



Navigating the Next Wave of ERISA Risk: PBM Reform and Benefit Plan Litigation Trends

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Seyfarth Shaw LLP

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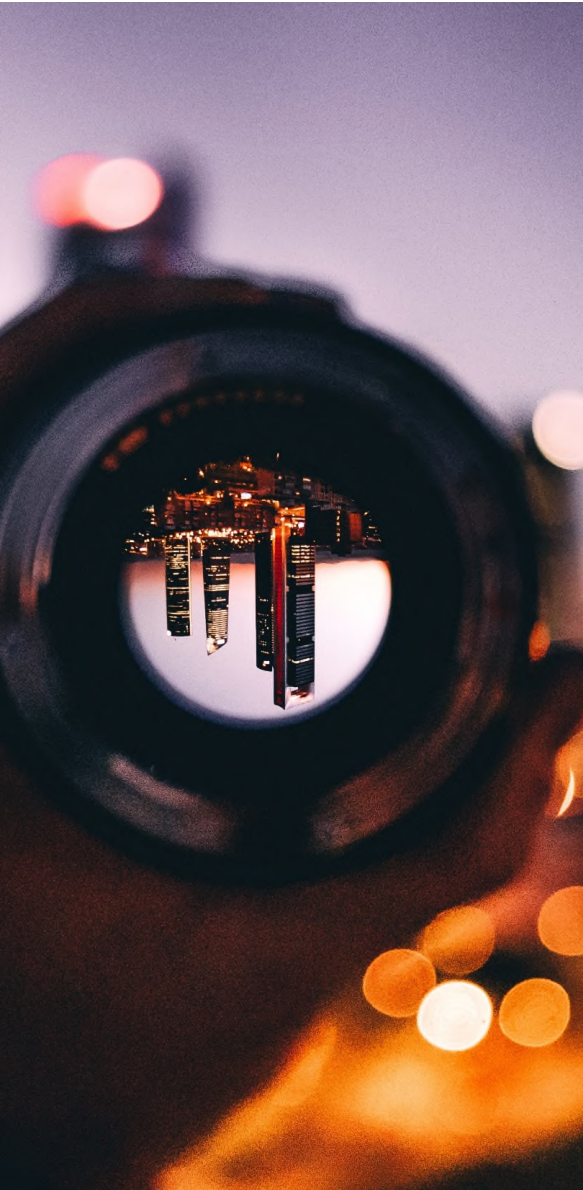
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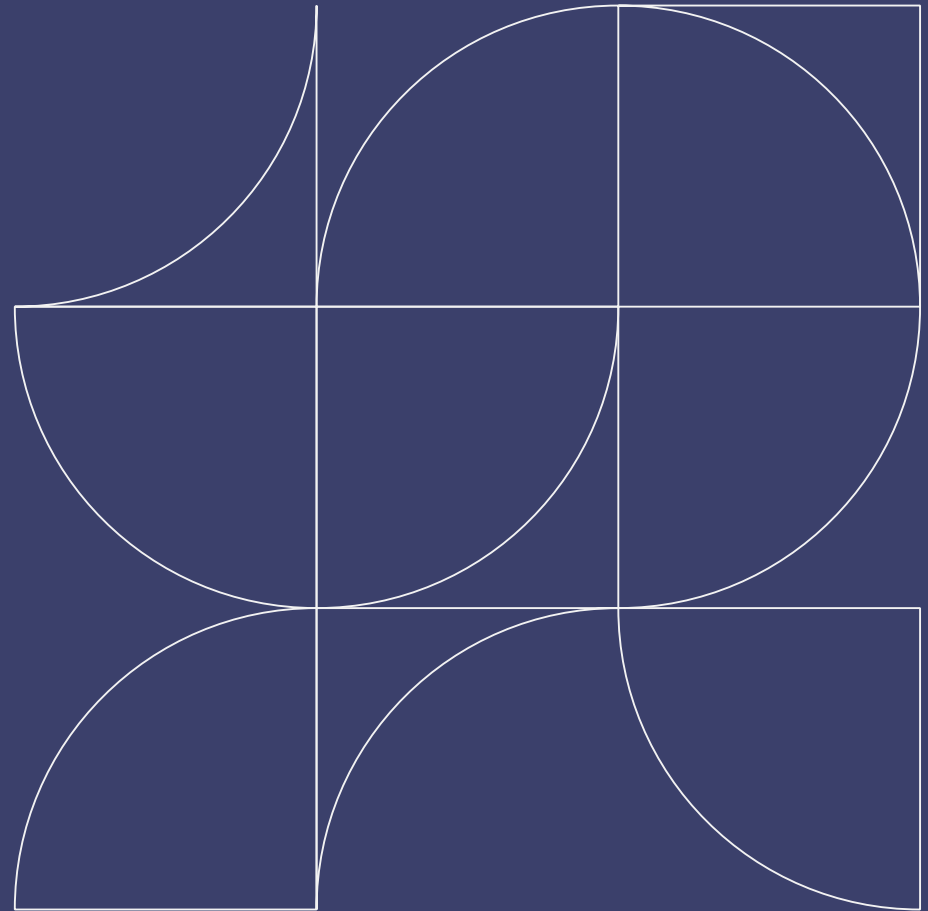
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Agenda

- 01** PBM Litigation
 - 02** PBM Reform Updates
 - 03** Anticipated Supreme Court Activity
 - 04** Welfare Plan Class Action Litigation
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PBM Litigation



PBM Litigation

Lewandowski v. Johnson and Johnson, 2025 **WL 3296009 (D. N.J.) Nov. 26, 2025**

- In February 2024, plaintiff filed a class action lawsuit against J&J and the fiduciaries of J&J's prescription drug benefits program in the District of New Jersey.
- The complaint claimed that the J&J Defendants' alleged mismanagement cost the Plans and participants millions of dollars in the form of higher drug costs, premiums, deductibles, copayments, and co-insurance, and lower wages.
- Alleged breach of fiduciary duty claims.

PBM Litigation

Lewandowski v. J&J, continued

- Court granted motion to dismiss first amended complaint on grounds that the plaintiff failed to demonstrate standing re: her fiduciary breach claims.
- Plaintiff filed an amended complaint naming a second plaintiff.
- Second amended complaint alleged that higher drug costs contribute to higher COBRA premiums.
- Court granted motion to dismiss second amended complaint – plaintiffs lacked standing because the alleged harm (higher premiums and out-of-pocket costs) was speculative and therefore not redressable, because numerous factors impacted the amounts that participants were required to contribute (*Lewandowski v. Johnson and Johnson*, 2025 WL 3296009 (D. N.J. Nov. 26, 2025)).
- Now on appeal to the Third Circuit.

PBM Litigation

Two Subsequent Lawsuits

- Both were also filed by the same plaintiffs' law firm that filed the *Lewandoski* matter, Cohen Milstein Sellers & Toll, against global banks.
- First was filed in the **District of Minnesota**.
- Plaintiffs alleged they paid more in prescription drug premiums and out-of-pocket costs than they would have but for defendant employer's mismanagement.
- Plaintiffs added a prohibited transaction claim.
- Court originally dismissed the case in 2025 and then dismissed the plaintiffs' amended complaint in 2026.

PBM Litigation

District of Minnesota

- The court held that the plan is closely analogous to the defined benefit plan at issue in *Thole v. U.S. Bank, N.A.*, 590 U.S. 538 (2020).
- “... the connection between what Plan participants were required to pay in contributions and out-of-pocket costs, and the administrative fees the Plan was required to pay [the PBM], is tenuous at best.”
- “There are simply too many variables in how Plan participants’ contribution rates are calculated to make the inferential leaps necessary to elevate Plaintiffs’ allegations from merely speculative to plausible.”

PBM Litigation

District of Minnesota, continued

- Plaintiffs filed an amended complaint and added a plaintiff who was participating through COBRA (thus paid the full employer and employee contribution).
- In March, 2026, Court again dismissed the case, holding that plaintiffs failed to allege an injury-in-fact.
- Adding the COBRA participant did not change the analysis, because the plan afforded the employer the discretion to require plan participants to fund all plan expenses.
- Distinguished excessive fee cases in the 401(k) context, where plaintiffs alleged losses to the plan and to their benefits. In the PBM context, plaintiffs did not allege any loss of their contractually-defined health benefits.

PBM Litigation

Southern District of New York

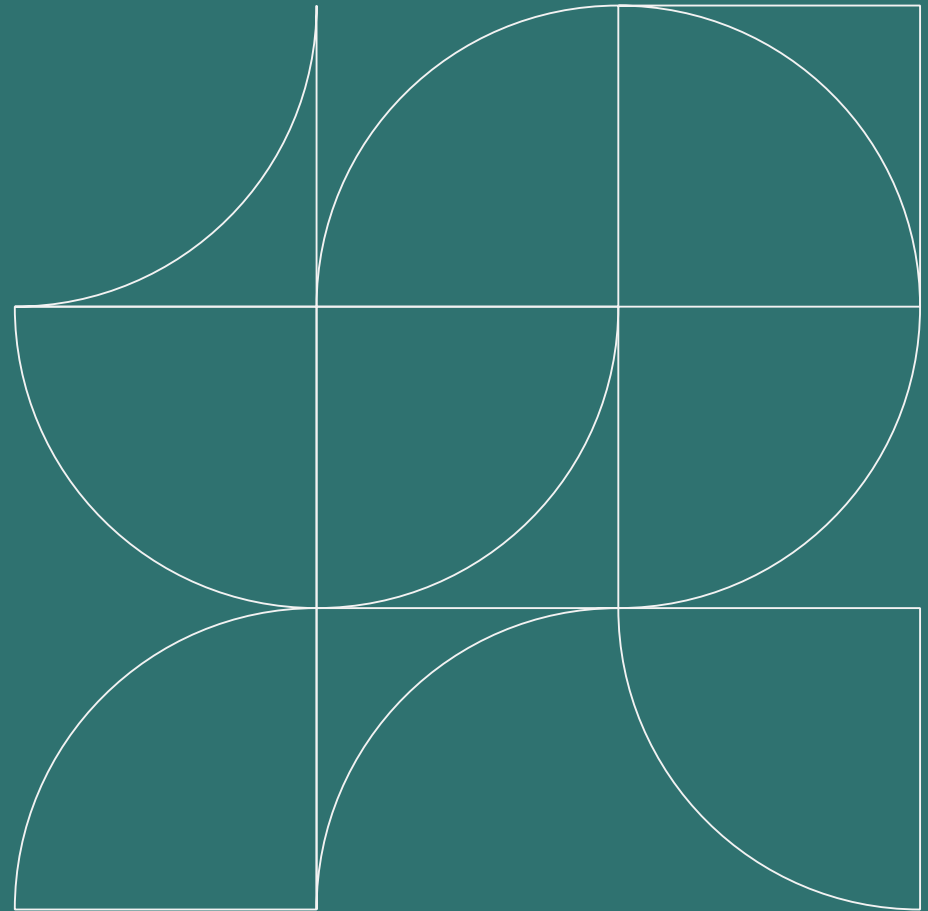
- Third suit from the same plaintiffs' firm, alleged employer defendant and fiduciaries breached their fiduciary duties of loyalty and prudence and engaged in prohibited transactions by mismanaging the prescription drug component of the self-funded health plan resulting in higher premiums and out-of-pocket costs.
- In March 2026, Court ruled on defendants' motion to dismiss.
- Similar to the other two cases, the court held that alleged increased premiums was too speculative to establish standing.
- However, the court held that plaintiffs did plausibly allege an injury-in-fact due to higher out-of-pocket costs from excessive drug prices set by the PBM, which was permitted by the employer's service agreement.

PBM Litigation

Southern District of New York, continued

- The Court agreed that defendants' failure to negotiate better terms and its decision to enter a contract with PBM that allegedly caused plaintiffs to pay higher costs for specialty drugs were settlor decisions.
- Citing the recent U.S. Supreme Court decision in *Cunningham v. Cornell University*, court held plaintiffs adequately alleged prohibited transaction claim.
- “Even though Defendants may have ample defenses to this claim, pursuant to the Supreme Court’s recent opinion in *Cunningham v. Cornell University*, Plaintiffs’ allegations are sufficient to assert a plausible prohibited transaction at this juncture.”

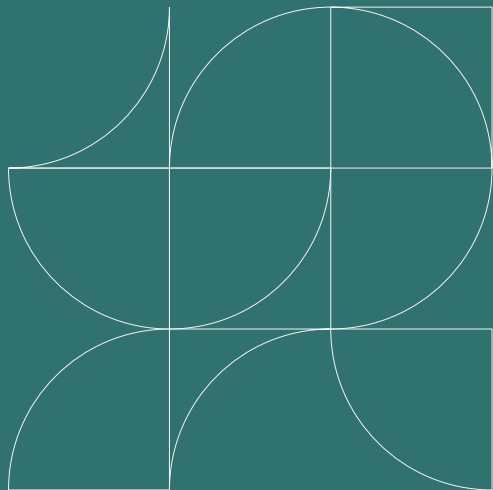
PBM Reform Updates



PBM Reform Drivers

- Market concentration
 - Three PBMs administer ~80% of U.S. prescriptions, shaping formularies, rebates, and reimbursement
 - Rebate incentives can lead PBMs to favor higher list prices, raising plan spend and member out-of-pocket costs
- Regulatory and legislative pressure
 - Bipartisan issue with broad congressional support
- Lack of transparency for employers and plan sponsors
- Rebate driven economics
 - PBMS compensated through rebates and fees tied to a drug's list price, rather than net cost or clinical value
 - Incentivizes placing higher-priced drugs with large rebates on formularies

Critical Reform Developments



**FTC
Litigation &
Settlement**

**DOL Proposed
Rule**

**Consolidated
Appropriations
Act of 2026**

**State PBM
Laws**

FTC Litigation & Settlement

- FTC targeting rebate and formulary-driven incentives that raised list prices, excluded lower-list-price alternatives, and increased cost sharing tied to WAC rather than net cost
- In September 2024, FTC sued PBMs alleging anticompetitive rebating and formulary practices that artificially inflated insulin list prices and increased patient OOP costs
- In 2026, one finalized settlement and one proposed settlement
 - finalized settlement terms include:
 - delinking PBM compensation from drug prices
 - prohibiting formulary preference for higher-priced drugs when lower-cost, clinically equivalent options are available
 - Net-price-based member cost sharing (patient cost sharing tied to net, not list, price)
 - Limits on spread pricing and expanded plan sponsor options for rebate-free models
 - Enhanced transparency: drug-level pricing, rebate disclosures, broker payments

DOL Proposed Rule: Fee Disclosures (Potentially July 1, 2026)

1

Covered Service Providers

- PBMs and any entities providing PBM services to **SF plans**
- Entities providing advice, recommendations, or referrals regarding PBM services (brokers/consultants)
- \$1,000 or more in direct or indirect compensation

2

Disclosures

- initial and semiannual reporting of all direct and indirect compensation
- payments from manufacturers, pharmacies, rebate aggregators, and other third parties
- clear accounting of amounts retained vs. passed through

3

Other Key Elements

- Annual audit right
- Fiduciary safe harbor
- Potential prohibited transaction/ fiduciary breach liability (excise taxes and equitable remedies) → non-compliance means the arrangement is “unreasonable”
 - Use disclosure to assess reasonableness of compensation and conflicts of interest

4

Looking Ahead

- DOL will likely revise to align with the more expansive framework under CAA 2026
- Comment Period ends April 15th
- If finalized, would take effect July 1, 2026

CAA 2026 Fee Disclosures (February 3, 2026)

1

Covered Service Providers

- **All** welfare plan service providers
- Self-funded **and** fully-insured plans
- Direct and indirect compensation greater than \$1,000

2

Disclosures

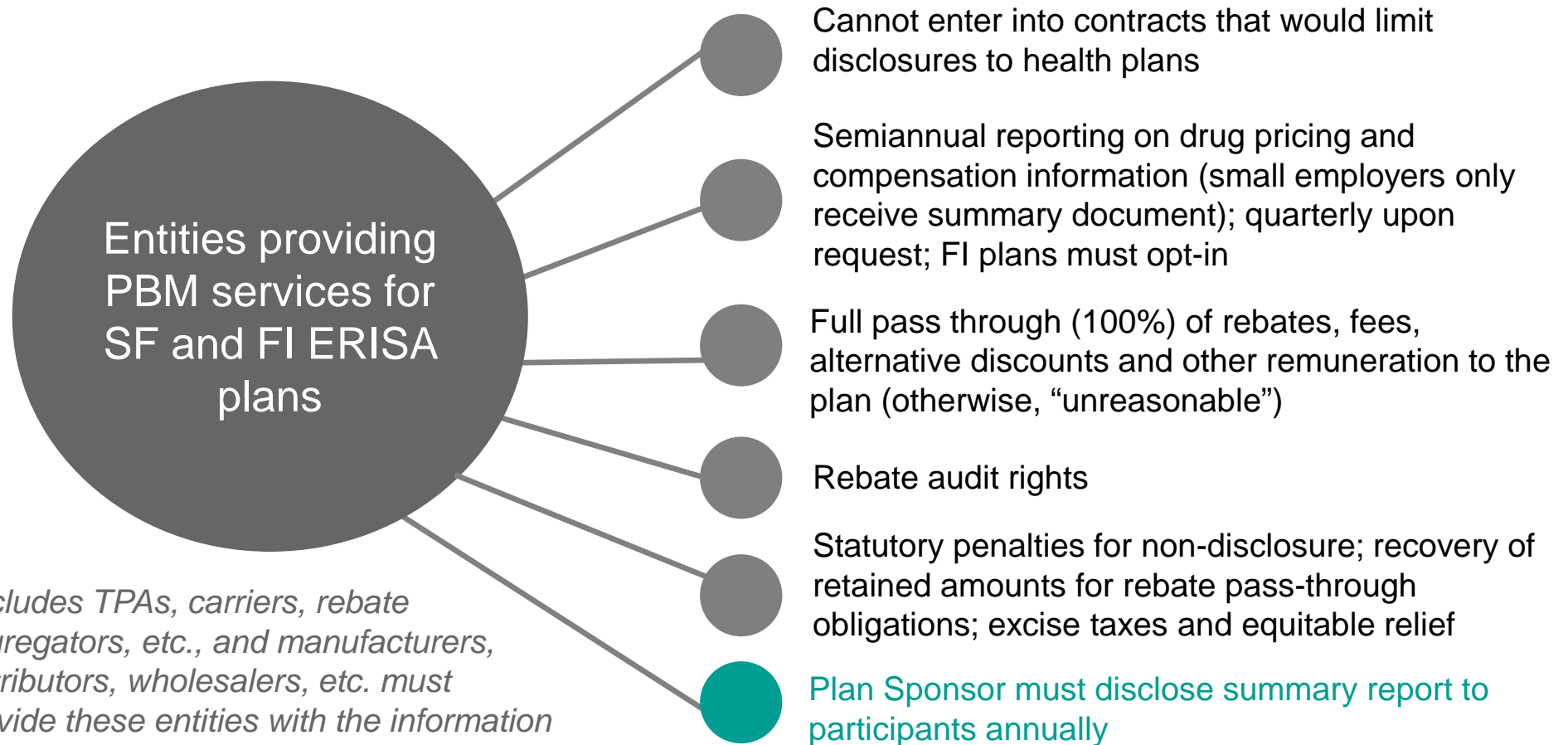
- Expansion of CAA 2021 408(b)(2) requirements imposed on brokers/consultants
- Reporting required at initial contracting phase and at renewal
- Direct and indirect compensation:
 - rebates
 - fees
 - alternative discounts
 - other remuneration

3

Other Key Provisions

- Effective immediately if no further guidance is issued
- No participant disclosure
- Potential prohibited transaction/fiduciary breach liability (excise taxes and equitable remedies)
- Civil penalties (\$10,000 per day for non-disclosure; \$100,000 per item for false information)

CAA 2026 Transparency Requirements (August 2028)



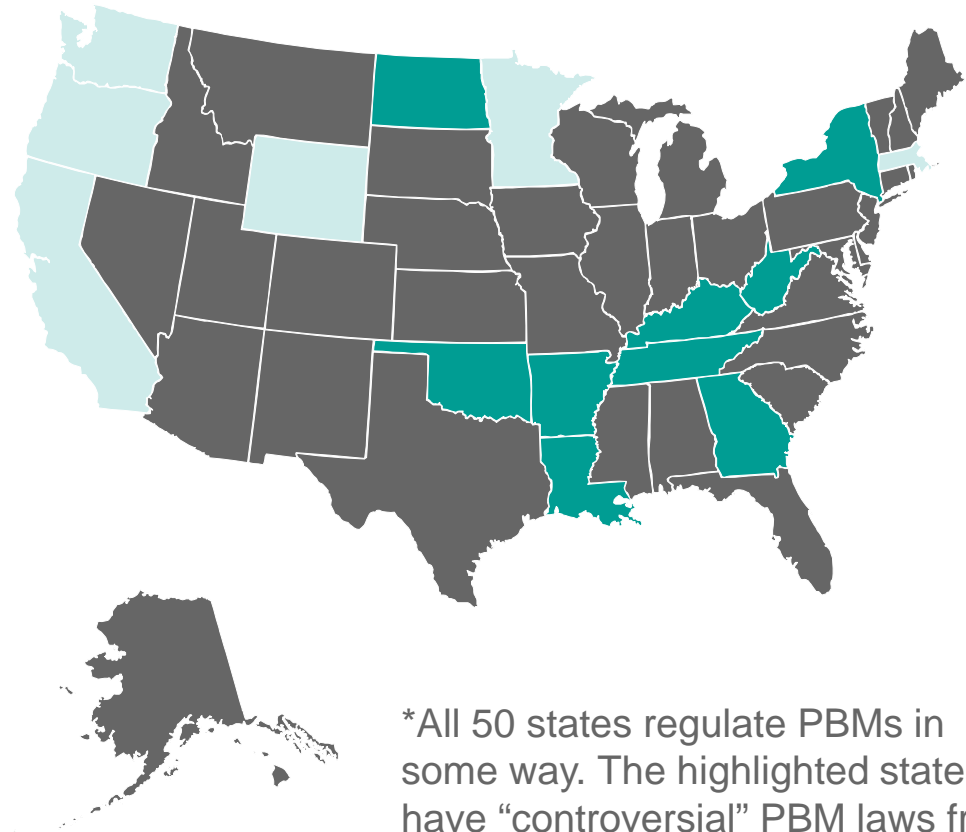
**Includes TPAs, carriers, rebate aggregators, etc., and manufacturers, distributors, wholesalers, etc. must provide these entities with the information*

Required Disclosure & Reporting Comparison

DOL Proposed Rule: Fee Disclosure (July 2026)	CAA 2026: Fee Disclosure (Now)	CAA 2026: Transparency (August 2028)
<ul style="list-style-type: none"> – Description of services – Direct and indirect compensation – Manufacturer payments – Spread compensation – Copay claw-backs – Price protection agreements – Compensation for termination of service contract or arrangement – Description of other compensation – Description of formulary placement incentives – Drug pricing methodology – Statement of fiduciary status (if applicable) – Statement of annual audit right 	<ul style="list-style-type: none"> – direct and indirect compensation – rebates – fees – alternative discounts – other remuneration 	<ul style="list-style-type: none"> – PBMs: <ul style="list-style-type: none"> ▪ Drugs issued and pricing ▪ PBM compensation based on utilization ▪ High-cost drug reporting ▪ “Steering” provisions to affiliated pharmacies ▪ Summary document – Plan Sponsor must disclose summary document to participants annually

State PBM Laws

- Generally targeting transparency, reimbursement, network, access, reporting, auditing, and consumer protections
- ERISA preemption is not always certain
 - States generally can regulate PBMs as market actors
 - States generally cannot mandate specific benefit structures or cost-sharing/formulary designs for self-funded plans



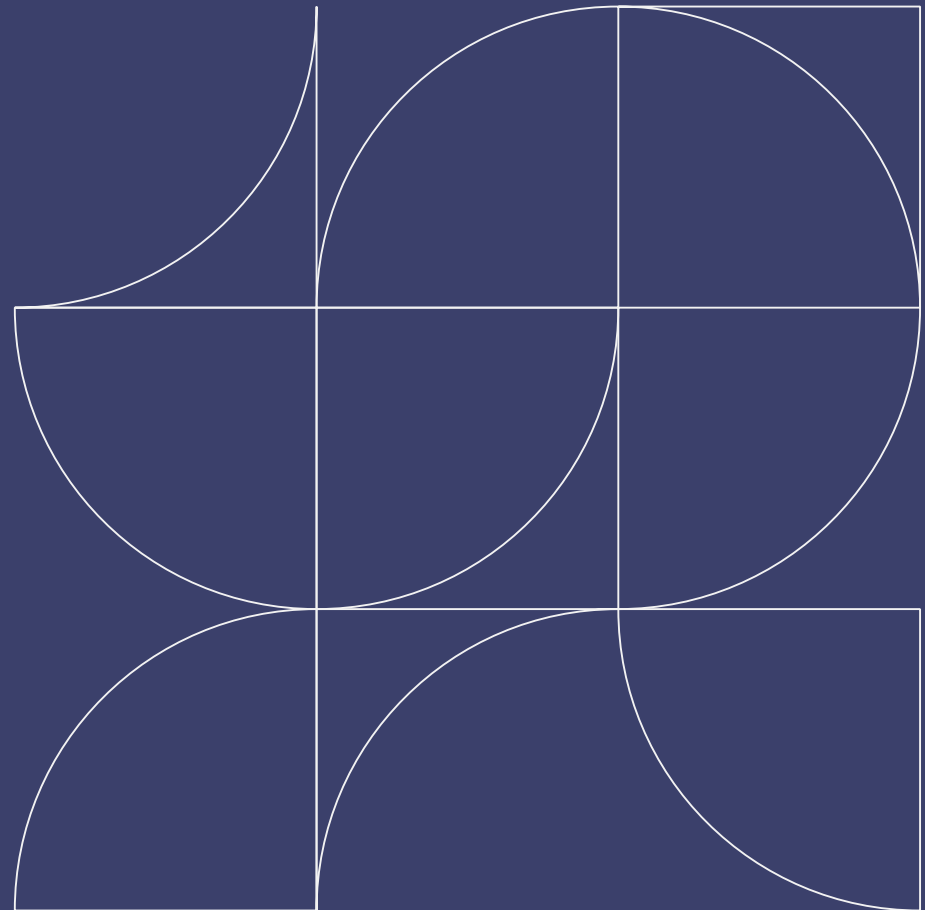
*All 50 states regulate PBMs in some way. The highlighted states have “controversial” PBM laws from an ERISA preemption standpoint.



Action Items

- Continue to monitor for:
 - DOL final rule
 - FTC settlements
 - Potential guidance on CAA 2026
 - ERISA class action litigation
- Review and update applicable service provider agreements with legal counsel
 - use renewals and RFPs to reset pricing and transparency
- Engage in relevant fee disclosure and transparency discussions with service providers
- Revisit fiduciary governance structure for health and welfare plans
 - designate committee(s)
 - set review cadence for PBM reports
 - engage advisors for specialized analysis
- Understand participant communications that will be required

Anticipated Supreme Court Activity



Case Overview and Background

Supreme Court Grants Cert on ERISA Fee Class Action Pleading Standard

- **Underlying Facts:** Company defined contribution plan participants sued plan fiduciaries for alleged breach of the ERISA duty of prudence. Plaintiffs challenged allocations to hedge funds, private equity, and other alternative investments within customized target date and global diversified funds
- **Alleged harms:** Higher fees and underperformance relative to more traditional plan investments
- **Lower Court Holdings:**
 - District Court: Dismissed plaintiffs' claims
 - Ninth Circuit: Affirmed, holding that plaintiffs relying on underperformance or excessive fees must identify a "meaningful benchmark" — a comparator with sufficiently similar aims, risks, and objectives. The Ninth Circuit rejected plaintiffs' proposed comparators (indices, Morningstar peer groups, other target date funds) as insufficiently similar to the Company's customized funds. Another judge's concurrence suggested imprudence can also be alleged through other circumstantial facts showing a flawed fiduciary process
- **Question Presented:** Whether allegations of fund underperformance, without a meaningful benchmark, are sufficient to state a claim for breach of the ERISA duty of prudence

Legal Context and Circuit Landscape

Supreme Court Grants Cert on ERISA Fee Class Action Pleading Standard

- The Supreme Court's recent ERISA pleading decisions — *Hughes v. Northwestern University* and *Cunningham v. Cornell* — left key questions unresolved about the appropriate limits on ERISA claims at the pleading stage
- A circuit court split exists on whether a meaningful benchmark is required for an ERISA breach of fiduciary duty claim
- A high volume of ERISA fiduciary litigation makes the stakes significant for plan sponsors and fiduciaries
- The Core Legal Tension:

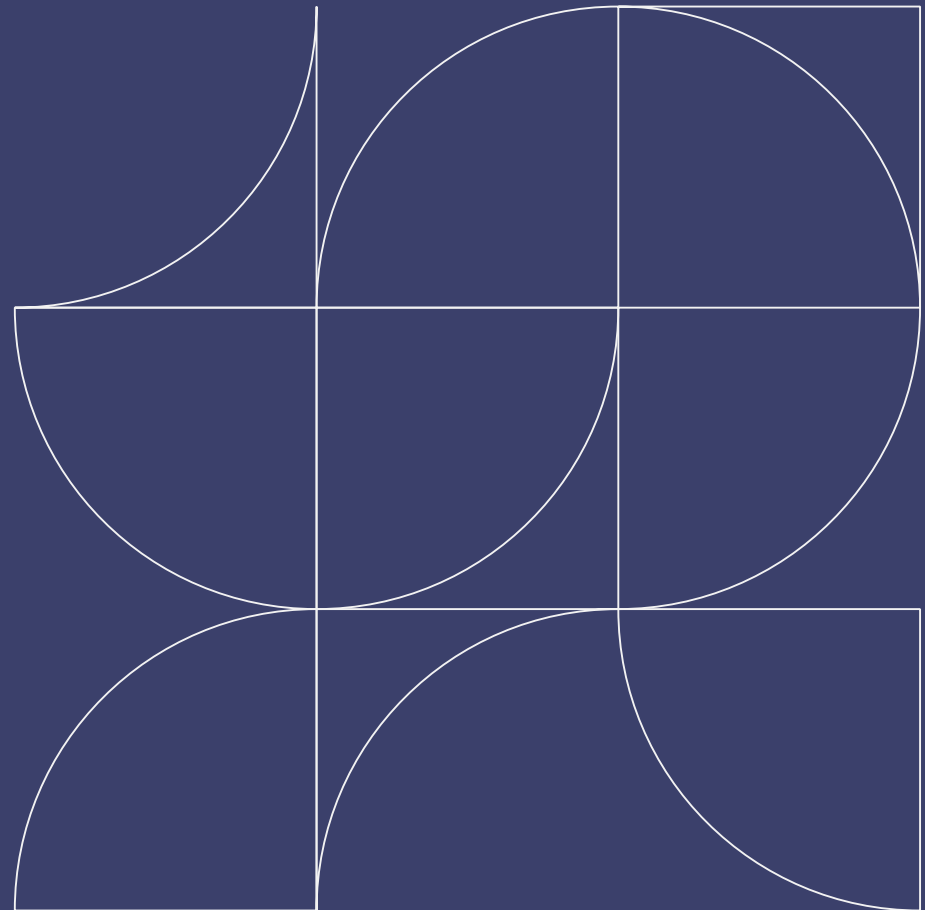
Ninth Circuit Position	Plaintiffs' Position
Meaningful benchmark required to survive a motion to dismiss	Categorical benchmark rule conflicts with ERISA's context-specific prudence standard
Close alignment of objectives and risk profiles required	Standard is so exacting it shields outlier strategies from judicial review
Absence of a comparator defeats the claim	Even extreme fiduciary decisions would escape scrutiny

Legal Context and Circuit Landscape

Supreme Court Grants Cert on ERISA Fee Class Action Pleading Standard

- **“Categorical” Pleading Rules**
 - Will the Court find the Ninth Circuit's benchmark requirement is an impermissible categorical rule in tension with the context-specific inquiry standard from *Hughes*, or simply a routine application of plausibility pleading?
- **Clarification of “Meaningful Benchmark”**
 - Will the Court relax or tighten the standard for what qualifies as a valid comparator? A relaxed standard could lower the pleading hurdle for excessive-fee and underperformance claims broadly
 - What if no meaningful benchmark exists (alternative investments)
- **Trajectory After *Hughes* and *Cunningham***
 - This case gives the Court a vehicle to clarify when and whether comparative allegations are necessary at the motion-to-dismiss stage
- **Practical Impact on Motion-to-Discard Strategy**
 - Affirmance: Reinforces rigorous judicial scrutiny of comparator allegations; gives fiduciaries a stronger early-dismissal tool
 - Reversal: Could prompt courts to reassess how comparative allegations factor into plausibility analysis; may increase litigation exposure for plan fiduciaries
- **In the interim:** Some lower courts may hold motions to dismiss under advisement pending the Court's guidance
- **Bottom Line:** This case is a significant opportunity for the Supreme Court to impose meaningful limits on ERISA fiduciary litigation at the pleading stage. The outcome will shape motion-to-dismiss strategy, comparator analysis, and the viability of challenges to alternative investment allocations in defined contribution plans nationwide.

Welfare Plan Class Action Litigation



Surcharge Litigation Key Allegations

- Tobacco surcharges constitute a fiduciary breach as by targeting employees based on their health status in that employers do not retroactively refund tobacco surcharges upon enrollment or completion of a tobacco cessation program.”
- Plaintiffs also raise allegations regarding an alleged lack of notice of reasonable alternative standard. Plaintiff contend Plan materials must include notice to participants that their personal physician’s recommendations will be accommodated.
- By collecting a surcharge and not placing it in a trust, employers engage in a prohibited transaction.

Cunningham v. Cornell

- What is the alleged prohibited transaction in surcharge cases
 - Transactions between a plan and parties in interest
 - Alleged impermissible use of plan assets via surcharges from participants
- Impact of *Cunningham*
 - Supreme Court held plaintiffs need only plead §406 elements, do not have to address §408

Most Common Defenses

- Lack of standing.
- No entitlement to retroactive rewards
- Plaintiffs do not qualify for an alternative standard.
- No loss to the Plan
- “Settlor” functions
- No prohibited transaction

- *Loper-Bright*

Surcharge Litigation

- Over 60 cases have been filed.
- To date, Motions to Dismiss have been filed in at least 40 cases
- Siri Glimstad filed bulk of actions
- Courts have split on motions to dismiss
- A number of claims have settled shortly after motion to dismiss stage

Voluntary Benefits Litigation

Recently Filed Cases Regarding Voluntary Benefits Health Care Plan Costs

- Several actions filed by a single law firm on December 22, 2025 against large employers targeting alleged excessive premiums in accident, critical illness, cancer and hospital indemnity insurance – benefits that are not subsidized by employers
- The lawsuits also name as defendants consulting/benefit administration firms, alleging that they collected additional undisclosed compensation.
- The complaints alleged that employer sponsors failed to conduct requests for proposals to determine if the marketplace offered a better value for the premium dollars their employees.

Voluntary Benefits Litigation, cont.

Threshold issue, the safe harbor: are these benefit offerings exempt from ERISA pursuant to 29 C.F.R. §2510.3-1(j), which exempts plans that meet all four of the following requirements

- 1) No contributions are made by an employer or employee organization;
- 2) Participation [in] the program is completely voluntary for employees or members;
- 3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
- 4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.



CLE: NEW PROCESS

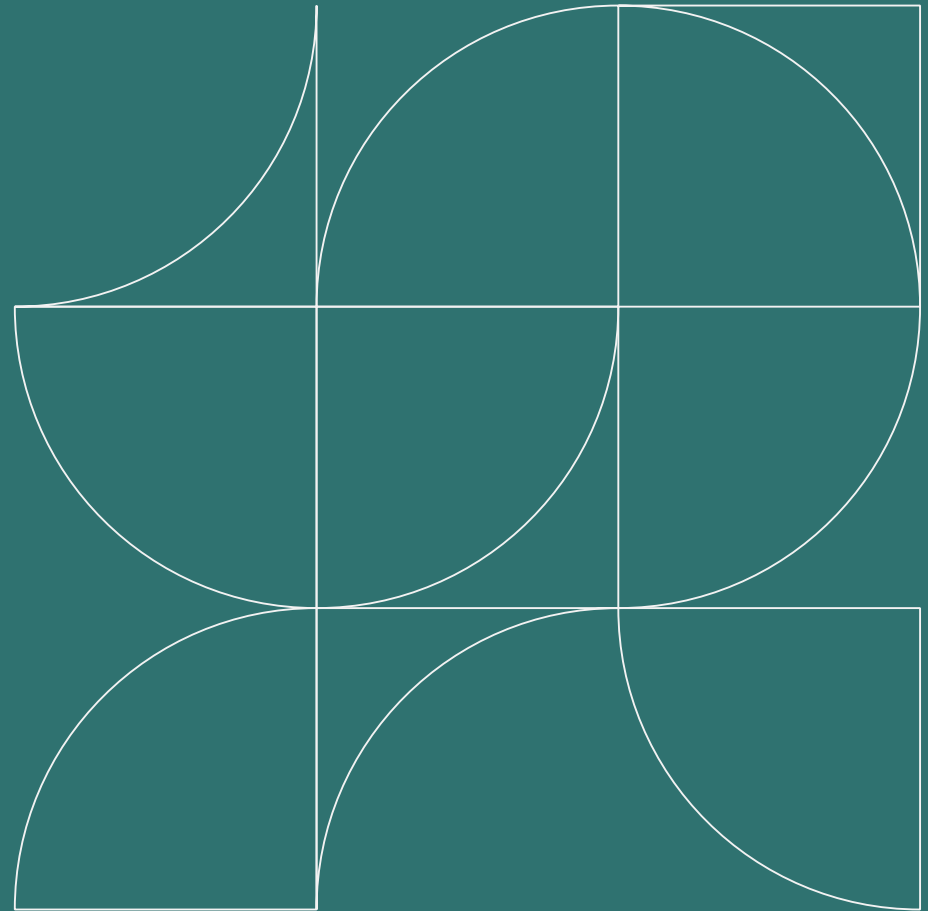
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Questions?



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