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Drug Pricing and PBM Compensation: DOL Proposed Rule for Improving Transparency

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On January 30, 2026, the U.S. Department of Labor ("DOL") published a proposed rule entitled, "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure" (the "Proposed Rule").[1] Under the Proposed Rule, pharmacy benefit managers ("PBMs" or, singularly, a "PBM") are generally required to disclose to fiduciaries of self-insured (also referred to as "self-funded") group health plans certain information, including compensation (both direct and indirect), formulary placement incentives, drug prices, price protection agreements and a statement of the plan's audit right.

The Proposed Rule has two main purposes: (1) to allow responsible plan fiduciaries to better fulfill their responsibility of ensuring that PBM service contracts are reasonable under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (2) to enhance market efficiency and improve access to affordable prescription drugs for consumers. The DOL is requesting comments on the Proposed Rule, with the goal of having the final rule apply to ERISA self-insured group health plans for plan years beginning on or after July 1, 2026. Below is a discussion of the background leading to the Proposed Rule, select key concepts regarding the Proposed Rule and recent related developments since the issuance of the Proposed Rule.

Background

Within the prescription drugs supply chain, PBMs (along with applicable related parties, i.e., affiliates, agents and subcontractors)[2] are intermediaries (or "middlemen") among the following key players: plan participants and beneficiaries,[3] plan sponsors (e.g., employers), plan administrators, drug manufacturers, drug wholesalers and retail pharmacies. As intermediaries, PBMs play a vital and powerful role in providing medications to the end users—plan participants and beneficiaries.

PBMs generally negotiate drug prices, establish drug formularies (lists of covered drugs under a plan), create pharmacy networks, process and pay claims, perform utilization review and management and decide appeals of denied claims. A recurring complaint of plan sponsors, plan fiduciaries and government entities is that they do not know how much compensation PBMs are actually receiving, whether that compensation is reasonable or competitive and to what extent conflicts of interest are present within the PBMs' dealings. Hence, the demands for more transparency.

With the exception of deciding appeals of denied claims (as applicable), PBMs are generally not considered fiduciaries. Each employee benefit plan subject to ERISA must have at least one named fiduciary.[4] Under ERISA, a fiduciary must act with respect to a plan ***solely in the interest of the participants and beneficiaries***, with such actions including payment of no more than reasonable expenses for administering the plan.[5]

ERISA further prohibits a fiduciary from causing a plan to engage in transactions in which there is direct or indirect "furnishing of goods, services or facilities between the plan and a party in interest."[6] PBMs fall within ERISA's definition of a party in interest, which includes "a person providing services" to the plan.[7] Thus, it would appear that plan fiduciaries cannot cause a plan to engage in transactions with PBMs. However, ERISA Section 408(b)(2) provides a statutory exemption from the prohibited transaction rules for a contract or arrangement with a service provider that satisfies the following conditions: (1) the contract or arrangement is reasonable, (2) the service is necessary to the establishment or operation of the plan and (3) no more than reasonable compensation is paid for the service.

The Proposed Rule, based upon the statutory prohibited transaction exemption described above, aims to empower fiduciaries with rights to receive certain information and to audit the validity of the received information. When these rights are honored per applicable law, the contracts or arrangements with the PBMs are deemed reasonable.

The DOL has been down this path before in a somewhat different context. In February 2012, the DOL issued regulations regarding fee disclosures for qualified retirement plans (the "2012 Pension Final Rule").[8] These regulations are intended to provide plan fiduciaries with, among other things, comprehensive fee information from service providers (record keepers, advisers and brokers) to enable them to assess the reasonableness of their fees.

In explaining the rationale for these pension regulations, the DOL said in July 2010 that the complexity of changes in the industry over the years had "made it more difficult for plan sponsors and fiduciaries to understand what service providers actually are paid for the specific services rendered."[9]. When finalizing the 2012 Pension Final Rule, the DOL thought it best to leave for a future date the "development of specifically tailored disclosure requirements for welfare plans."[10]

In December 2020, Congress passed the Consolidated Appropriations Act, 2021 ("CAA 2021"),[11] which imposes certain disclosure requirements for welfare plans. Under Division BB, Section 202 of CAA 2021, service providers, affiliates and subcontractors are required to disclose in writing all direct and indirect

compensation over $1,000 anticipated to be received as a result of performing brokerage services or consulting to ERISA-covered group health plans (whether fully insured or self-insured). CAA 2021 requires such disclosures to the fiduciaries reasonably in advance of the parties entering into, extending or renewing the applicable contract or arrangement.

With respect to PBMs, CAA 2021 appeared to focus on (1) brokerage services regarding the ***selection*** of pharmacy benefit management services and (2) consulting related to ***the development or implementation*** of pharmacy benefit management services. However, CAA 2021 did not define the terms "brokerage services," "consulting" and "pharmacy benefit management services." Furthermore, in Field Assistance Bulletin No. 2021.03, the DOL adopted a good faith, reasonable interpretation standard for the disclosures required under Division BB, Section 202 of CAA 2021.

Congress and the DOL are not the only federal entities that have been reviewing PBM compensation arrangements. The U.S. Federal Trade Commission ("FTC"), tasked with protecting the public from deceptive or unfair business practices and from unfair methods of competition, has taken note of PBM influence and methods. Historically, the FTC has in essence taken the position that imposing disclosure requirements on PBMs is not necessary. As will be discussed further below, the FTC's current position is now more in line with the position the DOL has taken in the Proposed Rule.

State governments have also engaged in regulating PBMs. After reviewing each state's publicly available database in November 2021, some state researchers found that all 50 states had enacted regulations specifically directed to PBMs.[12] One recent example involves California, as described in our January 2026 Benefits Report: PBM Fiduciary Provisions of New California Law Challenged by PBM Trade Association as Preempted by ERISA (https://www.truckerhuss.com/newsletter/benefits-report-january-2026/#article2). It is within this environment that the DOL has issued the Proposed Rule.

Select Key Concepts Regarding the Proposed Rule

The Proposed Rule's preamble emphasizes that the pharmaceutical supply chain is highly complex, involving many players and arrangements that can be quite opaque. Hence, the call for transparency. Below are select key concepts regarding the Proposed Rule, along with some background information (as applicable).

Information to be Disclosed

The Proposed Rule requires disclosure of the following information:

(A) Direct *compensation*. A description of direct compensation, both in the aggregate and by service, that the PBM reasonably expects to receive or has received on a quarterly basis from the plan or plan sponsor. An example of such compensation is an administrative fee calculated on a per-participant, per-month basis.

(B) Manufacturer *payments*. A description of manufacture payments, both in the aggregate and by service, that the PBM reasonably expects to receive or has received on a quarterly basis. An example of such compensation is a manufacturer rebate. The Proposed Rule specifies that this disclosure should include both (i) the amount that will be passed on to the plan and/or the plan sponsor and (ii) the amount that will be retained by the PBM.

(C) *Spread compensation*. A description of spread compensation, both in the aggregate and for each drug on the formulary—and for each pharmacy channel (i.e., retail, mail order and specialty pharmacy)—that the PBM reasonably expects to receive or has received on a quarterly basis. Spread compensation means the difference between the negotiated rate reasonably expected to be paid or that was actually paid by the plan to the PBM, and the corresponding negotiated rate to be paid or that was paid by the PBM to the pharmacy for dispensing drugs.

(D) Copay *claw-backs*. A description of the copay claw-backs that the PBM reasonably expects to receive or has received on a quarterly basis. Copay claw-back compensation means the dollar amount of the difference between (i) a copayment or coinsurance amount paid to the pharmacy by a plan participant or beneficiary and (ii) the reimbursement to the pharmacy. The Proposed Rule provides the following example: if a participant's copayment for a generic drug is $15 dollars, but the PBM has agreed to pay the pharmacy $5, the PBM may "claw-back" the excess $10 from the pharmacy.

(E) Price *protection agreements*. A description regarding any inflation protection or price protection agreements that the PBM has entered with any drug manufacturer or other party in connection with prescription drugs dispensed under the contract or arrangement with the plan. Each description should specify the amount the PBM reasonably expects to retain or has retained on a quarterly basis in connection with each such agreement, and the amount that will be passed on to the plan and/or the plan sponsor.

(F) Other *compensation descriptions*. To the extent not already disclosed, each "other compensation" description should include the following four items: (i) a description of the compensation the PBM reasonably expects to receive or has received on a quarterly basis in connection with the service contract or arrangement; (ii) the identification of the payer of such compensation; (iii) an identification of the services for which such compensation will be received; and (iv) a description of the arrangement between the payer and PBM pursuant to which such compensation is paid.

(G) Description *of services*. A description of each pharmacy benefit management service—or of the advice, recommendations or referrals regarding the provision of pharmacy benefit management services—to be provided to the covered plan pursuant to the service contract or arrangement. (See further below for the definition of "pharmacy benefit management services.")

(H) Compensation *for termination of service contract or arrangement*. A description of any compensation that the PBM reasonably expects to receive in connection with termination of the service contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

(I) Description *of formulary placement incentives*. Descriptions or identifications of (i) formulary placement incentives and arrangements between the PBM and any drug manufacturers, along with an explanation of how these incentives and arrangements align with the interests of the plan and/or its participants and beneficiaries; (ii) any reasonably available therapeutically equivalent alternatives and the reason for excluding such alternatives from the formulary for any drug which the PBM reasonably expects to receive compensation from the manufacturer; and (iii) information regarding the PBM's authority, if any, to modify the formulary during the term of the contract or arrangement.

(J) Drug *pricing methodology*. A description of the net cost to the covered plan of each drug on the formulary, for each pharmacy channel, expressed as a monetary amount. If a monetary amount is not ascertainable, the covered service provider must disclose the methodology used by the PBM under the service contract or

arrangement to determine the cost the covered plan will pay for each drug on the formulary, for each pharmacy channel, along with an objective means to verify the accuracy.

(K) Statement *of fiduciary status*. If applicable, a statement that the PBM will provide, or reasonably expects to provide, services pursuant to the service contract or arrangement directly to the covered plan as a fiduciary (within the meaning of ERISA Section 3(21)). Along with this statement, the PBM must disclose any activity or policy that may create a conflict of interest.

(L) Statement *of audit right*. A statement of the covered plan's right to an audit, as specified in the Proposed Rule, and the procedures for requesting such an audit. The terms of the Proposed Rule provide, in part, that a plan is entitled to an audit at least annually for the purpose of validating the accuracy of any disclosure made pursuant to the Proposed Rule. The plan fiduciary has the right to select an auditor, while the plan must bear the responsibility for all reasonable expenses related to the selection and retention of the auditor.

(M) Overage *explanation*. If any category of compensation previously disclosed as a quarterly estimate materially exceeds the actual quarterly amount, in the aggregate, then the amount of the overage (in the aggregate) must be disclosed along with the reason for the overage.

Frequency of Disclosure

- *Initial Disclosure*. Under the Proposed Rule, a covered service provider must disclose items (A) through (L) above by the date that is reasonably in advance of the date on which the service contract or arrangement is entered and extended or renewed. For this disclosure, monetary amounts are generally estimated based on what is reasonably expected to be received.
- *Semiannual Disclosure*. Under the Proposed Rule, a covered service provider must disclose items (A) through (F) and item (M) above on a semiannual basis, and that disclosure must be made no later than 30 calendar days after the end of each six-month period beginning on the date the service contract or arrangement is entered. For this disclosure, monetary amounts are generally actual amounts received.

Covered Plans

The Proposed Rule applies to self-insured group health plans, which are classified into two groups: (1) level-funded self-insured plans that have extensive stop loss policies to emulate features of fully insured arrangements, and (2) other self-insured plans which do not have such policies. The Proposed Rule does not apply to fully insured group health plans. The rationale for excluding fully insured plans is that prescription drug coverage is one component of a comprehensive health insurance policy which a plan sponsor purchases.

In the DOL's view, fiduciaries for fully insured plans will likely focus on different considerations than fiduciaries for self-insured plans when entering into and maintaining contracts or arrangements for services with other parties. Thus, the disclosures mandated by the Proposed Rule may not be helpful to fiduciaries of fully insured plans.

Covered Service Provider

Under the Proposed Rule, a covered service provider is a service provider that enters into a contract or arrangement with the covered plan and reasonably expects to receive $1,000 or more in compensation (direct or indirect) for providing pharmacy benefit management services or for providing advice, recommendations or

referrals regarding the provision of pharmacy benefit management services. The services may be performed or the compensation may be received by the covered provider or an affiliate, an agent or a subcontractor of the covered provider.

Under the Proposed Rule, the covered service provider is responsible for disclosing the applicable information to the covered plan. The fact that the covered service provider does not actually perform or receive compensation for all or some of the pharmacy benefit management services is irrelevant. If the covered service provider's affiliate, agent or subcontractor performs the services or receives the compensation instead of the covered service provider, then the latter is responsible for providing the required disclosures. In other words, if a PBM enters into a contract with a plan to provide pharmacy benefit management services but the PBM's affiliate, agent or subcontractor does the work or receives the compensation, the PBM is responsible for providing the required disclosures.

Pharmacy Benefit Management Services

The Proposed Rule broadly defines the term "pharmacy benefit management services" as the "services necessary for the management or administration of a covered plan's prescription drug benefits." The entity or person providing the service need not self-identify as a PBM.

Exemption for Responsible Plan Fiduciary

The Proposed Rule provides that a fiduciary will not be deemed to have engaged in a prohibited transaction under ERISA solely because the covered service provider failed to meet the disclosure requirements set forth in the Proposed Rule, provided the fiduciary take certain steps, including but not limited to (i) timely requesting correction of the failure from the covered service provider, and (ii) timely notifying the DOL Secretary of the covered service provider's failure.

Recent Related Developments

Within days of the DOL publishing the Proposed Rule in the Federal Register, additional federal action contributed to regulation of PBMs in alignment with the Proposed Rule. The Consolidated Appropriations Act, 2026 was signed into law on February 3, 2026 ("CAA 2026"). For more information on CAA 2026, see Mary Powell's article in this issue of the Benefits Report.

The second set of federal actions came from the FTC. By way of background, in September 2024, after further study of the PBM industry, the FTC filed an in-house administrative complaint against the three largest PBMs (i.e., CVS Caremark, Express Scripts, and OptumRx), accusing them of artificially inflating the list price of insulin drugs by using unfair rebating and anticompetitive practices. On February 4, 2026, the FTC announced a settlement with Express Scripts in which Express Scripts agreed, in part, to "Increase transparency for plan sponsors, including … disclosing payments to brokers representing plan sponsors."[13]

Next Steps

For those who want to provide comments to the DOL on the Proposed Rule, the deadline is March 31, 2026.

In this new world, plan sponsors and fiduciaries can expect to receive substantially more information than in the past regarding PBM practices and compensation. Plan sponsors, plan fiduciaries and plan administrators should consider in particular (i) hiring and training the appropriate individuals (whether internal or external to

the company) to effectively digest and utilize the enhanced disclosed information, and (ii) conducting audits to validate the accuracy of the disclosed information.

[1] 91 Fed. Reg. 4348 (January 30, 2026). The Proposed Rule implements section 12 of President Trump's Executive Order 14273 of April 15, 2025, *Lowering Drug Prices by Once Again Putting Americans First*. The DOL intends that the Proposed Rule, when finalized, will be codified within the Code of Federal Regulations ("CFR") at 29 CFR § 2550.408b-2 and 29 CFR § 2550.408b-22.

[2] Unless specified otherwise, in this article the term "PBM" means the pharmacy benefit manager and its affiliates, agents and subcontractors, as a whole.

[3] Beneficiaries within the context of group health plans are also known as dependents, which are spouses, domestic partners and children of the plan participants.

[4] ERISA Section 402(a).

[5] ERISA Section 404(a).

[6] ERISA Section 406(a).

[7] ERISA Section 3(14).

[8] These regulations may be found at 29 CFR § 2550.408b-2(c).

[9] 75 Fed. Reg. 41600, 41600 (July 16, 2010).

[10] 91 Fed. Reg. 4348, 4356 (January 30, 2026).

[11] Public Law 116-260 – Dec. 27, 2020.

[12] *State-level policy efforts to regulate pharmacy benefit managers (PBMs),* T. Joseph Mattingly II, Maisie Lewis, Mariana P. Socal and Ge Bai, Research in Social and Administrative Pharmacy 18, 2022, Pages 3995-4002.

[13] U.S Federal Trade Commission, News and Events, News, Press Releases, *FTC Secures Landmark Settlement with Express Scripts to Lower Drug Costs for American Patients: Settlement resolves FTC lawsuit alleging that Express Scripts' conduct resulted in artificially inflated insulin drug prices*, February 4, 2026.

Big Changes to PBM Contracting and Group Health Plan Service Provider Disclosures—Some NOW and some later!

Mary E. Powell

On February 3, 2026, Congress passed and the President signed the Consolidated Appropriations Act, 2026 ("CAA 2026"). The news outlets primarily discussed the funding provisions of this legislation for many federal agencies. For benefits professionals, we noted the significant disclosure requirements applicable to pharmacy benefit managers (PBMs)—effective 30 months following the enactment of the legislation—and the requirement for ALL service providers to group health plans to disclose all direct and indirect compensation they receive in connection with the plan, effective for contracts entered into or renewed after the effective date of the CAA 2026. These new rules will have a significant impact on the contracting process for all group health plan contracts.

Effective Now—Expanded Fee Disclosure Requirements under ERISA

Basic Rule. The Consolidated Appropriations Act, 2021 ("CAA 2021") amended ERISA § 408(b)(2) to require certain "covered service providers" to group health plans to disclose specified information to a responsible plan fiduciary about the direct and indirect compensation the covered service provider expects to receive in connection with its services to the plan. The CAA 2021 disclosure requirements apply to persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans who reasonably expect to receive $1,000 or more in direct or indirect compensation in connection with providing those services. In general, this information must be disclosed reasonably in advance of the parties entering into such contract or arrangement, or before the contract or arrangement is extended or renewed. The required disclosures are intended to provide the responsible plan fiduciary with sufficient information to assess the reasonableness of the compensation (both direct and indirect) to be received and potential conflicts of interest that may exist as a result of a covered service provider receiving indirect compensation from sources other than the plan or the plan sponsor.

The CAA 2026 expands the type of services that renders an entity a "covered service provider" under this disclosure rule so that it applies to virtually all group health plan service providers, including vendors that provide any of the following services: plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, employee assistance programs, or third-party administration services or consulting services related to any such services.

Focused on the Services Provided. While the CAA 2021 disclosure rule applied to those who provided brokerage and consulting services, the CAA 2026 removes the title of "brokerage services" and "consulting" and expands it to a wide variety of services that the vendors provide in connection to the group health plan—regardless of how the vendors label those services. The CAA 2026 also states that when an entity providing plan services contracts with a provider that performs pharmacy benefit management services, that contract is considered an indirect furnishing of services between the plan and the service provider for pharmacy benefit management services. For example, a PBM does not escape the rules by being bundled into a layered contract with an insurance carrier.

Effective Date. There is no specific effective date for these rules. Unless stated otherwise by the DOL (such as through non-enforcement relief), the provision is effective for contracts entered into, extended or renewed after February 3, 2026. Failure to comply with the disclosure requirements means that the service arrangement is not reasonable and is, therefore, a prohibited transaction for which the statutory ERISA §408(b)(2) exemption does not apply.

Trucker Huss Comment. Plan fiduciaries will need to create new processes when entering into agreements with vendors that provide services to group health plans. A responsible plan fiduciary will need to provide a form to the vendor requesting information about direct and indirect compensation. When the information is returned, the fiduciary will need to understand it—i.e., how the vendor is paid and if incentives align with the plan (rather than the vendor). With these disclosures, plan fiduciaries will have a better window into the vast network of service providers that are paid amounts related to plan services. The initial disclosures from the covered service providers may be limited or difficult to understand, as many of these vendors have not operated their organization with this disclosure in mind.

Full Rebate Pass Through to Plan

Basic Rule. For a contract between a covered plan (or the sponsor of a covered plan) and a covered service provider for the provision of pharmacy benefit management services to be considered reasonable for the ERISA §408(b)(2) prohibited transaction rules, the entity providing the pharmacy benefit management services must remit "100 percent of rebates, fees, alternative discounts, and other remuneration received from any applicable entity that are related to utilization of drugs or drug spending under such health plan or health insurance coverage to the group health plan or, in the case of a health insurance issuer offering group health insurance coverage in connection with a group health plan, to the health insurance issuers offering group health insurance coverage on behalf of the plan." In essence, PBMs are required to pass through 100% of the rebates and discounts from drug manufacturers and PBM affiliates to health plan and issuer clients.

Effective Date. This rule is effective for plan years beginning on or after 30 months from the date of the CAA 2026's enactment. For calendar plan years, the effective date is January 1, 2029.

Trucker Huss Comments. This will significantly change the negotiation process with PBMs (and other entities that provide PBM services, such as third-party administrators). This has been a major source of revenue for PBMs, and they will likely increase fees in other places. This provision does not prohibit the practice of "spread pricing" where the plan pays a higher fee to the PBM than what the PBM pays to the dispensing pharmacy. Nor does it prohibit other ways that a PBM can make money in a contract, such as broad exclusions of certain types of drugs from various financial guarantees. So, while this is a welcome change, plan sponsors still need to be very diligent in their contract negotiations (and drafting).

Transparency Provisions

The CAA 2026 amends ERISA by adding a new section 726 and adds parallel provisions to the Public Health Service Act (PHSA) and the Internal Revenue Code. The rule requires extensive reporting requirements from an entity providing pharmacy benefit management services to group health plans and from group health plans to participants.

Reports to Large Employers and Large Plans. There is a very detailed set of reporting obligations that must be made to self-funded group health plans offered by large employers (at least 100 employees) or that qualify as large plans (at least 100 participants). (Large insured health plans can opt into receiving the reports.) The rule prohibits the entity providing pharmacy benefit management services from entering into contacts that would limit their ability to provide the required reporting. The transparency provisions state that the required information must be provided not less frequently than every six months (or, at the request of the group health plan, not less frequently than quarterly). The required report includes such information as:

- A list of drugs for which a claim was filed and with respect to each such drug, the contracted rates paid by the plan, rates paid to the dispensing pharmacy, the difference between those two amounts and the type of dispensing channel used (retail, mail order or specialty pharmacy)
- Net pricing
- Details about participant cost-shares (including copayments, coinsurance and deductibles)
- Amount of rebates, fees, alternative discounts, or other remuneration to be received by the plan or issuer and the entity providing pharmacy benefit management services
- A list of each therapeutic class for which a claim was filed including detailed cost information
- Other detailed information regarding drug claims
- Additional reporting of all drugs for which the plan incurred $10,000 or more in gross spending during the reporting period (or the top 50 drugs in gross spending if fewer than 50 drugs met the $10,000 threshold)

- If the entity providing pharmacy benefit management services has affiliated pharmacies (e.g., specialty home delivery programs), an explanation of any benefit design parameters that encourage or require the use of those pharmacies and percentage of total prescriptions dispensed by such pharmacies.

Reports to all Plans. Entities providing pharmacy benefit management services must provide all plans (insured and self-funded) with a summary document of most of the information required to be disclosed to large employers and large group health plans.

Disclosures to Participants. Entities providing pharmacy benefit management services must provide a summary document for plans to provide to participants and beneficiaries upon request. Written notice must be provided to plan participants, on an annual basis, regarding the new reporting requirements. Participants and beneficiaries can request specific claim-level information for claims incurred by the participant or beneficiary.

Penalties. Failure to meet these requirements can result in a civil monetary penalty of up to $10,000 per day during which the information is not provided and $100,000 (for each item of false information) if the entity knowingly provides false information.

Effective Date. This rule is effective for plan years beginning on or after 30 months from the date of the CAA 2026's enactment. For calendar plan years, the effective date is January 1, 2029.

Trucker Huss Comment. Much of this information is similar to the information that must be disclosed under the Department of Labor proposed rule titled "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure." While those regulations may be subject to judicial challenges, the Congressional statute will not. This information will help plan sponsors understand cost issues, drug trends, potential conflicts and incentives that are not aligned with the plan (but rather aligned with the interests of vendors). We anticipate proposed regulations being issued within the next year. It will be interesting to see if there will be challenges to certain state laws that require reporting by PBMs, claiming preemption of those state laws now that ERISA contains a specific reporting requirement.

If you have questions regarding the requirements of CAA 2026, how it will impact plan fiduciaries obligations or the negotiation process with PBMs, please contact us.

Amicus Briefs: The Department of Labor's New ERISA Playbook

Xiaolu Xu

In the past few months, the U.S. Department of Labor (DOL) has increasingly attempted to use court filings to shape how retirement plan rules are applied. These filings, called amicus briefs ("friend of the court" briefs), allow the DOL to weigh in on cases even if it is not a party. In effect, the DOL is signaling to courts (and the public) how it interprets the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and how plan fiduciaries should act, potentially shaping litigation outcomes and clarifying expectations without formal rulemaking.

This approach appears consistent with the DOL's broader agenda aimed at reducing compliance burdens and providing plan fiduciaries with more flexibility in terms of fulfilling the obligations. As DOL Secretary Chavez-DeRemer announced in a July 1, 2025, press release, the DOL is focused on "eliminating unnecessary regulations that stifle growth and limit opportunity." At the same time, the DOL desires to expand flexibility for workers and businesses. While the DOL's litigation positions are case-specific, they appear to signal how the agency intends to apply ERISA in practice, thus providing plan fiduciaries with a "playbook" for which decisions and processes are more likely to be viewed as prudent.

What the DOL Is Doing

The DOL has filed amicus briefs in a wide range of high-profile ERISA cases on topics such as 401(k) plan investment performance, investment fees, use of forfeitures and pension risk transfers. In January 2026, the DOL also issued press releases on some of these cases, explaining the purpose of the filings and emphasizing its primary authority in interpreting and enforcing provisions of Title I of ERISA:

- **Pension Risk Transfers**: Pension risk transfers are transactions where a defined benefit plan sponsor transfers its pension obligations to an insurance provider. Some lawsuits have claimed that fiduciaries breached their duties by engaging in these transactions. In its amicus brief to the Fourth Circuit Court of Appeals in *Konya, et al v. Lockheed Martin Corp.*, No. 25-2061 (4th Cir.), the DOL emphasized that the decision to derisk is a business choice, not automatically a fiduciary breach and that "ERISA does not allow hindsight second-guessing or Monday-morning quarterbacking of discretionary fiduciary decisions." In a January 9, 2026, press release regarding its brief in *Konya*, the DOL further clarified its position by stating that "the decision to enter a pension risk transfer is a settlor function reserved for the plan sponsor."
- **Forfeiture Use**: When defined contribution plan participants terminate active participation before they have completely vested in employer contributions, plan fiduciaries may choose to use the participants' forfeiture amounts to reduce future employer contributions and/or pay reasonable plan administrative expenses. The DOL has filed amicus briefs in favor of employers, supporting dismissal of claims in the forfeiture cases *Hutchins v. HP Inc. et al*, No. 25-826 (9th Cir.), *Wright v. JPMorgan Chase & Co. et al*, No. 25-4235 (9th Cir.), *Cain v. Siemens,* 25-2564 (3rd Cir.), and *Barragan v. Honeywell Int'l Inc*., No. 25-2609 (3rd Cir.). Specifically, in *Barragan* currently pending before the Third Circuit Court of Appeals, plan participants challenged plan fiduciaries' decisions regarding the use of forfeitures, alleging that allocating forfeited amounts to reduce employer contributions, as opposed to defraying administrative expenses, violates the fiduciary duties of loyalty and prudence. The DOL emphasized in its amicus brief that fiduciaries have flexibility under the plan at issue and noted in its press release on this case that "[t]here is no *per se* rule barring plan fiduciaries from deciding to allocate forfeited employer contributions to reduce future employer contributions rather than using those funds to offset administrative costs," and "ERISA's core principle is to protect the benefits promised to plan participants."
- **Investment Performance and Excessive Fees**: Many ERISA lawsuits challenge alleged excessive fees or underperforming investments in 401(k) plan or other defined contribution plans. The DOL has filed amicus briefs in Supreme Court cases involving plan investment, including *Parker-Hannifin Corp. v. Johnson, No.* 24-1030 (6th Cir.), and *Pizarro v. The Home Depot, Inc*., No. 24-620 (11th Cir.). Specifically, in *Pizarro* plaintiffs alleged that the plan investment options had excessive fees and were imprudent investment options, and plaintiffs attempted to shift the burden of proof onto fiduciaries to prove they acted prudently. The DOL clarified in its amicus brief that plaintiffs must prove any losses themselves, stating in a press release that

> "ERISA does not impose a special burden-shifting framework requiring defendants to disprove loss causation. Consistent with Supreme Court precedent, plaintiffs bear the burden of proving the essential elements of their claims, including loss causation."

Notably, following the change in presidential administration last year, the DOL reversed its position on the burden-shifting issue in *Pizarro*. Specifically, the DOL filed two amicus briefs in this case: first to the Eleventh Circuit in February 2023 and later to the Supreme Court in December 2025. While the DOL had argued in its February 2023 Eleventh Circuit amicus brief that ERISA fiduciaries bear the burden of disproving causation, it has more recently stated in its December 2025 Supreme Court amicus brief that "the relevant authorities are better understood as leaving the burden of proving causation on ERISA plaintiffs." The plaintiffs shortly thereafter withdrew their Supreme Court petition, which the DOL welcomed in its January 9, 2026, press release. In that press release, the DOL warned that expansive readings of ERISA could "fuel meritless litigation and impose unnecessary costs on plan sponsors—outcomes fundamentally at odds with ERISA's goals of efficiency, predictability and encouragement of employer-sponsored retirement plans." The DOL said that the outcome "should provide reassurance…that the Department of Labor is committed to ending regulation by litigation and to defending ERISA as Congress intended."

Why the DOL's Amicus Briefs Matter for Plan Fiduciaries

These amicus briefs provide insights into how the DOL views key ERISA issues and how courts may treat certain claims. For example, the amicus brief in *Konya* marks the DOL's first public position on pension risk transfer since a wave of class action lawsuits began in 2024. Amicus briefs do not create new law, but they can influence how courts interpret existing law, especially on technical ERISA questions where judges often look to agency guidance. *Pizarro* shows this in action. In this case, plaintiffs sought Supreme Court review of the Eleventh Circuit's decision they claimed was favorable to the fiduciaries. After the DOL filed its amicus brief clarifying its view that plaintiffs bear the burden of proving losses and that ERISA does not require defendants to disprove causation, the plaintiffs withdrew their petition for Supreme Court review, effectively bringing the case to an end.

Practical Steps for Plan Fiduciaries

As Daniel Aronowitz, Assistant Secretary of Labor for the Employee Benefits Security Administration, noted in a January 9, 2026, press release on the DOL's amicus brief in *Konya,* "[the DOL's] amicus brief reinforces ERISA as law of process in which plan fiduciaries have discretion and flexibility to make informed judgment calls." While amicus briefs are not binding law, the DOL's positions in these filings provide useful guidance for plan fiduciaries in establishing benchmarks for proper governance and documentation practices, thus assisting fiduciaries in making decisions in a manner the DOL is more likely to view as prudent and consistent with ERISA and related DOL guidance.

To put the perspectives gleaned from the recent DOL amicus briefs into practice, fiduciaries should consider the following points:

- **Use DOL Briefs as a Roadmap**. Treat DOL amicus briefs as a practical guide to understanding how the DOL interprets ERISA and what the DOL is likely to expect from fiduciaries.
- **Document Your Decisions**. Keep clear records of meetings, investment reviews, and service-provider choices. Note why each decision was made, what options were considered, and how the choice supports the plan's objectives.

- **Follow Plan Rules**. Make sure discretionary actions, like allocating forfeitures, follow the plan documents.
- **Monitor Investments and Fees**. Track investment performance and service-provider fees, comparing results to meaningful benchmarks when available on an ongoing basis. Even if some investments underperform or fees are questioned, documenting careful review and monitoring shows prudence.
- **Review Governance Regularly**. Periodically assess committee charters, investment policies, and decision-making processes to confirm they follow DOL guidance and reflect thoughtful, prudent decision-making.

If you have questions regarding the impact of the DOL's recent use of amicus briefs to define ERISA fiduciary duties and obligations, please contact us.

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