Know Your Health & Welfare Plan Fiduciary Responsibilities: Avoiding Liability and Penalties

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Employer Fiduciary Responsibilities: Group Health Plans

What Is ERISA?

Employee Retirement Income Security Act of 1974

Imposes stringent standards on those with discretionary authority over employee benefits plans and plan assets

Imposes very strict rules prohibiting conflicts of interest and insider dealing

Allows plan participants, the Department of Labor ("DOL"), and subsequent fiduciaries to bring suit to enforce ERISA's provisions

Key Points on Serving as an ERISA Fiduciary

Separate Position. Serving as a health & welfare plan fiduciary is **not** just an additional part of an employee's work responsibilities for the Company. Serving as a health & welfare plan fiduciary is akin to working for a separate employer whose exclusive business is promoting the interests of the plans and participants in the Plans.

High Standard of Conduct. The ERISA fiduciary standards applicable to a health & welfare plan fiduciary are often higher than the standards that apply in normal corporate settings, as a health & welfare plan fiduciary is charged with holding and safeguarding the property of others. The "fiduciary standards" are discussed in more detail below. Corporate standards like the "business judgment rule" generally do not apply.

Knowledge Cannot Be Left at the Door. Under ERISA, plan fiduciaries are not free to disregard knowledge acquired from other sources in exercising their duties and responsibilities.

Key Points (*Cont'd*)

Interests of Employer/Sponsor Not Relevant. ERISA does not permit fiduciaries to make decisions for plans and plan participants based on what is in the best interests of employers or plan sponsors.

Fiduciaries Have an Affirmative Duty to Avoid Prohibited Transactions. ERISA imposes an affirmative duty on fiduciaries to avoid having plans engage in transactions that benefit persons who have pre-existing plan relationships with the plans, unless the transaction benefits from a statutory or regulatory exemption. This rule is particularly important where the plan sponsor is in the health industry and the plan utilizes the sponsor's services or products.

Fiduciaries May Be Personally Liable to Plan. Fiduciaries may be held personally liable to a plan for plan claims and losses. ERISA prohibits a plan (but not a plan sponsor) from indemnifying a fiduciary.

ERISA Fiduciaries

Who is an ERISA fiduciary?

Named in plan documents

Functional test

A person is an ERISA fiduciary with respect to a plan to the extent they do any of the following:

Exercise any discretionary authority over the management of the plan or disposition of plan assets: e.g. *health & welfare plan committee*

Have discretionary authority or responsibility in plan administration: e.g. *Human Resources, Finance*

Limited to areas where discretion or control are exercised or assigned. May be a fiduciary for one purpose and not another

ERISA Fiduciaries (*Cont'd*)

Who is an ERISA fiduciary?

- Fiduciaries include:
  - Plan sponsors
  - HR administrators
  - Health and welfare plan committee
  - Professionals who give advice related to the plan
  - Those responsible for selecting who sits on the plan committee

Why Does It Matter Who Is An ERISA Fiduciary?

"A fiduciary's duties under ERISA are 'the highest known to law.'" *Reich v. Valley Nat'l Bank*, 837 F. Supp. 1259, 1273 (S.D.N.Y. 1993) citing *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982)

ERISA fiduciaries can be held personally liable to reimburse the plan for any losses it suffers due to a breach of fiduciary duty

Fiduciaries can be held liable for failing to prevent ERISA violations of their co-fiduciaries

General Fiduciary Duties Under ERISA

Prudence: Reasonable person standard

Loyalty: Act for the exclusive benefit of participants and beneficiaries

Adhere to Documents: Act in accordance with documents and instruments governing the plan, to the extent such documents comply with ERISA

Compliance: Avoid prohibited transactions and follow various ERISA compliance requirements

ERISA Plan Assets

Fiduciary Risks

Assets must be held in trust – limited nonenforcement for group health plans

- Insured, self-insured and trusts

Where are the plan assets in a group health plan?

- Employee contributions
- Employer contributions
- Insurance policies
- Stop-loss policies

Plan assets and prohibited transactions in group health plans

No Surprises Act and Transparency in Coverage

No Surprises Act and Transparency in Coverage

Consolidated Appropriations Act of 2021

Took effect January 1, 2022.

Applies to group health plans.

Addresses balance billing plan participants, transparency in health care, and additional patient protections.

Does not apply to excepted benefits; short-term, limited-duration insurance; health reimbursement arrangements; or other account-based group health plans.

Fee Disclosure Requirements

Consolidated Appropriations Act of 2021

The CAA sets forth new compensation disclosure requirements applicable to certain service providers that enter into contracts or arrangements to provide "brokerage" or "consulting" services to group health plans subject to ERISA.

- The U.S. Department of Labor (DOL) has stated that one is subject to the disclosure requirements if the services are brokerage or consulting, even if they do not identify or are not licensed as a broker or consultant.
- The CAA applies to group health plans (insured and self-insured, large and small, and HRAs and health FSAs) and excepted benefits, such as dental and vision plans.

Covered service providers must disclose in writing the direct and indirect compensation that is expected to be received in connection with a contract or arrangement between the covered service provider and the plan, as well as other details about the services relationship.

Fee disclosure requirements are intended to help plan fiduciaries recognize and prevent potential conflicts of interest that can arise when plan service providers are compensated by third parties.

There are additional disclosure requirements on Form 5500 (Schedule C) regarding trust-funded group health plans.

Fee Disclosure Requirements

Consolidated Appropriations Act of 2021

Applies to broker and consultant contracts entered into, extended, or renewed on or after December 27, 2021.

Contracts with service providers that do not disclose required information will be deemed unreasonable and constitute a prohibited transaction.

- Plan fiduciaries are required to ensure that service providers to the plan are only receiving "reasonable" fees.

Fiduciary litigation risk.

Action steps for group health plan sponsors subject to ERISA:

- Request and receive required compensation disclosures prior to signing contracts, renewals, or extensions with covered service providers.
- Scrutinize fee information, particularly indirect compensation, in determining whether the fees are reasonable, specifically if plan assets are used to pay service providers.
- Document process and analysis.
- Potentially consider the creation of a benefits committee.

Prohibition on Gag Clauses

Consolidated Appropriations Act of 2021

Gag clauses are prohibited from being included in agreements between providers and group health plans (or insurers) that restrict the plan or insurer from:

- disclosing provider-specific cost or quality-of-care information or data to plan sponsors, referring providers, or eligible individuals; or
- electronically accessing de-identified claims information (in accordance with HIPAA, GINA, and the ADEA); and
- sharing this information with a business associate.

FAQs released on February 23, 2023, by the DOL, the Department of Health and Human Services, and the Department of the Treasury require health plans and health insurance issuers to submit their first attestation of compliance with the CAA's prohibition of gag clauses by December 31, 2023.

- Must be submitted annually.

Self-insured plans are required to complete the attestation.

- Can enter into a written agreement with the third-party administrator (TPA) where the TPA will provide the attestation on the plan's behalf
- Still required to ensure that timely attestation occurs.

Employers should make sure that contracts with TPAs and other providers do not violate the prohibition on gag clauses.

Price Comparison Tool

Consolidated Appropriations Act of 2021

For plan years beginning January 1, 2023, plans must offer price comparison guidance by phone and make a price comparison tool available online that allows a participant to compare cost sharing with respect to 500 "shoppable" services identified and specified by CMS.

- Effective January 1, 2024, plans must provide the same comparison tool **for ALL items and services.**

Fully insured plans should confirm that the health issuer will comply with comparison tool requirement

- Update agreements to reflect responsibility.

Self-funded plans should discuss with TPAs (and other service providers) to confirm that the TPA will be in compliance by the deadline.

- Revise agreements to clearly outline obligations.
- Continue to monitor TPA's compliance with this requirement since self-funded plans are ultimately responsible for compliance with the requirements.

Next Steps for Employers

Consolidated Appropriations Act of 2021

Request and receive required compensation disclosures prior to signing contracts, renewals, or extensions with covered service providers.

Scrutinize fee information, specifically indirect compensation, in determining whether the fees are reasonable, specifically if plan assets are used to pay service providers.

Ensure that contracts with TPAs and other providers do not violate the prohibition on gag clauses. An attestation of compliance with the prohibition of gag clauses is due by December 31, 2023, and must be submitted annually.

Consider establishing a committee to oversee the health and welfare plan process and administration.

Thoroughly document processes, procedures, and communications with TPAs.

Group Health Plan Audits and Litigation

Benefit Design Audit Risks

Supplemental Benefits

Recent practices in health care coverage

- Medical care expenses includes the costs of diagnosis, cure, mitigation, treatment or prevention of disease and for the purpose of affecting any part of the function of the body
- Cash incentives for healthcare/wellness/waiver of coverage
- Biden administration cracks down on “short-term limited-duration insurance” plans with proposed rule.

ERISA Group Health Plan Litigation

Claims Review

Recent litigation

Challenges to Claim Review

D.K., et al. v. United Behavioral Health, et al. (10th Cir. May 15, 2023)

- Medical necessity / residential treatment case involving a teen with a history of attempted suicide.
- Treating MD opinions, reviewing MD opinions, and "engagement" in the claims process.
- If the claim review includes enough errors, courts will order the benefit and not remand.

Provider litigation

- Providers are increasingly bringing derivative ERISA claims along with "direct" claims.
- Generally against carriers/TPAs.

Vendor Disputes

- ***Osceola Cty., Fla v. Gallagher Benefit Servs.*** (M.D. Fla, June 22, 2022)
- School system alleges Gallagher negotiated "secret" commissions despite the negotiated commission cap.
- Theories: breach of contract, breach of fiduciary duty, and fraud.

ERISA Group Health Plan Litigation

Litigation Risks

New wave of fiduciary litigation?

- Schlichter Bogard, LLC gained notoriety for 401(k)/403(b) "fee litigation."
- Schlichter recently posted advertisements looking for employees and potential plaintiffs at Target, State Farm, Nordstrom, and Pet Smart who participate in the group health plan.
- Focus appears to be on the CAA's fee disclosure requirements and the "reasonableness" of vendor fees and services for health care.

Behavioral Health Considerations

Behavioral Health Litigation

Anatomy of a behavioral health ~~law~~suit

- Typical benefits at issue are residential mental health treatment, ABA therapy, and wilderness therapy
- Typical legal claims:
  - Denial of benefits under § 502(a)(1)(B))
  - Equitable relief under § 502(a)(3)), e.g., reformation of the plan to comport with MHPAEA
  - Failure to provide plan docs under § 502(c))

Recent (or interesting) litigation

Wit, et al. v. United Behavioral Health, 2023 WL 5356640 (9th Cir. Aug. 22, 2023). Class challenge to coverage criteria that were more restrictive than "generally accepted standards of care" (GASC) (classes included residential treatment and outpatient classes).

- After trial, the district court ruled that United's internal guidelines deviated from GASC and state-mandated criteria, and as such, the benefits were wrongfully denied, and United breached its fiduciary duties
- 9th Cir: Benefits claim reversed: "UBH's interpretation that the plans do not require coverage for all care consistent with GASC does not conflict with the plain language of the Plans."
- Fiduciary duty claim remanded.

Doe v. United Behavioral Health, 523 F. Supp. 3d 1119 (N.D. Cal. 2021). Lawsuit against UBH (not Wipro Ltd.) for denied ABA therapy benefits

- UBH denies it is a fiduciary in its role as TPA/claims administrator and had to interpret the plan as written (even with parity issues). The court disagreed: ERISA "explicitly requires a fiduciary to apply a plan's terms, but only if those terms do not violate ERISA."

Behavioral Health Litigation (Cont'd)

Trends and Takeaways:

Document Request

- What's in a § 104(b)(4) and what's not?

"Dueling Doctors"

- Primarily relevant to benefit claims.
- Medical necessity/treatment step-down disputes.

Defendants

- Who is necessary for relief sought?

Defending at the pleading stage

- Has the plaintiff pled a factually plausible claim? Conclusory allegations are insufficient.

Mental Health Parity Special Issues

Plans must disclose the comparative analysis and related information to the DOL upon request.

- Participants and beneficiaries may also request this information under general ERISA disclosure rules.

Creates new authority for DOL to enforce parity with regard to insurance issuers.

Increased enforcement action by the DOL with a large number of open investigations.

- Focus on inpatient and outpatient benefits and scrutiny of prescription drug benefits.
- Investigations and documentation requests are best understood to be premised on a presumption of noncompliance.
- Can be challenging to prove that a policy or practice is “not more stringent.”
- Key is to ensure that a specific decision for a given limit, policy, or coverage design feature for a given benefit can be demonstrated to be the result of a general principle that is defined clearly and applied consistently across all benefits.

“Naming and shaming” required for violations, and plan fiduciaries are responsible for ensuring that the issuers or vendors they rely on for compliance with the MHPAEA are following its requirements and prohibitions.

Best Practices for Behavioral Health Risk Mitigation

Best Practices for Compliance Programs

Conduct a preliminary parity risk assessment.

- Analyze existing parity documentation for key NQTL types, quantitative testing for financial requirements, and definitions for conditions and classifications.

Develop formal policies and processes that govern parity compliance.

- Designate key personnel responsible for ongoing compliance and governance.
- Annual reviews of the five-step NQTL analyses and operations measures data.
- Update programmatic P&Ps, committee reporting templates, and other related documents, as needed, to maintain alignment with NQTL analyses.
- Internal communication plan for provider and member complaints, issues identified by regulators, and new guidance and enforcement.
- Regular collaboration with TPA.

Train all relevant personnel on parity requirements.

- Train on key parity requirements and documentation (NQTLs and QTL/FRs).
- Explain ongoing personnel roles in maintaining parity compliance.

Monitor TPA parity activities, and conduct a regular review of parity documentation, particularly NQTLs.

Monitor federal and state guidance and enforcement and private litigation.

Best Practices for Effective Governance

Best Practices for Effective Plan Governance

Effective Flow of Information

Timely and relevant information is distributed among decision-makers and service providers

Written Plan Policies

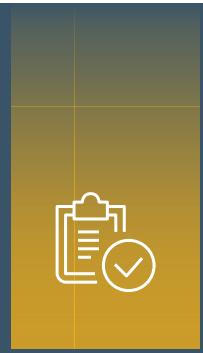
Written policies regarding how the plan is to be administered

Review plan design and determine if in best interest of plan participants

Ensure compliance with various disclosure requirements

Including new covered service provider fee disclosure rules and MHPAEA comparative analysis requirements

Fiduciary Liability Insurance/ Indemnification



Thank you!