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NEW ERISA CLASS ACTIONS ZERO IN ON GROUP HEALTH PLAN FIDUCIARY OBLIGATIONS: 10 BEST PRACTICES FOR EMPLOYERS

Insights
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ERISA class action lawsuits against retirement plan fiduciaries have become commonplace over the last few decades, usually alleging that imprudent processes and lack of oversight led to excessive fees for investment options, recordkeeping services, and investment management services. Now, thanks to new disclosure requirements and transparency laws, health plan fiduciaries are starting to face similar class actions. What can employers do to shield themselves from such claims? Here's an overview of what you need to know, key takeaways from a recently filed lawsuit, and 10 best practices for group health plan fiduciaries.

A New Wave of ERISA Excessive Fee Litigation

Under the Employee Retirement Income Security Act (ERISA), plan fiduciaries have a legal obligation to act prudently and solely in the best interests of plan participants. This includes paying reasonable and necessary fees for services provided to the plan. This duty applies to both retirement and health plan fiduciaries.

Historically, excessive fee lawsuits involved participants alleging that the retirement plan's fiduciaries breached their ERISA duties by failing to pay reasonable management and investment fees. As a result, these unreasonably high fees negatively impact the plan's performance and the participants' accounts.

ERISA excessive fee litigation has become more common in recent years as participants have become more aware of the

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fees charged to their retirement plans. Between 2016 and 2023, plaintiffs' lawyers filed just over 460 excessive fee lawsuits, with approximately 200 still pending.

In 2023 alone, there were just over 40 excess fee lawsuit settlements, with settlements ranging from $200,000 to $124.6 million. Settlements have continued to increase year over year.

Now, plaintiffs' attorneys are turning their eyes to group health plan fiduciaries in light of the Consolidated Appropriations Act of 2021 (CAA-21), which has ushered in a new wave of ERISA excessive fee litigation.

New Health Plan Fee Disclosure and Pricing Transparency Laws

The CAA-21 and the Transparency in Coverage (TiC) Rule comprise the most comprehensive health plan legislation and reforms since the Affordable Care Act. They place new obligations on group health plans and health insurance companies for plan fee disclosures and pricing transparency. Notably, these laws may contribute to new class action lawsuits against health plan fiduciaries.

Mandatory Fee Disclosures

CAA-21 was signed into law in December 2020, becoming effective for plan years beginning on or after January 1, 2021. This law requires service providers to give fee disclosures to group health plan fiduciaries, pursuant to ERISA (similar to those required for retirement plans that have been in effect since 2012).

Under ERISA Section 408(b)(2), any contract related to a group health plan is not reasonable (meaning it's a prohibited transaction) unless the direct and/or indirect compensation received by a health plan service provider (which equals $1,000 or more) is disclosed in writing to the plan fiduciary ahead of entering into the contract or extending the contract. For this purpose, covered "service providers" are brokers and consultants.

These required disclosures are designed to provide group health plan fiduciaries with sufficient information to help determine whether the fees are reasonable, as required by ERISA's fiduciary rules. Additionally, this law has enhanced cost awareness among health plan participants.

You should note that plaintiffs' attorneys are likely seeking information in these disclosures — or claiming these disclosures were not provided or received – to support participant claims against ERISA health plan fiduciaries and their service providers.

New Transparency Rules

The federal government also issued the TiC final rule in 2020, with rolling effective dates from 2022 through 2024. This rule requires group health plans to disclosure machine-readable data describing payment rates for in-network healthcare items and services, out-of-network allowable amounts, and prescription drug costs. These data files are intended to make healthcare pricing information accessible to participants, helping them know the cost of a covered item or service before receiving care.

The CAA-21 expanded upon this TiC rule by requiring group health plans to provide more expansive prescription drug and medical cost reporting. With many large, self-insured plans, these costs lie with third-party providers, like pharmacy benefit managers. Like the fee disclosures, this TiC data is also helpful in determining whether plan fees are reasonable under ERISA's fiduciary rules, potentially supporting excessive claims litigation.

Lawsuit Serves as Reminder to Employers

A recently filed lawsuit targets group health plan fiduciary obligations under ERISA and focuses on the "duty of prudence" when selecting and monitoring health plan vendors. The lawsuit alleges that the plan participants and beneficiaries were harmed by paying increased plan costs because of these fiduciary breaches. Although this case is pending, it's a reminder to employers sponsoring group health plans – especially self-insured health plans – to review their ERISA fiduciary obligations while maintaining robust processes and procedures.

In the February 5 complaint, participants alleged that group health plan fiduciaries at Johnson & Johnson breached their fiduciary duties under ERISA by allowing the plan and its participants to pay "extraordinary" costs for prescription drugs as compared to other market options, resulting in millions of dollars in unnecessary costs to the plan.

Specifically, the lawsuit alleges that the health plan fiduciaries mismanaged the plan's prescription drug benefits. That allegedly cost 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."

The participants alleged the plan's fiduciaries failed to:

- Pay the lowest possible costs for the offered drugs;
- Obtain competitive bids from other prescription drug service providers;
- Monitor plan expenses;
- Negotiate the prescription drug contract with its pharmacy benefit manager (PBM), especially given its bargaining power as a Fortune 50 employer;
- Fully inform participants about the mail-order program, where drug prices were routinely higher than options at retail pharmacies; or
- Protect the health plan's assets.

The complaint gave specific examples of these "extraordinary" costs. For instance, the plaintiffs claimed that the PBM charged the plan over $10,000 for a 90-day supply of a generic drug used to treat multiple sclerosis. This same drug was allegedly available without using insurance at various online and retail pharmacies for well under $100.

The plan participants are asking for various remedies while also seeking to hold the fiduciaries personally liable under ERISA for their actions and inactions.

The Johnson & Johnson lawsuit is one of the first of its kind, stemming from the disclosure and transparency in coverage requirements — but it mirrors the retirement plan excessive fee lawsuits that have come before it.

10 Best Practices for Group Health Plan Fiduciaries

In light of the Johnson & Johnson case and other health plan litigation, group health plan fiduciaries may want to evaluate their current governance structure. This includes any

policies and procedures, especially regarding selecting and monitoring plan providers and determining the reasonableness of plan costs and fees. Here are 10 best practices health plan fiduciaries should consider:

1. **Establish a health plan fiduciary committee** and adopt a committee charter setting forth its responsibilities. Be sure to hold committee meetings regularly.

2. **Review your existing group health plan service provider agreements** to determine whether a broker or consultant should disclose fees to you under the CAA-21. Once received, ensure that you carefully review the disclosure, fully understanding what the plan and your employees are being charged.

3. **Ensure that your third-party agreements are detailed** enough to allow you to determine, understand, and monitor any plan fees or costs.

4. **Establish a process to review and monitor your group health plan fees**, ensuring they are reasonable based on the services you're receiving and in relation to industry standards (for example, you may want to perform a benchmark analysis on your vendors).

5. **Periodically run your group health plan vendors through a "request for proposal" process**, helping you determine whether you're receiving the best services at reasonable costs.

6. **Consider amending your service provider agreements** to incorporate any contractual obligations related to fee disclosure requirements or health plan transparency.

7. **Implement ongoing training for plan fiduciaries** so they fully understand their responsibilities under ERISA.

8. **Acquire fiduciary liability insurance**, protecting plan fiduciaries from breach liabilities.

9. **Document your policies and procedures**, as well as your decision-making processes when hiring or monitoring a plan vendor. Documenting your procedural process is critical to ensuring compliance with ERISA.

10. **Work with counsel experienced in handling ERISA matters**, which can help you understand and comply with all the nuances of group health plan compliance.

Conclusion

If you have questions about group health plan compliance, feel free to reach out to your Fisher Phillips attorney, the author of this Insight, or any attorney in our Employee Benefits and Tax Practice Group. We will continue to provide tips, guidance, and updates on employee benefits and other workplace law topics, so make sure you are subscribed to Fisher Phillips' Insight System to get the most up-to-date information directly to your inbox.