 86-87).[10] Rather, Plaintiffs allege that, *given the benefit design JPMorgan chose to adopt*, it had an ongoing duty to monitor Caremark to ensure that costs were reasonable. *Id.* ¶¶ 2, 9, 18-19, 35-36.

JPMorgan's cases are distinguishable for the same reason. The only one that even mentions the duty to monitor is *Doe One v. CVS Pharmacy, Inc.*, 348 F.Supp.3d 967 (N.D. Cal. 2018), but it does so only to hold that the plaintiffs did not allege such a claim and instead challenged only the defendant's "agreement to provide a benefit plan." *Id.* at 1001-02. There were no allegations of excessive fees or that plan fiduciaries had agreed to unreasonable prices. *Id.* at 976-77. The other cases JPMorgan cites are likewise distinguishable. In *Argay v. Nat'l Grid USA Serv. Co., Inc.*, 503 Fed. App'x. 40 (2d Cir. 2012), the plaintiffs' claims arose from "Defendants' decision to amend Plaintiffs' … life insurance plan," which all agree is a non-fiduciary function. In *Moeckel v. Caremark, Inc.*, 622 F.Supp.2d 663 (M.D. Tenn. Nov. 13, 2017), and *Mulder v. PCS Health Sys., Inc.*, 432 F.Supp.2d 450 (D.N.J. 2006), the plaintiffs asserted fiduciary duty claims against service providers, not plan sponsors. Finally, *Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183 (10th Cir. 2023), is even further afield: it is a preemption case against Oklahoma's insurance commissioner that has nothing to do with fiduciary duties.

[10] JPMorgan claims there is no deductible and that preventative drugs are provided at no out-of-pocket expense. *See* MTD at 5. However, it does not dispute that participants foot some out-of-pocket drug costs and does not dispute that Plaintiffs paid some or all of the cost of drugs they purchased. *See* Compl. ¶¶ 247-49.

2. JPMorgan Failed to Prudently Monitor Expenses and the Plan's PBM

a. Plaintiffs' Cost Comparisons Strongly Support an Inference of a Fiduciary Breach

Plaintiffs plausibly allege that JPMorgan breached its duty to monitor Caremark and the Plan's expenses by allowing Caremark to charge excessive drug prices:

- Across 366 generic drugs on the Plan's published formularies for which there is a NADAC comparison—including the generics JPMorgan tells its members are "preferred" options—the Plan's prices reflect a markup of 211.1% above pharmacy acquisition cost. Compl. ¶ 112. The markups were sometimes over 5,000% and as high as 38,000% (*id.* ¶¶ 114-20).

- The excessiveness of these prices is confirmed by retail pricing information showing similar discrepancies and confirming that drugs are available for purchase at retail pharmacies for prices at or below NADAC. *Id.* ¶¶ 114-20.

- For the generic drugs on the Plan's published formularies for which NADAC data is not available, information from retail and online pharmacies shows that those drugs were similarly overpriced. *See id.* ¶¶ 121-25.

- Plaintiffs specifically were subject to markups ranging from 39.1% to 703.97% for their own prescriptions, with an average markup of 275.24% (worse than the general average). *Id.* ¶ 127.[11]

Generic Drug Name	Quantity	Pharmacy Acquisition Cost	Price JPMorgan Agreed To Pay	Markup %
[redacted]	30	$2.40	$9.31	**287.43%**
[redacted]	30	$18.35	$29.78	**62.28%**
[redacted]	30	$2.16	$4.96	**129.31%**
[redacted]	30	$4.97	$36.15	**627.22%**
[redacted]	100	$2.74	$4.73	**72.44%**
[redacted]	60	$2.01	$8.25	**309.59%**
[redacted]	90	$5.69	$45.73	**703.97%**
[redacted]	90	$4.30	$18.34	**326.51%**
[redacted]	90	$21.12	$60.26	**185.32%**
[redacted]	30	$1.87	$7.19	**284.49%**
[redacted]	90	$8.44	$11.74	**39.10%**

- The Plan's prices for brand-name drugs do not reflect special discounts that would offset the overcharges on generic drugs. *Id.* ¶ 128.

- JPMorgan squandered its bargaining power and, for many drugs, caused the Plan and its participants to pay more than someone would pay if they walked into a retail pharmacy and filled the same prescription *without* using insurance. *Id.* ¶ 108; *see also id.* ¶¶ 114-20, 122-25.

[11] Drug names shown in ECF 3 (sealed).

- Other PBMs like SmithRx, Navitus, and Capital Rx charge far less than Caremark. *Id.* ¶¶ 175-77.
- Even when compared against the Charter Communications Plan, a similarly sized plan that also uses Caremark as its PBM, the JPMorgan Plan's prices were, on average, 2.4 times higher for the same drugs. *Id*. ¶ 207.

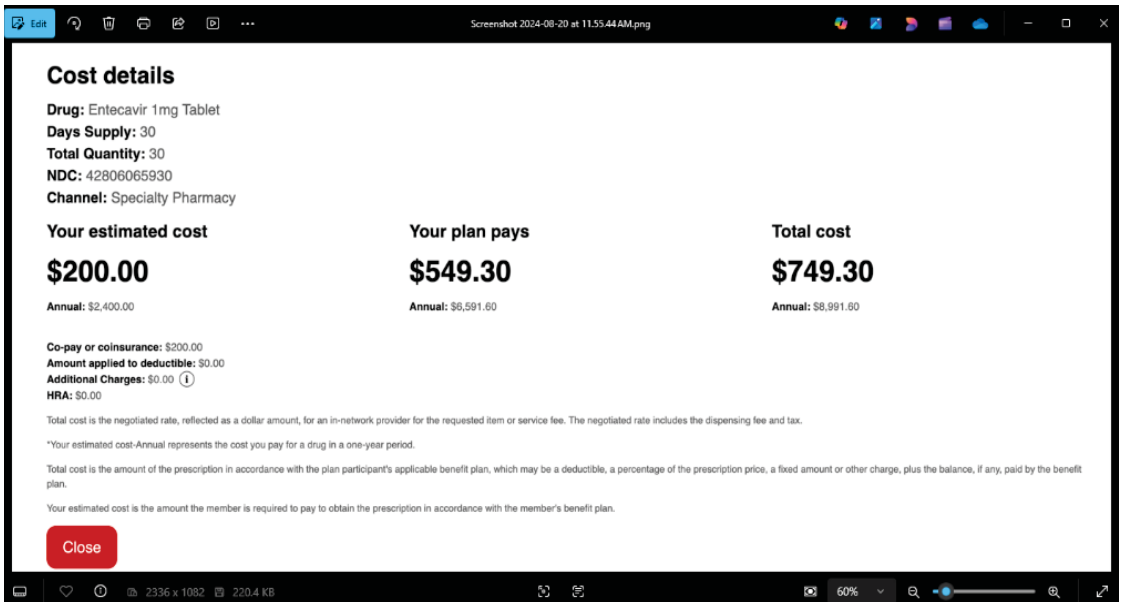
Similar allegations of excessive fees have repeatedly been held sufficient to support an inference of a fiduciary breach. *See, e.g., Sacerdote*, 9 F.4th at 108-10; *In re M&T Bank Corp. ERISA Litig*., 2018 WL 4334807, at *9 (W.D.N.Y. Sept. 11, 2018); *Moreno v. Deutsche Bank Americas Holding Corp*., 2016 WL 5957307, at *6 (S.D.N.Y. Oct. 13, 2016); *Leber v. Citigroup 401(K) Plan Inv. Comm.*, 2014 WL 4851816, at *4 (S.D.N.Y. Sept. 30, 2014).

JPMorgan's attacks on this pricing analysis are baseless. It repeatedly misstates the scope of the analysis, falsely asserting that it encompasses a "tiny sliver" or "narrow slice" of the "thousands" of drugs covered by the plan." MTD at 3, 20, 22, 23. JPMorgan does not identify any other formulary that Plaintiffs could have analyzed, and its repeated assertion that there are "thousands" of missing drugs is without citation, not alleged in the Complaint, and wholly improper. *See Allen v. Westpoint-Pepperell, Inc.*, 945 F.2d 40, 44 (2d Cir. 1991) ("[C]onsideration is limited to facts stated on the face of the complaint [or in incorporated documents]."). Regardless, JPMorgan is not entitled to an inference in its favor that cost comparisons to any other drugs on any other formulary would be any more favorable, *John*, 858 F.3d at 737.

Moreover, even if these unidentified other drugs had more reasonable prices (which there is *zero* reason to believe), that would not excuse the unreasonable prices that JPMorgan allowed Caremark to charge for the drugs analyzed in the Complaint. *See Hughes*, 595 U.S. at 176 (plan fiduciaries who offered unreasonably priced funds could not escape liability by also offering some reasonably priced ones); *Sacerdote*, 9 F.4th at 109 ("Fiduciaries cannot shield themselves from

liability—much less discovery—simply because the alleged imprudence inheres in fewer than all of the fund options."); *DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410, 423 (4th Cir. 2007).

JPMorgan's attempt to cast doubt on the accuracy of the Complaint's pricing allegations (MTD 23 at n.24) is mistaken and only confirms its fiduciary breach. Plaintiffs alleged that JPMorgan agreed to pay $749.30 for a 30-unit supply of Entecavir (1 mg). Compl. ¶ 119. JPMorgan, refusing to accept pleaded facts as true, counters that "the publicly available Plan benefits portal lists a total cost of $206.59." MTD at 23 n.24. But whatever the price is *now*, the price of Entecavir before Plaintiffs filed their Complaint was just as Plaintiffs alleged:



See Decl. of Tyler Haydell ¶ 5. That JPMorgan was apparently able to negotiate a lower price *after* the Complaint brought its imprudence to light only confirms the plausibility of Plaintiffs' allegations that JPMorgan could have obtained lower prices by acting more prudently beforehand.

JPMorgan's attacks on NADAC are equally unfounded. NADAC is a "widely-accepted benchmark" that is "commonly used by other plans." Compl. ¶¶ 110-111. For example, Express Scripts (a traditional PBM like Caremark) offers a "ClearNetwork" product with prices based on

the lowest of three benchmarks, one of which is NADAC. *Id.* ¶ 111. This shows that NADAC is not only a commonly-used benchmark, but a conservative one, as ClearNetwork's prices are based on the *lower* of NADAC and two other benchmarks. *Id.* Similarly, the PBM Capital Rx uses NADAC prices as a benchmark for its prices. *Id.* And, as pled in the Complaint, drugs are available from many pharmacies at prices *below* or roughly equivalent to NADAC averages, *see id.* ¶¶ 115-20, confirming that the 211.1% markup to which JPMorgan agreed was unreasonable. *See Harris v. Mills*, 572 F.3d 66, 72 (2d Cir. 2009) (court may "draw on its … common sense" in assessing plausibility).

At this stage, Plaintiffs' allegations that NADAC is an appropriate benchmark must be taken as true. *In re Omnicom ERISA Litig.*, 2021 WL 3292487, at *13 (S.D.N.Y. Aug. 2, 2021); *see also Krohnengold v. New York Life Ins. Co.*, 2022 WL 3227812, at *8 (S.D.N.Y. Aug. 10, 2022) ("Defendants' challenges to the appropriateness of the comparators selected by Plaintiffs … are premature and best deferred until after discovery"); *Bekker v. Neuberger Berman Inv. Comm.*, 2019 WL 2073953, at *4; (S.D.N.Y. May 9, 2019); *Cunningham v. Cornell Univ.*, 2017 WL 4358769, at *7 (S.D.N.Y. Sept. 29, 2017), *rev'd on other grounds,* 145 S.Ct. 1020 (2025). In any event, JPMorgan's focus on the NADAC allegations overlooks Plaintiffs' other allegations. For example, JPMorgan has no response to the fact that Charter Communications—a similarly sized plan that also uses Caremark as its PBM—pays ***58% less*** than JPMorgan across the 356 generic drugs available under both plans. Compl. ¶ 207. Taken together, Plaintiffs' allegations are more than sufficient to state a claim. *See Kaplan v. Lebanese Canadian Bank, SAL*, 999 F.3d 842, 865 (2d Cir. 2021) (courts must "consider all of the complaint's allegations, rather than considering each in isolation"); *Braden*, 588 F.3d at 598.

JPMorgan notes that Plaintiffs did not purchase *all* of the overpriced drugs. *See* MTD at 23. But there is no question that the Complaint identifies at least one excessively-priced drug for

each Plaintiff, *see* Compl. ¶¶ 247-49, and the scope of the lawsuit is not limited to the drugs they personally purchased. *See Leber v. Citigroup 401(k) Plan Inv. Comm.*, 323 F.R.D. 145, 155 (S.D.N.Y. 2017) ("Plaintiffs have standing to assert all of the claims brought in this action even though they did not invest in each of the Affiliated Funds at issue."); *Falberg v. Goldman Sachs Grp., Inc.*, 2020 WL 3893285, at *8 (S.D.N.Y. July 9, 2020) (cataloging cases and noting that "the majority of courts … both in this district and elsewhere are consistent with *Leber*"). Plaintiffs specifically allege that "[t]he price discrepancies noted [in the Complaint] are illustrative of a pervasive and systematic problem of unreasonable prescription drug charges," Compl. ¶ 8, and the drugs identified in the Complaint are "not the be-all-and-end all of the[ir] claims." *McGowan v. Barnabas Health, Inc.*, 2021 WL 1399870, at *4 (D.N.J. Apr. 13, 2021).

b. Plaintiffs Are Not Required to Allege Details Regarding JPMorgan's Fiduciary Process, But Have Done So Anyway

JPMorgan asserts that it "makes no sense" to infer a fiduciary breach based on "drug-by-drug comparisons" because those comparisons "say nothing about the *process* through which fiduciaries acted." MTD at 23; *see also id.* at 3, 18 (same argument). But it is black-letter ERISA law that no such allegations are required: "Even when the alleged facts do not 'directly address[ ] the process by which the Plan was managed,' a claim alleging a breach of fiduciary duty may still survive a motion to dismiss if the court, based on circumstantial factual allegations, may reasonably 'infer from what is alleged that the process was flawed.'" *Pension Benefit Guar. Corp. ex rel. St. Vincent Cath. Med. Ctrs. Ret. Plan v. Morgan Stanley Inv. Mgmt. Inc.*, 712 F.3d 705, 718 (2d Cir. 2013) ("*PBGC*") (quoting *Braden*, 588 F.3d at 596); *accord Sacerdote*, 9 F.4th at 107 & n.35. Among other reasons, "ERISA plaintiffs generally lack the inside information necessary to make out their claims in detail unless and until discovery commences." *PBGC*, 712 F.3d at 718.

JPMorgan concedes this at one point, *see* MTD at 19 (citing *PBGC*), yet persists in pressing this legally groundless argument.

JPMorgan argues that cost is only "*one* decisionmaking factor," *id.* at 19, but Plaintiffs' price comparisons involve *identical* drugs. The only distinguishing feature is cost, and there is "no corresponding benefit" associated with higher costs. Compl. ¶ 108. In this way, the present case is analogous to cases involving higher-priced share classes of otherwise identical investments, where the Second Circuit has held that price differences support an inference of a fiduciary breach. *See Sacerdote*, 9 F.4th at 109 ("[T]he alleged imprudent choice has nothing to do with the funds' [qualities]; the choice was simply between higher-or lower-cost shares of the same fund."); *accord Lutz v. Kaleida Health*, 2019 WL 3556935, at *5 (W.D.N.Y. Aug. 5, 2019); *In re M&T Bank Corp. ERISA Litig.*, 2018 WL 4334807, at *7; *Cunningham*, 2017 WL 4358769, at *8.

In any event, Plaintiffs ***do*** allege flaws in JPMorgan's process, including that it did not engage in an open request for proposal ("RFP") process for PBM services or survey the marketplace, *see* Compl. ¶¶ 105, 108,[12] as other plan sponsors do, *see id.* ¶¶ 68, 73-74. This further bolsters Plaintiffs' claims. *See George v. Kraft Foods Glob., Inc*., 641 F.3d 786, 799 (7th Cir. 2011) (failure to solicit bids and above-market fees supported fiduciary breach claim); *Vellali v. Yale Univ.*, 308 F.Supp.3d 673, 684-85 (D. Conn. 2018) (denying motion to dismiss where plaintiffs alleged "a decision-making process that was deficient in terms of monitoring, soliciting competitive bids, negotiating, and selecting a reasonably priced recordkeeper, all of which led to the inflated revenue-sharing fees"). And Plaintiffs also allege, among other things, that JPMorgan "allowed [its] selection of a PBM … to be guided or managed by a broker with a conflict of

[12] JPMorgan asserts that JPMorgan "engage[d] in an RFP process," MTD at 18 n.20, but does not dispute the Complaint's allegation that the RFP process was not "open" and "did not consider the full range of available options," Compl. ¶ 105.

interest," Compl. ¶ 106; failed to implement cost-saving recommendations from two organizations of which it is a member, *id.* ¶¶ 136-46; and succumbed to conflicts of interest, *see infra* at § II.B.3.

c. JPMorgan Is Not Insulated from Its Fiduciary Breaches Just Because It Contracted with a Traditional PBM

JPMorgan argues that "the vast majority of health plans use traditional PBM arrangements" (MTD at 19) and use "the 'traditional' spread model." (*id.* at 21). This is not a defense to liability. As a court in this District noted in an analogous context, "[w]hile revenue sharing is a 'common industry practice,' a fiduciary's failure to ensure that 'recordkeepers charged appropriate fees and did not receive overpayments for their services' may be a violation of ERISA." *Sacerdote v. New York Univ.*, 2017 WL 3701482, at *9 (S.D.N.Y. Aug. 25, 2017); *see also Taylor v. United Tech. Corp.*, 2007 WL 2302284, at *4 (D. Conn. Aug. 9, 2007). A fiduciary must act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a ***prudent*** man acting in a like capacity and familiar with such matters would use." 29 U.S.C. § 1104(a)(1)(B) (emphasis added). JPMorgan reads the word "prudent" out of the statute.

The fiduciaries of other plans took several prudent cost-saving measures that JPMorgan failed to take. *See* Compl. ¶¶ 205-20. JPMorgan should have done the same. *See Sweda v. Univ. of Pa.*, 923 F.3d 320, 330-31(3d Cir. 2019) (denying motion to dismiss where plaintiff "offered examples of similarly situated fiduciaries who acted prudently").[13] JPMorgan's own joint venture, Haven Healthcare, highlighted the problems associated with traditional PBMs and counseled against retaining them. Compl. ¶ 203; *see also id.* ¶ 149. And "even setting aside whether prudent and loyal fiduciaries would have contracted with Caremark," *id.* ¶ 171, JPMorgan failed to adequately monitor Caremark to ensure that drug prices were reasonable, *id.* ¶¶ 171-73, 178, as

[13] Plaintiffs' itemization of prudent measures taken by other plan fiduciaries—which JPMorgan mischaracterizes as "Yelp-style reviews" (MTD at 24)—are very similar to the types of allegations in *Sweda*.

evidenced by the fact that the Charter Communications plan—which also uses Caremark—pays so much less, *id.* ¶ 207. The prudent steps that needed to be taken were the subject of numerous published articles and guidance, *see id.* ¶¶ 179-200, and JPMorgan was aware of the necessity of those measures from its own business and trade experience, *see id.* ¶¶ 136-46, 200-04. JPMorgan's do-nothing approach was not prudent and cannot be squared with its fiduciary duties.

3. JPMorgan Failed to Carry Out Its Duties with an "Eye Single" to the Plan and Its Participants

In addition to all of this, Plaintiffs allege that JPMorgan "placed JPMorgan's business interests ahead of … the Plan and its participants" in managing the Plan. Compl. ¶¶ 10, 158. Specifically, JPMorgan was aware of various cost-saving measures that should have been taken, and which JPMorgan initially did pursue, but "abandoned these efforts under pressure from CVS and other banking clients." *Id.* ¶ 147; *see also id.* ¶¶ 148-57. These allegations of self-interested conduct lend strong support for Plaintiffs' claims, and set this case apart from other cases cited by JPMorgan where motions to dismiss have been denied. *See Kohari v. MetLife Grp., Inc.*, 2022 WL 3029328, at *9 (S.D.N.Y. Aug. 1, 2022); *Moreno*, 2016 WL 5957307, at *6. Fiduciary decisions must "be made with an eye single to the interests of the participants and beneficiaries." *Donovan*, 680 F.2d 263 at 271. Plaintiffs explicitly allege that "Defendants did not act with an eye single to the Plan and its participants" here. Compl. ¶ 169.

JPMorgan argues that Plaintiffs' allegations are "irrelevant" and do not permit a plausible inference of disloyalty or imprudence. MTD at 25. But it is wrong. Plaintiffs do not challenge the "dissolution of Haven Healthcare," *id.*, but rather JPMorgan's failure to implement known cost-saving measures *in managing the Plan* on account of JPMorgan's conflicts of interest. This was a fiduciary omission, separate from any "corporate decisionmaking" regarding whether to continue the Haven Healthcare business venture. *See id.*

Although JPMorgan asserts that it would be "illogical" for it to put JPMorgan's investment banking business ahead of the Plan and its participants, *id.*, the Complaint contains well-pled allegations showing that is exactly what happened. After initially expressing an intention to "analyz[e] the company's PBM arrangements" and "significantly overhaul benefit design," Compl. ¶¶ 148-49, JPMorgan received "complaints from healthcare companies," *id.* ¶ 151, specifically including CVS, *id.* ¶¶ 152-53, and backed off, *id.* ¶¶ 154-56. In addition, JPMorgan agreed to steer participants toward a higher-priced biosimilar drug from a CVS Caremark affiliate even though numerous lower-cost options were available. *Id.* ¶¶ 129-35; *cf. Braden*, 588 F.3d at 596 ("The complaint alleges … that these options were chosen to benefit the trustee at the expense of the participants. If these allegations are substantiated, the process by which appellees selected and managed the funds in the Plan would have been tainted by failure of effort, competence, or loyalty.").

In the meantime, JPMorgan preserved its banking relationships with industry insiders, Compl. ¶¶ 158-68, including both CVS and Caremark, for whom it completed numerous transactions during the relevant period, *id.* ¶¶ 165-66. Just **one** of those transactions—the CVS merger with Aetna—was a $69 billion transaction, *id.* ¶ 165, and CVS's acquisition of Caremark was a $21 billion transaction, *id.* ¶ 166. JPMorgan's efforts to minimize these conflicts by saying that JPMorgan's fees totaled "only" $178 million, MTD at 25, is wildly inaccurate: Plaintiffs alleged JPMorgan's fees for only two of the twenty-four specific transactions described, *see* Compl. ¶¶ 161-62, and *those two alone* totaled more than JPMorgan's unexplained "$178 million" figure.

JPMorgan's corresponding assertion that it makes "a billion dollars" in employer contributions to the Plan (MTD at 25) is irrelevant. *See Brotherston v. Putnam Invs., LLC*, 907 F.3d 17, 29 (1st Cir. 2018) ("Because Putnam's discretionary contributions were made in Putnam's

capacity as employer for the benefit of its employees qua employees, they are irrelevant to the analysis. … To hold otherwise would be to allow employers to claw back with their fiduciary hands compensation granted with their employer hands."). And, of course, it would not need to cut such a big check each year if it prudently managed Plan expenses.

It is fanciful for JPMorgan to suggest that "Plaintiffs could make these exact same allegations with respect to *any* plan sponsor that is connected with the healthcare industry." MTD at 26. Plaintiffs' allegations are specific to JPMorgan, and involve not only its financial conflicts of interest (which are significant), but also its abandonment of efforts to police its PBM arrangement and reduce costs. It isn't every day, or every company, where there is evidence like this.

CONCLUSION

For the above reasons, JPMorgan's motion to dismiss should be denied.[14]

Dated: July 25, 2025

Respectfully Submitted,

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[14] In the alternative, Plaintiffs respectfully request leave to replead. *See Ronzani v. Sanofi, S.A.*, 899 F.2d 195, 198 (2d Cir. 1990) ("[T]he usual practice is to grant leave to amend.").

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CERTIFICATE OF COMPLIANCE

I, Michael Eisenkraft, hereby certify that the foregoing Memorandum of Law in Opposition of Defendants' Motion to Dismiss contains 8,742 words, as reported by Microsoft Word, not including those portions of the document that do not count against the word limit.

Dated: July 25, 2025

/s/ Michael Eisenkraft
Michael Eisenkraft