THE NEWEST FIDUCIARY DUTY: PROTECTING PARTICIPANTS FROM THEMSELVES

Written By Jon Jablon, Esq.

The recent case of *Hughes v. Northwestern University* before the U.S. Supreme Court solidified a legal interpretation that many feel is a misstep when applied broadly to fiduciary duties. Although the case focuses on 401(k) plans, it has potentially broad implications for any plans governed by the Employee Retirement Income Security Act, or ERISA.

THE OLD WAY OF THINKING

The industry at large tends to conceptualize fiduciary duties a bit nebulously, especially in the context of what benefits are offered by a given health plan.

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Although a few federal laws require certain benefits be offered and outline under what circumstances they are, plan sponsors have enjoyed a great deal of freedom to offer any combination of benefits they see fit.

While pension plans are subject to some different regulation, they are mostly in the same boat when it comes to rules regarding plan administration under ERISA: pension plan sponsors are given a wide latitude to decide which investment options should be made available to their plan participants.

The Plan Administrator is charged with administering the benefits laid out in the applicable plan document, and ERISA Plan Administrators are subject to strict burdens, which can intersect with the plan sponsor's basic framework for the plan.

However, the Plan Administrator is not necessarily permitted to administer the plan exactly as written, creating an odd distinction between the employer's role as the plan sponsor and the employer's (or a third party's) simultaneous role as the Plan Administrator.

With *Hughes*, the Supreme Court has handed down additional clarification on how Plan Administrators can satisfy, or perhaps more relevantly, *fail* to satisfy, their considerable duties.

THE NEW WAY OF THINKING

To summarize this case, a group of 401(k) plan participants sued the Plan Administrator, alleging that the aggrieved plan participants had made poor investments, and that the Plan Administrator should not have allowed that to happen.

The Seventh Circuit Court of Appeals disagreed with that logic, opining that the participants were given all available information and made their own choices, and that the Plan Administrator is not responsible to curate 401(k) plan participants' investments. According to the appeals court, the participants *could* have made better investments; they just *didn't*.

The U.S. Supreme Court, however, unanimously disagreed, indicating that – among other things – "even…where participants choose their investments, plan fiduciaries are required to conduct their own independent evaluation to determine which investments may be prudently included in the plan's menu of options. If the fiduciaries fail to remove an imprudent investment from the plan within a reasonable time, they breach their duty."

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In other words, although Plan Administrators can certainly give plan participants freedom of choice in their investment options, the Plan Administrator must ensure that those investment options are all *good* options.

The Supreme Court imposed a fiduciary responsibility to protect plan participants from *themselves*, holding that the existence of "bad" options is not excused even by the prevalence of "good" options.

While the Court's opinion may seem confined to the pension plan space, it interprets the fiduciary duties imposed by ERISA, which of course apply to self-funded healthcare plans as well.

SCOPE OF BENEFITS

Take, for instance, a section 125 cafeteria plan that offers a cash-in-lieu-of-benefits option, a traditional and robust health plan, a high deductible health plan with qualified HSA, and a preventive-only health plan.

Intuitively, the practical result is that the Plan Administrator can compliantly offer three competing options, since participants choose to pay (or receive) a certain amount of money in exchange for benefits (or no benefits). That is a matter of participant choice, and traditionally there has been no question of whether it is appropriate for the plan to offer these options.

But, then again, we might have said the same thing about 401(k) investments.

One could argue that being uninsured is inherently a poor decision since most individuals will need some sort of medical care at some point. Regardless, consider a situation where a young, healthy, low-risk employee decides that having health insurance is unnecessary, and the employee elects the cash-in-lieu plan option.

To quote the Supreme Court, a fiduciary may have "breached the duty of prudence by failing to properly monitor investments and remove imprudent ones".

Interestingly, the difference between *investments* and *benefits* seems inconsequential here, since the defining relevant factors are apparently (1) that plan participants make the choice, and (2) that choice has a financial impact on the chooser.

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Admittedly, there are other factors at play in the *Hughes* case other than the participants' poor investment decisions. For example, certain investments were offered at a higher, retail-class rate than their institutional-class counterparts, thus costing participants more money than perhaps necessary.

The complaint also alleged that the plan fiduciary offered too many investment options, which "thereby caused participant confusion and poor investment decisions".

The Supreme Court did not elaborate, however, regarding which factors were relevant to this allegation or how many investment options would *not* have caused undue confusion, since making such specific determinations is not the Supreme Court's job. With any luck, more clear guidance may be forthcoming now that the Supreme Court remanded the case back to the lower Court of Appeals with further instructions on how to correct its prior errors.

It seems a bit irrational to think that a cafeteria plan fiduciary can be faulted for including a plan option that could result in financial detriment to the plan participant, despite being elected by an informed decision – but the Supreme Court has so determined with respect to 401(k) investments.

REFERENCE-BASED PRICING

In the industry today, no discussion of health plan practices seems to be complete without some mention of reference-based pricing (or RBP). That's because there are so many different factors involved in reference-based pricing touching upon so many aspects of the industry, making it an excellent example.

Reference-based pricing – or pricing claims based on Medicare or some other reference other than billed charges – is a practice that is increasingly common, necessitated by the growing feeling among those in the the self-funded industry that most medical bills are exorbitant, arbitrarily marked-up, and somehow immune from ordinary market forces.

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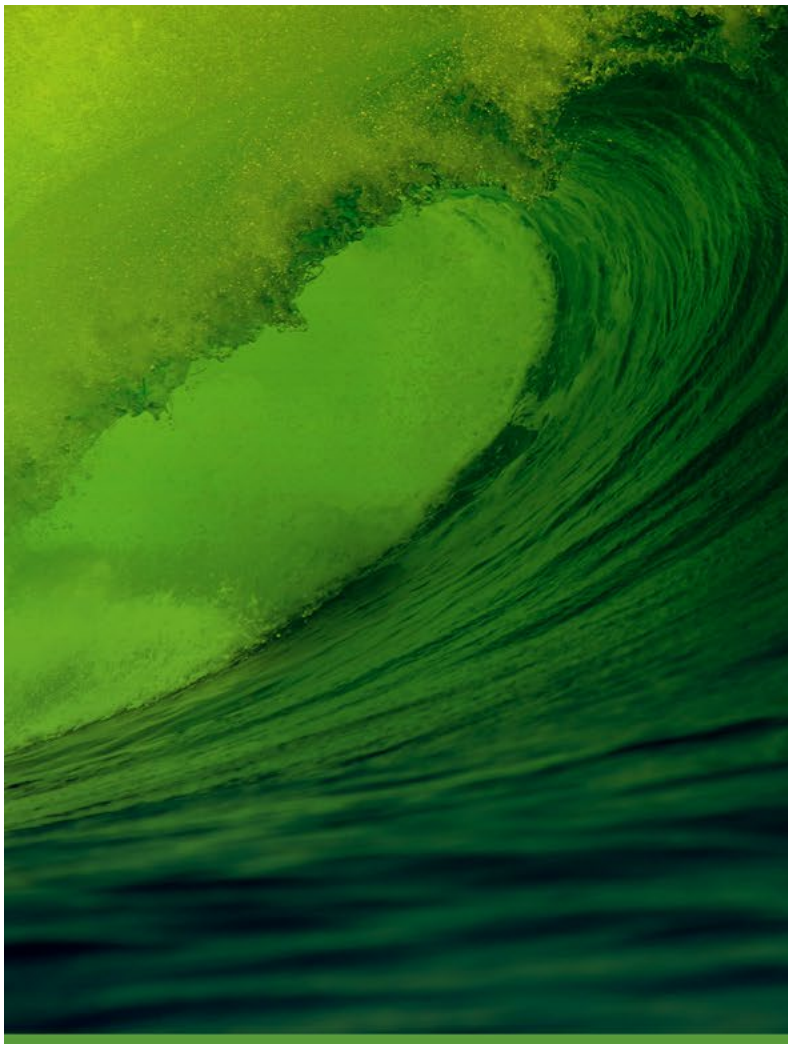

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Typically, health plans using RBP models are able to save a great deal of money in claims payments, resulting in a lower overall participant contribution. The primary trade-off is that the lower-than-billed payments provide significantly less protection for affected plan participants.

Whenever a non-contracted medical provider is paid less than its full billed charges, the provider may bill the balance to the patient (assuming that the claim in question is not one for which the patient is protected by the *No Surprises Act*, such as emergency claims, out-of-network air ambulance claims, or certain out-of-network claims rendered at in-network facilities).

This balance bill is a reality of almost all RBP programs.

Many health plans and their RBP vendors wisely adopt some way to mitigate balance bills and increase participant security, but there can be situations where balance bills still negatively impact the patient. Health plans can create "safe harbors" for participants with contracts or otherwise finding providers that will not balance bill, but one of the staples of a reference-based pricing model is that participants can choose to visit any providers they want.

Recall that 401(k) plan participants are also able to choose which investments they want. Recall also that the Supreme Court iterated that the fiduciary must ensure that participants are not even ***able*** to make poor decisions.

Since balance billing can have deleterious effects on plan participants when not effectively managed by a health plan, an important question is how the duty of prudency, as explained by the *Hughes* case, might apply to a situation where a health plan has elected to utilize some type of reference-based pricing model.

The *Hughes* decision tells ERISA-governed plans that their fiduciaries must protect plan participants from their own decisions. If a plan participant has the option to visit a contracted provider but chooses instead to visit a non-contracted provider, the participant may end up subject to a balance bill.

In that case, it seems clear that the plan fiduciary has allowed the participant to make what amounts to a poor investment decision: the patient effectively elected to incur a balance bill from its chosen provider, whereas a comparable provider down the street would have been subject to a contracted rate, leaving the patient with *no* balance.

Digging a bit deeper, perhaps the *Hughes* precedent would even require a plan fiduciary to remove higher-charging providers from the pool of provider options, effectively offering no benefits for those providers.

Literally speaking, if a provider is excluded from benefits altogether, the participant's cost for the claim is

maximized (since the full bill is the participant's responsibility) – but perhaps including all providers within the class of covered providers increases the number of analogized "investment options", contributing to the consumer confusion referenced by the plan beneficiaries in *Hughes*.

THE PARALLELS

The aggrieved plan participants in *Hughes* identified three primary allegations:

1. For some investments, there were multiple ways to elect them, some costing more than others for virtually the same result.
2. Some poor investment options were offered among the better options.
3. Too many investment options caused consumer confusion.

With the examples provided above – a cafeteria plan and a reference-based pricing model – those three allegations can be extrapolated into the health benefits universe.

It would be folly to suggest that the *Hughes* decision is confined to the pension plan space; the fiduciary duty explained by the Supreme Court in *Hughes* is an interpretation of existing ERISA law, which is the common denominator of pension plans and health benefit plans alike.

With an increased focus on consumer protection (take, for instance, the recent advent of the No Surprises Act and additional Mental Health Parity and Addiction Equity Act obligations and enforcement), health plans and their fiduciaries should be acutely aware of emerging consumer protection laws that in many ways change the historical application of ERISA.

ERISA is almost 50, but it continues to evolve with the times as much as ever. Who ever said you can't teach an old dog new tricks? ■

Jon Jablon, Esq. joined The Phia Group's team in 2013, after receiving his Juris Doctor from New York Law School and being admitted to the bars of New York and Massachusetts. He is well-versed in the ins and outs of ERISA, stop-loss policies, PPO agreements, administrative services agreements, and health plans. Jon works on a large variety of projects for The Phia Group's clients, including providing advisory opinions, consultative advice, and contract review.

As the Director of Phia Group Consulting's Provider Relations Team, Jon assists TPAs, brokers, stop-loss carriers, and other entities with disputes related to both in- and out-of-network claims, various claims payment methodologies (including reference-based pricing), appeals, medical bill negotiation, and much more.