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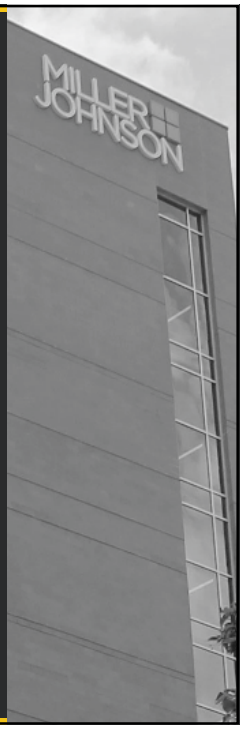
ERISA Fiduciary Duties (Do We Have Your Attention? If Not, A Lawsuit Will)



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Today's Topics

- Overview of ERISA Fiduciary Duties and Prohibited Transactions with Service Providers
- Health Plan Litigation:
  - Excessive Costs for Benefits and Services
  - Drug Rebate-related Revenues
  - Health Plan Premium Surcharges Based on Tobacco Use
  - State PBM Laws
- Retirement Plan Litigation:
  - Excessive Fees
  - Imprudent Investment Selection
  - Forfeitures
  - Pension Risk Transfer Activity (Lawsuits and Agency Actions)
  - Pleading Standard for Prohibited Transaction Claims

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Overview of ERISA Fiduciary Duties and Prohibited Transactions with Service Providers

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Fiduciary Duties

- To act solely in the interests of participants and beneficiaries (the duty of undivided loyalty)
- To act for the exclusive purpose of providing plan benefits, or for defraying reasonable expenses of plan administration (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 person" standard)
- To act based upon the plan documents unless those document are inconsistent with ERISA
- Duty to Diversify (when applicable)

Who is a Fiduciary?

- Named Fiduciary (e.g., plan sponsor or plan administrator)
- Functional Fiduciary – Individual with discretionary authority over management of a plan or plan assets or who provides investment advice for a fee
- Co-Fiduciary (delegation by fiduciary to another party such as an employee, committee, or TPA)
  - Cannot completely delegate fiduciary duties because the duty to monitor the delegated fiduciary remains

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Penalties for Breaching Fiduciary Duties

- Personal Liability
  - Any person who breaches any fiduciary duty may be held personally liable for any plan losses resulting from the breach
- Civil Penalties
  - 20% of applicable recovery amount
- Criminal Prosecution
  - Willful violations of ERISA may result in fines and up to 10 years imprisonment

Prohibited Transactions with Service Providers

- ERISA contains prohibited transaction rules that limit the types of transactions that a plan can enter into with a "party-in-interest" (including service providers to the plan)
- There is an exemption under Section 408(b)(2) of ERISA that allows a plan to pay **reasonable compensation** to a party-in-interest for **necessary** services for the establishment or operation of the plan
- Historically, there have been regulations for retirement plans (but not health and welfare plans) requiring service provider compensation disclosures to a plan sponsor

Disclosure Rules for Brokers and Consultants

- The Consolidated Appropriations Act, 2021 added disclosure requirements for ERISA covered group health plans so that no contract with a broker or consultant is considered "reasonable" unless certain disclosures are made
- Specifically, disclosures of "direct" and "indirect" compensation
- The rules apply to "covered service providers" who reasonably expect to receive $1,000 or more in compensation (adjusted for inflation)

Penalties for Non-Compliance

- Failure to receive the required disclosure means the contract is not reasonable under ERISA
- The arrangement would be deemed a "prohibited transaction"
- The plan sponsor could be liable for any losses to the plan resulting from the arrangement
- The plan sponsor could be subject to penalties under ERISA in connection with the prohibited transaction

Health Plan Litigation

Recent Trends

- Recently, lawsuits against retirement plans and plan fiduciaries related to excessive fees (investment fees, recordkeeping fees, etc.) have become common
- Plaintiffs' bar is now trying to bring similar lawsuits against health plans and plan fiduciaries
  - *Lewandowski v. Johnson & Johnson* – Failure to monitor relationship with its PBM, which led to higher plan costs
  - *Navarro v. Wells Fargo & Co.* – Similar to *Lewandowski*
  - *Knudsen v. MetLife* – Relates to diverting prescription drug rebates from the plan to the plan sponsor

Recent Trends (Cont.)

- The connection between the lawsuits against retirement plans and health plans are based on the breach of certain fiduciary duties under ERISA
- ERISA fiduciary duties apply equally to health plans as well as retirement plans. But the ERISA litigation trend only recently began to include health plans
  - Health plans are more similar to DB plans than DC plans, which makes it more difficult to establish damages outside of claim denials

Fee Transparency

- Fee "transparency" is also now required under final agency regulations – requiring plans to disclose rates and costs in "machine readable" format
- Entities that offer prescription drug coverage to Medicare Part D eligible individuals must disclose the coverage's creditable status to CMS
- Gag clause prohibitions
  - Health insurance companies and group health plans can't enter into agreements to restrict the sharing of certain cost and quality of care information/claims data with patients and other parties
  - Companies must submit a "Gag Clause Prohibition Compliance Attestation" annually

Fee Transparency and Fee Litigation

- Telephone/mail/Internet good faith estimates of charges for care must be provided to individuals upon request
- Fee litigation is ramping up related to health plans
- Plaintiffs' lawyers are actively recruiting for class action members on social media
- A recent class action case involving a PBM illustrates the types of arguments that are likely to be made

Fee Litigation in Health Plans

Lewandowski v. Johnson & Johnson

- Plaintiff alleges that J&J's health plan paid its PBM millions of dollars for prescription drugs that could have been purchased for much less
  - Example: the retail cost of a 90-pill prescription for a generic multiple sclerosis drug is between $40-$77 without a prescription, but cost J&J and its participants $10,239.69 per prescription – "not a typo"
  - The "inflated" amount is paid with plan assets and by participants who pay a portion of the cost out-of-pocket
  - Claims were paid through a VEBA trust
- Neither the PBM, nor the broker who recommended the PBM, are named defendants; only J&J and the fiduciaries are named

Lewandowski v. J&J (Cont.)

- The Plaintiff also alleges that the PBM was paid via a model that is opaque and riddled with conflicts of interest:
  - By using a traditional "spread pricing model" the PBM receives the difference in cost between what the plan pays and what the PBM pays pharmacies on behalf of the plan for the drugs
  - The prices are negotiated based on the overstated "average wholesale price"
  - "Traditional PBMs engaging in spread pricing try to exploit the disconnect between the prices they receive from plans and the prices they pay to pharmacies, pocketing the difference between the two prices"
  - The PBM also owns pharmacies, which means that it is also paid based on the difference between the retail cost and the wholesale cost of the drugs
- A "pass-through" approach, by contrast, is more transparent and would have led to lower costs (according to the plaintiff)

Lewandowski v. J&J (Cont.)

- Rather than prudently manage the Rx drug program, according to the plaintiff, the defendants:
  - "agreed to make the Plans and their beneficiaries pay extraordinarily high prices for prescriptions 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 take available steps that would have saved the Plans and their beneficiaries millions of dollars"

Navarro v. Wells Fargo

- Similar to the *Lewandowski v. J&J* case, employees alleged breach of fiduciary duties relating to the management of the prescription drug benefit plan
- Allegations:
  - Wells Fargo pocketed prescription drug rebates from PBM (Express Scripts Inc.)
    - Violation of exclusive benefit rule (duty of loyalty)
  - Failure to monitor the PBM (duty of prudence)
  - The contract with the PBM was a prohibited transaction

Knudsen v. MetLife Group, Inc.

- Employees alleged that MetLife improperly pocketed drug rebates instead of allocating those rebates to the plan, resulting in plaintiffs paying "excessive" out-of-pocket costs
  - Alleged that MetLife retained approximately $65 million in prescription drug rebates over a five-year period
    - Alleged violation of ERISA's anti-inurement provision
    - Plaintiffs sought disgorgement of profits, among other relief
  - Plan document provided that employer would receive rebates and apply them towards plan expenses, but rebates not considered in calculating any co-payments or co-insurance amounts
- Third Circuit (September 25, 2024): Plaintiffs failed to sufficiently allege a concrete financial injury because they could not show *how* out-of-pocket costs increased or by how much

Knudsen's Impact on *Lewandowski*

- On September 25, 2024, the plaintiffs in *Lewandowski* filed a notice of supplemental authority to advise the court of the Third Circuit's recent decision in *Knudsen*
- The notice states that instead of alleging that the defendant "may have" done various things, Plaintiff alleges, with accompanying data, that Defendants "set the required employee contributions each year as a percentage of expected spending by the Plans"
- If Defendants stopped causing the Plans to overspend on prescription drugs by millions of dollars each year, employee contributions would be lower as well (according to Plaintiff)
- Matter of time before fee litigation establishes a blueprint for other lawsuits to proceed against health plans?

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Health Plan Premium Surcharges Based on Tobacco Use

- Recently, plaintiffs have been alleging that health plan premium surcharges related to tobacco use or vaccination status violate the HIPAA non-discrimination requirement
- Lawsuits applicable to self-funded group health plans
- Lawsuits being brought despite the "outcome-based wellness program" exception that provides a basis for plans to apply such surcharges
  - Group health plans are generally prohibited from requiring enrollees to pay a premium or contribution that is greater than one charged to a similarly situated enrollee based on a health-status related factor
  - Tobacco use or addiction is a health-status related factor
  - Exceptions for participatory and health-contingent programs
  - "Outcome-based" wellness programs are a subset of health-contingent programs

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Health Plan Premium Surcharges Based on Tobacco Use (Cont.)

- In 2023, the DOL filed a lawsuit against an employer for, among other things, imposing a $20 per month premium surcharge on participants who disclosed tobacco use on health benefit enrollment forms
  - DOL's arguments:
    - No alternative standard (reasonable or otherwise)
    - Failure to disclose a reasonable alternative standard
- The court entered a consent judgment that required the employer to reimburse its plan participants the amounts that they paid for the surcharges and assessed a civil monetary penalty against the employer

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Health Plan Premium Surcharges Based on Tobacco Use (Cont.)

- Slew of recent cases with allegations of discriminatory premiums being imposed on tobacco users:
  - *Williams v. Target Corp.*, No. 0:24-cv-03748 (D. Minn.)
  - *Baker v. 7-Eleven, Inc.*, No. 2:24-cv-01360 (W.D. Pa.)
  - *Bokma v. Performance Food Group, Inc.*, No. 3:24-cv-00686 (E.D. Va.)
  - *Keesler v. Tractor Supply Co.*, No. 3:24-cv-01612
  - *Rogers v. Advocate Aurora Health*, No. 1:24-cv-08854 (N.D. Ill.)
- Assertions of no reasonable alternative standard
- Also assertions that, even if a plan offers a reasonable alternative standard, it is not clearly communicated to members

Predictions for Tobacco Use Surcharge Cases

- On September 26, 2024, the District Court for the Southern District of Ohio denied Macy's bid to dismiss an ERISA anti-discrimination claim brought against it by the DOL
- Macy's sought to dismiss a claim that its tobacco surcharge wellness program violated ERISA by discriminating against tobacco users
- The DOL is arguing that a requirement to be "smoke-free" after a tobacco cessation program is not a reasonable alternative standard to qualify for a refund of the tobacco use surcharge
- Will the District Court's denial of Macy's motion to dismiss embolden plaintiffs' attorneys to file more lawsuits?

State PBM Laws

- All 50 states have enacted some type of law regulating PBMs. Some are more stringent (Florida/Oklahoma) than others (Arkansas/Michigan)
  - The Pharmaceutical Care Management Association has challenged many of these laws based on ERISA preemption
    - Not successful in Arkansas (*Rutledge*)
    - Some success in Oklahoma (*Mulready*)
    - Florida not challenged (yet)
      - Do you have residents of Florida covered under your plan?
      - If so, you may need to attest (under penalties of perjury) that your PBM contract complies with Florida law
  - Michigan law only applies to health plans sold on the ACA Marketplace

Best Practices for Health Plans

- Create a welfare plan fiduciary committee and thoroughly document the committee's meetings
- Conduct RFPs for service providers (and ensure that fees paid to each service provider are "reasonable")
  - Identify any potential conflicts of interest (e.g., indirect commissions or revenue sharing)
- Monitor service providers
- Ensure that plan claims are administered in accordance with the plan's documented claim procedures
- Consider purchasing fiduciary liability insurance

Welfare Plan Fiduciary Committee

- Remove Board of Directors, Officers, and Owners (Shareholders, Members, and Partners) from potentially embarrassing depositions in lawsuits
- Require the committee to report (at least annually) to the Board or Owners (i.e., to satisfy the duty to monitor)
- Ideally, select individuals with knowledge about the health plan to serve on the committee
- Reduce conflicts of interest
- Facilitate the documentation of processes and decisions (i.e., help satisfy procedural and substantive prudence)
- Help prevent accidental fiduciaries

Retirement Plan Litigation

Excessive Fee Cases

- Plaintiffs frequently allege:
  - The participants paid excessive fees
  - Fiduciaries failed to conduct adequate due diligence – failed to understand the various methods by which service providers receive revenues and, therefore, failed to determine that the fees were reasonable
  - Fiduciaries failed to select the least expensive share class based on the plan's size (e.g., institutional shares)
  - Fiduciaries failed to negotiate lower recordkeeping fees either at the outset of the relationship or after plan assets substantially increased

Imprudent Investment Selection Cases

- Plaintiffs also allege:
  - Fiduciaries selected an investment lineup that was unreasonable – too many or too few options, not enough low-cost funds, or too many high-cost funds that underperform
  - Fiduciaries selected underperforming in-house funds or proprietary funds at the expense of plan participants

Protection and Investment of Plan Assets

- DOL states that plan fiduciaries must:
  - Establish a prudent process for selecting investment alternatives;
  - Select investment alternatives that are prudent and adequately diversified;
  - Ensure that fees paid by the plan are reasonable in light of the level and quality of services provided; and
  - Monitor investment alternatives and service providers once selected to confirm that they continue to be appropriate choices

Recent Fee-Related Settlements

Employer	Allegation	Settlement Amount
Xerox	Excessive Recordkeeping Fees	$4.1M
R.R. Donnelley & Sons	Excessive Recordkeeping Fees	$1.2M
Wake Forest	Expensive/Underperforming Investments – Recordkeeping Fees	$3.8M
Omnicrom Group	Expensive/Underperforming Investments – Recordkeeping Fees	$2.45M
Proactiv Evergreen Services	Excessive Recordkeeping Fees	$725K
Ventura Foods	Expensive/Underperforming Investments – Recordkeeping Fees	$1.5M
Salesforce	Expensive/Underperforming Investments	$1.35M
Magna International	Expensive/Underperforming Investments – Recordkeeping Fees	$2.9M
IQVIA	Expensive/Underperforming Investments – Recordkeeping Fees	$3.5M
Clean Harbors Environmental Services	Expensive Investments Underperforming Stable Value Fund	$395K
Maersk Inc.	Underperforming Investments	$225K

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Recent Fee-Related Settlements (Pt. 2)

Employer	Allegation	Settlement Amount
BHS Management Services, Inc.	Expensive/Underperforming Investments – Recordkeeping Fees	$1.5M
DaVita Inc.	Expensive/Underperforming Investments – Recordkeeping Fees	$2M
KPMG	Expensive/Underperforming Investments	$650K
Cintas Corp.	Expensive/Underperforming Investments – Recordkeeping Fees	$4M
Univar Solutions USA Inc.	Expensive/Underperforming Investments – Recordkeeping Fees	$1.1M
Advance Auto Parts	Expensive/Underperforming Investments – Recordkeeping Fees	$1.7M
Allegiant Travel	Expensive/Underperforming Investments – Recordkeeping Fees	$1.7M
MedStar Health Inc.	Underperforming Investments	$11.8M
Mitre Corp.	Excessive Recordkeeping Fees	$3.4M
Aegis Media Americas Inc.	Expensive/Underperforming Investments – Recordkeeping Fees	$500K

Some Takeaways

- "Prudent process" is critical
  - Governance: i.e., committee structure, authorizing resolutions, charter, regular meetings, etc.
  - Investment policy statement
  - Good, documented meeting minutes
  - Fiduciary training for committee members (knowing "settlor" v. "fiduciary" acts)
- Fiduciaries should continue to push service providers on fees
- Consider retaining independent expert/investment advisor
  - "Your overall fees are average for a plan your size" is likely not sufficient
  - Usually the argument is that a particular fund or fund family (e.g., target date funds) is too expensive – not the overall fees
  - Does a low-cost passive fund lineup + brokerage account make sense?
  - Carefully review all fee disclosures and determine whether fees are reasonable – e.g., don't overlook providers such as the automatic rollover vendor(s)
  - Consider whether a 3(38) investment manager arrangement may be appropriate

Some Takeaways/Best Practices

- Many complaints allege the lack of fiduciary oversight in failing to issue RFPs for vendor services at reasonable intervals (every 3-5 years)
- Ask detailed questions to investment advisors and document those questions, discussions, and decisions in the minutes
  - Do not rubber stamp recommendations
  - Documenting why an investment is retained or removed after it is placed on the "watchlist" is important
- What is your governance structure?
  - Do your plan documents refer to the "company" as the named fiduciary with no formal delegation to a committee?
  - Consider strategies for "insulating" board members to the extent possible

401(k)/403(b) Forfeiture Cases

- Recent spate of class actions – approx. 24 – mostly in California
  - Plaintiffs allege breach of fiduciary duties of loyalty and prudence, among other things, in the use of plan forfeitures to offset employer contributions
  - Three cases dismissed without prejudice and two cases are moving forward
  - Many plans (approved by the IRS) permit employers to use forfeitures to pay for administrative expenses, to offset future employer contributions, or to allocate to participants
  - Allegation is that implementing the decision of how to use forfeitures is a fiduciary decision, and the fiduciary should have allocated the forfeitures to participants or to offset expenses

401(k)/403(b) Forfeiture Cases

- Know what is in your document (and 5500 audit report)
- Consider amending the plan to remove discretion
  - If the employer consistently uses plan forfeitures to offset employer contributions, it may make more sense to take the discretion out of the plan document
  - Example: Forfeitures will first be used to offset future employer contributions, second to pay for plan expenses, and then be allocated to plan participants
  - Removing discretion should eliminate the argument that offsetting employer contributions is a fiduciary decision (time will tell)
- Consider whether the "offsetting" is even needed (e.g., discretionary profit sharing contribution)

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Pension Risk Transfers (PRTs)

- Pension risk transfers involve the transfer of pension liabilities to an insurance company
  - Could involve "retiree lift-out," plan termination, "buy-in/buy-out" arrangements
  - Common practice that has been noncontroversial for many years
  - One insurer failed, leading to DOL guidance for choosing the insurer (DOL Interpretive Bulletin 95-1)
  - Insurer selection is a fiduciary decision and employer is required to select the "safest available" annuity provider under 95-1
  - No PRT insurer has failed since 95-1 was published
- Large pension surpluses due to market performance and high interest rates created surge in demand in 2023 (over 700 PRTs)

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Pension Risk Transfers (PRTs) (Cont.)

- SECURE 2.0 required the DOL to issue a report on potential changes to IB 95-1
- On June 24, 2024, the DOL issued that report – kicking the can…
  - The report concludes that the DOL is not prepared to make changes to IB 95-1 at this time
  - Specifically, the DOL has concluded that IB 95-1 has been successful so far
  - However, the DOL will continue to evaluate the efficacy of IB 95-1 and may, at some point in the future, consider changes to IB 95-1 through a public process that provides stakeholders the opportunity to comment

Pension Risk Transfers (PRTs) (Cont.)

- SECURE 2.0 also includes new notice and disclosure obligations for lump sum windows, which often precede the annuity purchase
- In addition to more regulation, lawsuits have been filed against AT&T, Lockheed Martin, Alcoa, and others
  - Each company transferred its pension obligations to Athene Annuity & Life Insurance Company ("Athene")
  - Athene is a major player in the PRT market, but it is owned by private equity and it has a reinsurance subsidiary based in Bermuda
  - Plaintiffs allege that private equity ownership and "offshore structure" are inherently riskier than traditional insurer arrangements
  - As a result, the only possible reason for selecting Athene (according to the plaintiffs) would be to leverage cost savings for the employer's benefit
  - The demand in the AT&T case is in excess of $363 million

Pleading Standard in Prohibited Transaction Claims?

- Under ERISA, any transaction that a plan enters into with a service provider is a prohibited transaction
  - But there is a prohibited transaction *exemption* that allows a plan to pay **reasonable compensation** to a service provider for **necessary** services for the establishment or operation of the plan
- *Cunningham v. Cornell* - Second Circuit held that plaintiffs alleging a prohibited transaction must plead plausible facts showing that a prohibited transaction exemption does not apply

Cunningham v. Cornell University (Cont.)

- The Second Circuit's holding further divided a circuit split
- The Third, Seventh and Tenth circuits currently require plaintiffs to allege more than just a transaction involving a service provider
- Meanwhile, in the Eighth and Ninth circuits, the *defendant* has the burden to prove that the exception applies – meaning that the plaintiff only needs to allege that a transaction occurred involving a service provider
- On October 4, 2024, the Supreme Court granted the Cornell workers' petition to review the Second Circuit's decision

Questions?

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