JPMorgan Sued Over Management of Prescription Drug Benefits

By: Abby Blankenship

On March 13, 2025, several current and former participants in the JPMorgan Chase Health Care and Insurance Program for Active Employees, as well as its component Medical Plan (collectively referred to as the "Plan") filed a lawsuit against JPMorgan Chase & Co., JPMorgan Chase Bank, N.A., the JPMorgan Chase U.S. Benefits Executive, the JPMorgan Chase Compensation & Management Development Committee (the "Committee"), and several individual members of the Committee (collectively, the "Defendants"). The plaintiffs allege that the Defendants, as fiduciaries of the Plan, breached their fiduciary duties and engaged in prohibited transactions in violation of the Employee Retirement Income Security Act of 1974 ("ERISA").

The Allegations

The case, Seth Stern v. JPMorgan Chase & Co. et al., specifically alleges the following:

1. **Mismanagement of Prescription Drug Benefits**

The complaint alleges that the Defendants breached their fiduciary duties by agreeing to excessively inflated prescription drug prices, which resulted in significant financial harm to the Plan and its participants/beneficiaries. This harm manifested through higher payments for prescription drugs, increased premiums, higher out-of-pocket costs, elevated deductibles, higher coinsurance, higher copays, and suppressed wages.

The complaint specifically highlights the prices the Plan agreed to pay to one of its vendors, its Pharmacy Benefits Manager ("PBM"), for numerous generic drugs that are widely available at drastically lower prices in the marketplace. One example cited in the complaint is the price disparity for teriflunomide (generic Aubagio, used to treat multiple sclerosis). While individuals could purchase a 30-unit prescription for as little as $11.05 at various pharmacies, the Defendants allowed the Plan and its participants/beneficiaries to pay $6,229 for the same prescription. The complaint asserts that no prudent fiduciary would allow a plan and its participants/beneficiaries to pay over 500 times more than the out-of-pocket cost at a pharmacy for the same prescription.

Additionally, the complaint highlights that the per-prescription price difference (in this case, over $6,000) between a reasonable price for teriflunomide and what the Plan and its participants/beneficiaries pay primarily benefits the Plan's PBM vendor, CVS Caremark ("Caremark"). According to the complaint, this mismanagement extends across the entire Plan, as the Defendants agreed and/or allowed the Plan and its participants/beneficiaries to pay, on average, a markup of over 211% above the acquisition cost pharmacies pay for these same drugs.

Continue next page.

Inside this issue:

2. Failure to Satisfy Fiduciary Duties in Administering Prescription Drug Benefits

The complaint alleges that Defendants failed to meet their fiduciary obligations at multiple stages in the administration of prescription drug benefits under the Plan. Specifically, the Defendants failed to exercise prudence and act in the best interests of Plan participants and beneficiaries when selecting a PBM.

Furthermore, the complaint alleges that the process by which the Defendants selected Caremark as its PBM vendor was not an open RFP process. According to the complaint, the Defendants failed to consider the full range of available PBM options and allowed the selection process to be managed by a broker with a conflict of interest—i.e., a financial interest in steering Defendants toward specific PBMs or including certain provisions in the PBM contract, which were not aligned with the best interests of the Plan and its participants/beneficiaries.

The complaint emphasizes the fact that JP Morgan – a Fortune 500 company – has significant bargaining power to obtain the most favorable terms from third-party vendors.

3. Violation of ERISA's Prohibited Transaction Rules

Generally, many traditional PBMs generate revenue through their ownership of pharmacies. The complaint highlights that Caremark, for example, is "vertically integrated" with CVS Specialty, its mail-order pharmacy. The complaint emphasizes that such vertical integration can create conflicts of interest, potentially leading to actions that do not align with the best interests of the plan and its participants.

Key Takeaways

Although the lawsuit is in its early stages and it is uncertain whether the courts will ultimately rule in favor of the plaintiffs, the claims mentioned throughout the complaint offer important insights for employers to consider.

1. Evaluate Conflicts of Interest with Third-Party Service Providers, Consultants, and Experts
Employers should be diligent in identifying and addressing potential conflicts of interests when working with third-party service providers, consultants, and experts. Employers should require these providers to disclose any potential conflicts before entering into or renewing any contracts with such providers.

2. Conduct a Thorough PBM Selection Process
Employers should maintain a comprehensive, transparent, and well-documented selection process for choosing a PBM provider. Additionally, regularly reassessing PBM contracts can help employers make more informed decisions.

3. Evaluate PBM Recommendations Regularly
Employers should regularly evaluate PBM recommendations. Regularly reviewing, and if necessary, revising the terms of certain PBM contracts can help employers detect and prevent any conflicts of interest or other related issues.

Recent Litigation Emphasizes the Importance of Using Correct COBRA Notices

By: Abby Blankenship

In Marrow v. E.R. Carpenter Co., Inc., a former employee filed a proposed class action lawsuit against her employer, claiming that the company's group health plan failed to provide a proper COBRA election notice. The employee alleged that the notice was deficient in several ways, including: (1) not providing a specific deadline for electing coverage; (2) shortening the election period by giving her 60 days from her termination date rather than 60 days from the date of the notice; (3) providing inconsistent information about the premium amount and due date; (4) failing to identify the qualified beneficiaries entitled to elect COBRA; and (5) not being written clearly enough for the average plan participant to understand.

While the employer sought to dismiss the case, a federal district court in the Middle District of Florida has now ruled that the case may continue. While the employer argued that the employee did not establish an injury that can be traced to the allegedly improper notice, the court concluded that the employee had done enough to establish her claims at this stage. The court also ruled that the "good faith" standard no longer applies to employer distribution of effective COBRA notices, emphasizing that the notice must meet specific legal standards established by the Department of Labor regulations.

Employers can always download the most recent model COBRA notices formulated by the U.S. Department of Labor at its website here: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra

Continue next page.

Artificial Intelligence in the Health And Welfare Space: Opportunities and Considerations for Employers

By: Kate Belyayeva

Artificial intelligence (also commonly referred to as "AI") is rapidly reshaping industries, and the health and welfare space is no exception. As employers seek innovative ways to improve the administration of health and welfare plans, AI could be a potential tool to optimize operations and reduce costs, but the adoption of AI comes with challenges and ethical considerations, particularly in the areas of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Employee Retirement Income Security Act of 1974 ("ERISA") as well as the fiduciary responsibilities thereunder.

AI in Health and Welfare

In sum, AI is the simulation of human intelligence by computer systems. In the context of health and welfare plans, AI is most frequently utilized to: (i) automate administrative processes (*i.e.*, claims adjudication, billing, and eligibility verification); (ii) improve participant engagement through virtual 24/7 assistance; (iii) improve decision-making via data sets and prediction of patterns; and (iv) fraud detection. By way of automation of routine tasks, AI streamlines plan administration greatly and can reduce administrative costs by up to 30%. Employee experience can be also enhanced through AI-powered virtual assistance and decrease wait-time in appointment scheduling and claim statuses. Analysis of claims or social data can identify high-risk employees and use these insights for more targeted programs and pricing. For example, AI can spot anomalies in claims data and flag potential failures to ensure compliance. Language processing tools could also simplify plan document generation.

However, while the advantages of AI are compelling, there certain challenges and risks that employers must consider. Some of the top drawbacks are the data security and privacy concerns. Employers should be especially wary of the privacy and security rules within HIPAA, ERISA, and the emerging AI laws. In order for data analyses to be more accurate, AI requires access to large datasets. Generally, health data is highly sensitive, and the protective measures with regard to AI systems are unlikely to be sufficient, which makes HIPAA compliance critical. In addition, if the data is not desensitized of bias, AI systems may enforce disparities in healthcare and thus result in inequitable plan outcomes. Maintenance of AI is also quiet complex and expensive; thus, it could be inaccessible to small or mid-sized employers.

Most importantly, the legal framework around AI in healthcare is not entirely clear. The legislation around the use of AI in healthcare is still developing; however, in Compliance Assistance Release No. 2024-01, the Department of Labor's Employee Benefits Security Administration confirmed that its cybersecurity guidance applies to all employee benefit plans.

The courts are just starting to address the issue. For example, in *Kisting-Leung v. CIGNA, Corp.,* the District Court for the Eastern District of California dismissed the participants' ERISA claims involving wrongful benefit denials using AI-based algorithm called PxDx and failure of disclose the use thereof due to standing, but allowed certain fiduciary claims to proceed. With regard to the latter, the participants argued that the insurer's use of AI contradicted the health plan terms, which required medical necessity review by a medical director, and California law, which requires claims to be reviewed by a licensed health professional (see the Physicians Make Decisions Act). Furthermore, some legislatures are beginning to enact laws prohibiting algorithmic discrimination in AI (*e.g.*, Colorado Artificial Intelligence Act) while others require disclosure to customers when companies use chatbots for client interaction.

Employer Impact

While AI can help us manage complexity in health and welfare plans, employers should anticipatorily set certain guidelines to minimize risk. First and foremost, human oversight is still a crucial part of responsible AI integration. Regular reviews and internal audits are highly recommended. Fiduciary responsibilities under ERISA include the selection and oversight of third-party vendors. As such, employers should carefully vet vendors and only choose AI systems with a strong record in healthcare. Adequate protections can be accomplished by specific language in the service agreements with vendors regarding AI use (or misuse). Given the complexity of AI, employees should be trained accordingly to mitigate the risks, including health data access. Consistency with data governance policies and security protocols goes a long way. As part of HIPAA compliance, employers must ensure that proper Business Associate Agreements ("BAAs") with vendors supplying AI systems are in place.

Conclusion

Although it is unlikely that AI will entirely replace human oversight (though it is possible), its role in health and welfare plans is expected to expand. Employers must strike a balance between embracing innovation and upholding compliance obligations. Employers who correctly utilize AI systems will benefit significantly so long as they are capable of safeguarding the interests of their workforce.

Continue next page.

Compliance Corner: Understanding the Summary of Benefits and Coverage: A Primer for Employers

By: Kate Belyayeva

The Affordable Care Act (ACA) mandates that all group health plans and insurance companies provide individuals a "summary of benefits and coverage" (SBC) that outlines the key features and coverage under the plan. This month's Compliance Corner gives an overview of what the SBC is, why it matters, and how employers can ensure compliance with regulations.

Overview of the SBC

The SBC is a standardized document that outlines a health plan's expenses, benefits, covered services, exclusions, and other key features. It is designed to help individuals evaluate, compare, and select the coverage that best meets their needs. In addition to the SBC, group health plans and health insurance companies are also required to provide a Uniform Glossary that defines common medical and insurance-related terms.

Health plans that are subject to the SBC requirement include: (1) Fully-insured plans, such as traditional group health plans; (2) Self-insured plans, including certain types of health reimbursement arrangements (HRAs); (3) Individual health plans purchased through public or private health exchanges; and (4) Grandfathered plans, which are individual health plans purchased before the ACA was enacted in 2010.

However, under the ACA, plans covering excepted benefits are exempt from this requirement.

Key Features of the SBC

The document is required to be clear and concise, typically using plain language and standardized templates to ensure uniformity across all plans. The Department of Labor offers an SBC template on its website that employers can download and customize with the specific terms of their plan.

Specifically, the SBC must include the following:

1. The Uniform Glossary of standard health insurance and medical terms as it relates to coverage, so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
2. A description of the coverage for each benefit category;
3. Cost-sharing amounts, including deductible, coinsurance, and copayment obligations;
4. Limited and excluded services under the plan;
5. The renewability and continuation of coverage provisions;
6. Common medical situations and how cost-sharing, limitations, and exclusions function in the scenarios under the plan;
7. A statement about whether the plan meets ACA requirements regarding minimum essential coverage (MEC) and minimum value standards;
8. A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;
9. Contact information for questions;
10. The plan participant's rights regarding how to process to file grievances and appeals;
11. For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;
12. For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
13. For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and
14. An Internet address for obtaining the Uniform Glossary, as well as a contact phone number to obtain a paper copy of the Uniform Glossary, and a disclosure that paper copies are available.

Additionally, all English copies of the SBC must include a statement with contact information regarding accessing the notices in other languages.

Continue next page.

When and How Should Employers Provide the SBC?

Generally, employers must provide the SBC in specific situations:

1. **Enrollment**: Employees should receive the SBC when they first enroll in a health plan, whether through open enrollment or a special enrollment period.

2. **Annually**: The SBC must be provided annually to all employees, and is usually included as part of the annual notice packet employers provide to all employees.

3. **Upon Request**: Employees may request an SBC at any time, and employers are required to provide it within a reasonable timeframe.

4. **When Coverage Changes**: If there are significant changes to the plan (e.g., changes in cost-sharing, covered benefits, etc.), the SBC must be updated and provided to employees. Additionally, the document must be delivered in a way that employees can easily access and understand it. This can include handing out physical copies, providing it electronically, or offering access through an online benefits portal.

Conclusion

The SBC is an essential tool for both employers and employees. By providing clear, standardized information about health insurance plans, the SBC helps employees make informed decisions and ensures that employers remain compliant with federal regulations. Employers should review their SBC documents regularly, ensure they are distributed properly, and stay updated on any changes to the ACA's requirements to avoid potential penalties.

STAY IN THE KNOW…

- According to a Mercer survey, total health benefit costs per employee are projected to increase by an average of 5.8% in 2025. There are a few potential factors that contributed to this rise, such as escalating drug and PBM regulations. Smaller plans have been hit the hardest.

- On March 29, 2025, the Department of Homeland Security sent letters to employers affected by the agency's decision to terminate categorical parole programs for aliens working in the U.S. who are nationals of Cuba, Haiti, Nicaragua, and Venezuela, including their immediate family members. The immigration parole will end on the earlier of the individual's original parole ending date or April 24, 2025, an action that will require these individuals to leave the U.S. on or before the ending date.

- A pair of recent rulings in a Texas District Court, *Spence v. American Airlines, Inc.*, and *Utah v. Micone*, offer contrasting perspectives on the legal implications of employers incorporating environmental, social, and governance ("ESG") factors into retirement plan investing. Employers should closely monitor these developments, as they may signal the emergence of a clearer judicial framework surrounding ESG considerations in investment decisions and, if the decisions are upheld on appeal or adopted by other courts, these rulings could prompt a reevaluation of how investment decisions, particularly those involving ESG factors, are managed within benefit plans, potentially leading to widespread changes in fiduciary practices.

This Month's Contributors

Kate Belyayeva
Associate | kbelyayeva@maynardnexsen.com | 205.488.3597

Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her practice is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.

Abby Blankenship
Associate | ablankenship@maynardnexesen.com | 205.488.3607

Abby is an Associate in Maynard Nexsen's Employee Benefits & Executive Compensation practice group. Abby is experienced in advising public and private companies on various aspects of corporate and tax law, including mergers & acquisitions, private equity & venture capital, antitrust & trade regulation, and healthcare, franchise, and name, image & likeness (NIL) matters.

Matt Stiles
Shareholder | mstiles@maynardnexesen.com | 205.254.1071

Matt has over twenty years of experience representing employers in all facets of the employment relationship, including employee benefits and executive compensation, trade secrets and restrictive covenants, SCA and federal contract employer compliance, PEO, and staffing industry law. Matt regularly advises employers and benefits consultants in strategic benefit plan design, implementation, and compliance. He has extensive experience counseling employers involved in federaland state agency investigations.