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Health Plan Fiduciaries—Ways to Avoid Litigation Based on High Fees

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Introduction

- The Consolidated Appropriations Act, 2021 ("CAA") requires a new level of transparency on pricing and fees charged to health plans
- Health plan fiduciaries need to understand what do with this this additional information—and how to use it to negotiate lower fees
- We will discuss provisions of the CAA that a fiduciary can use to try and obtain information needed to determine if health plans are being overcharged for services
- We will also discuss how those requirements may create litigation risk for plan fiduciaries

Agenda

- Basics on Fiduciary Rules for Health Plans
- How the CAA impacts fiduciary obligations
- Analysis of the Prescription Drug and Health Care Spending Data Collection rules under the CAA
- Analysis of the "Responsible Fiduciary" rules under the CAA
- Review the Transparency in Coverage rules under the Affordable Care Act (ACA) and CAA
- Analysis of the Gag Clause rules in the CAA
- Discussion of recent litigation involving health plan fees
- Potential litigation risk to fiduciaries

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Why Are We Discussing This?

- ERISA class action lawsuits are at an all-time high
- Fiduciaries face exposure if they fail to prudently select and monitor the fees charged to plans
- These lawsuits have focused on retirement plans based on allegations that plan fiduciaries did not:
  - Select and monitor investment-related fees for retirement plan options; and
  - Monitor plan service provider fees to ensure they are reasonable
- Will these types of lawsuits be brought against fiduciaries of health plans?

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BASICS ON THE FIDUCIARY RULES FOR HEALTH PLANS

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The Cast of Characters

- The ERISA Plan—a separate legal entity
- The Plan Sponsor—in many cases, the employer
- Plan Fiduciaries—named fiduciaries (fiduciaries named in plan document, which will often include the employer) and others deemed to be fiduciaries based on the function they perform ("functional fiduciaries")
- Participants and Beneficiaries

Fiduciary

- A person (either an individual or an entity) is a fiduciary to the extent the person has any discretionary authority, control or management of an ERISA-covered plan (such as its administration, operations or assets) (ERISA §3(21))
- Oftentimes, certain employees of the employer have been tasked with the duty to protect the plan (fiduciaries)
- Under law, the failure to comply with fiduciary obligations can cause liability—both personal and to the company

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ERISA Fiduciary Responsibilities

- The primary responsibility of fiduciaries:
  - Run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses (the Exclusive Benefit rule)
  - To act with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims (the Prudent Expert rule)
  - Follow the terms of plan documents
  - Avoid conflicts of interest and prohibited transactions

Plan Assets

- A fiduciary must protect **plan assets** and ensure they are used for a proper purpose (benefits and direct expenses)
- Medical Plan: Plan assets include all contributions made by participants and beneficiaries
  - Even though there is a non-enforcement rule issued by the Department of Labor that, in general, premium amounts paid by active employees through a cafeteria plan do not need to be held in a trust—they are still considered plan assets

Plan Assets

- In DOL letters regarding prohibited transactions, plan assets also include amounts paid by participants for deductibles and co-insurance
- In summary, medical plans have many plan assets

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ANALYSIS OF THE PRESCRIPTION DRUG AND HEALTH CARE SPENDING DATA COLLECTION RULES (RXDC)

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RxDC Reporting

- The CAA requires health plans to report to the Departments of Labor, Health and Human Services, and Treasury (the "Departments") certain prescription drug and health care spending data
- The plan has the legal obligation to ensure that the reports are filed, but it can delegate this function to "Reporting Entities"

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RxDC Reporting

- Outside of ensuring that the reports are timely filed (and getting written confirmation of such), do plan fiduciaries have any other obligations?
  - The short answer is that we suggest that a fiduciary document a process that shows it tried to take certain actions, as protection against potential future lawsuits

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Entities

- This discussion is primarily focused on self-funded health plans
- Those plans usually have a third-party administrator (TPA). The TPA agreement will set forth the costs and fees that will be paid by the plan sponsor for healthcare benefits
- Those plans also have a pharmacy benefit manager (PBM). The PBM will determine which drugs are on the formulary, the cost the plan will pay for drugs, and numerous kinds of fees charged to the plan

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The Basics of RxDC Reporting

- The required information includes:
  - Identifying the plan and plan sponsor;
  - Beginning and end of the plan year; and
  - Number of participants and beneficiaries covered as of the last day of the reference year (calendar year)
- This is the only plan-level information that is required
- This information is generally reported/provided by the plan sponsor/employer

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The Basics of RxDC Reporting

- The information on the following slides will typically be reported by Reporting Entities
- Reporting Entities will aggregate the data according to market segment (such as self-funded plan for large employers) and any applicable state aggregation rules
- The Departments state that this aggregated reporting method is best for them in order to draw conclusions about market trends

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Required Reporting

- The information required to be reported under the CAA includes:
  - Brand prescription drugs most frequently dispensed
    - Have you reviewed these? You should be able to obtain this information from claims reports
  - Most costly prescription drugs
    - Have you reviewed these and questioned the PBM if a lower-cost generic (or biosimilar) is appropriate to be dispensed instead?
  - Prescription drugs with greatest increase in expenditure
    - Have you questioned the PBM about pricing for these drugs?

Required Reporting

- Total annual spending on health care services, broken down by certain types of costs
- Prescription drug spending and utilization, including:
  - Total annual spending by plan
  - Total annual spending by participants
  - The number of participants with a paid prescription drug claim
  - Total dosage units dispensed
    - For this category, have you implemented a robust process for negotiating your PBM contract, given the amount of money involved?

Required Reporting

- Premium amounts including:
  - Average monthly premium amount paid by employer on behalf of participants
  - Average monthly premium amount paid by participants
  - Total annual premium amounts
- Prescription drug rebates, fees, and other renumeration
  - Do you have an understating of the potential "spread compensation" received by the PBM and can you show a process of how you tried to decrease these amounts?
  - How is "rebate" defined in your PBM contract? Do you have point-of-sale rebates? If no, why not?

Required Reporting

- The method used to allocate prescription drug rebates, fees, and other remuneration
  - How do you use the rebate amounts?
- The impact of prescription drug rebates, fees and other remuneration
  - Do you understand the different kinds of fees that the PBM receives related to your contract?

Can you get the information on a plan-level?

- While the regulations do not require plans to participate in the aggregate reporting, and could instead undertake plan-level reporting, this is unlikely to occur
- This is because plans may lack the bargaining power to require Reporting Entities to assist with plan-level reporting
- BUT YOU SHOULD ASK FOR PLAN-LEVEL DATA!!
- A fiduciary should have evidence that it tried to get this information

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What Are the Departments Looking For?

- Confirmation that the PBMs are overcharging plans—and how bad it is
- Has the plan sponsor negotiated to get all rebates?
- Has the plan sponsor been able to negotiate obtaining any other remuneration from the PBM?
- Who gets the rebates? And are any paid directly to participants?

ANALYSIS OF THE "RESPONSIBLE FIDUCIARY" RULES

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Responsible Fiduciary

- The CAA establishes rules governing the disclosure of direct and indirect compensation paid to brokers and consultants who advise group health plans ("covered service providers")
- The rule applies to contracts or arrangements entered into, extended, or renewed on or after December 27, 2021

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Responsible Fiduciary

- The rule requires disclosure of "direct" and "indirect" compensation received during the term of the contract or arrangement to a "responsible plan fiduciary" of a covered health plan
- A "responsible plan fiduciary" means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement

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Covered Service Providers

- The DOL takes a broad view of "consulting" and "brokerage" services
- Consulting services by consultants include those related to the development or implementation of plan design, recordkeeping, pharmacy benefit management services, and other services listed in the statute

Covered Service Providers

- Brokerage services include the selection of recordkeeping services, medical management vendors, benefits administration, wellness services, transparency tools and vendors, disease management vendors and products, compliance services, employee assistance programs, third party administration services, and other services listed in the statute
- Compensation includes $1,000 or more in direct or indirect compensation

Enforcement

- The rule amends ERISA §408(b)(2) to make these disclosures a part of the "service provider" exemption to the prohibited transactions rules
- In general, the prohibited transaction rules prohibit fiduciaries from engaging in transactions with certain parties in interest
  - Transactions prohibited by these rules include the payment of compensation to parties in interest

Enforcement

- ERISA §408(b)(2) furnishes a statutory exemption from the prohibited transaction rule that covers "any contract…made with a disqualified person for…services necessary for the establishment or operation of the plan, **if no more than reasonable compensation** is paid therefore"

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Example—PBM Contract

- A PBM may be responsible for designing a plan by creating a provider network or prescription drug formulary
- It may also process claims, maintain records, and negotiate reimbursement rates
- This should be considered "consulting fees" under this rule—push to get disclosures

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Example—PBM Contract

- If you cannot understand the disclosure—or if the PBM provides a general disclosure where you cannot determine the actual amounts that it receives—push for a better disclosure
- If you cannot get a detailed disclosure, document that you tried to obtain it
- In all cases, document your process

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Responsible Fiduciary Action Items

- Identify consultants and brokers subject to the rule
- Assign internal responsibility for soliciting disclosures and evaluating compensation (designate individual or committee)
- Contractually obligate covered service providers to provide disclosures—specify deadline
- Develop evaluation process
- Document decision-making

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ANALYSIS OF THE TRANSPARENCY IN COVERAGE RULES

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Transparency in Coverage

- Both the CAA and the ACA contain numerous transparency rules for health plans—something we have never seen before, such as:
  - Robust price comparison tools
  - Requirement for the plan to make available to the public on an internet website an in-network machine-readable file and an out-of-network allowed amount machine-readable file that includes the information required under the regulations
    - These files are updated monthly

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Transparency

- This is a massive amount of information that is available to the public
- There are new vendors in this space that have created tools to analyze this data—with the idea that this information can be used to show which plans are overpaying the TPAs and PBMs for services

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ANALYSIS OF THE GAG CLAUSE RULES

Gag Clause Prohibition

- The CAA bans "gag clauses" that prevent disclosure of price or quality of care information in agreements between health plans and service providers
- A health plan is prohibited from entering into agreements with healthcare providers, provider networks, third-party administrators (TPAs) or other service providers offering access to a network of providers that include a gag clause

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Gag Clause Prohibition

- In addition, group health plans must attest annually that they comply with the gag clause prohibition
- Specifically, the contract cannot contain the following:
  1. Restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants

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Gag Clause Prohibition

2. Restrictions on electronically accessing, upon request, encounter information, de-identified claims information, or data for each plan participant to the extent allowed by HIPAA, GINA and the ADA
3. Restrictions on sharing information or data described in (1) and (2) with a HIPAA business associate

Examples of Gag Clauses

- A contract between a group health plan and a TPA that outlines payment to network providers at a certain rate and then prohibits the plan from providing details about the contracted network rates to plan participants would be impermissible
- A contract between a TPA and a group health plan that only allows the plan access to information related to network provider rates at the discretion of the TPA would be a prohibited gag clause

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Gag Clause Attestation Requirement

- The CAA requires that group health plans and insurers providing health insurance coverage attest that they comply with the gag clause prohibition by submitting an attestation annually
- The first attestation is due December 31, 2023, and subsequent attestations are due December 31st of each year
- Responsibility for filing the required attestation is different for fully-insured plans vs self-funded plans

LITIGATION INVOVLING HEALTH PLAN FEES

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Trustees of Int. Union of Bricklayers v. Elevance, et al. (D. Conn., Dec. 2022)

- Trustees of self-funded multiemployer health plans sued Elevance, Anthem, Blue Cross for alleged fiduciary breach ("Anthem")
- Trustees claimed that Anthem refused to provide them with access to the plans' claims data, which prevented the Trustees from fulfilling their monitoring responsibilities under ERISA
- Anthem claimed that this data (even in the context of a self-funded plan) was proprietary
- Trustees relied, in part, on CAA for claim that Trustees were prohibited from entering into agreements with entities like Anthem if such agreements restrict access to "claim and encounter data" for plan participants (i.e., violates the "gag clause" rules)
- Anthem moved to dismiss on grounds that it was not a fiduciary, and even if it was, the agreements did not contain gag clauses. The motion is pending

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Owens & Minor v. Anthem (ED Vir., Feb. 2023)

- Self-funded group health plan covered by ERISA
- O&M (also the ERISA plan administrator) said Anthem repeatedly refused to turn over claims data, which it needed to perform its fiduciary duty in monitoring payments for services
- O&M was concerned that Anthem incentivized healthcare providers to report that patients were sicker than they actually were, because the TPAs/insurers received more income for patients with more serious documented conditions
- Cited a *New York Times* report that this type of misconduct caused between $12 - $25 billion in overpayments by Medicare in 2020 alone
- In response, Anthem claimed that many types of payment arrangements between providers and insurers/TPAs are part of a proprietary arrangement, which Anthem did not want to become public
- Joint notice filed July 12, 2023 that the case would be dismissed

Kraft Heinz v. Aetna (E.D. Tex. June 2023)

- Kraft Heinz alleged that Aetna breached its fiduciary duties and engaged in prohibited transactions and asserted claims for equitable relief
- Aetna acted as an "intermediary" between Kraft Heinz and health care providers who treated Plan participants
- Kraft Heinz claimed that Aetna took more than $1 billion, which included millions of dollars in claims that shouldn't have been paid and undisclosed fees; and that Aetna engaged in misconduct related to claims processing
- Kraft Heinz also claimed that courts found Aetna acted as a fiduciary when acting as a third-party claims administrator, and that Aetna admitted to such in a prior case before the 9th Circuit
- Direct claims that Aetna breached its duties by failing to recoup overpayments and taking undisclosed fees, in addition to claims that Aetna improperly refused to provide Kraft Heinz with claims data
- Although not a major claim, Kraft Heinz alleged that Aetna prevented it from obtaining data, in violation of the "gag clause" rule under the CAA

Knudsen v. MetLife (D. N.J., July 2023)

- Knudsen alleged that the Plan "earned" $65 million in drug rebates between 2016 and 2021
- Alleged that MetLife caused 100% of that money to be paid to itself in breach of MetLife's fiduciary duties
- Claims brought under ERISA § 502(a)(2), (3) and ERISA's prohibited transaction provisions under ERISA § 404 and 406
- Knudsen alleged that MetLife acted as a fiduciary when it hired the plan's PBM and negotiated how rebates would be handled
- Plan document stated: *The Plan Sponsor (MetLife) and Claims Administrators (Express Scripts or Aetna) may receive rebates for certain drugs included on the Formulary … These rebates are not considered in calculating any co-payments or co-insurance under the Plan … The Plan Sponsor applies these rebates towards Plan expenses*.

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Knudsen v. MetLife (D. N.J., July 2023)

- MetLife paid approximately 70% of the costs for the health plan, and the employees paid 30%. There was no assurance to participants that this would be the ratio, it simply worked out this way
- MetLife was paying into the plan amounts greater than the rebate amounts, and it kept the rebate money
- MetLife moved to dismiss on grounds that (1) plaintiffs received all the benefits for which they were entitled under the Plan, which did not include any drug rebates, and (2) the plaintiffs lacked Article III standing because they were not entitled to any surplus beyond amount needed to fund promised benefits
- Court dismissed complaint based on lack of Article III standing and did not reach a conclusion regarding MetLife's first ground for dismissal

FIDUCIARY BEST PRACTICES: MITIGATING RISK

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Litigation Risk

- Reporting, transparency, and gag clause rules create an overall responsibility for fiduciaries to understand health plan fees
- Enforcement and responsible fiduciary rules, including interplay with 408(b)(2), will require health plan fiduciaries to monitor the fees paid for vendors and other services to make sure they are reasonable
  - Section 408(b)(2) disclosures have loomed large in retirement plan litigation

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Litigation Risk

- When "reasonableness" factor comes into play, it raises a host of fiduciary considerations – in particular, the requirement that fiduciaries monitor those fees on an ongoing basis
- Schlichter firm is looking for potential employee plaintiffs - https://www.napa-net.org/news-info/daily-news/schlichter-exclusive-does-new-wave-fiduciary-litigation-loom

Litigation Risk

- Under the ACA and CAA transparency rules, plans will have to make certain costs and claims data available to participants and even the public, which is a *massive* amount of information
  - Will participants (via enterprising plaintiffs' firms) use this information to allege that plans are overpaying TPAs and/or PBMs for healthcare services and prescription drugs?
  - What type of claims information is *owed* to the ERISA plan administrator that cannot be withheld under the gag clause prohibition?
  - What is considered "confidential" or "proprietary" information that does not need to be disclosed?
  - What do plan sponsors and fiduciaries need to do to obtain this information?
- Like we've seen in retirement plan litigation, without clear regulatory guidance, these questions may be resolved through litigation

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Mitigating Risk

- If you have not done so already, consider creating a fiduciary committee for health and welfare plans
- The ACA and CAA contain numerous obligations on the ERISA plan administrator (a fiduciary)
  - Absent a proper delegation of authority, the ERISA plan administrator is often the "employer" or the "company"
  - Company's board of directors, partners, or managers become potential defendants
- Employers can mitigate litigation risk by delegating fiduciary duties to a committee that follows a prudent process for following responsibilities under the ACA and CAA

Mitigating Risk

- Create and document a prudent process for negotiating and monitoring health plan fees
  - Regular meetings to review information and fees (e.g., 408(b)(2))
  - Seek advice from experts
  - Review PBM and TPA agreements for issues raised by the regulations
  - Determine whether plan can negotiate lower fees
  - Conduct RFPs for service providers

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Mitigating Risk

- Consider what information should be provided and what should be done to obtain that information
  - Push your PBM and TPA for compensation information and have a responsible fiduciary review the disclosure
  - Document that you asked for RxDC plan-level information

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An Example of Fees/Costs to Examine

- A self-funded health plan will often pay the TPA a "savings fee" when the TPA gets an out-of-network (OON) provider to accept payment that is less than the original billed amount
- EXAMPLE: The OON provider sends a bill for $2,000 but the TPA gets the OON provider to accept $500. Often there is a fee of 25% of that "savings" so that the plan is paying $375 to the TPA (25% of the $1500 "savings") plus the $500 for the actual claim

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An Example of Fees/Costs to Examine

- Try to reduce or remove that "savings fee" for OON claims covered by the No Surprises Act of the CAA
- For an OON claim covered by the No Surprises Act, the TPA is to offer the OON provider an amount equal to the Qualifying Payment Amount (QPA)
  - If the OON provider won't accept the QPA, they can go to arbitration. Why would the plan pay a high "savings fee" for these claims when there is a process under the CAA to resolve these payment disputes
- This is just one example of fees that should be reanalyzed and renegotiated

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