Compliance Insights

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Employee Benefits Compliance

ERISA Fiduciary Duties: The Impact of Transparency and How to Protect Your Plan

Introduction

The Employee Retirement Income Security Act ("ERISA") is comprehensive federal legislation enacted in 1974. It applies to "employee benefits plans," including health and welfare and retirement plans. The most common ERISA requirements are plan-related disclosures to participants (SPDs, SMMs) and governmental reporting (5500s). Title I of ERISA also imposes a strict fiduciary code of conduct for ERISA plan sponsors and plan administrators. A fiduciary duty is among the highest standards of care under law.

ERISA fiduciary duties are not new, but employer plan sponsors of group health plans should revisit these duties in light of new transparency and disclosure requirements[1]. Similar transparency and disclosure rules have applied to ERISA-governed retirement plans for some time. Notably, in the past several years, the number of class action lawsuits against retirement plans and plan sponsors has skyrocketed, with certain practitioners and stakeholders referring to it as an "epidemic" at this stage. Most of these cases claim breaches of ERISA fiduciary duty based largely on the information available from ERISA required disclosures.

Now that similar disclosure rules apply to group health plans, along with a host of new transparency requirements, employer plan sponsors of group health plans should understand the impact on their role ad fiduciaries of the plan. Specifically, significant information about the group health plan—including participant cost sharing, certain network provider rates and pharmacy drug prices—will be newly available and accessible not only to participants but also to the public, including the plaintiffs' bar. As a result, employer plan sponsors should be prepared for the possibility of litigation similar to what we see in the retirement space, and that preparation starts with a basic understanding of ERISA's fiduciary requirements.

Who is a Fiduciary

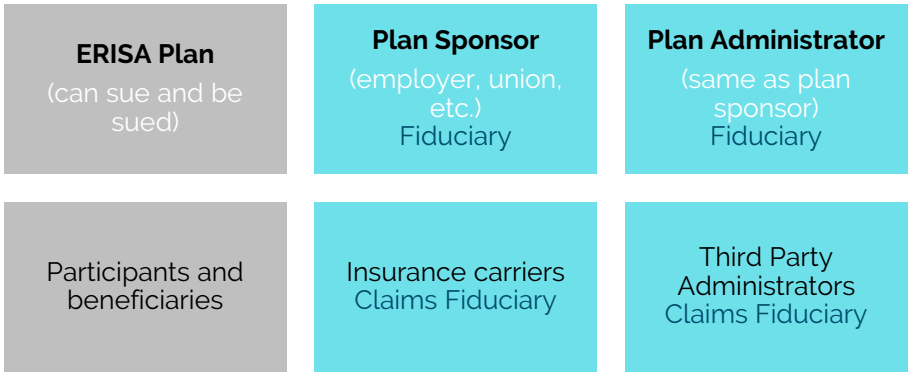
Under ERISA a fiduciary is anyone who:

- exercises discretionary authority or control of the management of the plan; or
- exercises authority or control of the management or disposition of the plan assets; or
- has any discretionary authority or responsibility in the administration of the plan.

A few introductory concepts are important to note. Namely, that for health and welfare plans, the "plan" is its own separate legal entity that can sue and be sued. The plan sponsor is generally the employer sponsoring the plan. The employer also wears a separate ERISA "hat" as the plan administrator. In sum, the plan exists as its own legal entity, and the employer is often both the plan sponsor and the plan administrator, and has fiduciary obligations regarding the plan and with respect to participants and beneficiaries. In addition to the foregoing concepts, it is important to note that there can be both named and non-named fiduciaries. The employer/plan administrator is most commonly the named fiduciary in underlying plan documents. An insurance carrier or third party administrator (TPA) is usually considered a claims fiduciary, and generally, professional advisors (legal, accounting), consultants, stop loss carriers, and pharmacy benefit managers

[1] Please see the Alliant Insights on Transparency and Broker Disclosure for thorough discussion of these requirements.

(PBMs) are not fiduciaries. But fiduciary status is almost always a fact specific analysis and designation—or lack thereof—given to an entity servicing the plan or plan fiduciaries does not determine whether the entity is acting as a fiduciary of the plan.



While certain tasks that implicate ERISA fiduciary duties may be delegated to third parties (e.g., claims administration) a plan fiduciary cannot delegate fiduciary duties by contract (e.g., you have agreed to assume our fiduciary role/obligations) or absolved by contract (e.g., we assert, and the parties agree, that we are not a fiduciary).

Listed Fiduciary Duties

A fiduciary duty exists generally when exercising discretionary authority with respect to an ERISA covered group health plan. However, ERISA also identifies the following specific fiduciary duties:

- **The Duty of Loyalty**: Fiduciaries must act solely in the interests of participants and beneficiaries with a duty of undivided loyalty. This includes not making false or misleading statements or misleading by omission. False statements and significant omissions can create significant liability.
- **The Exclusive Benefit Rule**: Fiduciaries must act for the exclusive purpose of providing plan benefits or defraying reasonable plan administration expenses. This duty is implicated in several common plan administration situations.
    - Rebates and refunds – Participant contributions are "plan assets" and plan assets can only be used for the exclusive benefit of participants (or for certain reasonable plan expenses). Where there is employee cost sharing any rebate or refund returned to the plan will include plan assets that cannot be retained by the employer/plan sponsor. Plans must identify the portion of any rebate or refund attributable to plan assets (e.g., if employees pay 60% of the cost of coverage than 60% of any rebate will be plan assets) and put that towards benefits enhancement or reducing participant costs. Because most ERISA plans avoid the requirement to hold plan assets in trust by limiting how long plan assets are held (90 days) and what they are used for a premium holiday is often they best approach to complying with the exclusive benefit rule in this content. Many plans experienced this in the context of Medical Loss Ratio (MLR) rebates or COVID-related utilization rebates.
    - Cross plan offsetting – Cross-plan offsetting describes a process where a TPA recovers overpayments to a health care provider made by one plan by withholding subsequent payments to that provider from another plan. This approach is considered a breach of fiduciary duty and should be affirmatively prohibited by the plan's agreement with its TPA(s). Using plan assets for plan expenses – Plan assets may be used to pay reasonable plan expenses, but not business expenses. For example, plan assets could not be used to fund a study and consider the options for establishing a plan but could be used to produce participant communications including SPDs and open enrollment materials. Practically,

however, plan assets will seldom be used to pay plan expenses connected to group health plans (outside of H-FSA forfeitures) because plan assets are generally limited to participant contributions and amounts held in trust.

- **The Prudence Rule**: Fiduciaries must act with the objective care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use (the "prudent expert"). This is an objective standard where the good faith of parties is generally disregarded. Here, the process the fiduciary undertakes is generally more important than the outcome.[2]
    - Monitoring service providers – Employer plan sponsors have a duty to select competent partners and oversee their performance. For group health plans that can mean due diligence with respect to HIPAA compliance, cybersecurity, and the ability of TPAs and other plan partners to fully comply with group health plan compliance mandates, including the new transparency and reporting rules.
    - Paying reasonable compensation – Employer plan sponsors are charged with ensuring that compensation paid to third parties is reasonable. Failure to monitor and ensure compensation is reasonable also creates a prohibited transaction (see discussion below). The new broker disclosure requirements fall squarely under this rule.
    - Selecting providers and networks - Employer plan sponsors must use a prudent selection process for health care providers and networks—one that takes into account the qualifications of providers, the quality of health care services offered, and the reasonableness of fees. This includes scope of services available under the plan, the qualifications of the providers and specialists, network accessibility, and patient satisfaction.
    - Decisions regarding plan assets – Group health plans do not generally invest plan assets but should avoid misuse of plan assets including proper handling of any refunds or rebates. Recall that in the group health plan context, the most common plan assets are participant contributions.
- **The Requirement to Follow Plan Terms**: Fiduciaries must act in accordance with the documents and the instruments governing the plan. This means ensuring the written terms of the plan are applied on a uniform and consistent basis. Most commonly, this means not making coverage exceptions for personal reasons—even well-intentioned exceptions—absent a prospective plan amendment applicable to all plan participants.

Settlor and Ministerial Exemptions

Fiduciary rules acknowledge that employers need to make a wide range of business and budgetary decisions regarding plan design and eligibility. These business decisions are considered "settlor" functions and not subject to fiduciary rules. In other words, in this capacity, the employer can remove its plan sponsor/plan administrator fiduciary "hat". For example, an employer may need to amend the plan to reduce benefits or even terminate the plan. Because these are settlor decisions, they do not violate the duty of loyalty or exclusive benefit rule. Note, however, that this can be a gray area (e.g., selecting healthcare providers and networks/network adequacy as well as ensuring basic compliance remain fiduciary roles). Ministerial functions are also not generally subject to fiduciary rules because these are administrative functions or actions that do not involve the exercise of discretion in most contexts. Ministerial decisions can include applying established rules to determine eligibility, preparing certain participant communications, and collecting and transmitting premiums/contributions.

[2] In *Hughes, et al. v. Northwestern University*, the most recent Supreme Court case on fiduciary breach in the retirement plan context, the Court emphasized the importance of the process, noting that "[a]t times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise."

Prohibited Transactions

In a concept closely related to fiduciary duties—and often included in ERISA litigation against plan sponsors—ERISA classifies certain transactions as "prohibited," unless an exemption applies. Prohibited transactions generally include "self dealing" or agreements between a plan and a "party in interest." The prohibited transaction rules apply not only to obvious situations, like embezzlement or misuse of plan assets (e.g., compensating persons who perform little or no actual services, loaning money to a financially troubled sponsoring employer) but actually also to many common day to day plan operations as well. Although many ordinary transactions in which a plan must engage are technically prohibited transactions (e.g., contracting for administrative services), a broad exception exists for (1) reasonable arrangements, (2) for necessary services, (3) for which no more than reasonable compensation is paid.

The Consolidated Appropriations Act of 2021 amended ERISA to add an affirmative obligation for covered service providers (CSPs)—including employee benefits brokers and consultants—to disclose compensation to group health plans to strengthen these prohibited transaction rules. A CSP's failure to timely disclose compensation to the plan means the contract or arrangement is not "reasonable" as required under the above exemption, and that the employer plan sponsor has engaged in a prohibited transaction and breached their fiduciary duties. This new disclosure must happen before an employer's decision to work with CSP (different from certain 5500 compensation disclosures) and includes both compensation the CSP receives directly from the plan or plan sponsor (direct compensation), and compensation the CPS receives from third parties related to the services the CSP provides to the plan, e.g., insurance carrier commissions (indirect compensation). Disclosures are also required on request and within 60 days of a change to compensation. CSP disclosure rules apply to all ERISA plans regardless of size.

The New Transparency Rules Require a Closer Look at the Duty of Prudence

As noted above, selecting competent partners is part of the duty of prudence. Selecting partners that do not facilitate compliance with group health plan mandates can give rise to scrutiny over whether the transaction falls outside of the exception to the prohibited transactions because it is not a reasonable arrangement. Recent transparency rules place significant obligations on plan sponsors that cannot be met without a complete commitment to compliance by plan partners like carriers, TPAs and PBMs. Meeting these new requirements and ensuring compliance will require significant contractual amendments. These requirements are summarized below and discussed in depth in our Alliant Insight - Transparency Rules and Surprise Billing Protections.

Consolidated Appropriations Act

- Detailed ID Cards (2022 PYs)
- Advanced EOB (delayed)
- Provider Directory Details (2022 PYs)
- Continuity of Care (2022 PYs)
- Rx & Healthcare Cost Reports (12/22)
- Removal of Gag Clauses (12/20)

Final Transparency Rules

- Internal Online Pricing Tool (2023 PYs)
- External Price Comparison Tool (7/22)
  - Publicly post 3 machine readable files: (1) all in-network rates for covered items and services, (2) out-of-network allowed amounts and billed charges for covered items and services, (3) all in-network negotiated rates and historical prices for prescription drugs (Rx component delayed)

Risks and Remedies

In order to effectively make plan-related decisions and comply with their ERISA fiduciary duties, employer plan sponsors must understand the full panoply of risk in this space. First, unlike most areas of group health plan compliance, which are largely the province of federal agency action and enforcement, ERISA fiduciary duties and alleged breaches can give rise to complex and expensive litigation. As noted above, this type of

litigation has exploded in the retirement space and, while there are some key distinctions between retirement plans and group health plans, many of the concepts and arguments set forth in the retirement plan complaints could be used against group health plan fiduciaries.

Specifically, a civil action under ERISA §502 may be brought by participants, beneficiaries, and fiduciaries for "appropriate relief" under ERISA §409, which creates liability for breaches of fiduciary duties that harms the plans. These claims can extend not only to the institutions that act in the fiduciary capacity, but also to any individuals acting in a fiduciary capacity. While the remedies normally available in litigation (e.g., compensatory and punitive damages) are not generally available for ERISA claims, the potential for significant recovery against fiduciaries remains by way of restitution to the plan, as well as any equitable relief, not to mention the cost to defend the case.

The risk of agency enforcement risk still exists as well. ERISA §502 provides that, in the case of any breach of fiduciary duty, or any knowing participation in such a breach by any other person, the DOL shall assess a civil penalty against the fiduciary or other person in an amount equal to 20% of the amount recovered by the DOL under a settlement agreement (generally resulting from negotiations with the DOL) or through an adverse court decision.

Finally, in order to properly prepare the organization, employer plan sponsors should speak to their insurance carriers about fiduciary liability insurance. This coverage has become increasingly costly in recent years with significant deductibles, but employers should address the issue with their internal risk management professionals and outside advisors.