

Compliance Directions

An Emerging Wave of Breach Claims Spells Trouble for Health Plan Fiduciaries

Gallagher

Filed at the end of July in a Minnesota federal court, [*Navarro v. Wells Fargo*](#) joins a similar New Jersey case filed several months ago against Johnson & Johnson in an emerging wave of claims brought under ERISA alleging mismanagement of prescription drug pricing due to fiduciary breaches. The *Wells Fargo* complaint describes similar claims as the *Johnson & Johnson* suit, although presumably learning from the motion to dismiss recently filed by Johnson & Johnson, the *Wells Fargo* complaint lists specific (although redacted) drugs prescribed and purchased by plaintiffs. The *Wells Fargo* complaint also adds the allegation that plan fiduciaries engaged in prohibited transactions under ERISA, causing the plan to pay excessive administrative fees to its pharmacy benefit manager (PBM). In both cases, Plaintiffs are seeking to hold the health plan fiduciaries personally liable for not paying the lowest possible cost for every drug offered by the plan.

Following the passage of the Consolidated Appropriations Act, 2021 (CAA), and the associated implementation of the Transparency in Coverage Rule requiring public posting of machine-readable files listing prescription drug prices, plan participants and their law firms can now compare and review fiduciary decisions via data that was not previously available. This increased scrutiny means health plan fiduciaries are now subject to increased litigation risk.

Fiduciary Breaches, Prohibited Transactions, and Excessive Fees

In general, ERISA requires fiduciaries charged with health plan management and operation to uphold certain duties of care. At issue here are the duty of loyalty to plan participants, which requires plan administration to be carried out in the best interest of plan participants, and the duty of prudence, which directs the fiduciary to act with care, skill, and diligence. Among other obligations, fiduciaries also must not be involved in prohibited transactions, which include improper influence, self-dealing, and conflicts of interest that may harm the plan. ERISA further requires that fiduciaries avoid unreasonable expenses related to plan administration.

Both lawsuits allege that fiduciary breaches occurred when each health plan's PBM ensured a large profit by overcharging participants for certain prescription drugs, in

Compliance Directions

some cases by over 5,000%, when compared with the cash price (i.e., the direct cost without insurance) for the same drugs. Specifically, the lawsuits allege that fiduciaries who choose traditional PBM pricing contracts breached their duty of prudence and duty to act in the best interest of plan participants when choosing a much more costly PBM model when other less costly arrangements were available.

Both complaints give the example of the generic teriflunomide, used to treat multiple sclerosis, alleging that both companies' PBMs agreed to make the plans pay over \$8,000 for each 90-unit prescription, instead of the \$0.91 per tablet cash price, which equates to an over 10,000% markup.

The *Wells Fargo* complaint adds the claim that plan fiduciaries engaged in prohibited transactions under ERISA by paying unreasonable and excessive fees to the PBM for administration. While administrative fees for several comparable plans ranged from \$1M to \$6M, Wells Fargo agreed to pay the PBM \$25M for administrative services.

Both lawsuits are ongoing. The court has not yet ruled on Johnson & Johnson's motion to dismiss, and the *Wells Fargo* case is next set for hearing in December.

Employer Action Steps

ERISA fiduciaries who violate their responsibilities under ERISA may be personally liable for any damages caused to the health plan or for any profit realized by the fiduciary through its violation. Fiduciary status is based on the function the individual performs for the plan, regardless of that individual's title or relationship with the plan. This means that the named fiduciary in the plan document may not be the only fiduciary. While simple plan administration activities do not trigger fiduciary obligations, functional fiduciaries could include those hiring and monitoring service providers, claims adjusters, those who handle rebates, refunds, or forfeitures, or others associated with administration and decisions related to the plan.

While neither the potential defenses either employer may raise nor the ultimate outcome is known in the cases, following the best practices below will ensure the greatest likelihood of protection against similar claims. For more information on ERISA plan fiduciary duties, please see our [ERISA Fiduciary Governance Toolkit for Health & Welfare Plans](#).

Compliance Directions

Best Practices for Fiduciaries

Fiduciary obligations often arise in the selection of a plan vendor and the determination of whether the fees, for the scope and quality of services, are reasonable. The fiduciary's obligation continues throughout the vendor relationship and requires continuous monitoring to ensure compliance with the plan document and any regulatory requirements. Further, the fees should be benchmarked on an ongoing basis to ensure that they remain reasonable. Assessing and benchmarking PBM contracts and the associated fees is not an easy task. For that reason, it is important to have knowledgeable individuals involved in the process.

Selecting the plan's fiduciary(ies)

Fiduciary status can occur in several ways. An individual or entity can be a fiduciary by being named in the ERISA plan document (the named fiduciary). Fiduciary status also arises when an individual exercises discretionary authority over the plan's management and assets (a functional fiduciary). In some instances, a third party can be a fiduciary if another plan fiduciary delegates that role (e.g., claims administrators).

When the plan sponsor is the named fiduciary, the organization's governing body (e.g., board of directors) is the plan fiduciary and must comply with the requirements when acting in a fiduciary role. Practically though, most governing bodies do not review health and welfare plan contracts or benchmark vendors through an RFP process. Rather, that role typically is handled by someone in the human resources or benefits role or department. In such an instance, the governing body should delegate that fiduciary function to that individual or role. However, before delegating the responsibility, the board must determine whether that individual has or will have access to the requisite knowledge and expertise to sift through RFPs, compare contracts, and assess fees.

Moreover, that individual must also be able to act as a fiduciary even when those actions may be at odds with the organization's business goals. When an individual is both an employee and plan fiduciary, that individual wears two hats – one hat when working as an employee and in the interest of the organization and another when acting as the plan fiduciary. Senior executives with broad responsibilities may not be able to make decisions in the interest of participants without considering their obligations to the organization. As such, it may be better for some organizations to establish a benefit plan committee. If you are interested in whether the committee is the right choice for your organization, see the Guide linked above for a more thorough discussion.

Compliance Directions

Develop a process for selecting and monitoring plan vendors

To properly document how a vendor was chosen, and a reasonable fee determined, sponsors must develop a consistent methodology to measure competing proposals. The review process must continue throughout the relationship and outline the considerations for fee or renewal increases. A clean and clear process ensures that contracts with variances are reviewed in a consistent manner, and when followed, can protect the plan in the event of litigation.

The determination of whether a vendor's fees are reasonable is based on the facts and circumstances and includes in the consideration what services are actually provided. The only way to understand whether a fee is reasonable is to benchmark those fees and services against competing vendors. Often, this process will require an expert to translate contract terms, relate them to competing contracts, and compare fees within that context. Documenting the benchmarking process will demonstrate the methodology for review of contract terms and fees and the considerations taken under advisement when determining if a fee is reasonable. Once a plan vendor is chosen, ongoing monitoring and regular audits should occur to ensure services provided match the contracted agreement.

Consider fiduciary liability insurance

Even with all these steps, it's important to protect the individual(s) serving in a fiduciary capacity. Fiduciaries can be found personally liable to the plan for any plan losses resulting from a breach of their fiduciary obligations. Liability insurance insures fiduciaries against losses resulting from breaches and generally covers negligent errors or omissions, receipt of improper legal advice, and improper plan amendments. Such insurance is sometimes combined with errors and omissions (E&O) and directors and officers (D&O) coverage though review of those policies to ensure protection is important. Employers can also indemnify the fiduciaries to compensate them for personal losses resulting from a fiduciary action.

The intent of this analysis is to provide general information regarding the provisions of current laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.