A "New" Litigation Target in Healthcare

Plan sponsors have long been on notice that they have a responsibility to ensure that the services provided to their retirement plan – and the fees paid for those services – are reasonable. Fee disclosure regulations under Section 408(b)(2), finalized in 2012, were designed to make it easier to do so. Now, under terms of the Consolidated Appropriations Act of 2021 (CAA), those same fee disclosure requirements are also applied to healthcare providers. Just as they have been required to do for retirement plans for years, healthcare plan sponsor fiduciaries are responsible for ensuring that those services rendered are for reasonable fees.

Here's What You Really Need to Know:

1. CAA as well as the Transparency in Coverage Act (TIC) are complimentary laws that seek to increase transparency in pricing to help consumers make more informed decisions about their healthcare services and to ensure that individuals are not overpaying for healthcare costs.

2. Litigation challenging high prescription drug fees and intermediary service arrangements has already been filed. More suits are likely in the future, as law firms have already been active on social media looking for potential plaintiffs including employer plan sponsors.

3. Some plan sponsors have already had to take action and file suit to obtain disclosures regarding plan administration costs/practices that they are required to obtain.

Let's Dive In...

Similar to the way that employers have to piece together several pieces of legislation, regulation, and sub-regulatory guidance for retirement plans, employer plan sponsors have to do the same with healthcare plans. CAA has been called the most significant compliance challenge employers have faced since the Affordable Care Act. With its passage, several new requirements are now in effect, including:

- **No Surprises Act**: intended to prevent surprise billing from out-of-network providers, including when a participant requires emergency services.
- **Prohibition of Gag Clauses**: many group health plan-related agreements have language that prohibits plan sponsors from receiving, using, or communicating to third parties (such as a benchmarking service) information about the costs and claims of the plan. CAA requires these so-called gag clauses be removed from all agreements and for the employer to attest that they've done so by December 31 of each year.
- **Prescription Drug Reporting**: insurance companies and group health plans are required to submit information about: (i) spending on prescription drugs and health care services; (ii) prescription drugs that

account for the most spending; (iii) drugs that are prescribed most frequently, (iv) prescription drug rebates from drug manufacturers and (v) premiums and cost-sharing that patients pay.

- **408(b)(2) Fee Disclosures**: any contract related to a group health plan is not reasonable unless the direct and indirect compensation (where applicable) received by a health plan service provider is disclosed in writing to the plan fiduciary ahead of entering into the contract or extending the contract. Brokers and consultants who receive $1,000 or more annually are considered "covered service providers" and will be required to deliver the disclosure.

Failure to comply with the requirements of the CAA leaves employers at risk of fines from the federal government and class-action lawsuits, akin to what we've seen happen in the retirement plan space over the past two decades.

In essence, ERISA Section 408(b)(2)—which greatly expanded fee disclosure responsibilities for retirement plan providers—now applies to health care providers as well, and plan sponsor fiduciaries are responsible for ensuring that those services rendered are for reasonable fees.

Participant Litigation

In July 2024, several employees of Wells Fargo filed suit against fiduciaries of the Wells Fargo & Company Health Plan alleging that over the past several years, defendant plan sponsor "breached their fiduciary duties and mismanaged Wells Fargo's prescription-drug benefits program, costing their ERISA plan and their employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher out-of-pocket costs, and lower wages or limited wage growth." The suit claims that evidence of the breach was overpayment to a Pharmacy Benefits Manager (PBM) for many generic drugs that are widely available at drastically lower prices. A PBM is a third-party administrator of prescription drug programs for health plans and large employers.

Another case was filed in February by an employee of Johnson & Johnson who made similar claims including, but not limited to, the argument that PBMs were overpaid. While not an attorney in either of these cases, the St. Louis-based firm of Schlichter Bogard LLC, which launched a wave of excessive fee litigation in 2006 against retirement plan sponsors and continues to be active, has targeted several national companies with a social media campaign seeking plaintiffs.

Suits to Get Disclosures

While the suits alleging fiduciary breaches by participants have just begun, some plan sponsors have had to file suit simply to get the information they are required to have to comply with CAA. In 2023, Kraft Heinz filed suit against Aetna who had served as a third party administrator (TPA) for the health plans dating back to at least 2007. Because the plans lacked the expertise to evaluate the claims for payment submitted by medical professionals, that responsibility was delegated to Aetna. Under ERISA, such delegation is not only allowed but required when fiduciaries lack the expertise required to perform a fiduciary duty. Kraft Heinz self-funds its employees' and retirees' medical expenses. The suit claims that "Kraft Heinz pays Aetna to prevent payment of duplicate claims. Yet, Aetna has taken millions from Kraft Heinz to pay thousands of duplicate claims since 2016."

In language common to retirement plan fiduciary breach litigation the suit alleged that "rather than prudently manage the Plans' prescription-drug program, Defendants agreed to pay extraordinarily high prices for prescription drugs, ceded control of the Plans' formulary to conflicted third parties, failed to supervise those conflicted third parties or otherwise ensure that decisions were made in the best interests

of the Plans and their beneficiaries, failed to conduct adequate reviews of the Plans' prescription-drug costs, failed to steer beneficiaries to lower-cost options, failed to engage in a prudent process for monitoring the Plans' formulary, and failed to take available steps that would have saved the Plans and their beneficiaries millions of dollars." The suit seeks class-action status.

In yet another case, the plans of W. Grainger, Inc. filed suit against Aetna Life Insurance Company, charging that while Aetna owed Grainger a fiduciary duty under ERISA in identifying and denying fraudulent, improper, or otherwise illegitimate claims, it instead "abused its authority to enrich itself to Grainger's detriment." In particular, the suit alleged that Aetna took money from Grainger "under the guise of claims administration, transferred the money to accounts under Aetna's control, paid a fraction of that money to health care providers to settle the claims, and kept the difference." As a result of its practices, Aetna was arguably unjustly enriched and also actively concealed its breaches of fiduciary duty to the plans.

Neither of those cases has yet come to trial or been resolved.

Action Items for Plan Sponsors

The obligations for ERISA plan fiduciaries for health plans are identical to those under retirement plans. What has changed is a new fee disclosure requirement which should help plan sponsors fulfill those obligations, but may, certainly in the short run, generate additional time, effort, paperwork, and perhaps confusion considering the sheer volume and complexity of healthcare programs and drug pricing.

Considering the upcoming open enrollment season, plan sponsors should:

1. Be aware of CAA and its implications for plan sponsors.

2. Contact providers – including PBMs and benefits brokers – and ascertain their awareness and readiness to provide disclosures in accordance with the requirements of the law.

3. Fully understand the direct and indirect compensation and revenue flows between all brokers, consultants, PBMs, pharmacy manufacturers and distributors, and other service providers.

4. Document the process of review and benchmarking.

5. Consider establishing a committee and governance structure for group health plans that is similar to what is in place for the retirement plan given that the responsibilities are substantially similar and given that the litigation environment.

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