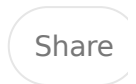
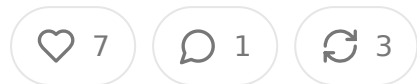


The Coming Storm: Why ERISA Fiduciary Liability Could Reshape Healthcare Benefits and Create a Massive Angel Investment Opportunity

NOV 16, 2025



DISCLAIMER: The views and opinions expressed in this essay are my own and do not reflect those of my employer, Datavant, or any other organization with which I am affiliated.

If you are interested in joining my generalist healthcare angel syndicate, reach out to treysrawles@gmail.com or send me a DM. Accredited investors only.

ABSTRACT

This essay examines the emerging wave of ERISA fiduciary liability lawsuits against self-insured employers and their potential to fundamentally restructure the American healthcare benefits landscape. Mark Cuban's recent warning that pharmacy rebate litigation will dwarf tobacco settlements may sound hyperbolic, but the underlying economics and legal framework suggest he's onto something significant. For healthcare tech angel investors, this represents a generational opportunity to back companies building transparent alternatives to the current opacity-driven benefits model. This essay explores the legal mechanics of ERISA fiduciary duty, analyzes recent high-profile litigation including Wells Fargo and Johnson & Johnson cases, examines how employers are caught between PBMs and employees, and identifies specific

investment opportunities in benefits administration, pharmacy services, claims analytics, and fiduciary compliance technology.

TABLE OF CONTENTS

The Legal Framework: ERISA Fiduciary Duty and the CAA

The Economics of Rebate Capture and Why Everyone's Incentives Are Misaligned

Recent Litigation: Wells Fargo, J&J, and Kraft Heinz as Canaries in the Coal Mine

The Employer Dilemma: Caught Between TPAs and Employee Lawsuits

Why This Could Actually Dwarf Tobacco Settlements

Investment Opportunities: Where Angels Should Be Looking

The Second-Order Effects Nobody's Talking About Yet

The Legal Framework: ERISA Fiduciary Duty and the CAA

So here's the thing about ERISA that makes this whole situation so explosive and most people outside benefits law don't fully appreciate. When Congress passed the Employee Retirement Income Security Act back in 1974, the primary focus was on pension plans and making sure employers couldn't screw over workers who'd spent decades at a company only to find their retirement benefits evaporated. But ERISA also covers health plans, and it imposes what lawyers call fiduciary duties on employers who sponsor self-funded health plans. These aren't just guidelines or suggestions. They're legally enforceable obligations that require plan sponsors to act solely in the interest of plan participants and beneficiaries, to act prudently, to follow plan documents, and to pay only reasonable expenses.

The key word there is reasonable. For decades, this requirement existed mostly in theory because employers had almost no visibility into what was actually reasonable healthcare pricing. The whole system was built on opacity. Your PBM tells you they negotiated great discounts, your consultant tells you the rebates are competitive

you have no real way to verify any of it because you can't access comparable price data and the contracts are written in a way that makes it nearly impossible to understand what you're actually paying for.

Then came the Consolidated Appropriations Act of 2021, which fundamentally changed the game in two ways. First, it required consultants and brokers to disclose any direct or indirect compensation they receive related to the services they provide to plan sponsors. This seems obvious in retrospect but was actually revolutionary because it forced into the light a bunch of relationships that had operated in the shadows for years. Your benefits consultant recommending a particular PBM arrangement might be getting paid by that PBM, which creates an obvious conflict of interest that the employer didn't necessarily know about.

Second, the CAA implemented price transparency requirements that gave employers new tools to actually understand what they're paying versus what services cost in the market. These transparency rules are still rolling out and enforcement has been inconsistent, but they're creating data that didn't exist before. When you can see your plan paid ten thousand dollars for a generic drug that costs forty bucks at a pharmacy, that's not just an academic exercise. That's evidence that you might be violating your fiduciary duty by paying unreasonable expenses.

What makes this particularly thorny is that ERISA fiduciary duty is a personal liability. It doesn't just attach to the company. It can attach to individual plan fiduciaries, which usually means HR executives, CFOs, and benefits committee members. These are people who often didn't fully understand they were taking on a high level of personal legal exposure when they agreed to oversee the health plan. And unlike corporate officers who have business judgment rule protections in a lot of contexts, ERISA fiduciaries are held to a prudent expert standard. You're supposed to act with the care and skill that a prudent person familiar with such matters would use.

The Economics of Rebate Capture and Why Everyone's Incentives Are

Misaligned

Let's talk about why Mark Cuban is specifically focused on pharmacy rebates, because this is where the economics get really perverse and where the potential damages from litigation could be astronomical. The pharmaceutical rebate system is one of the things that makes perfect sense if you don't think about it too hard and makes absolutely no sense once you understand how it actually works.

Here's the basic model. Drug manufacturers pay rebates to PBMs based on formulary placement and utilization. The more a PBM can steer patients toward a particular drug, the bigger rebate they can negotiate from that manufacturer. Sounds reasonable, right? The PBM is using their scale to negotiate better pricing. Except the rebate is typically based on a percentage of the list price, which creates an incentive for manufacturers to raise list prices so they can offer bigger rebates while maintaining their net revenue. And the PBMs prefer high-list-price drugs with big rebates over low-list-price drugs with no rebates, even when the low-list-price drug would actually cost the plan less overall.

So you end up in situations like the Johnson & Johnson lawsuit where a ninety-day supply of a generic multiple sclerosis drug costs the plan over ten thousand dollars when you could walk into a pharmacy and buy it for forty bucks cash. The reason that the drug is expensive to make or distribute. It's that it's been designated as specialty medication, which allows it to move through specialty pharmacy channels where the pricing is completely divorced from any underlying cost structure and instead reflects rebate arrangements and spread pricing and all sorts of intermediate value capture.

The PBM is making money on spread, on rebates that they may or may not fully pass through to the plan sponsor, on mail order fulfillment fees, on specialty pharmacy dispensing fees, and on data analytics services. The consultant who recommends a PBM arrangement might be getting a percentage of rebates or administrative fees that they're not fully disclosing. The plan sponsor thinks they're getting a good deal because the PBM tells them they're receiving millions in rebates, but they have no

visibility into how much rebate was actually negotiated or how much the PBM retained.

And here's where it gets even more twisted. The employees are paying copays and meeting deductibles based on these inflated prices. So when the plan pays ten thousand dollars for a drug that should cost forty dollars, the employee might be paying two thousand dollars in coinsurance. That comes out of their pocket, it counts toward their out-of-pocket maximum, and it's based on a price that has no relationship to the actual cost of the medication. From an ERISA perspective, that's potentially catastrophic because the fiduciary allowed the plan to pay unreasonable expenses, which directly harmed the plan participants.

The total amount of money flowing through this system is staggering. Americans spent about four hundred and twenty billion dollars on retail prescription drugs in 2023. Rebates are estimated at somewhere between fifteen and thirty percent of prices depending on the drug category, though the exact numbers are closely guarded secrets. Let's be conservative and say rebates are a hundred billion dollars annually. Even a quarter of that is being captured in ways that violate ERISA fiduciary duties. You're looking at twenty-five billion a year in potential damages. Multiply that by a few years of lookback period and you start to understand why Cuban thinks this dwarfs tobacco settlements.

Recent Litigation: Wells Fargo, J&J, and Kraft Heinz as Canaries in the Coal Mine

The Wells Fargo lawsuit filed in July is particularly interesting because Wells Fargo is exactly the kind of sophisticated employer you'd expect to have this stuff figured out. They're a massive financial services company with armies of lawyers and benefits experts. If they're allegedly paying inflated prices to Express Scripts, it suggests the problem is systemic rather than just a few unsophisticated employers getting taken advantage of.

The complaint alleges that Wells Fargo breached its fiduciary duties by failing to adequately monitor and control the costs charged by Express Scripts, by allowin

Express Scripts to charge excessive prices for prescription drugs, and by failing to leverage its size and bargaining power to negotiate better terms. What's notable is that the lawsuit isn't claiming Wells Fargo and Express Scripts engaged in fraud or that there was some hidden kickback scheme. It's arguing that the prices Wells Fargo agreed to pay were unreasonable on their face and that a prudent fiduciary would have negotiated better terms or selected a different PBM.

This is a much broader theory of liability than fraud-based claims, and if it succeeds it could open the floodgates. Because if the argument is just that employers have a duty to pay reasonable prices and to actively monitor whether their PBM is charging reasonable prices, then pretty much every large self-insured employer is potentially exposed. Very few employers have the data infrastructure and analytical capabilities to continuously benchmark their pharmacy spending against market rates and to understand whether the rebates they're receiving are competitive.

The Johnson & Johnson case is even more striking because of the specific example. Paying ten thousand dollars for a drug available for forty dollars cash isn't a close call. It's not a situation where reasonable people might disagree about whether the price was fair. It's prima facie evidence of unreasonable expenses. And J&J can't claim ignorance because the price transparency rules mean this data is theoretically available. The lawsuit specifically alleges that J&J knew or should have known about the pricing disparities and failed to act.

What makes the J&J case a potential bellwether is the theory that allowing these inflated drug costs harmed employees not just through direct cost-sharing but also through constrained wage growth. The argument is that every dollar the employer spends on excessive health plan costs is a dollar that can't be spent on wages or compensation. This dramatically expands the potential damages because now you're not just talking about recovering excess payments to the PBM. You're talking about compensating employees for the wage growth they would have received if the employer had been a prudent fiduciary.

The Kraft Heinz case against Aetna is interesting for different reasons. Kraft Heinz alleged that Aetna was enriching itself through undisclosed fees and processing

claims without adequate review, which Aetna was able to do because they control access to the claims data. When Kraft Heinz tried to audit their own plan, Aetna allegedly stonewalled them. The case ended up in arbitration, which means we won't get a public ruling, but the fact that it was filed at all shows that even employers who want to be good fiduciaries are struggling to get the data they need to fulfill that obligation.

This creates a fascinating dynamic where employers are simultaneously potential defendants in employee lawsuits and potential plaintiffs in lawsuits against their TPAs and PBMs. The employers are arguing they can't be good fiduciaries because TPAs won't give them data, while the employees are arguing the employers should have done more to obtain the data and monitor costs. Both things can be true, which is part of why this whole situation is such a mess.

The Employer Dilemma: Caught Between TPAs and Employee Lawsuits

There's a quote in the source material from Christin Deacon that really captures the employer predicament. She notes that if an employer signed a bad contract that allowed egregious behavior, the TPA can turn around and ask why the employer didn't act on that. This is the "you should have known better" defense, and it's surprisingly effective because ERISA fiduciary duty is a prudent expert standard. You're supposed to understand these contracts and what you're agreeing to.

But here's the reality. These contracts are deliberately complex and opaque. A typical PBM contract might be a hundred pages of defined terms and cross-references and carve-outs and exceptions. The pricing models involve ingredient costs and dispensing fees and rebates and administrative fees and network discounts and spread pricing and clawbacks and who knows what else. Most employers don't have anyone on staff with the expertise to fully understand these arrangements, which is why they hire consultants. But the consultants may have conflicts of interest that aren't fully disclosed, and even the consultants often don't fully understand the economics because the PBMs treat their pricing models as proprietary.

So employers are stuck. They can't fulfill their fiduciary duties without data and expertise they don't have. They can't get the data without aggressive auditing and litigation against their TPAs, which is expensive and time-consuming and might violate their contracts. They can't trust their consultants because the consultant might be getting paid by the vendors they're recommending. And they can't just ignore the problem because employees are starting to sue.

Deacon's advice is basically get your house in order. Review your contracts, request your data, document everything you're doing to try to be a prudent fiduciary. That's good advice but it's also kind of terrifying from the employer's perspective because it amounts to "create a paper trail showing you're trying to comply but probably still falling short." If you document that you asked for data and the TPA refused to provide it, that's evidence you knew there was a problem. If you don't document it, that's evidence you weren't being diligent. It's a lose-lose.

What I think is going to happen, and what creates the big investment opportunity, is that employers are going to start demanding fundamentally different arrangements. Instead of traditional PBMs with rebates and spread pricing and all the opacity, they're going to move toward pass-through pricing models where they can see exactly what they're paying for what. Instead of trusting consultants who might have conflicts, they're going to hire fiduciary advisors who have legal obligations to act in the employer's interest. Instead of accepting claims data in whatever format the provider feels like providing, they're going to demand normalized data feeds that can be analyzed against market benchmarks.

This is already starting to happen in pockets. Some employers have moved to direct contracting with pharmacies or manufacturer arrangements. Some have hired independent fiduciary advisors or brought benefits expertise in-house. Some have implemented advanced analytics platforms that benchmark their spending in real time. But it's still a small minority, and the inertia in this market is enormous. Many employers are still in denial about the scope of the problem.

Why This Could Actually Dwarf Tobacco Settlements

When Mark Cuban says this could dwarf tobacco settlements, people's initial reaction is usually that he's exaggerating for effect. The tobacco settlements were about two hundred and six billion dollars over twenty-five years. That's an enormous amount of money. How could pharmacy rebate litigation possibly reach that scale?

But when you actually run the numbers, it's not that crazy. There are about thirty-three thousand self-insured employers in the United States covering roughly six hundred million people. Total healthcare spending for employer-sponsored insurance is about one trillion dollars annually, of which maybe four hundred billion is pharmacy. If you assume fiduciary breaches led to excess costs of even ten percent of pharmacy spending, that's forty billion a year. Over a six-year statute of limitations for ERISA claims, you're at two hundred and forty billion in potential damages before you even consider wage loss claims or multipliers for bad faith.

And unlike tobacco litigation where the defendants were a relatively small number of manufacturers, in ERISA fiduciary litigation, every self-insured employer is a potential defendant. The law firms bringing these cases can file hundreds or thousands of lawsuits targeting employers across every industry. Class certification is relatively straightforward because all the plan participants were harmed in the same way by the same fiduciary breaches. The discovery process forces employers to produce their contracts and claims data, which often reveals even worse problems than the plaintiffs initially alleged.

What's more, these cases can be brought by individuals or small groups without needing government enforcement. The tobacco settlements required state attorneys general to drive the litigation. ERISA cases just need affected plan participants, and there are tens of millions of them. Once a few cases result in significant verdicts or settlements, you'll see a litigation wave that makes the PBM pricing lawsuits of the last few years look quaint.

The other factor is that ERISA allows for recovery of profits by fiduciaries who breached their duties. If a PBM or consultant or TPA made money because of a fiduciary breach, the plan can recover those profits even if they exceed the plan's actual losses. This creates a multiplier effect where damages could be much larger than just the excess costs paid by the plans.

There's also the potential for criminal liability in extreme cases. ERISA violations can be federal crimes if they involve fraud or intentional misconduct. While most of cases are probably civil matters, if discovery reveals that PBMs or consultants knowingly structured arrangements to violate fiduciary duties, DOJ could get involved. That would take this to an entirely different level.

Investment Opportunities: Where Angels Should Be Looking

Okay, so if you accept the premise that there's going to be a massive restructuring of the employer benefits market driven by ERISA litigation and fiduciary concerns, where are the investment opportunities? I think there are several categories that are going to see explosive growth over the next five to seven years.

First, transparent PBM alternatives and pass-through pricing models. Companies like Mark Cuban Cost Plus Drug Company are the obvious examples, but there's room for a lot more innovation here. You need solutions that can work at scale for large employers, that can handle complex formulary management and utilization management, and that can integrate with existing benefits administration platforms. The key differentiator is complete pricing transparency and alignment of incentives. The PBM should make money from transparent administrative fees, not from rebate retention or spread pricing. Employers should be able to see exactly what they're paying for every prescription and how that compares to market rates.

The challenge with this model is that you're asking employers to give up rebates, which sounds scary even though the rebates are often illusory. The pitch has to be that with transparent pricing, the net cost is lower even without rebates because you're not paying the markup that funds the rebates in the first place. You also need to solve

specialty pharmacy, which is where the worst abuses occur but also where traditional PBMs claim they add the most value through clinical management.

Second, fiduciary compliance and monitoring platforms. Employers need tools to help them fulfill their ERISA obligations by continuously benchmarking their costs, identifying outliers, and documenting their oversight activities. Think of it as compliance software but for health benefits instead of financial reporting. The platform would ingest claims data from the TPA, benchmark it against market rates and peer employers, flag potential fiduciary issues, and create an audit trail showing what the employer did to investigate and address problems.

This is a technical challenge because claims data is notoriously messy and non-standardized. You need sophisticated data normalization and entity resolution to make apples-to-apples comparisons across plans. You also need benchmarking data, which means either building a network of employers who'll share anonymized data or licensing data from clearinghouses. The business model is probably SaaS with pricing based on covered lives, and you'd sell to CFOs and benefits leaders who are terrified of personal liability.

Third, independent fiduciary advisory services. This is less of a technology play and more of a professional services opportunity, but there's absolutely a tech-enabled version of this. The idea is to create a firm that explicitly takes on fiduciary responsibility for benefits decisions, charges transparent fees, has no conflicts of interest with vendors, and helps employers navigate the complexity. You'd do RFPs for PBMs and TPAs, review contracts, monitor ongoing performance, and provide documented advice on fiduciary compliance.

The key innovation is structuring this as an actual ERISA 3(16) or 3(38) fiduciary where you're taking on legal liability, not just consulting. That's scary from a liability perspective but it also commands much higher fees and creates real differentiation. You could build a platform that automates a lot of the analytical work while still providing expert human judgment on the hard decisions. The market is employers who want to outsource this headache to someone who actually knows what they're doing and is willing to put skin in the game.

Fourth, direct contracting infrastructure and enablement. Employers who want out the PBM middleman and contract directly with pharmacies or manufacturer need tools to actually operationalize that. You need claims adjudication platform can handle direct contracts, network management tools that can credential and contract with pharmacies at scale, and member-facing interfaces that explain how new model works. You also need actuarial and clinical expertise to design these arrangements in a way that manages risk and maintains quality.

This is probably a picks-and-shovels opportunity where you're not the employer PBM replacement but you're providing the infrastructure that enables direct contracting. The business model could be transaction fees or SaaS or some combination. The challenge is that every direct contracting arrangement is somewhat bespoke, so you need platforms that are configurable rather than one-size-fits-all.

Fifth, litigation support and expert services. There's going to be a cottage industry of expert witnesses, consultants, and data analysts supporting ERISA litigation. Plaintiff's attorneys need experts who can analyze claims data, opine on whether fiduciaries acted prudently, and quantify damages. Defendants need experts who defend their decision-making and show they acted reasonably given the information available. This isn't a venture-scale opportunity but it's a good services business that might be a precursor to building software tools that commoditize some of the analytical work.

The Second-Order Effects Nobody's Talking About Yet

Beyond the direct investment opportunities, I think there are some second-order effects of this ERISA litigation wave that are going to create interesting market dynamics and additional opportunities.

One is that employers are going to dramatically reduce their risk by shifting back to fully-insured plans where the insurance carrier takes on the fiduciary liability for benefits decisions. This sounds like it would shrink the market for benefits innovation, but I actually think it could accelerate it because fully-insured carriers

going to face the same transparency and fiduciary pressures. They can't just tell employer clients "trust us, we've got it handled" anymore. They need to prove they're delivering value and managing costs appropriately.

Another is that benefits brokers and consultants who have conflicts of interest are going to get disintermediated. The traditional broker model where you get paid commissions and fees from carriers is fundamentally incompatible with fiduciary duty. Some brokers are already pivoting to fee-only models, but a lot of them are going to struggle with this transition. That creates opportunities for new players who are built from the ground up as fiduciaries with no legacy conflicts.

There's also going to be pressure on PBMs to either go full transparency or exit the employer market entirely. The traditional PBM model of rebate retention and spread pricing is probably incompatible with ERISA compliance, which means PBMs either need to restructure as transparent pass-through service providers or focus on fully insured plans and Medicare where fiduciary standards are different. This is actually one of the reasons I think the PBM consolidation trend might reverse. The vertically integrated insurer-PBM model made sense in a world where opacity was profitable but it's a liability in a world where transparency is legally required.

We might also see regulatory intervention if the litigation wave gets bad enough. Congress could amend ERISA to provide safe harbors for employers who follow certain processes or meet certain disclosure standards. DOL could issue guidance on what constitutes reasonable expenses in different contexts. This would create compliance opportunities but also risk cementing incumbents if the regulations favor existing players.

The last second-order effect I'll mention is the potential impact on drug pricing broadly. If employer plans start refusing to pay inflated prices for generic drugs, that puts pressure on the whole specialty pharmacy pricing model. Manufacturers and specialty pharmacies can't sustain their current economics if large employers are contracting around them. You could see a repricing of entire drug categories, which would have knock-on effects on Medicare and Medicaid and the uninsured. This

probably a good thing from a societal perspective but it's going to be chaotic for companies whose business models depend on the current pricing structure.

For angel investors, the key insight is that we're at the beginning of a multi-year restructuring of a trillion-dollar market driven by legal liability and fiduciary duty. The companies that can help employers navigate this transition, that can provide transparency and alignment of incentives, and that can demonstrate defensible fiduciary compliance are going to capture enormous value. This isn't a story about incremental improvement in benefits administration. It's a story about forced migration from an opacity-based market structure to a transparency-based market structure, and those kinds of transitions create generational investment opportunities.

The tobacco settlement analogy might actually undersell it, because tobacco was about paying for past harms while this is about restructuring an ongoing market. Every dollar that currently flows through opaque PBM arrangements is potential for grabs. Every employer that's currently at risk of ERISA litigation is a potential customer for compliance and monitoring tools. Every benefits advisor that's currently conflicted is a potential customer for fiduciary enablement platforms. The total addressable market is measured in hundreds of billions of dollars, and we're in the early innings of companies being built to capture it.



7 Likes • 3 Restacks

← Previous

Next →

Discussion about this post

Comments

Restacks



Write a comment...



Randy  Randy Nov 16

100% Support!

 LIKE  REPLY