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Preventive Medicine

Five Health Plan Lawsuit Risk-Mitigation Steps

AS THE FIDUCIARY BREACH LAWSUIT THREAT GROWS, IT'S TIME FOR HEALTH PLAN FIDUCIARIES TO STEP UP THEIR OVERSIGHT.

BY JUDY WARD

The number of fiduciary-breach lawsuits over employers' health plans continues to rise.

The federal Consolidated Appropriations Act of 2021 (CAA) created more transparency around health plans' costs, and lawsuits have already been filed as a result: by participants against plan fiduciaries and by plan sponsors against a health plan service provider.

It should be a wake-up call.

Employers have long had a governance committee and processes for their retirement plans, but it's been less common to have a fiduciary committee on the health and welfare side, particularly because many plan sponsors had delegated their health plan's administrative duties to service providers, said Susan Nash, a Chicago-based partner at law firm Winston & Strawn LLP.

"These lawsuits are a good reminder that health plan fiduciaries have an ongoing duty to monitor their plan providers," Nash added.

To mitigate their legal risk, employers must consistently follow a prudent set of governance processes for oversight of health plan fees and providers.

"That is, I think, where many employers fall short," said Liliana Salazar, Los Angeles-based senior vice president and employee benefits compliance practice leader at HUB International Ltd. "They trust the vendors to do what they agreed to do, and they never ask questions."

Participant vs. Plan Fiduciary

Prescription drug costs have been a big focus In the lawsuits filed by participants against plan fiduciaries, alleging a fiduciary breach. Kara Petteway Wheatley, a Washington, D.C.-based principal at Groom Law Group, isn't surprised that the plaintiffs' bar has latched on to prescription drug costs as an early focus.

That topic has been in the news and under much scrutiny at the federal level lately, particularly in the Federal Trade Commission's focus on pharmacy benefit managers (PBMs). She added that the plaintiffs' bar has picked up on that and is trying to leverage it in these cases.

A couple of reasons come to mind when John Schembari thinks about the reason for the participant lawsuits' focus in this area. Prescription drug costs typically make up a large percentage of a health plan's claims, and the costs tend to be rising at a faster rate than the costs for traditional medical care, said Schembari, an Omaha, Nebraska-based partner and leader of the national employee benefits and executive compensation group at law firm Kutak Rock LLP.

A tremendous amount of confusion exists about how PBMs operate: how they set drug prices overall, how they get paid, and why they charge substantially more for certain drugs than the retail price an individual would pay at many pharmacies.

Multiple participant lawsuits have a central theme alleging that the plan fiduciaries failed to negotiate the best deal for their plan in selecting the pharmacy benefit manager and/or failed to adequately monitor the PBM's subsequent work for the plan and the costs. Wheatley said these cases are the first in a wave of similar litigation that Groom Law Group thinks will be filed against employers.

"These suits allege that the plan fiduciary didn't properly negotiate the prescription drug contract with the pharmacy benefit manager, and that allowed the PBM to charge substantially more for some drugs than reasonable. The allegation is that participants paid too much for a drug that they could get for cheaper at a retail pharmacy," Schembari said.

Another emerging theme is the claim that because a plan's fiduciaries permitted charging an exorbitant amount for certain prescription drugs, it increased what the employer paid, driving up the overall costs for all plan participants, as the employer passed costs along in the form of higher premiums.

Among cases filed so far, the plaintiffs tend to focus on the cost of particular drugs. A lawsuit filed in March against JPMorgan Chase & Co. alleged, for example, that a 30-unit prescription for the multiple sclerosis drug Teriflunomide cost $6,229.00 through its health plan, versus prices at retail pharmacies without using insurance as low as $11.05 for a 30-unit supply.

"It's a 'black box,' the PBM industry, and we don't know why a PBM charges so much for one particular drug," Schembari said. "But if there are any drugs with a really egregious cost, the plan fiduciaries need to ask the PBM why. They need to ask, 'Hey, why are our participants who need this specialty drug paying so much more for this drug than they could pay at Walgreens?' We don't have any evidence from any of the cases filed so far that the plan fiduciaries asked these questions, but that doesn't mean the evidence does not exist."

Nash said it's tough to establish the "fair" price for a particular drug in these cases. In reality, when plan fiduciaries choose a PBM, they make a decision based not on a few specific drugs' cost but on the overall cost structure, as well as on how well the PBM's services match up with what that plan and its participants need (such as which pharmacies are in-network for the PBM). She added that ERISA doesn't require health plan fiduciaries to pick the PBM offering the best price. Still, fiduciaries have to ensure

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that the overall arrangement is in the best interests of plan participants and their beneficiaries.

A key to the fate of the participant cases against plan fiduciaries will be whether the plaintiffs can prove that they individually suffered harm due to the fiduciaries' actions. Wheatley said that the plaintiffs need to identify a particular injury they experienced as a result of the prescription drug cost.

It's not enough to just claim, "I paid too much for my prescription drugs," she explained. Plaintiffs will need to specifically identify how they were injured and how that harm relates directly to the plan fiduciaries' conduct.

Schembari said that a prudent fiduciary should question prescription drug costs significantly out of line with the market cost. To win cases like this, employers must show that they asked the granular, hard questions. As more employers become aware of the legal risk and the steps needed to mitigate it, he anticipates they will take those actions. But it may be hard in some of the earlier cases for the employer to prove that, he added.

"I think it will be relatively easy for an employee who has been using that specific medication to prove that they were harmed," Schembari said. "But for employees who argue that they were harmed because the plan's premiums went up due to the prescription costs, they will have to prove that and tie it to the behavior of the plan fiduciary. I think that's where plaintiffs will have a harder time proving their case."

Plan Fiduciary vs. TPA

Several employers have filed a lawsuit against their third-party administrator (TPA), alleging the TPA–acting in a fiduciary capacity–mismanaged the health plan. A lot of times, no fiduciary obligations are contracted for when a health plan sponsor signs a service agreement with a TPA, said Joanne Roskey, Washington, D.C.-based practice lead, ERISA and Employee Benefits Litigation at the law firm Miller & Chevalier.

When a health plan TPA does agree upfront to serve as a fiduciary, generally, the contract will stipulate that the TPA will serve in a fiduciary capacity only in certain specified areas, such as for claims administration and participants' claims-decision appeals. (She added that when fiduciary services are part of the contract, the TPA may charge a significantly higher fee.)

"But even in the situations where TPAs did not agree in a contract to be a fiduciary, TPAs are nonetheless at risk of being held by the courts to be a fiduciary, if they meet ERISA's definition of a 'functional fiduciary,'" Roskey said.

ERISA's functional fiduciary definition revolves primarily around whether an entity or person has authority or control over plan assets or administration. So, Roskey said, the question in the lawsuits filed by employers against a TPA often becomes, has the TPA crossed the line and met the functional definition of a fiduciary? It's a complex question.

For example, if a plan's TPA arranges with a pharmaceutical company to get part of the prescription drug refunds paid when the plan's participants use a particular drug, is the TPA taking control over plan administration or plan assets

(the rebates)? Or if a TPA subcontracts with another vendor to handle part of an employer's health plan administrative needs, and in return, the TPA gets part of the contractor's earnings from that work in a fee-sharing arrangement, are these payments plan assets or not? Or alternatively, are those payments unreasonable compensation that ERISA prohibits?

"More and more of these cases are coming, and they are very facts-dependent," Roskey added. "It makes it hard to predict the outcome because it depends both on the contractual terms and on what's actually happening on the ground." Despite the uncertain outcomes, she anticipates an increase in employer lawsuits versus a health plan TPA or PBM.

"Employers themselves are worried about getting sued by health plan participants. There are more and more class-action suits that are being filed by employees, and that puts pressure on employers," Roskey said. "So there is an incentive for employers to proactively file these types of cases, to show that they're being diligent in monitoring their health plan's fees and that they are trying to recoup any amounts that allegedly were received improperly by the TPA or PBM."

Schembari said it's possible that more employers will proactively file a lawsuit against a health plan provider. What weighs against that likelihood is the high cost of litigation for employers, he said.

And an employer, unless it's very large, probably doesn't have the resources of leading health plan providers such as Aetna Inc, Cigna Health and Life Insurance Co., or United Healthcare. Don't be surprised, he said, if employers begin banding together to bring a class-action lawsuit against a health plan provider they all utilize.

Risk-Mitigation Steps

Health plan sponsors can take steps to mitigate their risk. Here are five:

1. *Ensure contracts allow sufficient monitoring:* Before a health plan sponsor signs a contract with an administrative provider, it's crucial to understand the provider's compensation–both how much it gets paid, and from whom it gets paid–Salazar said. It's also important to set contract terms that will allow the plan sponsor to do the ongoing monitoring it needs to do.

TPAs or PBMs often will advocate for a service agreement that limits an employer to auditing a maximum of 250 claims, and that also requires a minimum of 24 months between employer audits.

But plan sponsors need to reserve the right to audit their plan's claims whenever they see fit, such as if there's a jump in participant complaints, she said. And a service agreement should give the plan sponsor the ability to audit an unlimited number of its plan's claims; otherwise, the provider could just pick out 250 claims that have been previously audited to ensure they're all OK.

Many TPAs or PBMs also include clauses in their service agreements that prohibit the plan sponsor from sharing the results of claims audits with third parties.

If that provision becomes part of the contract, it is impossible for a plan to work with an outside expert to review the plan's claims, Salazar said, or to share that audit data with an employer's outside legal counsel. It's important for the service agreement to include a provision that allows the plan sponsor to share claims data and the results of audits with third parties.

2. *Examine fee disclosures closely:* Health plan sponsors must carefully review the annual fee disclosure they now get from administrative services providers. If an employer doesn't have the in-house expertise to do the disclosure analysis, it needs to work with an outside expert.

The key is to ensure every year that the plan and its participants are not overpaying for what they are getting, said Cassie Schlarb, vice president of risk and analytics for the West Region at OneDigital in Irvine, California. It's especially helpful to compare the year-over-year increase in plan administrative costs. A general rule of thumb is that an administrative fee increase of more than 5% is beyond the norm enough to need much closer scrutiny, she said.

3. *Benchmark administrative fees annually:* Fee benchmarking should be done annually for a health plan, Schlarb suggested, and include both the individual administrative fees from plan providers as well as the overall plan administrative cost. There's now a lot of third-party benchmarking data available from industry associations and advisory/consulting firms, she said, adding that it's helpful to compare a plan's costs to costs of peer employers in the same industry, of a similar size and in the same geographic region.

"We always want to make sure that a fee is in line with the market," Schlarb continued. "What becomes difficult in benchmarking is making sure that it's an apples-to-apples comparison because not all administrative service providers provide the same levels of services." Some TPAs offer concierge services to participants on clinical navigation, for example, while others don't. And some providers willingly furnish plan sponsors with more performance data than others.

4. *Examine performance metrics regularly:* If a plan hires a new TPA, it can make sense to do a claims audit 12 months after the contract begins, Salazar said.

That allows the employer to learn if issues are emerging in areas such as improper claims payments. After that, if administration is running smoothly and there hasn't been a spike in participant complaints every two years, it is probably OK to audit data on claims a TPA processed, she added.

Salazar also suggested annual performance reviews of a health plan's PBM. She said that plan fiduciaries need to be very diligent in enforcing whatever performance guarantees they received from their PBM in the service agreement. For example, if the PBM agreed to a specified amount of guaranteed savings on prescriptions for plan participants versus the average wholesale price, has that been achieved? Has that materialized if the PBM ensured a specified dollar amount of prescription drug rebates? "The plan fiduciaries need to look at, 'What are the savings that the plan actually has received? The PBM promised a rebate of X dollars: Are we actually getting that?'" Salazar added.

5. *Do RFPs periodically:* Schlarb said that the best practice is to do RFP (request for proposal) processes for both a health plan TPA and PBM every three to five years. If a plan's costs have been pretty steady and there haven't been many service issues, five years can make sense, while cost spikes or ongoing service issues point more toward a three-year cycle. Compared to annual fee benchmarking, she said, this is a much more in-depth look at what services a health plan and its participants get, the fee components, and what's available in the marketplace.

"Doing an RFP process for a TPA is a lot less complex than doing an RFP for a PBM," Schlarb added. "The PBM industry figured out a long time ago that they have multiple ways to make money, and a PBM may have dozens of different income streams." NNTM