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Employee Benefit Plan Review

Drugmaker Sued for . . . Overpaying for Drugs? Lawsuit Ushers in Expected Wave of Welfare Fiduciary Litigation

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The first complaint has been filed in what is expected to be a wave of litigation alleging breach of fiduciary duty in selecting and monitoring welfare plan vendors.[1] While the facts of this particular case may make it somewhat distinguishable from the circumstances involved in most employer-sponsored plans, it does provide early insight into how future litigation may proceed.

Background

In early February, pharmaceutical giant Johnson & Johnson (J&J) and its benefit plan committee were sued in a putative class action alleging the company breached its fiduciary duty in its selection of its pharmacy benefit manager (PBM), its reliance on a biased consultant in the selection process, and its failure to negotiate more participant-friendly contract terms in implementing the services. To understand the basis for the lawsuit, it is important to first recount the developments of the last few years:

- *Decades of Retirement Plan Litigation.* Beginning in 2006, and continuing to present, 401(k) and 403(b) plans have been the subject of putative class action lawsuits alleging excessive fees. These lawsuits focus on fiduciary responsibilities with respect to vendor selection, fees and investment performance (several of these cases have made it all the way to the U.S. Supreme Court).
- *New Welfare Plan Transparency Law.* In late 2020, Congress passed the Consolidated Appropriations Act (CAA), debuting a series of reporting and disclosure measures intended to bring greater transparency to the medical and prescription drug industry. Specifically, the CAA required health plans to:

(a) Post machine-readable files reporting the rates paid to network and non-network providers for a series of services;
(b) Create price estimator tools that allow participants to determine in advance how much a supply or service will cost;
(c) Document the processes used to create limits on access to mental health or substance use disorder services; and
(d) Solicit fee disclosures from brokers and consultants involved in the plan design upon entering into a contract (or renewing a contract).

- The CAA also prohibited health plans from entering into contracts with network administrators that would restrict access to price or quality of care information.
- *Shifting Focus to Welfare Plan Fee Litigation*. Recently, a number of welfare plans brought suit against their third party administrators. These suits alleged that the TPAs refused to provide requested information relating to pricing, inflated costs and held conflicts of interest. At the same time, Jerry Schlichter (an ERISA plaintiffs' attorney in numerous 401(k) fee cases) gave several interviews indicating he intended to shift his focus to welfare plan fee litigation (and even went so far as to name upwards of ten companies that were in his sights). Later in 2023, a number of companies began receiving ERISA document requests seeking six years' worth of plan documents as well as a link to the plans' price estimator tool.
- *Lawsuit Filed Alleging Fiduciary Breach in Rx Fees*. As noted above, J&J, its fiduciary committee, and individual committee members have been sued for purported breach of fiduciary duty with respect to their ERISA-governed prescription drug benefit program. The lawsuit provides insight into potential theories as to how other plans may be targeted in this new wave of fiduciary litigation.

What are the Allegations?

It is important to note that the lawsuit contains a number of unsubstantiated allegations. The complaint attempts to make a splash by relying on shocking price disparities between the price pharmacies charge to uninsured/cash paying participants for a prescription drug versus what they charge to commercial group plans. This overlooks the practical reality underlying the U.S. healthcare system, which is that commercial plans are regularly charged a higher rate as a form of price subsidy for the uninsured. (This was the entire premise of the Affordable Care Act, which attempted to "bend the cost curve" through reducing the rate of under-insured Americans.)

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With that caveat noted, the complaint alleged that J&J breached its fiduciary duties through a series of actions resulting in the plan (and its participants) overpaying for prescription drugs. The alleged breaches included:

- *Failure to Adequately Consider Non-Traditional PBMs*. The complaint alleges J&J's committee failed to conduct periodic requests for proposal (RFPs). Moreover, the complaint alleges that when they did so, they failed to consider so-called "non-traditional" PBMs that were compensated based on pass-through pricing rather than spread pricing and rebates (see below for a more thorough description of PBM pricing models). The complaint names several lesser-known PBMs that it suggests J&J should have considered. The complaint appears to allege that use of any compensation method other than pass-through pricing constitutes a de facto breach of fiduciary duty because it incentivizes the PBM to overcharge and pursue other tactics that are contrary to the interests of the plan and its participants. Moreover, the complaint alleges the plan committed a breach of fiduciary duty in relying on its benefits broker/consultant in selecting and structuring the PBM agreement because the consultant was paid on commissions. The complaint alleges that this incentivized the consultant to select a vendor (and pricing model) that maximized plan spend to increase the consultant's compensation.
- *Failure to Adequately Negotiate Favorable Contract Pricing Terms*. The complaint alleges that J&J completely deferred to its PBM on development of the plan's formulary (the list of covered versus excluded drugs). The complaint suggests this allowed the PBM to favor more expensive drugs over generics, which increased the PBM's compensation at the plan's expense. As noted above, the complaint criticized J&J for entering into a contract that compensated the PBM via rebates and spread pricing, which allegedly resulted in the plan paying significantly more for prescription drugs as compared to what the plan could have paid. To this end, the complaint pointed to the cash/uninsured rate for these drugs and/or the government-developed "NADAC" rates for drugs (a tool reporting average drug procurement cost which many criticize as inadequate because it relies exclusively on self-reporting), which in many instances publicly reported lower drug costs.
- *Failure to Carve Out Specialty Pharmacy From Contract*. Finally, the complaint alleged that

J&J relied on the PBM's specialty pharmacy service rather than carving out specialty pharmacy to a separate third-party vendor. According to the complaint, this resulted in the PBM designing the plan's incentives to steer participants toward the PBM-owned specialty pharmacy rather than toward a lower-cost option.

The complaint then attempts to establish that any fiduciary would be well aware that the only prudent option was pass-through pricing and an employer-designed formulary. For support, plaintiffs cite various articles and employer statements over the last decade.

Explaining PBM Pricing Models

PBMs are traditionally compensated through one or several of the following methods:

- *Spread Pricing*. Under a spread pricing model, the PBM is compensated based on the "spread" between what the PBM paid to acquire the drug, and what the PBM charges the employer health plan for the drug. For example, if the PBM obtains a drug from the drug manufacturer for $10, and the PBM charges the plan $15 for the drug, the PBM would retain the difference ($5) as compensation.
- *Rebates*. PBMs often negotiate rebates from drug manufacturers based on their bulk purchasing power (i.e., the volume of drugs the PBM purchases for its entire customer base). PBMs may then retain some or all of this rebate as compensation rather than refunding the rebate to its customer plans on a pro rata basis.
- *Pass-Through Pricing*. PBMs that offer pass-through pricing charge their customer plans the drug's acquisition cost. Because the PBM does not receive compensation through spread pricing or rebates, the PBM in this context is often compensated in a different manner (e.g., through a per-employee, per-month rate.)

How Were the Plaintiffs Harmed?

ERISA generally allows for equitable relief where a plaintiff can establish a breach of fiduciary duty that harmed participants. A fiduciary is evaluated based on whether its process and decision were reasonable (fiduciaries are not mandated to follow a set process as many different approaches could be reasonable). Here, the complaint alleges participants were harmed in several ways:

- *Overpayment of Cost-Sharing*. Because the J&J plan required participants to satisfy a deductible prior to receiving plan benefits, the complaint asserts that participants overpaid due to the plan's failure to negotiate lower drug rates. Moreover, even after participants satisfied their deductible, they were required to pay copays or coinsurance for drugs until they satisfied the plan's out-of-pocket maximum. While copays are generally fixed amounts that do not fluctuate based on the drug cost, the complaint alleges that certain design features incentivized lower copays when participants used PBM-owned or affiliated pharmacies. And while using such a pharmacy may have saved the participant money at the point of purchase, the complaint alleges it ultimately cost the plan more because the drug was available at a cheaper rate at an unaffiliated pharmacy. Finally, where the plan assessed a coinsurance (i.e., where a participant paid a percent of the total cost), a higher drug procurement cost would have resulted in a greater participant out-of-pocket expense.
- *Inflated Overall Plan Cost*. The complaint further alleges that increased spend, even if derived from the employer's portion of cost-sharing, has a detrimental impact on participants. Specifically, the complaint alleges that employers continue to pass more and more of the overall health plan spend on to participants. So, the greater the overall plan cost, the greater the participant premium/contribution rate. To be clear, setting participant premiums is a settlor/design decision, not a fiduciary decision. As such, it will be challenging to state a viable claim based on this theory.
- *Depressed Wages*. The complaint asserts that when health benefits cost more, employers pay employees less. In other words, the complaint alleges that the plan fiduciary's purported failure to rein in prescription drug spending resulted in the company paying its employees less. While the complaint cites to a study supporting this proposition, we are aware of no precedent supporting this theory of harm.

Why Might this Case be Unique?

As noted at the outset, we suspect the decision to file the seminal welfare fee case against J&J was calculated because J&J's welfare plan is funded by a trust. Most health plans are not. This is significant because in order to establish a breach of fiduciary duty, plaintiffs must establish that the plan's fiduciary exhibited imprudent stewardship of "plan assets." Plan assets include participant contributions, but they generally would not include company contributions unless those contributions are held in trust. (All monies residing in an ERISA trust are considered plan assets.) So while most companies would be able to effectively parry much of the complaint's allegations

by alleging any overpayment only runs to the detriment of the company, J&J may be required to defend the entirety of the plan's spend.

In short, employers should continue to engage in prudent fiduciary decision-making processes in their selection of PBMs and consultants and their contracting with other vendors.

What Should Plan Fiduciaries do Now?

In the wake of this lawsuit, and given all the indicia that this is simply the first in a coming torrent of similar suits, it merits considering what actions (if any) employer plan fiduciaries should take. In short, employers should continue to engage in prudent fiduciary decision-making processes in their selection of PBMs and consultants and their contracting with other vendors. Contrary to the allegations in the complaint, ERISA does not dictate a one-size-fits-all approach. In our discussions with various industry experts, it has become apparent that designing a plan exactly in accordance with the specifications outlined in the complaint could very reasonably be expected to result in increased plan costs and participant expenses. So, designing a plan to satisfy all the allegations in the complaint cannot be taken as a road map to insulate from litigation.

Instead, plans should engage in a prudent process for designing their prescription drug and medical benefits. While plan fiduciaries should consider different vendors and design options, ERISA does not require that plan fiduciaries select the lowest cost vendors. There are myriad reasons why a plan would reasonably choose not to engage a "non-traditional" PBM, even if that PBM purports to offer lower drug pricing. For instance, such a decision could lead to sacrificed network access, drug selection, claims processing, or other factors that are at least, if not more, significant to plan participants than finding the lowest cost drug.

Note

1. https://fingfx.thomsonreuters.com/gfx/legaldocs/znpnkkrmbvl/EMPLOYMENT_JANDJ_ERISA_complaint.pdf.

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