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ERISA Fiduciary Rules for Health and Welfare Plans: Compliance Requirements and Litigation Risks for Plan Sponsors

Minimizing Liability of Health Plan Operations, Prohibited Transactions, and Conflicts of Interest

WEDNESDAY, DECEMBER 14, 2022

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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ERISA Fiduciary Rules & Duties for Health and Welfare Plans

December 14, 2022

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Overview

- ERISA Fiduciary Duties
- Definition of a Fiduciary Under ERISA
- Fiduciary v. Settlor
- Fiduciary Duties
- Roadmap for Fiduciary Compliance
- DOL Position on Fiduciary Duties for Health and Welfare Plans
- Impact of the Consolidated Appropriations Act of 2021

Fiduciary Duties

- The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), imposes specific duties and obligations on fiduciaries and others providing services with respect to employee benefit plans.
- Many focus on fiduciary requirements in the retirement plan context.
- These concepts apply to health and welfare plans as well.

Definition of a Fiduciary Under ERISA

•A fiduciary is broadly defined under ERISA as any person who satisfies one of the following conditions with respect to an employee benefit plan that is subject to the fiduciary duty provisions of ERISA:

- exercises any discretionary authority or control over the management of an employee benefit plan;
- exercises any authority or control (discretionary or otherwise) over the management or disposition of plan assets;
- provides investment advice regarding plan assets for a fee or other compensation, whether direct or indirect, or has any authority or responsibility to do so; or
- has any discretionary authority or responsibility in the administration of the plan.

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Who is a Fiduciary?

1. Some titles by their very nature carry the authority to perform fiduciary function, and therefore are considered a fiduciary, such as:

- A Plan Trustee
- A "Named Fiduciary"

➢ERISA requires a Named Fiduciary to be specified in the plan document or to be appointed by a procedure described in the plan document

➢A Named Fiduciary can be an individual, a committee, a third party, or the plan sponsor

➢There can be multiple Named Fiduciaries

Who is a Fiduciary?

2. ERISA allows fiduciary duties to be allocated among the Named Fiduciary and others.

- Unlike other fiduciaries, the Named Fiduciary has the authority under ERISA to designate another fiduciary and also to appoint an investment manager.

3. Service providers can be, but do not necessarily have to be, fiduciaries.

- If service providers exercise discretion over the plan, they can be fiduciaries. This is true regardless of what the service provider contract says.

Who is a Fiduciary: Functional Test

4. Individuals can be deemed fiduciaries if they exercise discretion within the meaning of ERISA.

- This determination is made based on the nature of their actions and decisions.
- A formal authorization or designation as a fiduciary is not necessary to be deemed a fiduciary.
- The final decision making authority does not need to rest with the individual.
- The person may not even explicitly know that he/she is a fiduciary (such as a third party administrator who make claim decisions).

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Fiduciary v. Settlor

- The acts relating to establishing amending or terminating a plan constitute "settlor" functions that are not subject to the fiduciary responsibility provisions of ERISA.
- When making settlor decisions, an individual may act in the best interest of the employer without regard to fiduciary responsibilities to plan participants.

> Investment decisions and claims review are considered fiduciary functions.

- A person serving as fiduciary may also serve as settlor.

It is important for the individual to be clear about when he/she is acting in a settlor capacity versus a fiduciary capacity.

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Fiduciary Duties Under ERISA

- Fiduciaries must know and understand their duties under ERISA as

  Fiduciaries can be held personally liable for breaching their duties, even if they do so unintentionally.

- ERISA imposes **four** primary fiduciary duties:
  1. the duty of undivided loyalty to plan participants;
  2. the duty of prudence;
  3. the duty to diversify the investments of the plan; and
  4. the duty to administer the plan in conformity with the plan documents.

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1. Duty of Loyalty (Exclusive Benefit Rule)

Duty of Loyalty: the obligation to discharge fiduciary duties solely in the interest of plan participants and beneficiaries. To comply with the duty of loyalty, a fiduciary must:

- act for the exclusive purpose of providing benefits to participants and beneficiaries; and
- pay plan expenses that are reasonable and relate only to plan activities.

The Consolidated Appropriations Act of 2021 (CAA) adds new information and requirements for these tasks.

Duty of Loyalty (Exclusive Benefit Rule)

Conflicts of Interest: fiduciaries must also avoid conflicts of interest – they may not engage in transactions on behalf of the plan that benefit parties related to the plan, such as:

- Other fiduciaries;
- Service providers; or
- The plan sponsor.

Duty of Loyalty (Exclusive Benefit Rule)

- **Duty to Disclose Information** (a derivative fiduciary duty of the duty of loyalty).
  - Must effectively protect participants in a plan by disclosing certain plan and investment related information to participants.
- In connection with the duty to disclose, a fiduciary should also not mislead participants about the the nature of their benefits.
- Fiduciaries should consider affirmatively disclosing material changes that have been decided by the plan sponsor with certainty.

2. Duty of Prudence

Duty of Prudence: A fiduciary must act with the same care, skill, prudence and diligence under the circumstances that a prudent fiduciary acting in "*a similar capacity and familiar with these matters*" would use in a similar plan with the same goals.

- The ERISA prudence standard considers:
  - the relevant facts and circumstances, and
  - looks to what a hypothetical comparable fiduciary would do under comparable circumstances, not simply what a prudent person would do.
- Therefore ERISA's prudence standard is often referred to as a prudent "expert" rule.

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Duty of Prudence

- This standard imposes on fiduciaries an active duty to understand what is going on.
- Fiduciaries without sufficient understanding of an area have the responsibility to hire people with the background and experience to give appropriate advice.
- They cannot rely solely on following the advice of experts.
  - Must ask questions, consider the advice, and then act prudently.

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Procedural Prudence

- Determining whether fiduciaries satisfy ERISA's prudence standard involves an analysis of the procedures that the fiduciaries establish and follow.
- Procedural prudence emphasizes the fiduciary decision-making process instead of focusing solely on the results.
- The procedures adopted by fiduciaries and the process of going through a specific protocol or policy are important.

Procedural Prudence

- Based on the allocation of different fiduciary functions:
  - the respective areas of responsibility of the different fiduciaries should be identified, and
  - the process and procedures they will follow in implementing the responsibilities should be addressed.
- When developing their procedures, fiduciaries should consider the type of plan involved and the variety of its assets.
- By establishing a process and following a constant methodology, fiduciaries will increase the likelihood of performing their duties in accordance with ERISA's fiduciary standards.

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Procedural Prudence

- To demonstrate their procedural prudence, fiduciaries should document:

  - their activities, including minutes of all meetings and discussions;
  - the advice received from experts;
  - any legal opinions;
  - deliberations based on the advice received; and
  - the actions eventually taken.

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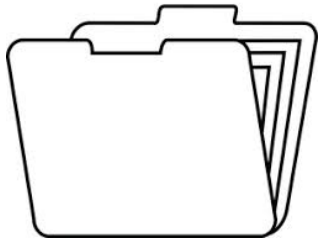
Procedural Prudence

- In addition, fiduciaries should maintain files of the relevant documents that they reviewed, such as:
  - financial statements;
  - actuarial reports; and
  - auditor and other reports on fund and plan operations.



For health and welfare plans, plan sponsors should keep all proposals, RFPs and any other related plan documents.

4. Duty to Follow Plan Documents

- Fiduciaries must act in accordance with applicable plan documents if the documents are consistent with ERISA.
- Fiduciaries must ensure that the plan documents are followed correctly.
  - But fiduciaries cannot follow plan provisions that violate ERISA.
- Every ERISA plan must be in writing and contain all required sections and provisions.

Fiduciary Duty and Plan Operations

- **Employee Contributions**:
  - If a plan provides for salary reductions from employees paychecks, a trust must be used:
    - unless the salary reductions are through Section 125 (cafeteria) plan; or
    - if participant contributions are used to pay insurance premiums within 90 days of receipt.

A Fiduciary must be careful regarding offsets of premiums or contributions of any kind in health and welfare plans.

Fiduciary Duty and Plan Operations

- **Medical Loss Ratio(MLR)**
  - Under the Affordable Care Act, insurance companies must rebate a portion of insurance premiums to policyholders (including health plans)

  Do participants have a right to the rebates?

  Factors to determine so include:
    - whether the plan or plan sponsor is the policyholder.
    - Terms of the plan.
    - Whether any portion of the premium is paid by plan participants.

Fiduciary Duty and Plan Operations

- **Medical Loss Ratio(MLR)** *(continued)*
  - If any part of the MLR is a plan asset, the decision on how to apply is a fiduciary function.
  - Determining allocation methods:
    - distribution to participants;
    - enhancing plan benefits; and/or
    - reducing future premiums.
  - A Fiduciary must weigh the costs and benefits of each option.

Fiduciary Duty and Plan Operations

- Hiring service providers is a fiduciary function.
- When selecting a service provider, a fiduciary needs to:
  - get information from more than one provider;
  - compare firms based on the same information;
  - obtain information about the firms; and
  - evaluate information with no bias.

Fiduciary Duty and Plan Operations

- Fees charged to the plan need to be "reasonable."
- The plans' fees and expenses should be monitored to determine whether they continue to be reasonable.
- Investigate whether services provider receives fees from third parties (commissions, revenue sharing, etc.).

The CAA should assist with this requirement.

Roadmap for Fiduciary Compliance Regarding Service Providers

- Regular review of third-party administrator (TPA) and insurance broker's services and fees, including their effectiveness and scope.
- Annual meetings with the TPA, broker and individual trustee, including reviewing each of their annual reports.
- An annual plan audit performed by an outside accounting firm (if a trust is involved).

Roadmap for Fiduciary Compliance Regarding Service Providers

- Outside legal counsel's review of service provider contracts.
- Periodic monitoring of the plan's administrative and claims procedures.
- Informal market information collection on service provider options and alternatives by talking to other service providers at conferences and gauging their fees, even if formal, written requests for proposals (RFPs) were not undertaken.

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Health Plan Fees and Expenses

- The U.S. Department of Labor (DOL) has taken the position that **plan sponsors and administrators must know the costs of the services they procure on behalf of the plan** and apply due diligence to minimize the costs relative to the level of services desired.
- Employers sponsoring self-funded welfare programs have difficulty obtaining the actual amounts insurance carriers or third-party administrators (TPAs) pay to medical and other health care providers.
- Insurance carriers and TPAs are often reluctant to disclose information that they consider proprietary (or that is encumbered by non-disclosure agreements with third-parties).

The CAA requires more disclosure from insurance carriers and TPAs.

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DOL Position on Fiduciary Duties for Health and Welfare Plans

- In 2012, the DOL indicated in the Final Regulations on Fee Disclosures for Retirement Plans (408(b)(2)) that it "believes that fiduciaries and service providers to welfare benefit plans would benefit from regulatory guidance in this area."
- Based on public comment and testimony, the DOL acknowledged that there are significant differences between service and compensation arrangements of welfare plans and those involving pension plans.

DOL Position on Fiduciary Duties for Health and Welfare Plans

- The final rule regarding retirement plan fee disclosures reserved a section in the regulation for a comprehensive disclosure framework applicable to reasonable contracts or arrangements for services to welfare plans, to be issued at a later time.
- The DOL stated that until that time, ERISA section 404(a) continues to obligate fiduciaries to "obtain and consider information relating to the cost of plan services and potential conflicts of interest presented by such [health and welfare plan] service arrangements."

NO regulations have been issued yet but the CAA provides new responsibilities for vendors and sponsors.

Impact of the Consolidated Appropriations Act of 2021(CAA)

- The CAA adds transparency to the health plan arena in multiple ways.
  - Requires the removal of gag clauses from plan contracts, giving plan sponsors new access to (and permission to use) their health plan data.
  - Requires vendors that service health plans to disclose all compensation
  - Requires plan sponsors to determine if compensation paid to vendors is "reasonable."
  - Requires plan sponsors to submit an annual report on prescription drug usage and costs, and an attestation of compliance.

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ERISA FIDUCIARY RULES FOR HEALTH & WELFARE PLANS: LITIGATION RISKS

December 14, 2022

Overview

- **Prohibited Transactions Overview**
- **New CAA Requirements & Related Litigation**
  - Self-Dealing & TPA/PBM Compensation
  - Mental Health Parity
- **Other Litigation Issues**
  - COBRA Notice Cases
  - Discovery Issues
  - Arbitration
  - Post-*Dobbs* State Regulation of Abortion Services

Prohibited Transactions Overview

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Prohibited Transactions Overview

- In addition to fiduciary duties of loyalty and prudence, fiduciaries have a duty to avoid **prohibited transactions**
  - Prohibited transactions = certain transactions between a plan and either a fiduciary or a "party in interest" ("disqualified person" under Tax Code)
- No self-dealing
  - Cannot deal with plan assets in own interest or for own account.
- No conflict of interest transactions
  - Cannot act in a transaction involving the plan on behalf of any adverse party.
- Other prohibited transactions
  - Cannot cause the plan to engage in certain specified transactions with parties in interest unless there is an exemption.

Recent CAA Requirements & Related Litigation

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Consolidated Appropriations Act of 2021 (CAA)

- Provisions part of year-end funding bill
- Includes broad-based health provisions that build on Affordable Care Act structure
- Some of many requirements include:
  - **Price transparency requirements**
  - **Cost reporting for medical and prescription drug costs**
  - **Mental health parity requirements**
  - Provider nondiscrimination
  - Surprise billing requirements

Disclosure of Compensation Paid to Service Providers

- ERISA's prohibited transaction rules require that compensation paid to service providers is "reasonable and necessary"
  - Exemption to Section 406(a): "[c]ontracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or **other services necessary for the establishment or operation of the plan**, if no more than **reasonable compensation** is paid therefor."
- Section 408(b)(2) regulations provide additional guidance:
  - No contract or arrangement is "reasonable" unless it permits termination by the plan on reasonably short notice and without penalty.
  - A service is "necessary for the establishment and operation of the plan" if it is "appropriate and helpful to the plan obtaining the service in carrying out the purposes for which the plan is established or maintained."

Disclosure of Compensation Paid to Service Providers

- Regulations also impose certain disclosure requirements for a contract or arrangement to be considered “reasonable”:
  - Service providers must provide certain information about direct and indirect compensation
  - Disclosures are intended to make compensation more transparent and to help plan fiduciaries to determine whether compensation is reasonable.
  - Failure to make the required disclosures results in a prohibited transaction.

Disclosure of Compensation Paid to Service Providers

- Service provider compensation EBSA enforcement priority and litigation issue
- EBSA concerned about health plan service providers like TPAs and PBMs providing services for undisclosed fees
- When fees are not known to plan fiduciaries, service providers could be exercising discretion over plan assets or dealing with plan assets for its own gain (self-dealing prohibited transaction)
- Also has been private plaintiff litigation regarding undisclosed compensation

Peters v. Aetna, Inc.

- Fourth circuit case involving administrative fees for subcontractor "buried" in a bundled rate
  - Services Agreement permitted subcontracting but required Aetna to pay associated fees
  - Aetna contracted with Optum to provide chiropractic and physical therapy services for a fee
  - Aetna had Optum "bury" its fee within the claims submitted by the providers, so plan and participants paid part or all of fee
- Plaintiff brought suit on behalf of herself and the health plan, alleging fee arrangement was fiduciary breach
  - Sought surcharge, restitution, disgorgement, and declaratory and injunctive relief

Peters v. Aetna, Inc.

- Fourth circuit found:
  - Plaintiff had standing to bring claims and could represent class
  - Summary judgment could not be granted on plaintiffs' claims because reasonable fact finder could conclude:
    - Aetna was operating as a functional fiduciary under ERISA and breached its fiduciary duties
    - Optum was acting as a party in interest engaged in prohibited transactions, but not as a fiduciary
  - Plaintiff suffered no direct financial injury as a result of the use of the bundled rate in the claims process, so she could not pursue a restitution claim, but she could pursue disgorgement, surcharge, and other equitable relief that did not require proof of direct financial injury

Standing after *Thole v. U.S. Bank, N.A.*

- The Supreme Court found that a participant or beneficiary who brings a suit for fiduciary breach under ERISA must still establish Constitutional standing in order to sue
- Constitutional standing requires a plaintiff to demonstrate (1) a concrete injury; (2) that was caused by the defendant; and (3) would likely be redressed by the requested relief
- Thole was a lawsuit for fiduciary relief under a defined benefit retirement plan, where the plaintiffs alleged mismanagement of the plan assets
- But the Supreme Court found there was no injury (and therefore no standing to sue), because the plaintiffs were receiving the pension benefits they were entitled to under the plan terms, regardless of the fiduciaries' investment decision
- Application of *Thole* with respect to health & welfare disclosure lawsuits may depend on specific remedy plaintiff seeks

When Are TPAs Fiduciaries?

- *Hi-Lex Controls v. Blue Cross Blue Shield of Michigan*
  - 2014 Sixth Circuit case in which court determined TPA was fiduciary with respect to its "retention reallocation" biling practices
  - Decision hinged on whether employee contributions sent to BCBSM from Hi-Lex to pay claims were plan assets
- But see recent district court decision, *Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts*
  - District court concluded funds transferred to BCBSMA from multiemployer fund to pay claims were not plan assets under "ordinary notions of property rights"
  - On appeal to First Circuit

Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA)

- Legislation passed in 2008 allows participants, beneficiaries, and DOL to use ERISA's civil enforcement scheme in Section 502 to file lawsuits to enforce MHPAEA requirements
- Increased DOL enforcement activity and litigation recently
- Under MHPAEA, financial requirements and treatment limitations imposed on mental health/substance use disorder benefits can be no more restrictive than predominant financial requirements and treatment limitations on substantially all medical and surgical benefits

Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA)

- Recnt litigation has been filed challenging exclusions and/or limitations in health plans related to:
  - Residential treatment
  - Wilderness therapy
  - Nutritional counseling for eating disorders
  - Applied behavioral analysis (ABA) (for Autism Spectrum Disorders)
  - Gender dysphoria
  - Network adequacy
- Plaintiffs challenge guidelines used by insurers and TPAs as breach of fiduciary duty claims under ERISA § 502(a)(3) (or 502(a)(1)(B)) or bring similar claims solely as MHPAEA violations

Recent Case: *Wit v. United Behavioral Health*

- Class action brought in Northern District of California alleging that United Behavioral Health ("UBH") breached its fiduciary duties under ERISA §§ 502(a)(1)(B) & 502(a)(3) in its administration of mental health treatment claims
- After bench trial, court determined UBH breached its fiduciary duties by implementing coverage guidelines for mental health treatment claims that were inconsistent with **generally accepted standards of care** and "tainted by UBH's financial interests"

Recent Case: *Wit v. United Behavioral Health*

- Court also found that UBH guidelines for substance use disorder claims were not consistent with American Society of Addiction Medicine (ASAM) Criteria
- UBH violated certain state laws (IL, TX, CT & RI) by applying criteria not consistent with state law requirements for coverage determinations of substance use disorder claims
- Ninth Circuit reversed. Found that it was reasonable for UBH to interpret the plans at issue to NOT require consistency with the generally accepted standards of care

Other Litigation Issues

COBRA Notice Cases

- COBRA provides a way for workers and their families to elect to temporarily maintain their employer-provided health insurance after a job loss or reduction in hours worked
- Recent trend: class actions alleging violations of COBRA's notice provisions
- Focus mostly on the adequacy of the statutorily-required notice provided by the employer to individuals about their rights to continue healthcare coverages

COBRA Notice Cases

- COBRA requires the administrators of most group health plans to provide notice to any qualified beneficiary of their rights to continue coverage under COBRA after a qualifying event
- This notice must be provided in accordance with regulations passed by DOL
  - COBRA notice "shall be written in a manner calculated to be understood by the average plan participant."
  - Must contain other specific information, including identity of plan administrator, mailing address for payments, explanation of how to enroll, description of the continuation coverage, and other items
- Regulations provide model notice but many employers/vendors do not use

COBRA Notice Cases

- Lawsuits typically allege notice was not “calculated to be understood by average participant,” did not follow model notice, and was missing very specific information required by regulation (i.e. name of plan administrator)
- Is strict or substantial compliance with the regulations required?
- Courts have found the notice must be sufficient to permit the discharged employee to make an informed decision whether to elect coverage.
- Technical violations of COBRA without a concrete injury do not result in standing – alleged defect must have caused an actual lapse in plaintiff’s healthcare coverage in order to have standing

COBRA Notice Cases

- Damages = $110 per day per person for a failure to provide sufficient notice
- If a class is certified, damages can be large
- Example: class action on behalf of 1,000 individuals who lost healthcare coverage for an average of 120 days could equal penalty up to $13.2 million, plus attorneys' fees
- Courts have discretion to award penalties and legal fees, and can factor in good faith

Discovery Issues

- ERISA does not establish judicial standard of review when claimants challenge an adverse benefits determination under ERISA § 502(a)(1)(B)
- Denial of benefits is reviewed under default de novo standard unlessthe plan grants the administrator discretionary authority, in which case more deferential arbitrary and capricious / abuse of discretion standard applies
- But about half of the states have passed insurance laws **banning discretionary clauses** in health and welfare benefit plans
  - The Sixth, Seventh, and Ninth Circuits have found that these laws are not preempted by ERISA in insured plans

Discovery Issues

- When reviewing under deferential arbitraty and capricious standard, most courts limit discovery to administrative record in benefit claims brought under ERISA § 502(a)(1)(B)
- But circuit courts appear to be split regarding proper scope of discovery under de novo standard
  - In Seventh and Eleventh Circuits, the court can limit itself to deciding the case on the administrative record but should also freely allow the parties to introduce relevant extra-record evidence and seek appropriate discovery
  - Fourth and Fifth Circuits strictly limit the introduction of any new evidence in litigation even under de novo review

Arbitration Clauses in ERISA Plans

- Are ERISA claims arbitrable?
- Current caselaw is unsettled
- Additionally, the arbitrability of claims for benefits from group health plans and disability plans is governed by the limitations in the claims regulations
  - Non-binding arbitration can be one of the levels of appeal
  - Voluntary level of appeal may include binding arbitration
  - Plan may offer binding arbitration after completion of appeals process
  - The arbitration must comport with timeframes and notice requirements in regulation

Arbitration Clauses in ERISA Plans

- When coupled with a class action waiver, arbitrability mostly turns on the question of whether § 409(a) claims under § 502(a)(2) are brought in a representative capacity on behalf of the plan as a whole, such that one participant can sue to restore losses to the entire plan, even without a class action
- Enforceability will depend on language of clause and waiver itself, its location in the plan or other document, and the specific relief plaintiff seeks

Arbitration Clauses in ERISA Plans

- Before adding an arbitration clause, consider pros and cons
- Pros:
  - Prevent large breach of fiduciary duty class actions forcing participants to bring individualized claims one by one
  - Disincentivize plaintiffs' law firms from targeting the plan fiduciaries
  - Privacy
- Cons:
  - Lose benefits of federal court forum, i.e. high-quality jurists, precedent, and appealability
  - "Death by a thousand cuts"
  - Deciding arbitrability first can ADD to costs of litigation

Post-*Dobbs* Considerations

- In *Dobbs v. Jackson Women's Health Organization*, the Supreme Court overturned its ruling from *Roe v Wade* that the Constitution confers a right to abortion services
- The ruling opened the door to state regulation of abortion services
- Legal considerations for health & welfare plans that decide to continue offering abortion-related benefits (including abortion coverage, abortifacient drugs, travel benefits):
  - ERISA Preemption
  - "Aiding and abetting"/ "persuading" criminal liablity
  - Extra-territorial enforcement

Questions?

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