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Excessive Fee Suits Imperil ERISA Fiduciaries for Health and Welfare Plans

By Mark E. Bokert and Alan Hahn

The standards that ERISA fiduciaries owe to the plans they oversee have been called "among the highest duties known to law . . . more exacting than the duties imposed upon common law trustees."[1] In recent years, ERISA fiduciaries of retirement plans have experienced heightened scrutiny from plan participants, including through a slew of legal challenges to allegedly excessive fees levied to administer such plans, sometimes resulting in eight-figure payouts.[2]

Now, however, plaintiffs have taken aim at the fiduciaries of ERISA health and welfare plans, too. These cases, like those described in further detail below, present a variety of risks and potential liabilities that employers must understand and monitor. Such exposure should be discussed with ERISA counsel and consideration should be given to the "next steps" that follow this article.

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THE STANDARDS OF CARE

A fiduciary under ERISA is anyone who:

(i) Is so named, formally designated by the ERISA plan;

(ii) Exercises discretion regarding the management or administration of the ERISA plan;

(iii) Exercises discretion regarding ERISA plan assets; or

(iv) Provides advice on ERISA investments for a fee.[3]

The list of stakeholders to whom such designations apply varies: members of a benefit plan committee, third-party plan administrators, investment advisors, and trustees.

Fiduciaries owe a number of broad-based duties to the plans they oversee as well as the participants and beneficiaries thereof, particularly the duties of loyalty and prudence. The duty of loyalty requires fiduciaries to act "solely in the interest of the participants and beneficiaries . . . for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan."[4] The duty of prudence requires fiduciaries to act with the "care, skill, prudence, and diligence under the circumstances" expected for a similar enterprise with similar goals.[5] The duties of loyalty and prudence are, separately, exceedingly high standards of care and together form the basis of the dispute in *Lewandowski v. Johnson and Johnson et al*.[6]

LEWANDOWSKI V. JOHNSON AND JOHNSON ET AL.

In an amended class action complaint filed with the U.S. District Court for the District of New Jersey in May 2024 (originally filed in February 2024), Ann Lewandowski, on behalf of herself, the Johnson & Johnson Group Health Plan and its component benefits (the Plan), and its participants, alleges that her employer, Johnson & Johnson (J&J) and its Pension & Benefits Committee breached their ERISA duties of loyalty and prudence as administrators and fiduciaries of the Plan. J&J terminated Lewandowski's employment shortly after the original complaint was filed in February 2024; however, she continues to be eligible to participate in the Plan via COBRA.[7]

Lewandowski alleges in pertinent part that J&J and the Committee violated their duties of loyalty and prudence because they:

(i) Failed to prudently manage the Plan's prescription drug benefit and the Plan's relationship with its Pharmacy Benefit Manager

(PBM) to ensure that the Plan – and, by extension – its participants, did not overpay for prescriptions with Plan assets and out-of-pocket costs;

(ii) Effectively abdicated their duties to the Plan's for-profit PBM to monitor and periodically review drug prices; and

(iii) Neglected to timely furnish relevant plan documents to Lewandowski upon request, as required by ERISA.[8]

The PBM

Spread Pricing

The complaint describes in depth the relationship between J&J and its PBM, Express Scripts, which serves as the third-party administrator of the Plan's prescription drug program and the intermediary between the Plan and pharmacies that source drugs for Plan participants. Express Scripts allegedly earns approximately $2 million in fees each year for its role as PBM in addition to any profits it collects through its pricing model as a for-profit company. Express Scripts is not named as a co-defendant in the lawsuit.

Some PBMs like Express Scripts purchase drugs from pharmacies with which they have relationships and then charge their client plans for the same drugs, the profit from which the PBM retains. Though this practice, called "spread pricing," is common among PBMs as a means to generate profit, the complaint alleges that J&J effectively eschewed its fiduciary duties to the Plan because it failed to monitor the relationship among Express Scripts and the pharmacies and review the resulting pricing mark-ups relative to cheaper substitute options or the same drugs offered by other pharmacies. The spread pricing model, it alleges in this case, motivates Express Scripts to emphasize drugs with wider profit margins, at higher overall costs to participants, but lower out-of-pocket percentages. A right which it has as a for-profit company, but at the expense of the Plan.

As an alternative to spread pricing, the complaint offers that J&J should have considered a PBM that employs a "pass-through" pricing model, in which a plan pays its PBM an administrative fee and, in turn, the PBM charges the plan the same prices for pharmaceuticals that the PBM pays to the pharmacy.

Cheaper Alternatives

The complaint further alleges that the defendants breached their duties because they neglected to (i) investigate offering on their formularies generic alternatives to brand-name drugs, which are oftentimes far

cheaper once they become available to the public, and (ii) review the designation of certain drugs on the Plan's formulary as "specialty drugs," which it contends is an arbitrary label that permits the PBM to charge higher prices relative to other drugs that provide the same benefits without the "specialty" distinction for a fraction of the cost to the Plan and its participants.

Drug Prices Increase as a Result

The confluence of "spread pricing" and the failure to offer cheaper generic alternatives caused the prices of drugs to spiral, according to the complaint. It provides numerous examples of drugs that a similarly situated plan administered by a PBM may offer in its formulary, comparing the prices PBMs would pay to the pharmacies relative to the prices the Plan would then pay to the PBM. Though certain drugs had discounts as low as 32.54%, the markups for others exceed 12,000%.[9]

POPOVCHAK ET. AL. V. UNITEDHEALTH GROUP INCORPORATED ET. AL.

In a similar vein to *Lewandowski*, a class action lawsuit originally filed in the Southern District of New York in December 2022 on behalf of plan participants of certain self-insured plans administered by United HealthCare (United) alleged, among other claims, that United has continuously violated its ERISA fiduciary duty of loyalty to plan participants through a framework known as its "shared savings" program.[10] Whereas network providers agree contractually to reimbursement rates with United, out of network providers are generally not subject to definite pricing structures, and may bill clients as they wish for care. Pursuant to its "shared savings" arrangement, self-insured plans that United administers are required to pay incremental fees to United based on the difference between charges billed by out of network care providers and the amounts United ultimately deems eligible for reimbursement under its plans.

The complaint alleges that United used third-party "repricer" data to calculate favorable expense ratios for out of network care providers, resulting in incremental fees of up to 35% in certain cases.[11] Furthermore, because the care provider is not obligated to accept the discounted rate set by United as full payment, plan participants who seek care may bear the cost of any unpaid portions of the bill.

Under the "shared savings" arrangement, the plaintiffs contend, United minimized reimbursement rates and forced the self-insured plans and their participants, to whom United owes an ERISA fiduciary duty of loyalty, to bear the costs, characterizing it as a "self-serving scheme . . . to fuel its own profits at the expense" of the participants.[12] Though the

court dismissed certain class action claims in response to a motion filed by United in May 2023 on their merits and on procedural grounds, it has permitted other allegations to proceed against United, including the duty of loyalty claims.

THE IMPLICATIONS OF LEWANDOWSKI AND POPOVCHAK

Whether and to what extent these claims hold merit, substantiating breaches of the defendants' duties of loyalty and prudence, remains to be decided. The court's decision on the defendants' motion to dismiss in *Lewandowski* is due in August 2024. Following its partial dismissal, the fact-finding and discovery process in *Popovchak* is set to continue into 2025.

Regardless of the courts' decisions in these cases, though, the lawsuits themselves and the hundreds of pages of detail therein illustrate the broader trend of scrutiny toward ERISA fiduciaries with respect to health and welfare plan administration. Not only must fiduciaries be concerned with fulfilling their own duties of loyalty and prudence, they may also need to assess and periodically review their internal procedures as well as the practices of those with whom they contract to provide such services. As drug prices continue to skyrocket, plan participants may continue to pursue relief through legal channels, with employers, their plan fiduciaries, and their lofty standards of care, as targets.

In another case recently dismissed by the U.S. Court of Appeals for the Third Circuit, plaintiffs lodged similar fiduciary-based allegations against Metlife.[13] If the outcrop of retirement plan lawsuits is any indication, additional lawsuits against health and welfare plan fiduciaries are likely to follow.

NEXT STEPS

Proactivity is paramount to stave off legal risk with respect to fiduciary compliance. To that end, a high-level list of next steps for plan sponsors, third-party administrators, and other fiduciaries follows here to help ensure compliance with applicable law and ongoing adherence to fiduciary obligations. Consulting experienced ERISA counsel will assist in bolstering compliance and ensuring that such duties of loyalty and prudence are upheld through plan governance.

Evaluate Third-Party Vendors. To adequately address the risks described herein to health and welfare plans, employers should critically evaluate their third-party vendors who may hold ERISA fiduciary obligations. Employers should determine whether they have adequately shielded their plans' assets, if any, from profit-motivated pricing models of third parties. In the context of health plan due diligence, plan sponsors should consider periodic audits of their service providers, including

critical review of their drug costs, service fees, and rebate arrangements. Furthermore, employers should ensure alignment among all plan fiduciaries with periodic communications and meetings, and document same.

Review Formularies and Pricing. Employers should also review their pharmaceutical plan formularies to understand whether cheaper options are available and take care to document ongoing efforts with rigorous written policies. Remaining up to date on the latest developments regarding generic alternatives may provide helpful context for pricing trends and identifying cost-effective drugs.

Plan Documents and Employee Communications. Employers should work with ERISA counsel to periodically review and audit plan documents and communication material provided to employees. These documents often form the basis for plaintiffs' lawyers' arguments and an employer's defenses. A review of a wrap plan, plan document, benefits booklet and summary plan description should be performed annually to ensure compliance with regulations issued by the U.S. Department of Labor, and current best practices recommended by ERISA counsel. Employers should pay particular attention to which entity is designation as fiduciaries of the plan in the applicable documents as well as what time limits might apply to bar an employee claim.

Security Efforts. ERISA fiduciary obligations are not limited to fee considerations. Plan sponsors should consider working with data privacy experts to introduce and/or review internal cybersecurity procedures to understand areas for weakness in the context of sensitive participant data, including personal health information, and develop strategies to limit liability with respect to third-party vendors over whose cybersecurity frameworks they do not have control. In doing so, plan sponsors can better safeguard participant information and avoid misuses of the same.

Compliance with Enhanced Disclosure Requirements. For certain group health plan contracts or arrangements entered into, amended, or renewed on or after December 27, 2021, brokers and consultants who provide services to ERISA group health plans are required to disclose to plan fiduciaries compensation they receive for services to such plans.[14] Though the disclosure requirements are directed at brokers and consultants, ERISA fiduciaries may be liable for failure to evaluate such disclosure. As such, employers should take care to understand these disclosure requirements and to whom they apply, compel action by such third parties to timely deliver the required data, and develop well-documented frameworks to evaluate the data.

Appoint Fiduciary Committees. Whereas maintaining committees to ensure compliance with applicable law and ERISA fiduciary duties is commonplace in the context of retirement plans, employers should consider establishing fiduciary committees for health and welfare plans, too. Forming committees comprised of employees with familiarity of one's benefit offerings as well as experts with nuanced knowledge and experience regarding effective compliance procedures can provide a critical

lens through which to evaluate plan administration and governance. In addition to performing the steps listed in the above bullets, employers could assign health and welfare plan fiduciary committees a variety of compliance-related responsibilities, such as reviewing claims and appeals processes, identifying and eradicating any systemic issues with plan administration or insurance coverage, and evaluating relationships with third parties. Plan fiduciaries should further consider implementing mandatory periodic meetings for their committees to ensure they remain up to date on legal developments and their plan operations.

CONCLUSION

Overall, though heightened scrutiny of health and welfare plan fiduciaries may be inevitable, the above strategies provide a framework through which employers can effectively operate their plans and mitigate litigation risk in the process.

Notes

1. Retirement Plans Comm. of IBM v. Jander, 589 U.S. 49 (2020) (per curiam).

2. Lockheed Martin to Pay $62 Million to Settle 401k Lawsuit, Fortune (Feb. 20, 2015), https://fortune.com/2015/02/20/lockheed-martin-to-pay-62-million-to-settle-401k-lawsuit/.

3. 26 U.S.C. § 4975(e)(3).

4. 29 U.S.C. § 1104(a)(1)(A).

5. 29 U.S.C. § 1104(a)(1)(B).

6. Lewandowski v. Johnson and Johnson et al, No. 3:24-CV-00671 (D.N.J.).

7. Id.

8. Id.

9. Id.

10. Popovchak et al. v. UnitedHealth Group Inc., No. 1:22-cv-10756 (S.D.N.Y. Dec. 21, 2022).

11. Id.

12. Id.

13. Knudsen et. Al. v. Metlife Grp., Inc., No. 2:23-cv-00426, (D.N.J.).

14. The Consolidated Appropriations Act (CAA).