The Case for a Health and Welfare Committee

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Agenda

- The new focus on fiduciary duties for health plans
- Basics of fiduciary duties for health and welfare plans
- How to create a health and welfare committee, including required documentation
- Agenda items for the committee
- Lessons learned from analogous retirement plan fiduciary breach cases where the employer had a committee that followed, and documented, a diligent process

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Why Are We Talking About This?

- When the Affordable Care Act (ACA) was passed, its main purpose was to expand and enhance healthcare coverage.
- The cost control mechanism in the ACA was the Cadillac tax (a 40% excise tax on high-cost employer-sponsored health plans). No one liked that provision, and it was repealed.
- Since that time, there has not been any law that would cap the cost of medical/prescription drug coverage for ERISA plans. Rather, we have the opposite—certain coverage is mandated and there cannot be lifetime limits on essential health benefits.

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Why There Is A New Focus On Fiduciary Duties For Health Plans

- The ACA and the Consolidated Appropriations Act, 2021 (CAA) added new cost transparency rules.
- These cost transparency rules are the mechanism that plan sponsors (in their fiduciary capacity) are to use to limit the cost of healthcare for ERISA plans.
- Plan fiduciaries are to obtain the cost information that is now available under the ACA and CAA and demand better contract terms.
- The plaintiffs' bar has begun to bring lawsuits against plan sponsors (in their fiduciary role) for not utilizing the cost data available under the transparency rules to try and bring down healthcare costs. These cases are in their early stages.
- One may ask why Congress does not outright ban excessive pricing in health plan contracts. Generally, the government cannot directly control the contract terms between two private parties due to the "Contract Clause" in the U.S. Constitution. (There are some exceptions to that rule.)
- Later in the webinar, we will discuss how a diligent health and welfare committee can be a strong defense in these cases.

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BASICS OF FIDUCIARY DUTIES FOR HEALTH AND WELFARE PLANS

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The Basics

- ERISA stands for the Employee Retirement Income Security Act of 1974, as amended.
- It is a federal statute that governs “employee benefit plans” such as 401(k) plans, health plans, long-term disability plans and life insurance.
- In many cases, certain employees of the plan sponsor have been tasked with the duty to protect the plans (the fiduciaries).
- Under law, the failure to comply with these fiduciary obligations can cause personal and corporate liability.

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The Basics—Fiduciary

- A person (either an individual or an entity) is a fiduciary to the extent the person has any discretionary authority, control or management of an ERISA-covered plan (such as its administration, operations or assets) (ERISA §3(21)).
- In many cases, the employer/plan sponsor is the ERISA Plan Administrator—which is a named fiduciary role.

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ERISA Fiduciary Responsibilities

- The primary responsibility of fiduciaries:
  - Run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses (the Exclusive Benefit rule).
  - To act with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims (the Prudent Expert rule).
  - Follow the terms of plan documents.
  - Diversify the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so (not applicable to most H&W plans, because they do not have a trust).
  - Avoid conflicts of interest and prohibited transactions.

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Plan Assets

- A fiduciary must protect **plan assets** and ensure they are used for a proper purpose (benefits and direct expenses) and not engage in prohibited transactions.
- Medical Plan: Plan assets include all contributions made by participants and beneficiaries .
  - Even though there is a non-enforcement rule issued by the Department of Labor that, in general, premium amounts paid by active employees through a cafeteria plan do not need to be held in a trust—they are still considered plan assets.

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Settlor Decisions

- Business decisions relating to *formation/design* rather than the *administration/management* of a plan are not subject to ERISA's fiduciary rules.
- This includes decisions, for example, to establish a medical plan, amend a medical plan (e.g., to add a covered benefit) and to terminate a medical plan.
- Activities that *follow* a business decision (implementation activities) are subject to ERISA's fiduciary rules. See examples on next slide.

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Business Decisions vs. ERISA Fiduciary Activities

Business Decisions (Formation/Design)	Fiduciary Activities (Subject to the Fiduciary Duties)
Whether a medical plan should be offered to employees	Selecting and monitoring medical carriers and third party administrators to administers claims under the medical plan
What portion of total healthcare costs will be borne by the plan sponsor/employee and what portion of the premiums employees will be charged	Selecting a third-party administrator to ensure that the employees are charged the correct amount of premiums
What benefits the medical plan will provide	Communications to employees about the benefits available under the plan

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Avoiding Conflicts—Prohibited Transactions

- Avoiding Conflicts: 2 main sets of rules—self-dealing and transactions with a party in interest.
- A fiduciary may not use assets of the plan to serve his own interest or his own account (self-dealing).
- A fiduciary may not cause a plan to enter into transactions with a party in interest, unless specifically permitted by law (party in interest).
- Parties in interest include any entities that have a direct or indirect relationship to the plan (e.g., fiduciaries, administrators, service providers, employers of employees covered by the plan).
- ERISA's basic structure: every plan interaction with a party in interest is a **prohibited transaction** unless a specific exemption applies.

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RECENT LITIGATION

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Recent Litigation Against Health Plan Fiduciaries

Lewandowski v. Johnson & Johnson

- In 2024, plaintiff Ann Lewandowski filed a class action lawsuit against Johnson and Johnson (J&J) and the fiduciaries of J&J's prescription drug benefits program ("J&J Defendants") in the District of New Jersey.
- Lewandowski's claims are premised on an alleged violation of ERISA's fiduciary duty of prudence.
- At its highest level, she claims that the J&J Defendants acted imprudently by failing to manage drug costs of two J&J-sponsored health plans.
- The complaint claims that the J&J Defendants' alleged mismanagement has cost the plans and participants millions of dollars in the form of higher drug costs, premiums, deductibles, co-payments, and co-insurance.

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Recent Litigation Against Health Plan Fiduciaries

Lewandowski v. Johnson & Johnson

- The complaint contains many allegations, including that the J&J Defendants did not meet their fiduciary obligations and:
  - Failed to engage in a prudent and reasoned decision-making process before entering into the PBM contract that included such high costs
    - *J&J could have used its bargaining power to get better terms*
    - *Did not include a pass-through PBM in the RFP process*
  - Failed to adequately negotiate favorable contract pricing terms
  - Failed to obtain the ERISA Section 408(b)(2) disclosures for its broker, to determine if the broker had a conflict of interest (prohibited transaction)

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Recent Litigation Against Health Plan Fiduciaries

Lewandowski v. Johnson & Johnson

- The initial ruling from the court stated that the plaintiff lacked Article III standing.
- With regard to the plaintiff's allegation that the defendants' fiduciary breach caused her to pay higher premiums for the health plan, the court stated that the injury was "speculative and hypothetical."
  - The fact that the employer paid such a large amount of the premium factored into this aspect of the court decision.
- With regard to her claim that paying higher prices for drugs caused her to pay more out-of-pocket costs, the court noted that her **other** out-of-pocket claims would have caused her to meet the out-of-pocket maximum—so there was no harm to be addressed by the court.

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Recent Litigation Against Health Plan Fiduciaries

Lewandowski v. Johnson & Johnson

- The plaintiff filed a second amended complaint on March 10, 2025.
- This complaint added several new elements:
  - (1) it focused on the COBRA premium costs and retiree health plan premium costs (which are entirely paid by former employees) and explained how high-costs in the plan impact COBRA and retiree premium rates; and
  - (2) included a plaintiff who had not met the plan's out-of-pocket maximum.
- There has been no ruling on this second amended complaint yet.

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Recent Litigation Against Health Plan Fiduciaries

Navarro v. Wells Fargo & Co.

- A very similar case was filed in a U.S. district court in Minnesota in July of 2024-- *Navarro v. Wells Fargo & Co.*
- The big difference from the *Lewandowski* case is an allegation that the plan fiduciaries engaged in prohibited transactions under ERISA by causing the health plan to pay excessive and unreasonable administrative fees to its PBM.
- The complaint alleges the $25 million in administrative fees the plan agreed to pay Express Scripts (the PBM) in 2022 greatly exceeds what comparable plans paid for similar services and is thus unreasonable and a prohibited transaction.
- There has been no decision in this case yet.

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Recent Litigation Against Health Plan Fiduciaries

Seth Stern et al. v. JPMorgan Chase & Co

- In March of 2025, plaintiffs who were participants in the JPMorgan-sponsored health plan, filed a complaint against JPMorgan, certain members of the Board of Directors and certain executives for breaching their fiduciary duties by mismanaging the prescription drug plan.
- The allegations in the complaint are similar to allegations in made in *Lewandowski v. Johnson & Johnson* and *Navarro v. Wells Fargo & Co.*
- Some of the differences are discussed on the following slide.
- Note that CVS is the PBM for the health plan.

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Recent Litigation Against Health Plan Fiduciaries

Seth Stern et al v. JPMorgan Chase & Co

- **Conflicted Broker/Employee Benefits Consultant.** Allegation that JP Morgan breached its duty by hiring a conflicted consultant to manage the PBM RFP process.
    - This was included in the other cases, but if more fully fleshed out in this complaint.
- **Conflict of Interest:** The business relationship with CVS was scrutinized for conflicts of interest. Allegedly, JPMorgan abandoned its joint venture, Haven Healthcare (HH), because of pushback from its private banking healthcare clients, including CVS . HH was formed with the goal of eliminating the need for healthcare intermediaries, including PBMs. JPMorgan clients, including CVS, complained about HH and the project was dropped by JPMorgan. The complaint uses this as evidence that JPMorgan was fully aware of the excessive pricing issues with CVS and chose not to pursue ways to minimize that in their PBM contract with the plan due to its business relationship with CVS.
        - Note that it is a business decision if JPMorgan wanted to move forward with HH. What the complaint appears to allege is that JPMorgan was fully aware of the excessive pricing issue but did nothing to combat that in the PBM agreement because of its business relationship with CVS.

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Recent Litigation Against Health Plan Fiduciaries

Seth Stern et al v. JPMorgan Chase & Co

- **Certain Board Members Named as Defendants.** The plaintiffs sued the Compensation Committee (CC) of the Board and each individual member of the CC because the CC retained fiduciary responsibility over the JPMorgan prescription drug plan.
    - Given that Board members are not engaged in the RFP process for the PBM or monitor the services of the PBM, we assume that any deposition of Board members will not go well.
- **Contract Language.** The plaintiffs allege that JPMorgan could have negotiated contractual terms that would have minimized or eliminated excessive compensation paid to CVS.
    - They cite to industry leaders who have provided examples of "bad" contract language that should be removed from contracts and tools for negotiating better contracts.
- **Vertical Integration.** The plaintiffs discussed the vertical integration of CVS and the failure by JPMorgan to address that in PBM contract. CVS owns Aetna. It also owns its own pharmacies and biosimilar drug manufacturer (Cordavis). As an example of a vertical integration issue, the complaint alleges that the plan's formulary only contained the biosimilar for Humira that was manufactured by Cordavis, even though it is significantly more expensive than other Humira biosimilars.

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Self-Funded vs Insured Plans

- While the current lawsuits have focused on self-funded plans, many of these same obligations and risks apply to insured plans.
- Health plan fiduciaries will not be protected from these lawsuits just because the plan is insured.
- The fiduciaries will still need to show a robust process for selecting and monitoring the vendors associated with the insured plans.

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CREATION OF THE COMMITTEE

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Why Need This?

- Fiduciary governance means an established framework for the management of fiduciary responsibility and oversight of ERISA-covered plans.
- This established framework helps identify fiduciaries, outline responsibilities, and provides guidelines for how processes and documents are maintained and monitored.
- Why does fiduciary governance matter? ERISA is a process driven statute. Compliance is demonstrated through process.
- A strong governance framework helps by:
  - Identifying fiduciaries,
  - Preventing unnecessary spread of fiduciary responsibility,
  - Ensuring fiduciary responsibilities are fulfilled at regular/appropriate intervals, and
  - Creating a record

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Example of What We Do NOT Want

- The company maintains a health plan but there is no H&W committee.
- The “company” is named as the ERISA plan administrator in the plan documents and SPD.
- The company’s Board of Directors and many of the executives will be the fiduciaries for the health plan.
- The health plan is sued and the plaintiffs' lawyers depose board members and senior executives, asking them detailed questions about RFPs, monitoring vendors, etc.
- It is unlikely that those depositions will go well.

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Creation of Committee

- The fiduciary governance framework begins with the Named Fiduciary.
- The Named Fiduciary is listed in the health plan document. Typically, this is the company sponsoring the plan.
- The Named Fiduciary is the entity that authorizes the establishment of a H&W Committee and assigns or delegates ERISA Plan Administrator responsibilities.
- The H&W Committee acts as Plan Administrator within the parameters of the assignment or delegation from the Named Fiduciary.
- The parameters are normally established in a Committee Charter.

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Creation of Committee

- Any delegated fiduciary responsibility, including Plan Administrator responsibilities by the Named Fiduciary, must be monitored by the delegating fiduciary.

- Having a strong governance framework helps clarify who has monitoring responsibilities, and who has related reporting responsibilities.

- Failure to monitor can result in a fiduciary breach.

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Suggested Process

- The Board should assign the H&W Committee as the Named Fiduciary of the H&W plans—and the plans (and SPDs) should be amended to reflect that.
- This should be hardwired into the documentation—you may not want to have the Board delegate fiduciary duty to the H&W Committee. Rather, you may want to the Board to assign that to the H&W Committee.
- A committee on the Board (such as the compensation committee) could retain certain "settlor" responsibilities over the H&W plans.

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Suggested Process

- Why have this structure where the Board assigns the fiduciary obligation to a H&W Committee?

  - Protect the Board from related legal actions:
    - The Board would not be responsible for complying with the "duty to monitor" the H&W Committee, nor any other fiduciary duty under ERISA.
    - In the event of a lawsuit against the Company and/or Board members based on an alleged breach of fiduciary duty regarding the H&W plans, we should have legal grounds to limit the legal defendants to members of the H&W Committee.

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Suggested Process

- Better protection of legal advice regarding H&W Committee work:
  - Legal advice related to H&W plan fiduciary responsibilities generally are not protected by attorney-client privilege.
  - Legal advice related to settlor functions can be protected by attorney-client privilege.
  - Having one group have settlor functions (like a compensation committee) and another have fiduciary obligations (such as the H&W Committee) would divorce the settlor functions (which would remain with the BOD) from the fiduciary responsibilities (which would go to the H&W Committee) and better protect attorney-client privileged communications on settlor duties as it would be less likely that advice on settlor duties is intermingled with advice on fiduciary responsibilities.

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Creation of Bylaws

- The bylaws should contain the following sections:
  - Objectives—A summary of the source of the committee's authority (when and how created). Which plans it has power, authority, discretion and control over as the plan fiduciary.
  - Members—Have a senior officer (such as the CEO) with the ability to appoint the initial members of the committee. After that, the committee could be self-sustaining, if the CEO does not want to be a fiduciary. If the CEO maintains appointment authority, case law has concluded the CEO is a fiduciary because of the effective control of the committee.
    - Explain the process of how a member can resign or when their term ends (such as when they terminate from the company).
    - We suggest that members should be employees from HR, Benefits, Accounting, Finance and Recruiting.
    - We do not suggest having the general counsel for the company be on the committee.
    - Determine who is the Chairperson, Vice-Chair and Secretary.

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Creation of Bylaws

- The bylaws should contain the following sections (continued):
  - How meetings are announced
  - Meetings can be held in person or video conference
  - Frequency of meetings (such as at least 4 times a year)
  - Quorum (both presence and voting rules)
  - Guidelines on actions by unanimous written consent in lieu of meetings
  - Statement on retention of minutes
  - Statement on ability to create subcommittees
  - Indemnification provision
  - How the bylaws can be amended

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AGENDA ITEMS FOR COMMITTEE

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Agenda Items

- The Committee should be tasked with various fiduciary obligations, such as:
  - Selecting vendors
  - Ensuring regular cadence for request for proposals (RFPs)
  - Monitoring service providers (fees, services, audits, performance guarantees)
  - Ensure vendors are assessed for cybersecurity compliance
  - Determining appeals (if applicable)
  - MHPAEA certification
  - Review fiduciary insurance
  - Review for conflicts of interest

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Initial Meetings of Committee

- To get started, we suggest that the first few meetings discuss the following:
  - How the Committee was created and the bylaws.
  - Fiduciary training.
    - What are the plans under the purview of the Committee.
    - The basics on ERISA and fiduciary rules for H&W plans.
    - An explanation of how the Affordable Care Act and the Consolidated Appropriations Act, 2021 have changed H&W fiduciary obligations.
    - Recent litigation.
  - Review when RFPs have been done for the major vendors and the current RFP schedule.
  - Review of which consultants run RFPs and if there has been proper disclosure from those consultants to understand any conflicts.
  - Review who in benefits/HR reports to the Committee about the actions taken monitor vendors (their fees, performance and cybersecurity assessment).

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Initial Meetings of Committee

- While consultants can assist HR/Benefits with these tasks, they should not control the Committee meetings.
- Meetings should be conducted by someone in HR/Benefits.
- Consultants and vendors can be guests at certain meetings and present at certain meetings.
- Legal counsel should attend meetings.

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LESSONS LEARNED FROM "EXCESSIVE FEE" LITIGATION

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Retirement Plan "Excessive Fee" Litigation

- In 2006, 13 lawsuits were filed against major companies claiming breaches of fiduciary duty under ERISA in connection with 401(k) plan fiduciaries' imprudent selection and retention of funds charging excessive fees.
- Since then, plaintiffs' firms have created a cottage industry bringing "excessive fee" lawsuits against plans of all sizes.
- Lawsuits were later brought against 403(b) plans starting in 2016.
- Continuing introduction of novel theories of liability. Creative plaintiffs' attorneys.
  - The PBM-related cases filed to date are likely only the tip of the iceberg. We can expect to see additional theories advanced, and an increase in volume if and when cases get traction in the courts.

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Retirement Plan "Excessive Fee" Litigation - Theories

- Failure to monitor and control plan administrative expenses.
  - Asset-based fees vs. per-participant fees.
  - Revenue sharing paid to recordkeepers improper.
  - Failure to conduct recordkeeping RFPs on a regular basis.
  - Use of related company as recordkeeper (duty of loyalty).
- Failure to monitor and manage investment options and fees.
  - Failure to offer lowest cost investment options.
  - Inclusion of proprietary funds (duty of loyalty).
  - Imprudent investment selection (poor performance or high fees).
  - Retail vs. institutional share class.
  - Active vs. passive investments.
  - Too many investment options.

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Retirement Plan "Excessive Fee" Litigation – 2024 Overview

- 35% increase in excessive fee litigation in second half of 2024, driven by surge in plan forfeiture lawsuits (28 in 2024).
- 18-month period starting January 2023 had seen a more moderate pace of filings.
- Three consecutive years of record settlements.
- Between 2016-2024, an average of 58 cases were filed each year.
  - 2020: 101
  - 2021: 60
  - 2022: 88
  - 2023: 48
  - 2024: 65

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Retirement Plan "Excessive Fee" Litigation – 2024 Overview

- What's behind the increase in filings in 2024?
  - Increased number of plaintiffs' firms in the space.
  - Backlog in prior cases settled, freeing up legacy firms. 153 total pending cases out of 526 filed from 2016-2024. 90% of cases filed in 2020 now settled.
  - Increased number of smaller plans being targeted.
- Settlements (publicly disclosed).
  - 2022: 31 cases settled, totaling $150M.
  - 2023: 42 cases settled, totaling $353M (includes $125M outlier settlement in the *Ruane, Cuniff & Goldfarb Inc.* case).
  - 2024: 53 cases settled, totaling $204M.

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Litigation Risks

- "Excessive fee" cases are difficult to win at the pleading stage via a motion to dismiss. Once a case proceeds to discovery, costs of defense increase significantly, thereby increasing pressure to settle.
- Payouts by insurers have led to increased costs of fiduciary liability coverage: higher premiums, higher self-insured retentions (SIRs).

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Liability for Breach of Fiduciary Duty

- A Plan fiduciary who breaches his or her fiduciary duty under ERISA shall be personally liable to:
  - make good to the Plan any losses to the Plan resulting from the breach; and
  - restore to the Plan any profits which the fiduciary has made using Plan assets.
- The court may grant any other equitable or remedial relief as the court deems appropriate, including removal of the fiduciary.
- Even if a fiduciary fulfills his or her own responsibilities under ERISA with respect to a Plan, he or she may still be liable for breaches of duty by another fiduciary of the Plan (co-fiduciary liability).

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Recovery of Attorneys' Fees

- In any action brought under Title I of ERISA by a participant, beneficiary or fiduciary, the court in its discretion may award reasonable attorneys' fees and costs of action to either party.
- In practice, the courts lean in favor of awarding attorneys' fees to prevailing plaintiffs while applying a stricter standard to the award of attorneys' fees to an employer or fiduciary who has successfully defeated a claim by Plan participants or beneficiaries.

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Case Study: Wildman v. American Century (W.D. Mo. 2019)

- Defense judgment after rare 11-day trial on the merits.
- Great resource for defining prudent process.
- Proprietary fund case. Alleged that "at all stages, both in selecting the Plan's designated investment alternatives and in monitoring those investments, Defendants only considered investments affiliated with American Century, in furtherance of their own financial interests, rather than the interests of Plan participants."
- *Wildman v. Am. Century Servs., LLC*, 362 F. Supp. 3d 685, 693 (W.D. Mo. 2019)

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Case Study: Wildman v. American Century (W.D. Mo. 2019)

- Committee members received "training and information about their fiduciary duties, including a 'Fiduciary Toolkit,' which outlined their duties as fiduciaries, as well as a summary plan document, and articles regarding fiduciary duties in general." Also received Investment Policy Statement (IPS).
- Committee met three times a year, and had special meetings if something arose that needed to be discussed outside of regular meetings.
- Meetings were productive and lasted as long as was needed – on average, an hour to an hour and a half.
- Committee looked at IPS first to determine what funds should be included.
- Committee thoroughly discussed the composition of the Plan's lineup to ensure it covered the entire risk/reward spectrum without duplication. Considered the Plan's sophisticated investor base.

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Case Study: Wildman v. American Century (W.D. Mo. 2019)

- Committee received detailed written materials prior to each meeting.
  - Copy of IPS, list of funds on watch list, benchmark summary, performance report for funds in core lineup, update regarding plan assets, participant rates and deferral rates.
- Committee also received and reviewed a report containing each fund's expense ratio compared to mutual funds in the same category, as well as information regarding the funds in the Plan with the median expense ratio of fund within the same Morningstar category.
- Committee sometimes heard presentations at meetings from consultants who presented findings from their research and lawyers providing information relevant to the Committee's work.
- The Committee also asked investment professionals to present information on a fund, especially when a fund was underperforming.
- Minutes were thorough, capturing the topic of discussion, who initiated questioning, and then the outcome of the vote or the Committee's ultimate decision.

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Case Study: Spence v. American Airlines, Inc. (N.D. Tex. 2025)

- Four-day bench trial involving issue of ESG funds.
- Court found Defendants breached their duty of loyalty by allowing BlackRock to engage in ESG-oriented proxy voting and investment strategies using plan assets.
- However, the court found there was no breach of the duty of prudence because the Defendants' monitoring practices were in line with the prevailing standards among similarly situated fiduciaries.
- *Spence v. Am. Airlines, Inc.*, No. 4:23-CV-00552-O, 2025 WL 225127 (N.D. Tex. Jan. 10, 2025)

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Case Study: Spence v. American Airlines, Inc. (N.D. Tex. 2025)

- Defendants' prudent process:
  - Regular committee meetings (at least quarterly) to review plan investment performance, including considering detailed reporting regarding market developments, as well as information regarding aggregate performance of Plan's investments and underlying investment managers.
  - Committee prepared minutes summarizing discussions and decisions.
  - Use of internal and external experts to review the Plan's investment lineup and investment managers. External consultant (Aon) retained following RFP.
  - Consulted with company's Asset Management Group, which regularly reviewed detailed information regarding the Plan's investment options.
  - Any perceived shortcomings in monitoring adviser's proxy voting practices was outweighed by the Committee's robust process for scrutinizing investments.
  - Focus on industry practice (proxy voting issues not typically judged as material).

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Case Study: In re: Prime Healthcare ERISA Litigation (C.D. Cal. 2024)

- Lawsuit involved claims that fiduciaries of the Prime Healthcare Services, Inc. 401(k) Plan, a multiple employer plan with 68 different participating employers, caused the Plan to pay excessive recordkeeping fees and retain underperforming investments.
- After four-day bench trial, court concluded Defendants used a prudent process to select, monitor and retain investments, to monitor recordkeeping and administration fees, and to monitor share classes.
- *In re Prime Healthcare ERISA Litig.*, No. 8:20-CV-1529-JLS-JDE, 2024 WL 3903232, at *1 (C.D. Cal. Aug. 22, 2024), appeal dismissed, No. 24-5841, 2024 WL 5277219 (9th Cir. Oct. 4, 2024)

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- Evidence of Defendants' prudent process:
  - Defendants relied on an expert witness who opined as to the Committee's process.
  - The court found Defendants' expert's testimony to be "highly probative," citing the expert's "broad, longstanding, and substantial experience in the retirement-benefits industry," including providing consulting services to thousands of retirement plans, including large retirement plans with up to $10 billion in AUM.
  - The court noted the Committee followed the process outlined in the Plan's IPS for selecting, monitoring and removing investment options, which included reliance on quantitative and qualitative metrics.
  - Meeting minutes showed Defendants engaged with the Plan's investment advisor and conducted meaningful discussions.
  - Committee received regular fiduciary training that kept members up to date on the latest developments.
  - Conducted RFI and vendor benchmarks.
  - Committee member emails showed discussion re: share classes with advisors.

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ACTION ITEMS

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Best Practices – Committee Structure and Membership

- The H&W Committee should be assigned as the named fiduciary/ERISA plan administrator (not delegated) in order to shield the Board of Directors and executive officers.
- Charter/bylaws should be adopted setting forth responsibilities and procedures.
- Membership should consist of 5-7 qualified employees.
  - Ideally, an attorney will be present at meeting.
- The on-going process for membership should be self-contained (no ongoing involvement of the Board of Directors).
- Members are provided all plan materials (charter, plan documents, educational materials) as part of the on-boarding process.
- Members should receive periodic trainings and education regarding: (1) fiduciary duties, (2) how to find/see various fee provisions in contracts with a PBM or third-party administrator and (3) updates on major changes to health plan laws and recent litigation against employer-sponsored health plans.

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Best Practices – Committee Meetings

- Meetings should be at least 3 times a year; quarterly recommended.
- Meeting agenda and materials should be provided in advance of the meeting.
- Chairperson should organize and run meeting.
- Attendance and all decisions, actions and inactions should be carefully documented in meeting minutes.
    - Secretary should be well-versed in the subject matter to accurately capture discussions.

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Best Practices – Selecting Service Providers

- Among other things, the H&W Committee should:
  - Document the process by which candidates for service providers will be chosen;
  - Gather relevant information from each service provider bidding for the work/responding to the RFP regarding their qualifications;
  - Review their fee structures (direct and indirect compensation); and
  - Obtain a list of client references.
- We suggest that this same action be taken both for a health plan third-party administrator (TPA) and PBM—but also for the consultant that runs the RFP for that TPA and PBM.

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Best Practices – Selecting Service Providers

- Train the group of employees who are running the RFP on how fees are hidden in contracts.
  - We are not suggesting that the employees receive a PhD in health plan costs, but we suggest they receive an hour training on what to look for in the RFP process.
    - Plan sponsors cannot solely rely on brokers/consultants.
  - A training would allow the employees to more meaningfully engage in the RFP process and have the tools to evaluate the work being conducted by the consultant/broker.
    - The training should not be done by the consultant/broker who will assist with the RFP.

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Best Practices – Selecting Service Providers

- Dig into the information needed to understand if the provider may have conflicts.

<u>Examples for Consultants/Brokers Who Run the RFP for the PBM</u>

- Try to obtain information on all revenue streams of the candidates that relate to the services.
  - For example, does the consultant/broker also have a "PBM Coalition" where it receives compensation from the PBMs?
  - Does the consultant/broker receive a commission if it recommended the PBM to the plan sponsor?
- Did the consultant/broker solicit bids from a wide-range of PBMs (or just a smaller group of PBMs, that are the ones that offer indirect compensation to the consultant/broker)?

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Best Practices – Monitoring Service Providers

- Request an actual dollar amount from the service provider of the direct and indirect compensation received in the former year related to the services provided to the plan/plan sponsor.
  - This may be hard to obtain but ask for it (in writing/an email)—a few times.
  - They may want to provide you with a written summary of various ways they make money—but try to get the actual dollar amount.
- Review service provider performance and performance guarantees on an annual basis.
- Conduct a market check of service provider fees every year or two.
  - For a PBM, conduct a claims audit that shows the amount paid for drugs by the plan versus the cost of the drug on NADAC (National Average Drug Acquisition Cost).

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Best Practices – Service Provider Fees and Performance

- Conduct RFPs on a regular cadence, such as every 3-5 years.
  - When running an RFP for a PBM, include a pass-through PBM as one of the candidates.
- Consider a schedule of when—and which—service providers will have their services audited.
  - Consider what would trigger the employer to conduct an audit
  - For its largest plans (such as a health plan or prescription drug plan), consider if audits should be conducted on a regular schedule.

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Best Practices – General

- Periodic review of H&W Committee process (self-assessment).
- Periodic review of Charter and Plan documents.
- Periodic updates to any person or entity with authority over Committee (to the extent fiduciary authority is delegated to the Committee by named fiduciary).
- Maintain fiduciary liability insurance.
- Document, document, document. Key evidence in defense of litigation.

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Questions?

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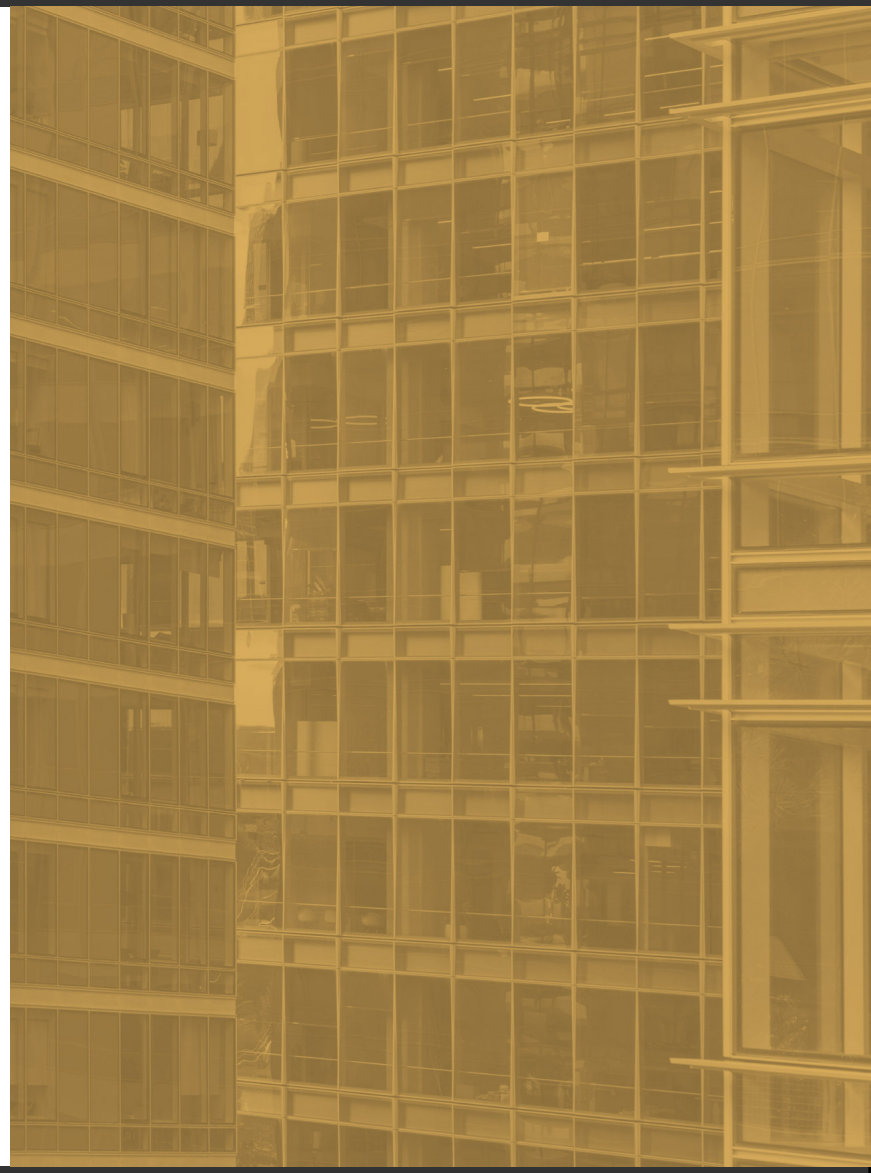

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