Benefits Law Hot Topics: 2025's Most-Important Items for Plan Sponsors

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Topics for Today

- What benefits-related changes is the Trump administration likely to make?
- New health plan fee litigation – what steps should plan fiduciaries take to reduce risk?
- Steps to prepare for a governmental audit
- Legal issues related to high-cost health plan enrollees
- New cases and other developments

Trump Administration Agenda on Benefits

- Not much in 2024 Presidential campaign on benefits-related topics
- So far, Congress has been very focused on extending 2017 tax cuts
- Will Republican differences on cost-cutting sink the bill?
  - Will finding "savings" cause Congress to implement other tax savings (next slide)?
- Little legislative action currently on benefits-related topics
  - Employers hoping for telehealth extension and perhaps PBM reforms
- Is this just a "temporary delay"? Will Trump administration circle back to benefits-related topics?
- Will they mirror Project 2025?
- Republican Study Commission: Tax-free nature of employer-provided health benefits "drives hyperinflation and inefficiency of the health care industry

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Trump Administration Agenda on Benefits

- Project 2025: Calls for limiting tax-free nature of most employer-provided benefits to a total of $12,000 (“and preferably lower”; not indexed to inflation)
  - Largest tax expenditure in Tax Code, so it’s an appealing target
- Other Project 2025 suggestions:
  - No tax deductions for cost of child’s coverage if child is 23 or older
  - Weaken ERISA preemption so states can regulate “anti-life” benefit terms such as abortion, surrogacy and others
  - If health plan covers abortion, must also cover “equal or greater” benefits for childbirth, pregnancy, maternity and paternity
  - Health plans not required to cover abortions
  - HRA expansion
  - Association health plan expansion

Trump Administration Agenda on Benefits

- Trump administration (e.g., DOGE) cost-cutting moves may impact benefits enforcement
  - And tariffs may impact costs. April 2025 Mercer article discusses survey of healthcare industry experts. 82% expect hospital costs to increase by 15% in next 6 months and 10% spike in pharmaceutical costs (but longer contract terms may mean no immediate increase in 2025)
- May 2025: Trump administration proposes 35% funding cut to DOL
- April 2025: DOL offers early-retirement buyout to certain more-experienced staff (with at least 20 – 25 years of experience)
- Not clear yet how many will take it, but PSCA April 2025 article says 20+% of EBSA enforcers take buyout
- Will reduced headcount lead to less enforcement? Less guidance on important issues?

Trump Administration Agenda on Benefits

- Continued focus on pharmacy benefit manager ("PBM") regulation and restrictions
- President Trump issued an Executive Order on April 15, 2025, related to lowering prescription drug plan costs
  - Action on it by mid-October 2025
- Calls for "Improving disclosure of fees that [PBMs] pay to brokers for steering employers to utilize their services"
  - Do employers know if their advisers are receiving compensation "behind the scenes"?
- Also calls for, within 180 days, DOL to "propose regulations" pursuant to ERISA's prohibited transaction rules "to improve employer health plan fiduciary transparency into the direct and indirect compensation received by" PBMs

Trump Administration Agenda on Benefits

- Probably a good strategy, as ERISA Section 408 arguably requires disclosure of compensation
- How will PBMs respond?
- U.S. Senate Judiciary Committee (April 2025) advanced to full Senate six bills related to PBMs and drug pricing
  - Many are not directly related to employer health plans
- State regulation of PBMs continues
- New Arkansas law limits PBM ownership of pharmacies
  - Teamsters fund sues (April 2025)
- In response, CVS closing 23 pharmacy locations there
- Florida begun enforcing PBM disclosure law

Trump Administration Agenda on Benefits

- February 21, 2025 Executive Order on “America First Investment Policy”
- Directs the DOL to “publish updated fiduciary standards under [ERISA] for investments in public market securities of foreign adversary companies”
- “Foreign adversaries” defined as China, Macau, Cuba, Iran, North Korea, Russia and Venezuela
- Scope of this not clear. Would also seem to apply more to retirement plans (although some health plans are funded)
- February 2025 Executive Order on “Expanding Access to In Vitro Fertilization”
  - Calls for “easing unnecessary statutory or regulatory burdens to make IVF treatment drastically more affordable” – May 19 update?

Health Plan Fee Litigation

- Refresher on ERISA fiduciary duties
- “Fiduciary” is one who acts in best interests of another
  - Very old concept – older than the USA!
- Every ERISA-covered plan has fiduciaries
- Exclusive benefit duty
- Prudent expert duty
- Plan adherence duty
- Disclosure duty
- Duty to monitor
- Not violate other laws
- Diversify assets

Health Plan Fee Litigation

- "Procedural prudence" (perhaps 80% of the risk) versus "substantive prudence" (perhaps 20% of the risk)
- Establish a good, clear process. Document the process and your decision
- Duty to monitor more-difficult
  - By definition, you probably hired experts (e.g., sophisticated TPA and PBM) because employers generally cannot perform those services
- But must try to comply, especially with regard to fees
- DOL's 2015 publication "Understanding Your Fiduciary Responsibilities under a Group Health Plan"
  - When "fees for services are paid out of plan assets, fiduciaries need to understand the fees … [and] fees charged to a plan [must] be 'reasonable'"

Health Plan Fee Litigation

- Excessive fee litigation in the health plan space is relatively rare and sporadic. When it's occurred, it's usually been focused on lawsuits against TPA / insurer, not employer / plan sponsor
- Recent examples include the following
- 2017: DOL sues, then settles with, MagnaCare. Claim was that TPA violated ERISA by charging plans an undisclosed markup over $ paid to providers
- 2019: The Depot, Inc. v. Caring for Montanans (9th Cir.). Claim was that insurer charged extra fees and used those as a "kickback" to local chamber of commerce
- 2010s: BCBS of Michigan pays hundreds of millions over "hidden fees" (lawsuits primarily brought by self-funded employer clients)
  - Did that help "fend off" participant lawsuits against employers, for failing to monitor?
- 2023: Plaintiff-side law firm advertises in this space (Petsmart, Target, State Farm were targets)

Health Plan Fee Litigation

- February 2024: Erie County sues diabetes drug manufacturers and PBMs (CVS, ESI, OptumRx) over “insulin pricing scheme” (high costs that its self-funded health plan paid for insulin)
- February 2024: Johnson and Johnson (“J&J”) hit with sophisticated, detailed complaint from employee
- Sent “shockwaves” through industry
- Note that it related to a Wisconsin-based employee

Health Plan Fee Litigation

- J&J case allegations: Claims “mismanagement” of plan demonstrated by high-cost prescription drugs
- E.g., plan agreed to pay (allegedly) $10,239 for a 90-day supply of generic form of drug Aubagio, supposedly available for $40 - $77 at a local grocery store / pharmacy
- Complaint includes summary chart of 42 drugs with alleged cost of $28,000, for which J&J plan agreed to pay $167,000 (a “markup of 498%”)
- Complaint attacks process by which PBM was hired
  - Argued about hidden broker compensation in RFP process
- Focus on “transparent” pricing v. “spread” pricing

Health Plan Fee Litigation

- J&J had some good defenses
- E.g., the lead plaintiff apparently hit her out-of-pocket maximum each of the relevant years
  - So, unclear how she could have been "damaged" by any mismanagement
- January 2025: Court dismisses case against J&J, but allows for new complaint to be filed
- Which the plaintiffs promptly do (March 2025)
- Plaintiffs raise many, similar claims

Health Plan Fee Litigation

- Wells Fargo sued (July 2024) under similar theory
- That is, excessive prescription drug costs and fiduciaries failed to monitor these costs
- March 2025: Court rules in favor of Wells Fargo
- Finds that damages are “merely speculative”
- This case was also dismissed without prejudice, so it can be re-filed by the plaintiffs
- April 2025: Plaintiffs told court that they want to “amend their complaint” and that March 2025 decision was in error. Court agreed to allow them to re-file it

Health Plan Fee Litigation

- J.P. Morgan Chase sued under similar grounds (March 2025)
- Similar allegations as other cases
- But a few new wrinkles
- Mainly, that their PBM (CVS) was also a major banking client and that this created a conflict of interest
  - E.g., that “JPMorgan executives put lucrative investment banking revenue ahead of their fiduciary obligations to their employees”
  - Could someone make that claim against you and how your health plan is administered? Do you have such a conflict?

Health Plan Fee Litigation

- What are the “lessons learned” so far?
- First, pretty early in the “story” of these lawsuits. Plaintiff lawyers clearly struggling to find damages
  - But they seem committed to developing this area. Have they “drained the well” on the retirement plan litigation side?
- Second, plans with “plan assets” seem more-likely to be targeted
  - Plaintiff firms may be using public, Form 5500 filings to identify which companies have “funded” plans
  - If your plan is funded, should you terminate the VEBA, etc.?

Health Plan Fee Litigation

- Third, fundamental fiduciary concepts and processes will help a lot
- Do you have a Benefits Committee or similar entity which takes on fiduciary responsibility?
  - If you do not, then your Board or similar high-level entity may have this liability and risk
- Clearly identify the Committee's responsibility
- Fourth, consider hiring experts to help you monitor the other experts you hired. For example, consider a PBM consultant who will review your PBM's operations

Health Plan Fee Litigation

- Fifth, pay close attention to contracts
- Try to obtain guaranteed access to plan data
- Try to obtain disclosures about your vendors' compensation (especially when it is not coming from you)
- Will also enable you to "clean up" old contracts with things that should be in them now
  - Later slide: New "Gag Clause" FAQs (January 2025) – put that into your contracts

Gag Clause Update

- Gag Clause continues to be difficult topic
- CAA (December 2020) makes it unlawful for an employer to have a “Gag Clause” in a contract with its vendor
  - Generally, contract that limits disclosure of certain health plan claims or financial information
- Employer must “attest” every year it complies
- Many TPAs and PBMs continue to push back
- New FAQs Part 69 (January 2025) provide additional clarity
- Note that this was issued at tail end of Biden administration
  - But no indication that Trump administration will repeal it

Gag Clause Update

- FAQs Part 69 provide certain examples of clearly-prohibited Gag Clauses
- Limiting access to “statistically significant” amount of claims data
- Limiting access to only one category (e.g., audits)
- Limits on frequency of review (e.g., once per year)
- Limiting number and types of claims plan can access
- Only providing access at TPA’s physical premises

Gag Clause Update

- “Downstream” entities part of compliance attestation
- So, if your TPA / network provider has negotiated with 300 health systems around the country for specific rates / discounts, **PLAN FIDUCIARY is responsible** for ensuring that the 300 contracts do not have a Gag Clause
- How would plan fiduciary ever do that? Seems unrealistic…yet it’s the current law
- Likely need to put the burden on the vendor, because plan fiduciary very unlikely to be able to access those 300+ contracts (in this example)

Claims Denials: Down the Rabbit Hole

- Still a lot of litigation over denied mental health claims
- TPAs and group health plans have mixed results in cases, in general
- One important factor in favor of TPAs and group health plans is ensuring that plan's decision receives "deference" and that decision-maker has "discretion"
- Plan documents should have this language
- Without discretion, court reviews situation "de novo" and can substitute its own judgment
- That is bad for plans, as many of these cases involve sympathetic plaintiffs and situations

Claims Denials: Down the Rabbit Hole

- Recent case from the 10th Circuit imposes stringent requirements on plans, in terms of what the denial letter must say
- D.K. v. United Behavioral Health (10th Cir., May 15, 2023)
- Case relates to United's denial of proposed, lengthy residential treatment facility stay
- Enrollee, a teenage girl, was said to need 8-18 months of residential treatment, backed by treating physician's written recommendations
- United approved lesser stays
- Plaintiff's attorney seems to have had a strategy of showing that United failed to follow ERISA's procedural rules on what should be in a denial notice. Apparent goal was to find technical error, then have court review claim de novo, with no deference to plan's decision

Claims Denials: Down the Rabbit Hole

- ERISA does impose some stringent requirements for denial notices
- They must "provide adequate notice in writing … setting forth the specific reasons for such denial" and must "affordable a reasonable opportunity … for a full and fair review"
- United defended by saying that it was "not required to engage with treating physician opinions"
- And, even if it was, just because the record does not mention them in writing does not mean that they were ignored
- Court found that United "specifically declined [the enrollee's] parents' request to consider extensive treatment opinions" from four doctors
- By not addressing these four doctors' opinions, seemingly on a point-by-point basis, United was not properly "'engaging' with these opinions" and United effectively "shut its eyes" to "readily available medical information"
- Thus, United "acted arbitrarily and capriciously"

Claims Denials: Down the Rabbit Hole

- Court also said that United needed to "engage in meaningful dialogue" as part of "full and fair review"
- Court expected to see a "back-and-forth", which is "how civilized people communicate with each other regarding important matters"
- At that point, court applied de novo review and found in favor of enrollee
- Similar case in March 2025 (Doe v. Deloitte Grp. Ins. Plan (S.D.N.Y.))
- Should discuss with TPAs and PBMs
  - And perhaps put into their contracts
- Self-audit? Ask TPA for a complicated claim. Look at the EOBs plan enrollees received. Does it make sense to you?

Artificial Intelligence and Claims Processing

- Several recent lawsuits in Medicare Advantage space (NOT employer-sponsored group health plan space) claim that large insurers are improperly using AI to process claims
- Let's define some terms first
- Algorithms v. "explainable" AI v. "black box" AI
- Frequently, health plan claims processing is automated. Generally not an inherent concern (and software, if well-designed, may be more accurate than human claims processors)
- ERISA concerns seem very possible with black box AI
- ERISA requires "full and fair review". If TPA / plan sponsor cannot explain why AI reached decision it did (and cannot ensure that future, similar claims will be processed the same), seems like ERISA claim is possible

Artificial Intelligence and Claims Processing

- E.g., Lokken v. UHC (D. Minn. November 2023) is typical case
- Plaintiffs claim that UHC used AI to determine whether certain procedures were “medically necessary” under MA plan
- UHC developed the “nH Predict AI Model” to predict how many medical services the enrollee is expected to need (next slide)
- Plaintiffs claim that the AI had a “90% error rate” but profitable for UHC because only a small percentage (claimed to be 0.2%) will appeal the denial
- Plaintiffs claim that UHC employees cannot approve more than 1% variance in services, or risk being terminated or disciplined
- Allegedly, without regard to what the doctor recommends for treatment / individual’s specific situation
- New, March 2025 WI OCI guidance on AI (for insurers, not ERISA plans)

Artificial Intelligence and Claims Processing

- Recent case was an ERISA case
- Kisting-Leung v. Cigna (E.D. Cal. March 30, 2025) – court allows suit to proceed on ERISA breach grounds, related to algorithm that denied benefits, in alleged contradiction of plan document
  - Plan document allegedly implied that medical necessity decisions would be made by a doctor, not an algorithm
- Good idea to ask TPAs and PBMs if they use AI and if it is "explainable" or "black box"
- Build answers / representations into future contract terms

Abortion Coverage Under Health Plans

- April 1, 2025 abortion decision in Alabama
- Yellowhammer Fund v. Marshall
- Alabama could not bring criminal action against those who assist woman in leaving state to obtain an abortion which is legal in the other state
- Relief for employers / plan sponsors. Had been concern that paying for abortions (or travel for abortions) could fall under this rule
  - However, decision was not in the health plan context. So not completely certain if it applies in that context

Coverage of Weight-Loss Drugs

- Weight-loss drugs are very popular – but also very expensive
- If a health plan does not cover those drugs, is it violating federal law? For example, might some severely obese plan enrollees be "disabled" under ADA? And if plan does not cover those drugs, could they claim plan violates ADA?
- Are some technical arguments and defenses for the plan
- Recent court case from Maine (Holland v. Elevance Health, April 2025) says that there is no violation of ADA
  - Good for employers. But not a lot of guidance in this area

High-Cost Claimant Concerns

- Continue to see lot of creative ideas on how to address high-cost claimants
- Some propose to pay for individual to seek Exchange coverage
  - Is specific federal guidance saying this does not work (e.g., HIPAA nondiscrimination violation). But how "strong" is that guidance?
- Others try to arrange for charity care
  - If an employer cannot pay directly for employee to go to Exchange, could a third party do so?
- Or use prescription drug "coupons" or manufacturer discounts
  - Likely do not need to "count" those towards deductible, out-of-pocket max
- Most raise some legal concerns, but some employers proceed anyways

High-Cost Claimant Concerns

- Another regular question that comes up relates to international sourcing of prescription drugs
- In general, federal law prohibits that
- And it likely would be taxable under your health plan
- Manufacturers increasingly aggressive in this area
- E.g., Gilead Sciences sued ProAct and Rx Valet in December 2024 for helping to arrange importation of drugs through an "alternative funding program"
- Claim focused on trademark infringement and violation of Food, Drug and Cosmetics Act
- April 19, 2025: Defendant's motion for on lack of personal jurisdiction denied

New CHIP Model Notice / New Creditable Coverage Rules

- New CHIP model notice dated March 17, 2025
- Should start using soon
- Plan sponsors generally need to determine if their prescription drug coverage is “creditable”
- Basically, if it provides “pretty good” (my term) coverage of prescription drugs
- Inflation Reduction Act of 2022 changed determination
- New CMS rules from April 2025 provide guidance
- Two main methods: simplified determination and actuarial determination. If receive Retiree Drug Subsidy, must use latter. In general, plan must pay 72% of drug costs

ACA Changes

- ACA just celebrated its 15-year anniversary – but the litigation continues
- April 2025 case, Faulk v. Becerra, in which it's now questionable whether the IRS can assert any 4980H penalties under Employer Shared Responsibility Rule
  - Court held that IRS did not follow proper notification process
- Also December 2024 legislative relief
  - New reporting options
  - 90 days to respond to 226-J
  - IRS has shorter statute of limitations period
- Braidwood case – Supreme Court considers scope of ACA "preventive care" benefits. Justices seem inclined to not strike down that ACA provision

Other Litigation Matters

- April 2025: Supreme Court case, Cunningham v. Cornell University
- Likely will make it easier for plaintiffs to plead a case and survive a motion to dismiss (initially), which will likely lead to more discovery
  - Technical case over how to plead a “prohibited transaction” claim
  - Will make it more-important than ever to carefully document how and why you hired vendors and prove that their fees are proper

Other Litigation Matters

- Continue to see large number of tobacco litigation (wellness plan) lawsuits
- Many claim that wellness plan violates law by failing to retroactively remove penalties or providing sufficient means to have penalties be waived
- So far, employers have generally done well
- Mehlberg v. Compass Group (April 2025): Rare victory for plaintiffs in tobacco litigation cases (but only motion to dismiss stage)
- Still, good idea to review your wellness programs

Other Litigation Matters

- Mejia v. Credence Management Solutions (C.D. Ca. 2025)
- Plaintiff was a plan enrollee in health plan sponsored by Credence. TPA was UHC
- Plaintiff had $101,000 medical procedure, out of network. Plan paid $1,600
- Plaintiff asked employer to negotiate on her behalf. Appears they said “no”
- Plaintiff sued plan fiduciaries, arguing they had a “fiduciary duty to attempt to negotiate” out-of-network claim payments
- Court held the claim survived a motion to dismiss
- Would be a pretty remarkable case, if final decision holds that

Other Litigation Matters

- CAA requires provider directories to be regularly updated
- TPAs should be ones to do it
- Concern about “ghost networks” and lack of availability of doctors (especially mental health providers)
- Some lawsuits in this area
  - E.g., October 2024 Anthem was sued over this issue
    - Plaintiffs lawyer did a “secret shopper survey” of 100 listed mental health professionals. Could only schedule appointment with 7. How would your plan do?
  - Cigna (acting as a TPA) also sued (2024) in Illinois over this
  - Mayo Clinic sued over this also (alleged RICO violation)
- Could be ERISA fiduciary duty breach
- Employers should update TPA contracts

Mental Health Parity Update

- Final MHPAEA regulations issued September 2024
- Make a number of changes (relatively small) for 2025
- Larger changes for 2026
  - But some are being challenged in court
- Federal agencies still auditing in this area
  - Often seems to be complaint-driven
- IRS, DOL and HHS said they would provide guidance on what "data" is needed for 2026. But they have not done that yet
  - Unclear what an employer should do in the absence of that guidance. Are some standard data points most TPAs and PBMs will provide, such as denial rates and turn-around-time averages

Cybersecurity Guidance

- In September, DOL issued Compliance Assistance Release 2024-01
- Confirms that 2021 DOL guidance on cybersecurity best practices applies to all ERISA-covered employee benefit plans, including health and welfare plans
- This had been unclear
- Three broad areas under 2021 guidance
- “Tips for Hiring a Service Provider”
- “Cybersecurity Program Best Practices”
- “Online Security Tips”, for plan enrollees
- Plan sponsors should start building these into RFPs (and address with current vendors)

Questions?

THANK YOU!

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