Look Before You Leap! Understanding Your ERISA Fiduciary Duties & Other Hot Topics in Benefits Law

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Presentation Objectives

- ERISA fiduciary status and identification
  - What plans are impacted
- Fiduciary duties
- Your risks and how to mitigate them
- Fee monitoring obligations
- Other hot benefits law topics
  - Legislative update
  - Use of coupons for prescription drugs
  - Exclusion of high-cost prescription drugs
  - Individual coverage health reimbursement arrangements ("ICHRAs")
  - Open enrollment communication reminders

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ERISA in General

- Due to perceived abuses by employers and other plan sponsors with respect to retirement and health plans, Congress enacted the Employee Retirement Income Security Act in 1974
- ERISA imposes a large number of requirements on plan sponsors
  - E.g., Form 5500; nondiscrimination rules (ERISA Section 510); mandatory coverage requirements (e.g., coverage for mastectomies)
- ERISA enforced by federal government (Department of Labor ("DOL") primarily) but also IRS (which deals with parallel tax code rules)
  - Sometimes HHS / CMS wades into the area too (e.g., HIPAA Privacy Rules; also for self-funded, non-federal government plans)
  - State laws usually modest, but could apply if a governmental or church plan (not likely to apply to private employers)
  - Governments (city, county, K-12 schools, etc.) avoid ERISA

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ERISA in General

- Many – but not all – plans are subject to ERISA (or portions of it)
- Covered: Medical; dental; vision; disability; life insurance; Rx
- Sometimes covered: Voluntary plans; employee assistance programs
- Some sections of ERISA apply: Certain nonqualified deferred compensation plans
- Not covered: Certain benefits not listed in ERISA (e.g., pet insurance)
- Important to know when ERISA applies
  - E.g., suppose you receive a rebate from an insurer. Under ERISA, rebates can be "plan assets" – either in their entirety or in % attributable to employee contributions
  - If a rebate is a "plan asset", ERISA limits what employers can do with the rebate (e.g., use for benefit enhancement; pay certain fees)

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ERISA in General

- Congress imposed among the highest known legal requirements under ERISA upon those who are "fiduciaries"
  - Concept of a "fiduciary" is one who acts in the best interests of a third party who is relying upon the fiduciary
    - E.g., the executor of a will, who cannot misinterpret the will and take benefits for himself / herself
- Every ERISA-covered plan must have a "named fiduciary" and a "plan administrator" (often the same)
  - "Point person / entity" who must oversee the plan and satisfy various obligations (e.g., Form 5500; summary plan description distribution)
- In addition, certain people will be a "fiduciary" based on their actions or responsibilities

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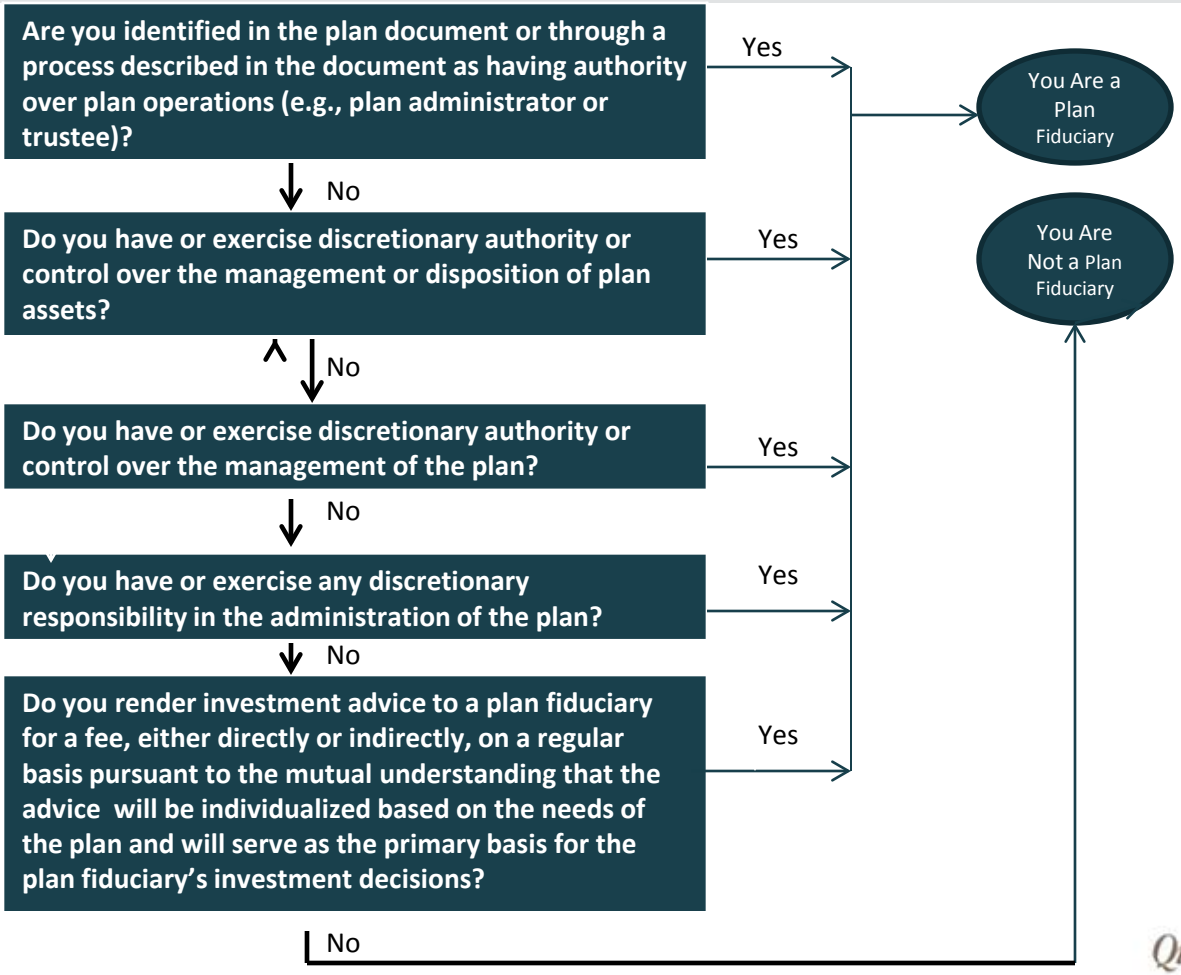
Are You a Fiduciary?



"Settlor" Exception --Which Hat Are You Wearing?

Fiduciary

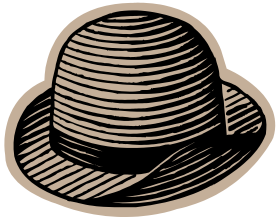
- Plan Administration
- Implementation of Amendment/Termination
- Holding/Investing/Using Plan Assets (likely includes clinic role)
- Participant Communications
- Participant Claims
- Attorney-Client Privilege Generally Does Not Apply

Decisions in your fiduciary role are subject to ERISA's requirements

Settlor

- Plan Design
- Amendment or Termination
- Employer Contributions
- Employee Communications
- Attorney-Client Privilege Applies

Decisions in your role as an employee of the plan sponsor are not subject to ERISA



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Fiduciary Liability

Personal liability for:

- Losses from breach of fiduciary duties
- Breaches by other fiduciaries if:
  - Failure allowed the breach
  - Knowingly participated in the breach
  - Concealed the breach
  - Do not take action to correct the breach

What Are An ERISA Fiduciary's Duties?

- Exclusive Benefit Duty
- Prudent Expert Duty
- Plan Adherence Duty
- Disclosure Duty
- Diversification Duty (usually only retirement plans)
- Duty to Monitor
- Not Violate Other Rules (e.g., "Prohibited Transaction" Rules)

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Exclusive Benefit / Prudent Expert Rules

- Exclusive Benefit: Actions must be for the exclusive purpose of providing benefits to plan participants and beneficiaries and defraying the plans' reasonable administrative expenses
- Actions taken with an eye toward plan sponsor's goals (or other goals of third parties) may violate this duty
- Prudent Expert: Use the level of care that a "prudent man knowledgeable about such matters" would use in the same situation
  - DOL Guidance: The fiduciary should appropriately consider all the facts and circumstances that apply
    - "Substantive prudence" – maybe 20% of the risk?
  - "Procedural prudence": A fiduciary's conduct is evaluated according to the result of a decision as well as the process used to make the decision
    - Maybe 80% of the risk?

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Procedural Prudence

- Identify factors relevant to the decision-making process;
- Identify necessary fact-finding steps and background information;
- Identify required expertise and knowledge needed; when necessary, consult with outside experts (e.g., accountant, actuary, legal counsel);
- Evaluate relevant criteria; and
- Document the evaluation, decision and monitoring in writing
  - For example, if trying to identify what health care providers should be in the network, look at fees providers charge and discounts available. Do similar analysis for TPAs and PBMs, etc. (especially if plan assets are used)

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Plan Adherence / Disclosure Duties

- Actions must be in accordance with the:
  - Plan document
  - Summary plan description
  - Other documents under which plan operates
  - Can come up with respect to power to amend plan and power to pick service providers
    - Charter provides authority to Committee for many actions, but "Plan Sponsor" also has authority (per Wrap Plan) and FH Leadership Development and Compensation Committee too, along with Board of Directors
- Unless it is contrary to ERISA
- Provide all legally-required documents (e.g., summary plan descriptions)

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Duty to Monitor

- Fiduciary must review activities/processes of other fiduciaries to whom it delegates responsibility; also must assess delegated fiduciaries' compliance with applicable law and with plan provisions

- Depth and frequency must be consistent with the needs of plans in light of complexity of operations and foreseeable risks

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Prohibited Transaction Rules

- ERISA generally prohibits the use of "plan assets" to pay a "party in interest" – this is called a "prohibited transaction"
- Plan sponsor generally is a "party in interest"
- Prevents, e.g., employer from "hiring itself" to run its retirement plan (and then taking fees from retirement plan assets as payment)
- There are some "automatic" exemptions to the prohibited transaction rules
  - E.g., can pay vendors reasonable fees
  - If you don't meet one of those, need to seek a specific exemption just for your situation

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Fee Monitoring

- Although more cases involve retirement plan fees, health plan fees also can raise issues
- 2018: Blue Cross Blue Shield of Michigan agreed to pay $30,000,000 to resolve claims that it charged self-funded employers extra fees, not allowed by contract
  - Right now we are dealing with a different TPA in Illinois whose contract appears to allow this practice (contract says, basically, "Provider may charge $1000 for procedure, but we can bill employer $1,100 and keep the $100")
- Cigna sued in 2018 by Macy's and Staples participants over allegedly charging extra fees for certain medical services
  - Plan fiduciaries not sued yet, but could be if Cigna does not pay

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Fee Monitoring

- In 2016, Cigna and 231 plans (including their named plan administrators) were sued by health plan participants
  - Allegedly failed to monitor Cigna's excessive payments to itself
  - E.g., Cigna received a percentage of savings from certain "cost-containment fees" if it negotiated a deal with non-network providers
    - But Cigna allegedly just took the money, with no deals
- In 2018, various providers in Montana were sued by health plan participants over agreement to provide BCBS of Montana the TPA work for six years
  - BCBS then allegedly gave $20,000,000 in "kickbacks" to the hospitals
  - Participants angry because they shared in the cost of the plans
    - So, theory is that portion of the participant contributions ("plan assets") were used to pay the "kickback"

Fee Monitoring

- So, in general, deciding what to pay third parties can be viewed as a fiduciary determination – if "plan assets" are used
- When a provider has employees, this raises a difficult issue. How much can the provider charge its own employees / its own plan when employees, spouses and children use the provider?
  - If there are any "plan assets" (which include participant contributions towards premiums) then could be a prohibited transaction
  - Not really an issue for employers which are not providers (unless they operate an on-site clinic and "pay themselves" through that)

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Ways to Reduce Fiduciary Risk

- Know what the law is and how you follow it
- Monitor for changes in the law
- Do periodic reviews of whether policies are being followed in practice
- Make sure plan document / SPD have "best in class" language
  - E.g., discretionary "Firestone" language
  - Recent litigation opens up new possibilities too
- Some courts have upheld "anti-assignment" language
- *Eden Surgical Center v. Cognizant Technology Solutions Corp.* (9th cir., 2018)
- *American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield* (3rd cir., 2018)

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Ways to Reduce Fiduciary Risk

- In *Epic Systems Corp. v. Lewis* (2018), the Supreme Court ruled that class action waivers in employment arbitration agreements do not violate federal law and are in fact enforceable
- Previously, there had been a circuit split as to whether it was a violation of federal labor laws for employers to require employees to agree to arbitrate any work-related claims and waive their rights to participate in class action lawsuits pursuant to a mandatory arbitration policy
- Supreme Court resolved circuit split by ruling that such agreements are enforceable
- Recent 9th Circuit opinion upheld arbitration provisions for ERISA plans
  - Consider it, but arbitration is not necessarily a "silver bullet"

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Ways to Reduce Fiduciary Risk

- Consider including a "venue selection" clause
- Venue relates to where litigation will occur
  - E.g., suppose you have an employee who retires and moves to Florida. The employee then brings a claim under one of your plans and files a lawsuit in Florida. Can you force the employee back to a WI court?
- A recent case in the 7th Circuit upheld a venue selection provision in a employee benefit plan governed by ERISA
- The court followed a similar decision from the 6th Circuit that held venue selection provisions in ERISA plans are generally enforceable

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Legislative Update

- Health care continues to be big issue in early Presidential campaigns
- On Democratic side, push to either improve current system (Biden) or "Medicare for All" (Sanders, Warren)
  - Biden plan would create public option and increase ACA subsidies
  - Other ideas include Medicare buy-in for early retirees / older workers
  - One contentious idea is whether private health insurance would be eliminated or subjected to new, more-stringent rules
- On Republican side, discussion of some health care topics but no large, overarching changes being pushed
  - Will discuss President Trump's Executive Order in a bit
- Significant House bipartisan support for eliminating "Cadillac tax" (passed 419 – 6) and "surprise" medical bills

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Legislative Update

- Lower Health Care Costs Act (S. 1895) has bipartisan support, would:
  - Limit surprise medical bills (e.g., amount owed to out-of-network providers)
  - Try to control prescription drug costs (e.g., ban spread-pricing by PBMs and require that rebates go back to employers)
  - Create nonprofit entity to gather claims information to create database
  - Ban certain steering clauses in contracts between providers and plans
- No Surprises Act (HR 3660), would:
  - Base provider payments on median in-network rate
  - Provide for arbitration of disputed amounts

Presidential Orders

- 2017 order from President Trump directed changes with respect to health reimbursement arrangements ("HRAs"); association health plans; and short-term, limited duration insurance
- 2019 order directed action on:
  - Hospitals posting standard charge information
  - Self-funded plans, insurers and providers must provide expected out-of-pocket costs before patients receive care
  - Expanded definition of "preventive care" for health savings account ("HSA") purposes
  - Direct primary care and healthcare sharing ministries as medical expenses
  - Increase health FSA carryover amount

Presidential Orders

- Some action by regulators in response to orders, but some still open
- Association health plan rules finalized June 2018
  - Would allow for unrelated employers to more-easily band together to provide health insurance or even be self-funded
  - Rules challenged by states
  - Court ruling in 2019 effectively halted rules; no indication Trump administration will revive them

HRA Changes

- Under ACA, health reimbursement arrangements ("HRAs") could not be used to purchase individual health insurance policies
  - Concern is that HRA by itself would not meet annual and lifetime limits and that HRA could not be "integrated" with individual policy
- Final regulations from June 2019 reverse this
- Allow for "individual coverage HRAs" ("ICHRAs")
- Also allow for stand-alone HRAs so employees can pay for out-of-pocket medical expenses and certain premiums ("Excepted Benefit HRAs")

ICHRAs

- Individual covered by ICHRA must be enrolled in health insurance coverage purchased in individual market
- Employer cannot offer the same class of individuals covered by the ICHRA and a "traditional" health plan
- Employer must offer the ICHRA on same terms to all employees in a "class"
- Employees must have ability to opt out of receiving the ICHRA (in order to receive a premium tax credit through an Exchange)
- Employers must provide detailed notice to employees of ICHRA terms
- Coverage will help employer meet 95% Employer Shared Responsibility rule requirements
  - We suspect this may be its greatest value – offer ICHRA to class in order to meet that 95% test

Excepted Benefit HRAs

- Most ACA rules do not apply to "excepted benefit" plans (like dental or vision)
- Excepted-benefit-only coverage also does not prevent an employee from receiving an Exchange subsidy
- Excepted Benefit HRA requirements:
  - Employer must offer other, non-account based medical coverage to employees that is not an excepted benefit
  - Amount of new employer contributions each year cannot exceed indexed amount (initially set at $1,800)
  - Cannot be used to reimburse medical expenses and premiums or contributions for COBRA or excepted benefits coverage
    - But can be used to reimburse for other individual or group coverage
  - Made available on a uniform basis to all similarly situated employees
  - Employer cannot offer this and an ICHRA to same group of employees

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Preventive Care Changes

- Background: In order to establish or contribute to an HSA, a high-deductible health plan ("HDHP") must meet several criteria
  - One of them is no medical care until deductible is met
  - Exception for "preventive care" such as immunizations and annual physicals
- Exact scope of "preventive care" somewhat unclear
- Some argued it should include "secondary preventive care"
  - E.g., normally taking insulin for a diabetic is treating a current condition and is therefore not "preventive care"
    - However, if diabetic person fails to take insulin, can lead to other complications
    - So, arguably, taking insulin "prevents" these other conditions
    - IRS informally pushed back because no real limits

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Preventive Care Changes

- But, President Trump's order put pressure on IRS to do something
- IRS responded with a narrow set of "chronic care" preventive care treatments which are ok from an HSA perspective
  - Must be strictly on the list. For example, there are drugs to take for hypertension. But only a blood pressure monitor is on the list. So drugs cannot be provided as "preventive care" for hypertension
- Note: NOT preventive care for ACA purposes; a non-grandfathered health plan does not need to cover them on a first-dollar basis

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Preventive Care Changes

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

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High-Cost Drugs and Coupons

- For several years drug manufacturers have offered "coupons" for certain, usually high-cost, prescription drugs
  - Per Health Affairs, in 2009 fewer than 100 brand name drugs had coupons
  - By 2015, up to over 700; by 2016, 20% of all prescriptions used some type of copay assistance
- For example, suppose Ed is an employee of Acme Co. and is in the Acme Co. prescription drug plan. Ed uses a particular drug which costs $5,000 per week.
- The drug manufacturer offers a coupon program bringing the cost of the drug down, at least for a few months, to $5 per week (i.e., a $4,995 coupon)

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High-Cost Drugs and Coupons

- Ed goes into his local pharmacy and picks up the drug. Assume he has no copayment or coinsurance. Assume the plan's deductible is $3,000 and the out of pocket maximum is $5,000
- Ed pays his $5. The plan gives him credit for the $5 towards the plan's deductible and the out of pocket maximum
- Must the plan also give Ed credit for the $4,995 coupon "payment"? If so, Ed will have immediately satisfied his deductible and out of pocket maximum
  - Even though Ed only spent $5 of his own money
- Typical plan position is that the coupon does not count towards the deductible and out of pocket maximum
  - But, is some variation here

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High-Cost Drugs and Coupons

- April 2019 CMS regulations address coupons and drugs
- Poorly written and hard to discern what the agency said
- Appears that CMS stated that insurers and self-funded plans (including ERISA plans) MUST give credit for the coupon in some situations
- Raises communication issues of how to explain in SPD, etc.
- If you have an HDHP, would seem to "blow up" HDHP
  - IRS guidance requires that only amounts enrollee pays "counts"
- August 26, 2019: IRS, DOL and CMS put a "pause" on this – no need to count coupons for now
  - Expect more guidance by January 2020, to be effective 2021

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High-Cost Drug Issues

- Growing concern among employers about high-cost drugs
- Includes "gene therapy" drugs which replace a gene that is causing a medical problem, adding genes or turning off genes that cause issues
- Many are one-time – and expensive
  - Luxturna for blindness (about $1,000,000)
  - Zolgensma for infants with "SMA" (about $2.1 million)
- Dozens, or more, of others in the drug manufacturer "pipeline"
  - So, even if the conditions are rare, can foresee a time when coverage will be not uncommon
  - August NY Times article on Ohio boilermakers plan with 3 family members, each with $2M per year for Strensiq
    - 16,000 members paying 35 cents per hour

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High-Cost Drug Issues

- Employers beginning to look at ways to mitigate cost / risk
- Verify if stop-loss policy excludes these treatments
- Some self-funded employers have begun excluding coverage
  - Raises some concerns under ACA (can avoid them usually), ADA and HIPAA nondiscrimination rules (employment law possible also)
- Verify process for reviewing claims is being followed
  - Does your plan / SPD clearly state who reviews the initial claim? If it's the TPA, does TPA have good language allowing it do so? If appealed, who is appeal sent to? Person / committee? Good language on discretion to review?
    - You do NOT want an "ad hoc" process here. You want to be able to show a court that you followed your procedures and had discretion / authority at every step

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High-Cost Drug Issues

- Note that may be some level of "game-playing" here also
- Possible that, if insurer / plan denies coverage for a drug, that manufacturer will provide a "charity care" cost
  - Some businesses are springing up to help guide participants to this charity care

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Wellness Rules

- Law remains jumbled
- Had certainty due to EEOC, IRS, DOL and HHS all issuing wellness regulations (even though some variance in requirements)
- But, EEOC's 30% wellness discount was challenged by AARP and EEOC lost
- Effective 1/1/2019, 30% maximum is no longer the law
- Leaves it unclear what IS the law – presumably prior, muddled law
  - EEOC final regulations might still be years away
- Some employers are not doing any physical examinations which could trigger EEOC rules applying
- Others are comfortable taking some risk (because risk is similar to what it was for 20+ years when EEOC was silent)

Mental Health Parity Update

- Mental health parity rules updated in 2013
- New rules very difficult to apply
- Bipartisan political pressure to enforce rules
- In last year, about ½ of all DOL audits and penalties related to mental health parity

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Mental Health Parity Update

- Lawsuits somewhat-frequent
  - "Wilderness therapy" cases are hot now. Cases are mixed
- Seen arguably abusive practices involving drug testing clinics "on the beach"
  - Can it be limited through amendment?
- As a practical matter, many TPAs / PBMs won't do the test
  - May run the "quantitative treatment limitations" test but won't touch the "non-quantitative" test
  - Even if TPA does, may not be right

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Mental Health Parity Update

- Wit v. United Behavioral Health (March 2019)
  - UBH adopted mental health guidelines drawn from national standards – but NOT identical to those standards
  - UBH had fiduciary discretion to interpret plan and ensure guidelines "consistent with ... accepted standards of care"
  - Court ruled that UBH had "conflict" and its care guidelines resulted in breach of "duty of loyalty, duty of due care and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care"
    - Court arguably is wrong on this – seems like a "settlor" activity
    - But court has not been overruled so far
  - Net result is that even if your TPA / PBM / you are following third-party guidelines to show parity, possible that you still will fail the test

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Cross-Plan Offsetting

- We've covered the details in other BHCG presentations, so won't go through detailed example now
- In our experience, some insurers / TPAs of insurers have stopped doing cross-plan offsetting
  - UHC's loss in the 8th Circuit earlier this year was a significant blow to the practice
- UHC has not stopped it yet, but does allow clients to "opt out"
- UHC has appealed the loss to the U.S. Supreme Court, but not certain if court will accept the appeal

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Open Enrollment Matters

- Main thing to focus on is clear and careful communications
- Go through the list of required notices
- Verify you have each one
- Verify if it needs to be changed or if template / model has changed
- Verify how to distribute
  - E.g., electronic distribution fairly easy for employees who work with computers on the job

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Next Steps / Questions

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