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Health and Welfare Benefit Plan Fiduciary Governance in the Wake of the Johnson & Johnson Lawsuit

by Christopher S. Lockman on April 22, 2024

For the past few years, we have encouraged plan sponsors to focus on matters of fiduciary governance for their health and welfare benefit plans (see our 2021 blog post). Yet many plan sponsors overlook the fact that the fiduciary standards of ERISA apply equally to retirement plans **and** health and welfare benefit plans. Specifically, the duties of loyalty and prudence demand that health and welfare benefit plan fiduciaries act solely in the interest of plan participants and beneficiaries and adhere to a "prudent expert" standard of care. Health and welfare benefit plan fiduciaries are also required to administer plans in accordance with their written terms. Fiduciaries of health and welfare benefit plans that fund benefits through a trust have an additional duty to diversify plan investments. Recent changes in the health and welfare benefit plan fiduciary landscape show that now is a critical time for plan sponsors to reevaluate their approach to fiduciary governance for their health and welfare benefit plans. It is important that plan fiduciaries use a reasoned and prudent process when considering next steps and that plan sponsors act cautiously in making changes to their plans' benefit structures.

Much has been written about *Lewandowski v. Johnson & Johnson*, Case No. 3:24-cv-00671 (Complaint, D.N.J., Feb. 5, 2024) and similar impending litigation. To summarize the allegations in the J&J Complaint, the plaintiff alleges on behalf of a putative class that the defendants – J&J, its pension and benefits committee, and individual fiduciaries of the J&J plans – breached their fiduciary duties under the J&J prescription drug benefits program. According to the complaint, the alleged breaches occurred because the fiduciaries, among other things, (1) failed to act prudently when selecting Express Scripts, Inc. as the pharmacy benefit manager (PBM), (2) agreed to a "spread pricing" formulary for prescription drugs, and (3) failed to adequately monitor the PBM to leverage better pricing on certain categories of prescription drugs. The plaintiff alleges that these failures resulted in harm to the plan and its participants by causing them to significantly overpay for widely available generic-specialty drugs, costing the plan millions of dollars and resulting in higher premiums, higher cost sharing, and lower wage growth.

The Complaint alleges in three different places that ERISA's duty of prudence compels fiduciaries "to seek the lowest level of costs for the services to be provided, and to continuously monitor plan expenses to ensure that they remain reasonable under the circumstances" (Complaint, ¶¶ 2, 9, and 30). This assertion could be understood to suggest that plan fiduciaries have a duty to negotiate the lowest possible price on all drugs, and other medical goods and services, available through the plan. The Complaint, which focuses on excessive spending for only one category of drugs – generic-specialty drugs – attempts to set an almost unattainable fiduciary standard that does not reflect the current reality of healthcare pricing in the group health insurance market. Indeed, most third-party administrators and PBMs would refuse to

negotiate the cost of medical goods and services or prescription drugs on an item-by-item and service-by-service basis for each plan they service.

The Consolidated Appropriations Act of 2021 (CAA) and the November 2020 Transparency in Coverage Final Rule (TiC) create new disclosure requirements for group health plans regarding the cost of medical goods and services and require plan fiduciaries to evaluate the "reasonableness" of fees charged by group health plan consultants and brokers based on required disclosures of direct and indirect compensation. Although the CAA and TiC requirements are powerful tools that plan sponsors can leverage to negotiate prices for medical goods and services, they are imperfect. For example, public pricing disclosure information does not clearly tie to hospital pricing transparency disclosures and is difficult to analyze. Also, Prescription Drug Data Collection (RxDC) reports often contain pricing data that concerns a PBM's entire book of business, rather than plan level information. Moreover, despite TiC and CAA requirements, it can be difficult for plan sponsors to obtain all data necessary to benchmark pricing for every medical good and service provided through their plan, much less negotiate the individual prices.

The degree to which plan fiduciaries are required to negotiate prices for individual medical and prescription drug goods and services (if at all) is a question that may be answered by the J&J lawsuit and future health and welfare benefit plan fiduciary litigation. For now, the only substantive pleading is the Complaint. Counsel for the J&J defendants have entered their appearance and immediately indicated their desire to file a Motion to Dismiss. The motion will likely challenge not only the standing of the plaintiff to assert her claims, but also the basis of her allegations against the plan fiduciaries. Plan sponsors should not overreact to the allegations in the Complaint by rushing to change their formulary, PBM structure, or vendors in an attempt to insulate themselves from litigation. Indeed, these snap decisions run contrary to the requirement that fiduciaries engage in a prudent process and consider broader concerns of the plan participants before acting.

If the merits of the J&J lawsuit are litigated, we can infer from analogous fee litigation concerning retirement plans that the question before the court will be whether the J&J defendants engaged in and documented a prudent process in selecting and monitoring the plan's PBM and its prescription drug benefits. Accordingly, we recommend taking the following steps to mitigate fiduciary liability exposure in the health and welfare benefit plan context:

- Identify fiduciary acts that concern group health and welfare benefit plans and the individuals responsible for oversight of those activities.
- Segregate fiduciary and settlor (plan design) functions.
- Ensure the terms of any fiduciary liability insurance policy extend to health and welfare benefit plan activities.
- Demand and carefully review direct and indirect compensation disclosures from benefit brokers and consultants and monitor fees and expenses.
- Work with brokers and vendors to assure compliance with new transparency and disclosure requirements.
- Collect and review the terms of all administrative services, PBM, and broker agreements. Amend the agreements as necessary to ensure vendors will assist group health plan fiduciaries in complying with the transparency and disclosure requirements

under the TiC and CAA and to insulate plan fiduciaries against mistakes made by the service provider.
- Utilize an RFP process to assure competitive pricing and quality service from health and welfare benefit vendors.
- Create a compliance calendar to assure all required notices are timely provided and all required filings are timely made.
- Understand what information is available regarding cost and quality and utilize that information to the extent possible to determine value received in exchange for cost. The extent to which this must occur on an item-by-item or service-by-service basis will be determined by future litigation.

The best means to accomplish the above tasks on an ongoing basis is a health and welfare benefit plan fiduciary committee made up of the appropriate decision makers at the plan sponsor that will serve as the designated “plan administrator” for the health and welfare benefit plans. The committee should adopt a charter that outlines its membership, purpose, authority, duties, and operating procedures. In addition, the committee should follow a fiduciary governance calendar, keep minutes of meetings, and engage expert consultants. The committee should also undergo fiduciary training to ensure its members understand their duties and responsibilities with respect to the plans they oversee.

If you have any questions about fiduciary oversight requirements for your health and welfare benefit plans, or if you would like to discuss formation of a health and welfare benefit plan fiduciary committee, please contact a member of our Employee Benefits & Executive Compensation Group.

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