Benefits Report January 2026

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Are "Voluntary" Benefit Programs The Next Big Thing In ERISA Litigation?

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In late December 2025, the same law firm that initiated the wave of "excessive fee" 401(k) litigation matters in 2006 (which continues to this day) filed a spate of lawsuits alleging that several large employers (and their benefit consultants) breached their fiduciary duties under ERISA by allowing excessive or unreasonable premiums to be charged to their employees in connection with so-called "voluntary benefit" programs offered by those employers.

The common element of these voluntary benefit programs—such as accident, critical illness, cancer screening and hospital indemnity insurance—is that employers do not contribute to the premiums. Employees pay 100% of the premiums through payroll deductions.

As alleged in the complaints, voluntary benefit programs may be marketed as a way for employees to protect against rising out-of-pocket costs not covered by their employer-sponsored health insurance. For example, a "critical illness" policy may provide a lump-sum benefit to employees who are diagnosed with one of certain specified major illnesses.

The complaints generally allege that the employers offering these programs could and should have negotiated lower premiums. According to the plaintiffs, the higher premiums may be the result of potentially excessive broker commissions, and excessive compensation to the consultants that administer them. The complaints speculate that employers offer these voluntary benefit programs without first engaging in a request for proposal process.

The complaints ultimately hinge on a threshold issue: do the voluntary benefit programs at issue constitute "employee welfare benefit plans" within the meaning of ERISA §3(1) (29 U.S.C. §1002(1))? If the programs constitute employee welfare benefit plans, the fiduciaries of those plans are subject to ERISA's fiduciary duties,

including the duty of loyalty and prudence. If courts determine that the programs at issue constitute ERISA-governed benefit plans, the defendants could be held liable for breaching ERISA's fiduciary duties if they also conclude that they failed to engage in an appropriate process to negotiate the premiums being charged for those programs. If, on the other hand, the programs do not constitute employee welfare benefit plans, neither the companies that sponsor them nor the consultants that administer them could be held liable as ERISA fiduciaries in connection with their administration.

At least some employers that offer these programs do so on the assumption that they fall within a Department of Labor ("DOL") "safe harbor" regulation, 29 C.F.R. §2510.3-1(j). That regulation provides that the term "employee welfare benefit plan" *shall not* include programs that satisfy its requirements, which are that:

1. no contributions are made by an employer or employee organization (such as a union);
2. participation in the program is completely voluntary for employees;
3. the employer's sole functions regarding the program are, without endorsing the program, to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions, and to remit them to the insurer; and
4. the employer receives no consideration—cash or otherwise—in connection with the program, other than reasonable compensation (but not profit) for administrative services actually rendered in connection with payroll deductions.

Historically, most of the litigation addressing whether an employer meets the requirements of the safe harbor regulation turns on whether, in the opinion of the judge reviewing the situation, the employer's conduct rises to the level of "endorsing" the program for purposes of the third element of the regulation. DOL Advisory Opinion 1994-23A states that an employer will be considered to have endorsed a program if it "expresses … any positive, normative judgment regarding the program." As a result, the "endorsement" question is likely to be highly dependent on the specific facts of the case—as well as on the view of the judge to whom the issue is presented. In some instances, open enrollment materials and other communications generated by employers could be viewed as touting these benefit programs—facts that would tend to weigh in favor of the conclusion that the employer endorses the program.

In the context of these voluntary benefit programs, plaintiffs are also likely to assert that employers may have received some form of consideration as a result of offering the program. For example, they may assert that employers or benefit consultants have received revenue sharing, or alternatively, that benefit consultants have provided free or discounted services for the employer or its other benefit programs in recognition of the commissions the benefit consultants have received in connection with the sale of the voluntary benefit program. Those facts, if proven, could be used to show that the employer has failed the fourth element of the safe harbor regulation—that the employer has received no consideration in connection with the program.

Moreover, courts may take into account the extent to which the employer negotiates the program's premiums or features. The Sixth Circuit Court of Appeals, for example, has expressly stated that one of the factors courts should consider in determining whether an employer has "endorsed" a program is whether "… the employer plays an active role in either determining which employees will be eligible for coverage *or in negotiating the terms of the policy or the benefits* provided …" *Thompson v. America Home Assur. Co.,* 95 F.3d 429, 436 (6th Cir. 1996). Consequently, employers who actively engage in negotiating the program's terms and costs are, other things being equal, less likely to satisfy the safe harbor provisions. If courts accept the plaintiffs' theory that

the voluntary benefits programs constitute employee benefit plans, then employers who have simply offered the programs without actively negotiating their terms risk a finding that they have breached their fiduciary duties for having failed to do so.

Note that a program offered by an employer who satisfies the safe harbor requirements "shall not" be an employee welfare benefit plan. For the moment, the DOL position is that, at least with respect to larger employers, the *only* way for a program to avoid employee welfare benefit plan status is for the employer to satisfy the safe harbor regulation: "It is the Department's position that a program will be excluded from Title I of ERISA pursuant to regulation section 2510.3-1(j) only if the activities of the employer or employee organization do not exceed any of the limitations set forth in the regulation." (Adv. Op. 1994-23A.) But the DOL does not have the final word on the subject. In other contexts, courts hold that a program may not be an ERISA plan *even if* the employer has not satisfied all of the applicable safe harbor regulation's requirements: "[t]he fact that [a] plan is not excluded from ERISA coverage by this regulation does not compel the conclusion that the plan is an ERISA plan." *Howard Jarvis Taxpayers Ass'n v. California Secure Choice Ret. Sav. Program*, 997 F.3d 848, 858 (9th Cir. 2021).

Traditionally, we would expect the DOL to advocate for the position most favorable to employees/participants—in this case, that a voluntary benefit program constitutes an ERISA plan. Today's DOL may or may not toe that same party line. In recent months, the DOL has filed amicus briefs in multiple litigation matters siding with employer-defendants in ERISA litigation matters. Whether it will side with employers (and benefit consultants) in this current round of cases remains to be seen. But as a practical matter, courts facing the issue are more likely to conclude that programs sponsored by employers who do not meet the safe harbor regulation's requirements are, in fact, employee welfare benefit plans—and that those employers are subject to ERISA's fiduciary duties in connection with those plans.

In the short term, we expect most employers (and benefit consulting firms) that have been sued so far to challenge these cases on motions to dismiss. Those defendants are likely to argue, among other things, that it is purely speculative to assume that lower premiums would have resulted if the employers had negotiated more aggressively. Those arguments may resonate with business-friendly judges who are reluctant to disincentivize employers from offering valuable benefits to their employees.

What can employers that offer these programs do while we await the outcome of that litigation? First, they should review the roster of programs they offer, critically assess how those programs are communicated to their employees, and evaluate the likelihood of a successful argument that they are "endorsing" the program. They should also review the services that their benefit consultants provide for the employer and the compensation the consultant receives for those services, and evaluate whether the employer itself is receiving any consideration in exchange for offering the program to its employees. Going forward, employers should assess whether it makes more sense to assume that a court may ultimately find their program to be an employee benefit plan—and to treat those programs with the same level of oversight they do their acknowledged benefit plans—rather than to rely on a federal judge to ultimately conclude their program is exempt from ERISA.

It also makes sense for employers to assess whether they have appropriate insurance coverage in the event they are sued with respect to their voluntary benefit programs.

PBM Fiduciary Provisions of New California Law Challenged by PBM Trade Association as Preempted by ERISA

Sarah Kanter

With the passage of Senate Bill 41 (SB 41), signed by Governor Newsom on October 11, 2025, California joins a growing list of states regulating the business practices of Pharmacy Benefits Managers ("PBMs" or, singularly, a "PBM"). SB 41, authored by Bay Area Assemblymembers Scott Wiener and Aisha Wahab, regulates nearly every aspect of a PBM's business practice, including its relationships with pharmacies, drug manufacturers, health insurers, health care service plans—it even contains provisions that apply to self-funded health plans. In so doing, SB 41 makes changes to California's Business and Professions Code, various sections of the Health and Safety Code, and the Insurance Code.

One of the more notable provisions of SB 41, added to the Business and Professions Code, is that a PBM owes a "fiduciary duty" to any self-funded employee benefit plan with which it contracts. This specific provision is now the subject of a lawsuit filed on January 2, 2026, by the Pharmaceutical Care Management Association ("PCMA"), a trade association of PBMs ("the Complaint"). The Complaint, which names the California Attorney General and Director of the California Department of Consumer Affairs, seeks to enjoin this provision on the grounds that it is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). Below is an examination of the legal framework, the fiduciary standards requirement of SB 41, the pending PCMA lawsuit and relevant precedent.

ERISA Background

To understand the PCMA lawsuit, it is important to understand fiduciary status and preemption under ERISA.

Under ERISA, whether a person is a fiduciary can be based on the tasks they perform for an ERISA-covered employee benefit plan—that is, it can be a functional inquiry. Specifically, ERISA Section 3(21)(a) states that a person is a fiduciary with respect to an employee benefit plan if they (i) exercise discretion related to the management of the plan or disposition of plan assets; (ii) render investment advice for a fee; or (iii) possess discretion regarding the administration of the plan.[1] A person who performs purely ministerial functions for a plan within a framework of policies, procedures and rules made by other persons is not a fiduciary.[2]

Consequently, whether a PBM (or any other service provider) is a fiduciary with regard to the contractual services they perform for health plans, like pricing or formula creation, is a functional test as to whether they are exercising discretion over the management of the plan or its assets. Courts have reached varying conclusions when examining whether a PBM is fiduciary based on the specific duties performed by the PBM and the relevant contractual language.[3] Most PBM contracts contain provisions expressly stating that the PBM is not an ERISA fiduciary, except when they exercise discretion to determine appeals on behalf of the plan.

Fiduciary status is critical, because it triggers ERISA's fiduciary standards, which importantly includes:

- *The exclusive purpose rule*—fiduciaries must act for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan; and[4]

- *The prudence rule*—fiduciaries must act with the care, skill, prudence and diligence that a "prudent man" familiar with such matters would use.[5]

Fiduciaries are also prohibited from entering into "prohibited transactions"[6] and may face civil and financial penalties for breaches of fiduciary duty.

Suffice it to say, if PBMs were universally required to be ERISA fiduciaries it would necessitate a seismic shift in their current business practices and compensation model.

ERISA Preemption

ERISA Section 514 contains a broad preemption clause which states that ERISA supersedes "any and all State laws insofar as they may now or hereafter relate" to any "employee benefit plan" subject to ERISA.[7] ERISA does not preempt state laws that regulate the business of insurance, banking or securities. Under Supreme Court precedent, a state law "relates to" an employee benefit plan if it has an "impermissible connection with" or a "reference to" such a plan.

- *Connection With*—Courts consider whether a state law governs a central matter of plan administration or interferes with a nationally uniform administration.[8]
- *Reference To*—A state law refers to ERISA if it acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation.[9]

Fiduciary Duties Imposed on PBMs by SB 41

SB 41 amends California's Business and Professions Code to apply to any PBM contract entered into or renewed on or after January 1, 2019. For self-insured group health plans, the law specifically states that PBMs have a "fiduciary duty" to a "self-insured employer plan" that includes:

- A duty to be fair and truthful to your client;
- To act in the client's best interests;
- To avoid conflicts of interest; and
- To perform its duties with care, skill, prudence and diligence.[10]

While similar to ERISA's fiduciary requirements, it does not use identical language, or state that the PBM is a fiduciary *under* ERISA.

PMCA's Lawsuit

PMCA's Complaint, filed in the U.S. District Court for the Central District of California, asserts that SB 41's fiduciary duty provision is preempted by ERISA. PMCA seeks a declaration that this provision is preempted by ERISA and an injunction prohibiting it from being enforced.

PMCA's arguments in favor of ERISA preemption of the fiduciary standards provision for self-funded employer plans center around three main points:

- It makes an impermissible reference to ERISA plans because it specifically references "self-insured employer plans" (i.e., ERISA plans) in the law itself;
- It regulates in a field already fully occupied by federal standards given ERISA comprehensively governs fiduciaries, including who is a fiduciary and under what circumstances fiduciary duties may be delegated,

and what is required of a plan fiduciary in protecting beneficiaries and plan assets; and
- It requires plan sponsors to design or structure their plan in a particular way, by requiring that plan sponsors design their benefit plan around the fact a PBM will be considered a "deemed fiduciary" under California law.

The Complaint asserts that absent immediate relief, this provision will "upend existing contracts, compels costly alterations to business practices and exposes PBMs to new litigation risks untethered to ERISA's uniform fiduciary framework."

Relevant Precedent

We have only been able to find one other state, Maine, that has a similar law to SB 41's fiduciary standards provision. While other states, such as Vermont, impose fiduciary standards on PBMs that contract with insured health plans, Maine is the only state we are aware of that imposes a fiduciary standard on contracts with self-funded plans. In 2005, the First Circuit Court of Appeals upheld Maine's Unfair Prescription Drug Practices Act ("UPDPA") against an ERISA preemption challenge.[11] The UPDPA, among other things, imposed on PBMs certain fiduciary duties and "required practices," which duties and obligations are owed to the PBMs' benefits provider customers—labeled "covered entities" under the UPDPA. Among other duties, the UPDPA requires that PBMs "shall notify the covered entity in writing of any activity, policy or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of interest with the duties imposed by this subsection." The UPDPA also compels PBMs to disclose certain financial and pricing information to covered entities.

The PCMA challenged the UPDPA as being preempted under ERISA. In examining the issue, the First Circuit found the following:

- the UPDPA did not circumscribe the ability of plan administrators to structure or administer their ERISA plans.
- the existence of ERISA plans is not essential to the operation of the UPDPA because the UPDPA applies regardless of whether PBMs are serving ERISA plans, because "covered entities" under the UPDPA includes health plans, labor union plans, association plans, insurance companies, HMOs, medical service organizations and the state Medicaid program. If the reference to employee health plans was deleted from the text of the UPDPA, the statute would still be operable.[12]

Trucker Huss Note: Central to the First Circuit's determination that the UPDPA was not preempted was that it applied to other entities, such Medicaid plans and insured plans, not just ERISA plans. Given that the fiduciary standards provision at issue in the lawsuit expressly applies only to "self-insured employer plans" and does not apply to any other entities, it may be harder for California to argue that SB 41 does not make an impermissible "reference" to an ERISA plan. However, the analysis will be complicated by the fact that a different section of SB 41 amends the Health and Safety Code to require that PBMs have a fiduciary duty to insured plans, using nearly identical language.[13]

Next Steps

The Attorney General has not yet responded to the Complaint. We anticipate that this will be the first of many lawsuits challenging SB 41 on various legal grounds.

We will keep you apprised as the litigation proceeds.

[1] A person may also be considered a fiduciary by the nature of the position they hold with respect to the plan, such as Trustee or plan administrator, because by the very nature of the position the person would have discretionary authority over the administration of the plan. ERISA Section 402((a) also requires that the written plan document provide for one or more "named fiduciaries" who are responsible for the control and management of the operation and administration of the plan.

[2] See for example, *Chicago District Council of Carpenters Welfare Fund v. Caremark, Inc.* 474 F.3d 464 (7th Cir. 2007); *Moeckel v. Caremark, Inc.,* 622 F.Supp. 2d 663, 682 (M.D. Tenn. 2007); *Negron vs. Cigna Health & Life Ins.,* 300 F. Supp. 3d 341 (D. Conn. 2018).

[3] ERISA Section 404(a)(1)(A).

[4] ERISA Section 404(a)(1)(B).

[5] ERISA Section 406.

[6] 29 U.S.C. §1144(a)

[7] *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016).

[8] *Id.*.

[9] Business and Professions Code § 4441(c)(2).

[10] *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005)

[11] *Id.* at 304.

[12] Health and Safety Code 1385.0022.

PUBLICATION INFO:

The Trucker Huss Benefits Report is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of the Benefits Report are posted on the Trucker Huss website (www.truckerhuss.com (https://www.truckerhuss.com))

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