

ERISA Fiduciary Responsibilities for Health Care Plans

Broadly speaking, the Employee Retirement Income Security Act of 1974 (ERISA) regulates two types of employer-sponsored benefit programs: retirement plans and welfare plans. In dividing up regulatory authority, President Carter signed a reorganization plan in 1978 that allocated ERISA's regulatory authority between various federal agencies:

- Department of Treasury (Treasury) was given lead authority to regulate federal income tax provisions (including tax deductions and when an ERISA plan may be considered discriminatory and therefore not entitled to a tax deduction);
- Department of Labor (DOL) was given lead authority to regulate who is an ERISA fiduciary, as well as regulate the acceptable conduct between ERISA fiduciaries and third-parties;
- Pension Benefit Guaranty Corporation to insure ERISA-covered defined benefit pension programs. [\[1\]](#)

ERISA's statutory scheme imposes certain "duties" on parties ERISA defines as fiduciaries. While ERISA's fiduciary requirements apply to both retirement and welfare plans, welfare plans have historically not faced the same level of fiduciary 'rigor' (from the DOL) that ERISA retirement plans have faced because welfare plans tend not involve the use of ERISA-covered "plan assets" and many employers provide welfare benefits through ERISA-exempt insurance products, which are regulated at the State level.

ERISA's Fiduciary Standard for Selecting Health Care Plan Service Providers

The DOL has stated that plan sponsors, administrators, and trustees are covered by ERISA's fiduciary requirements when selecting a health care plan service provider.[\[2\]](#) As such, the person making the selection must engage in a "prudent selection process" (as determined based on what a knowledgeable fiduciary would do) that considers the provider's qualifications, as well as the quality of health care services offered. Failure to do so could constitute a breach of fiduciary duty when the selection involves the disposition of plan assets. Since the determination of whether the ERISA fiduciary engaged in a prudent process is evaluated largely by what a knowledgeable fiduciary would do, adherence to best practices and industry standards are key. At present, welfare plan industry standards generally do not provide employers with broad rights to data and pricing information that can be used to stimulate competition within the provider community. For example, it is not uncommon to find prescription benefit manager contracts that limit employer-sponsor's data and audit rights. Moreover, while insurance carriers provide employers access to claims data, carriers often do not provide employers with access to what the carriers pay providers. This makes it more difficult for employers to determine if the third-party administrator or insurance carrier is keeping a portion of the spread between the claims cost charged to the employer and what the provider is actually paid or if such amount is reasonable.

Although neither the law nor regulations prescribe a method for selecting health care plan service providers, when engaging in a prudent selection process, plan fiduciaries need to consider a wide range of factors, including the scope of services available; the qualifications of the available medical providers and specialists; ease of access to providers and information about provider operations; effectiveness of internal inquiry and complaint procedures; patient confidentiality; enrollee satisfaction; and the providers' ratings or accreditation.^[3]

When health care plan contracts limit the rights of plan sponsors and administrators to health care quality data, their ability to evaluate the provider quality or compare provider efficacy across competing networks is made much more difficult. The lack of full access to cost and quality data may make it more difficult for plan sponsors to discharge their ERISA fiduciary duties.

ERISA's Fiduciary Standard for Determining Reasonable Health Plan Expenses

The DOL has also taken the position that plan sponsors and administrators must know the costs of the services they procure on behalf of the plan and apply due diligence to minimize the costs relative to the level of services desired.^[4] As previously stated, ERISA requires plan sponsors to pay only "reasonable expenses" for the benefits offered through a health plan.^[5] However, to control health care costs and manage plan assets in a way that meets their fiduciary responsibilities, employers sponsoring self-funded welfare programs have struggled to obtain the actual amounts insurance carriers or third-party administrators (TPAs) pay to medical and other health care providers. Although there is little question that such information is important for plan sponsors in their role as fiduciaries, insurance carriers and TPAs are often reticent to disclose information that they consider proprietary (or that is encumbered by non-disclosure agreements with third-parties). In fact, many health care providers require plan administrators to sign "gag agreements" that prevent the administrator from fully utilizing health care pricing and quality data or sharing such important information with their employees.

Because plan sponsors are required to monitor and preserve plan assets under ERISA, entering into a gag agreement that intentionally obscures pricing information could arguably implicate ERISA fiduciary duty provisions. When answering comparable questions in other contexts, the DOL has emphatically stated that it is incumbent on plan fiduciaries to "take all reasonable action to ascertain the necessary information" prior to distributing plan assets.^[6] In the retirement plan context, this means that plan fiduciaries must fully understand the mechanics of transactions involving plan assets and evaluate the risks associated with each type of investment, including the applicable valuation methodology.^[7] However, when acting in the health plan context, carriers and third-party administrators frequently contract with plan sponsors to limit the use of healthcare quality or pricing information.

As plan fiduciaries, employers should know exactly what their TPAs are paid for the services rendered to the plan, and how much TPAs are paying to the health care providers offering services under the plan. However, plan sponsors often do not have a clear line of sight to the fees TPAs receive as part of the normal negotiating process. Without such detail, an employer may not be able to determine if the plan is entering into a TPA agreement that violates ERISA's prohibited transaction rules, such as the prohibition on unreasonable compensation (ERISA 406(a)(1)(C)) or engaging in self-dealing (ERISA 406(b)) and could be subject to DOL enforcement as a result.

In 2010, DOL indicated in the Interim Final Regulations on Fee Disclosures for Retirement Plans (408(b)(2)) that it "believes that fiduciaries and service providers to welfare benefit plans would benefit from regulatory guidance in this area for the same reasons that apply to defined

contribution plans and defined benefit plans. However, the Department [was] persuaded, based on the public comment and hearing testimony, that there are significant differences between service and compensation arrangements of welfare plans and those involving pension plans and that the Department [needs to] develop separate, and more specifically tailored, disclosure requirements under ERISA section 408(b)(2) for welfare benefit plans.”^[8] Accordingly, the interim final rule regarding retirement plan fee disclosures reserved a section in the regulation for a comprehensive disclosure framework applicable to reasonable contracts or arrangements for services to welfare plans, which the Department anticipated developing and issuing at a later time. The Department noted, however, that in the meantime, ERISA section 404(a) continues to obligate fiduciaries to “obtain and consider information relating to the cost of plan services and potential conflicts of interest presented by such [health and welfare plan] service arrangements.”^[9] To date, DOL has not proposed any regulations in this area.

Conclusion

Employers, as ERISA welfare plan fiduciaries, appear to have a duty to verify that the health plan service providers offering services to the plan meet the fiduciary’s quality standards, and that the fees paid to the plan’s service providers and health care providers, are “reasonable” considering the quality of healthcare services provided to the plan. Executing this duty is challenging without access to quality and pricing information from health care providers and carriers that would allow a plan fiduciary to weigh the benefits received under the plan against the cost of services for each health care provider.

It is therefore in the best interest of plan participants that all fiduciaries have the unfettered right to access, analyze, and compare health servicing provider pricing, network fee arrangements, and quality data, and to communicate that information to stimulate competition. Federal policy should be reviewed with an eye towards making clear that fiduciaries have such rights.

Examples of Gag Language in TPA Contracts

The following language is from actual TPA agreements that effectively restrict employer access to TPA arrangements and create fiduciary challenges for employers.

- “Neither the customer (employer) nor its representatives may make or retain any record of provider negotiated rates or information concerning treatment...”
- “(Employer) shall, under no circumstances, seek recovery of overpayment from network providers...”
- “Customer agrees to be bound by all [TPA’s] network provider agreements” (Note: This includes fee agreements, but the employer has no access to those agreements).
- “The amount a (third-party) vendor pays to a healthcare provider through the vendor’s contract with the provider may be different than the amount paid pursuant to the plan, because the allowed amount under the plan will be the Plan’s contracted rate with the vendor, and not the contracted amount between the vendor and the healthcare provider.” (Note: there is no provision for what happens when the plan pays more than the amount that the vendor is obligated to pay the provider and there is no obligation for the TPA to pay that amount back to the health plan or plan participants).

Endnotes

[1] Presidential Reorganization Plan No. 4 of 1978. Available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/executive-orders/4>.

[2] DOL Information Letter to Diana Orantes Ceresi, 1998 WL 1638068 (Feb. 19, 1998).

[3] *Id.* Most employers rely on third-parties (often insurance carriers) to consider these factors when designing health care provider networks.

[4] DOL Information Letter to Kirk Maldonado, 1987 WL 754933 (Mar. 2, 1987).

[5] Technical Release No. 1992-01, DOL Enforcement Policy for Welfare Plans with Participant Contributions. Available at: <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/92-01>. The Department cautioned that plan sponsors and fiduciaries must ensure that participant contributions “are applied only to the payment of benefits and reasonable administrative expenses of the plan.”

[6] ERISA Opinion Letter No. 93-23A.

[7] *Id.*

[8] 75 FR 41603 (July 16, 2010).

[9] *Id.*