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BLOG

Recent Developments Highlight the Need for Fiduciary Attention to Health Plan Fees

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New transparency requirements under the Affordable Care Act and the Consolidated Appropriations Act have ushered in a new era of fee and pricing transparency with respect to the Employee Retirement Income Security Act (ERISA) group health plans. These rules place new obligations on group health plans and health insurance issuers, including publicly reporting health plan prices for medical and prescription drug services, developing cost-sharing tools for plan participants, eliminating surprise billing, removing gag clauses from health plan contracts, and reporting pharmacy benefits and prescription drug costs to the federal government. The new transparency rules also require brokers and consultants who provide services to group health plans to provide certain fee disclosures to plan fiduciaries so that they may satisfy their ERISA obligations to determine reasonableness of fees.

We have received several inquiries from clients with regard to their fiduciary obligations when engaging and monitoring their health plan service providers in light of recent case law and regulatory guidance. In addition, the plaintiffs' bar has taken interest in this issue, as evidenced by a recent case filed in the U.S. District Court of New Jersey.

In *Lewandowski v. Johnson & Johnson*, a participant in the Johnson & Johnson medical plan (the Plan) filed a class action against the Plan and its fiduciaries alleging that the defendants breached their fiduciary duties and other violations under ERISA, seeking damages as well as injunctive and equitable relief.[1] The lawsuit alleges that the fiduciaries mismanaged the Plan's prescription drug benefits, costing the Plan and its "employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth." Specifically, the plaintiffs allege the Plan's fiduciaries mismanaged the Plan's specialty drug program by agreeing to pay the Plan's pharmacy benefits manager (PBM) higher prices for many generic specialty drugs that are available at lower prices and by designing the Plan to incentivize Plan participants to obtain prescriptions from the PBM's own mail-order pharmacy, even though the mail-order pharmacy's prices are higher than the prices participants and the Plan would pay at other pharmacies. The plaintiffs further allege that the Plan's fiduciaries breached their fiduciary obligations by failing to exercise prudence in selecting the PBM as a service provider, failing to adequately negotiate the Plan's contract with the PBM and prudently exercise their rights under the PBM agreement, and failing to adequately consider carving out their specialty drug program from their broader PBM contract. The plaintiffs allege that these failures resulted in higher profits for the PBM, which retained the difference between the amount the PBM paid to obtain the drug and the amount charged to the Plan and its participants. A unique fact in this case is that the Plan is funded through a VEBA.

The Consolidated Appropriations Act's transparency rules (the Transparency Rules) and ERISA Section 408(b)(2) may be contributing to these lawsuits. For plan years beginning on or after January 1, 2024, the Transparency Rules require health plans to provide participants an online tool providing personalized, real-time, cost-share estimates for medical and pharmacy covered services. This requirement has enhanced cost awareness among plan participants. In addition, amendments to ERISA Section 408(b)(2), which has been extended to health plans, require a health plan's fiduciaries to review the direct and indirect compensation paid to certain types of service providers when determining whether the service provider's fees are reasonable. The new disclosure rules place increased obligations on health plan fiduciaries to determine whether any direct or indirect compensation paid to a broker or consultant in connection with an ERISA group health plan is reasonable. Penalties for failure to comply with these new disclosure requirements could include the plan fiduciary being held liable for any losses to the plan that result from the non-exempt prohibited transaction and fiduciary breach associated with an imprudent services arrangement. Damages can include removal of the plan's fiduciar(y/ies), removal of service providers, restoration to the plan of any excess fees or commissions, liability for knowing participation in a prohibited transaction, participant class actions, and U.S. Department of Labor (DOL) actions or settlements, any of which could also result in reputational damage to the plan sponsor and the plan.

Most employer-sponsored group health plans are subject to ERISA, which places strict obligations on the conduct of plan fiduciaries responsible for such plans. A person exercising discretion in administering and managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for, or on behalf of, the plan. Fiduciaries are required to act solely in the interest of plan participants and beneficiaries, for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan, and in accordance with the duty of care and prudence required under ERISA. While ERISA applies equally to retirement and health and welfare plans, the fiduciary spotlight has traditionally been focused on retirement plans, which have been subject to a dramatic increase in class action fee litigation, resulting in high-dollar court decisions and settlements. As a result, retirement plan fiduciaries have been motivated to develop rigorous plan governance and oversight of the plan's service providers. Historically, less attention has been paid to the service providers that serve group health plans, but the new Transparency Rules and fee disclosure requirements necessitate a fresh review of group health plan fiduciary governance and administration.

ERISA's prohibited transaction rules limit the types of transactions a plan can enter into with "parties in interest," which include insurers and service providers to the plan. The service provider exemption to the prohibited transaction rules permits a plan to pay reasonable compensation to a party in interest providing necessary services for the plan. Thus, fiduciaries of ERISA group health plans have a duty to ensure that the assets of the plan are used only to pay benefits or reasonable expenses of the plan. Complying with ERISA fiduciary duties for group health plans has been challenging due to the lack of fee transparency. However, the new Transparency Rules and fee disclosure requirements seek to put more fee and pricing information into the hands of health plan fiduciaries and other stakeholders to shed light on the opaque nature of these fees.

Winston Takeaway: In light of these new transparency requirements, plan sponsors would be well advised to assess their group health plan governance and fiduciary oversight of service providers. In particular, plan sponsors should engage in the following action items:

- Consider whether to formally delegate fiduciary responsibility for group health plan governance to a committee and develop a committee charter to set forth committee responsibilities and any limitations on authority.
- Confirm group health plan fiduciaries are covered under existing fiduciary liability insurance and indemnified in plan documents.
- Review existing group health plan service provider agreements to confirm whether the new broker/consultant disclosure requirements apply, and if so, request service provider fee disclosures.
- Evaluate service provider disclosures in accordance with the ERISA fiduciary requirements in relation to the quality, nature, and scope of the services provided. In particular, consider following existing DOL guidance on retirement plan fees. Another helpful resource is the DOL white paper, "Understanding Your Fiduciary Responsibilities Under a Group Health Plan."

- Consider amending service provider agreements to incorporate contractual obligations requiring the service provider to cooperate with the plan sponsor in meeting the new group health plan transparency and fee disclosure requirements.
- Establish a process to regularly monitor group health plan fees to ensure that they are reasonable and in accordance with industry standards. Consider conducting an RFP for group health plan service providers every few years to benchmark fees, compare available pricing options and service providers, and evaluate negotiated pricing for underlying drugs and health care services accessed through the service provider.
- Document the review process and specify how the reasonableness of compensation was determined in selecting and monitoring service providers. Documentation of a well-designed and prudent fiduciary process for group health benefit plan governance is key.

By addressing best practices, effective plan governance, and fiduciary obligations proactively, plan sponsors and fiduciaries of group health plans will be better positioned to defend against government audits and excessive-fee litigation. For more details on procedurally prudent best practices, please contact your Winston & Strawn benefits partner.

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[1] *Lewandowski v. Johnson & Johnson, et al.*, 1:24-cv-00671 (Feb. 5, 2024).

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