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ERISA Class-Action Litigation over Fees in Health and Welfare Plans

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Sponsors and fiduciaries of health and welfare plans should be aware of a recently filed class-action lawsuit against alleged fiduciaries of a health plan. It challenges health-plan fiduciary oversight and reasonableness of fees and is similar to actions against fiduciaries of defined-contribution retirement plans. The action highlights the importance of establishing and documenting prudent fiduciary processes for making decisions on behalf of health and welfare plans.

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A class of participants and beneficiaries in pension, 401(k), and health and welfare plans sued the Charlotte-Mecklenburg Hospital Authority (d/b/a "Atrium") in the Western District of North Carolina. Although the primary issue is whether these plans were improperly designated as governmental entity plans, which are exempt from the Employee Retirement Income Security Act of 1974 (ERISA), the key issue for health-plan fiduciaries is whether Atrium retained a costly, affiliated entity as a third-party administrator for its health plan and failed to ensure that participants paid only 'reasonable' fees for services, co-insurance and deductibles.

Regarding Atrium's health plan, the complaint alleges a prohibited-transaction claim based on the plan's retention of MedCost as the network provider and third-party administrator. The plaintiffs allege that MedCost is 50 percent owned by Atrium, thus a "party-in-interest" under ERISA's prohibited-transaction provisions and that the arrangement is prohibited under ERISA unless exempt by one of ERISA's exemptions from the prohibited-transactions provisions (¶139). One such exemption applies to arrangements between a plan and party-in-interest if the party-in-interest provides services for reasonable compensation, but the complaint alleges that Atrium offered other employers using the MedCost network greater discounts than Atrium offered participants in its own health plan. The plaintiffs allege that Atrium received a benefit from the portion of plan assets MedCost received as administrative costs and thus acted in its own self-interests (¶145) (which amounts to self-dealing for which there is no exemption) (¶144). The plaintiffs also allege that participants paid MedCost "far greater amounts" for medical services than they would pay under other available managed care networks (¶141), and that MedCost has higher deductibles and co-insurance amounts and returns higher reimbursements to Atrium than alternate networks (¶¶142-43).

This case is unique because it challenges health-plan fees with allegations similar to those alleged in 401(k) and 403(b) fee actions. Sponsors and fiduciaries of health plans should note that perhaps one of the explanations for the dearth of lawsuits by participants against sponsor fiduciaries of health and welfare plans over their fees is because fee "reasonableness" involves a more complicated analysis for health plans than retirement plans. In any ERISA action challenging the reasonableness of fees, a court will ask whether the fiduciaries could have obtained other identical or materially similar services for less. In the health-plan context, there are questions about whether plaintiffs can plead that the other available providers could have provided nearly identical services to the services provided by the plan's service providers. Even in retirement plan cases, it can be difficult for plaintiffs to establish that other providers could provide nearly identical services for lower rates and, in the context of health plans, there are likely many more differences among providers and networks. This could make it much more difficult for a court to find that the "same" services could have been obtained at a lesser price. Also, in many health plans, fees are paid with employer funds—not plan assets—which makes it more difficult for participants to argue that the plan suffered damages (although see the First Circuit's decision in *Brotherston v.*

Putnam, 907 F.3d 17 (1st Cir. 2018)).

Importantly, the complaint alleges that "there is no difference in quality between MedCost and alternate networks that would justify the selection of MedCost" (¶141). This allegation likely is meant to address the general principle that service providers to ERISA plans are not fungible, meaning there may be reasons why one service provider charges higher fees than another service provider in view of the particular services and quality of services. Allegations that other, less-expensive service providers can provide the same services are commonly seen in lawsuits against fiduciaries of defined-contribution retirement plans, which often attack plan fiduciaries' choice of record keepers or investment managers on the grounds that they are unreasonably more expensive than other supposedly identical options.

ERISA's fiduciary duties, including the fiduciary obligation to avoid non-exempt prohibited transactions, apply to all ERISA plans, including health plans. This means that parties exercising discretionary authority over an ERISA health and welfare plan are required to act solely in the interest of plan participants and their beneficiaries, to do so prudently, and to ensure that the plan pays no more than reasonable compensation to service providers. While the plaintiffs in this case have not asserted a general breach of fiduciary duty claim, the prohibited-transaction claim raises similar issues—namely, whether the fiduciaries caused the plan to pay more than reasonable fees in view of the services the plan received. In addition, health-plan participants could conceivably choose to challenge health-plan fees with general fiduciary-breach claims. In fact, it is reasonable to expect that such claims will be made against other health-plan sponsors, given that plaintiffs' firms have begun to solicit potential class representatives and request health-plan fee information from employers.

To date, the reported ERISA cases involving health plans and challenges to fees have largely been brought against pharmacy benefit managers or third party administrators and focused on whether certain defendants were fiduciaries under ERISA or whether written plan agreements with third parties permitted certain charges. Ultimately, however, ERISA fiduciaries must be able to demonstrate a prudent decision-making and oversight process. In a 2015 publication entitled "Understanding Your Fiduciary Responsibilities Under a Group Health Plan," the Employee Benefits Security Administration of the Department of Labor took the position that health-plan fiduciaries need to monitor fees similar to the way retirement plan fees are monitored. The best way to do this is to establish and maintain a well-documented fiduciary process for selecting service providers and third party administrators and monitoring plan fees. Once that process is established, fiduciaries should understand how fees are calculated and paid to health plan vendors, whether fees are paid to related entities and whether fees are reasonable in view of the services the plan receives.

While many courts will hold that a breach in process alone does not establish liability if a prudent fiduciary could have made the same decision, a complete breakdown in, or lack of, process might lead a court to find some form of damage to plan participants. Another point of vulnerability for health plan sponsors might be any failure to negotiate fees with existing providers. While the fiduciary duty to pay only reasonable plan expenses has always existed for ERISA health and welfare plans, this case serves as a reminder of the importance of establishing and documenting prudent fiduciary processes for making decisions on behalf of health and welfare plans.

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