TESTIMONY OF KAREN L. HANDORF

Hearing on "ERISA's 50TH ANNIVERSARY: THE PATH TO HIGHER QUALITY, LOWER COST HEALTH CARE"

U.S. House of Representatives Committee on Education & the Workforce

Subcommittee on Health, Employment, Labor, and Pensions

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Chairperson Good, Ranking Member DeSaulnier, and members of the Subcommittee.

I am a Senior Counsel in the Employee Benefits and ERISA Practice Group at the law firm of Berger Montague P.C., in its Washington, D.C. office. I represent plan participants and fiduciaries in litigation brought against third-party administrators of ERISA-covered health plans, including litigation seeking plan claims data and relief for mismanagement of claims administration. I also advise employers and plan fiduciaries on provisions in their administrative service agreements that might cause them to violate ERISA. Prior to entering private practice, I spent 25 years at the Department of Labor, where, among other senior positions, I was the Deputy Associate Solicitor in the Plan Benefits Security Division, Office of the Solicitor. During my tenure at the Department of Labor, I litigated the Government's position on a wide variety of ERISA issues, including remedies, preemption, benefit claims denials and the fiduciary duty to monitor plan service providers.

My written testimony was prepared in consultation with five former DOL officials, each of whom has more than 35 years' experience in ERISA, and who responded as a group to Chairwoman Foxx's Request for Information on ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage. I thank the subcommittee for this opportunity to present views on needed reforms to the regulation of employer sponsored health care plans.[1]

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[1] The following individuals were consulted:

The Honorable Phyllis C. Borzi, a nationally recognized expert in ERISA, was the Assistant Secretary of Labor for the Employee Benefits Security Administration from 2009-January 2017, after her unanimous confirmation by the U.S. Senate. During her more than 45-year career in employee benefits, Ms. Borzi has worked in a variety of settings, including in private law practice at the Washington DC law firm, O'Donoghue & O'Donoghue (1997-2009), as a research professor in the

I. Background

Many of the current problems in employer-sponsored health care could not have been anticipated by ERISA's drafters in 1974. At that time, most employers provided

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Department of Health Policy, School of Public Health at The George Washington University (1997-2009), and as Pension and Employee Benefit Counsel for the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Labor-Management Relations (1979-1997). She currently serves on six Boards of Directors of organizations in the employee benefits field, including as an ERISA fiduciary for the Goodyear Retiree Health Care Trust. Ms. Borzi is a founding member and former president of the American College of Employee Benefits Counsel.

Elizabeth Hopkins spent over three decades at the Department of Labor, the bulk of which she spent heading the ERISA amicus and appellate program and overseeing nationwide litigation designed to advance the interests of workers, retirees, and their families with regard to their employee benefits. After her long and fulfilling career in the federal government, she became a partner at the law firm of Kantor & Kantor, where she specializes in pension, health care, and other ERISA litigation. She is also the co-editor of a widely subscribed blog, which reports weekly on ERISA developments and is frequently called upon to speak and comment on ERISA issues.

Marc I. Machiz has more than 35 years as an employee benefits attorney representing the Secretary of Labor or participants and beneficiaries or managing EBSA's enforcement activity including service as Associate Solicitor of Labor, PBSD from 1988 to 2000, benefits partner and chair of the employee benefits practice at Cohen, Milstein, Sellers and Toll, PLLC and its predecessor 2000 to 2012, and enforcement official at EBSA from 2012-2016, including Regional Director of the Philadelphia Region, EBSA from 2012-2015. Mr. Machiz is retired from legal practice and conducts mediations as a principal at Justican Mediation, LLC.

Daniel J. Maguire has worked in the employee benefits field for over thirty-five years. He worked on ERISA issues in the Office of the Solicitor at the Department Labor for fifteen years before serving an additional fifteen years as the Director of the Office of Health Plan Standards and Compliance Assistance for the Employee Benefits Security Administration.

William W. Taylor worked on ERISA matters in the Office of the Solicitor at the Department of Labor for 34 years in litigation and advisory capacities. From 1992 to 2016, he served as Counsel for Regulations in the Plan Benefits Security Division. He is currently retired.

health insurance to their employees through the purchase of insurance subject to state insurance regulation. Plans generally reimbursed medically necessary expenses at the usual and customary rate. The concerns that motivated Congress to legislate substantial substantive requirements for pension plans in 1974 were simply not present for health plans.

Employer-sponsored health plans have changed dramatically since 1974. Sixty-five percent of workers are in plans that are self-funded, and thus exempt from state insurance regulation.[2] Most large employers provide health care benefits through self-funded plans, which typically contract with large insurance companies to gain access to the insurance companies' networks of providers and for related claims administration. Most self-funded plans insure against catastrophic loss by purchasing stop-loss insurance, minimally regulated by the states. While self-funded plans were traditionally the province of large employer, small employers are increasingly providing health benefits through such plans.

ERISA has not kept pace with those changes. The large insurers who provide the networks and manage claims, often referred to as third-party administrators (TPAs), operate under a veil of secrecy. They are not directly regulated by ERISA, and they are not regulated by the states, leaving a regulatory vacuum. To the extent the states attempt to regulate them, ERISA preemption stands in the way.

Because of these regulations and enforcement gaps, employers who attempt to control costs and prudently manage their health care plans are met with a stone wall. Employers and plan fiduciaries cannot obtain their own claims data showing how the benefits they provide their employees are priced, whether the fees charged are reasonable and whether the service provider is operating under a conflict of interest, despite a provision in the Consolidated Appropriations Act ("CAA") aimed at preventing this kind of stonewalling through so-called "gag clauses." And despite the CAA's extensive fee disclosure requirements for health plans, TPAs and pharmacy benefit managers (PBMs) refuse to comply, leading to a lack of transparency and making it virtually impossible for employers and plan fiduciaries to monitor the fees of the largest service providers to the plans.

While Congressional intent in passing both the gag clause prohibition and fee disclosure provisions of the CAA is admirable, the enforcement mechanism—terminating contracts—is not practical when alternative service providers either do

[2] https://www.kff.org/report-section/ehbs-2023-section-10-plan-funding/#:~:text=plan%20in%202023.-,SELF%2DFUNDED%20PLANS,61%25)%20%5BFigure%2010.2%5D.

not exist in the plan's geographic area or the alternative service providers engage in the same practices. As these are industrywide practices, there is no negotiation possible and there are no workarounds for employers, and certainly none for employees and their families.

This lack of accountability has allowed unregulated middlemen to obtain compensation arrangements that have significantly inflated the cost of care and defeats express congressional intent that the money in plans should primarily be used to pay for benefits. And when TPAs and other service providers avoid accountability, both employers and workers suffer.

A recent New York Times article describes a common practice of TPAs that illustrates the impact on both participants and employers. The article describes the situation where out-of-network claims are repriced by insurers who take a portion of the "savings" as a fee.[3] As the article outlines, insurance companies are using the algorithms of external firms to lower their own reimbursement obligations by repricing claims and then charging a portion of the difference between the billed and repriced amount as a fee to the plans. A major problem with this billing model is that providers have not agreed to accept these amounts as their full payment. Thus, the figures TPAs are calling "savings" are then often billed directly to patients. In one reported case, a plan participant was left with $100,000 in medical debt to her doctor for the difference between the billed and repriced amount, which was passed on to her. Through these practices, the plan and sponsoring employer also suffer because they pay a significant and undisclosed percentage-based fee for processing the claims. One employer was charged $50,650 by the TPA for processing a single hospital bill. The higher the billed amount, the higher the fees to the third-party administrators. By tying their own fees to bills they deem unreasonable, TPAs are perversely incentivized to raise costs. And they do all this, while arguing to employers their practices are combatting egregious overbilling by health care providers.

In making needed reforms, Congress must not lose sight of the fundamental purpose of ERISA which is to protect the interests of plan participants and beneficiaries. Employees receive health and other benefits in lieu of receiving additional wages. Congress gives employers tax incentives to provide health care benefits because a healthy workforce is in the public interest. Workers choose jobs, in large part, because of the health care benefits provided by employers. Workers indirectly pay for their health insurance through wage concessions and directly pay for health care

[3] https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html.

through out-of-pocket expenses, including premium payments, co-payments, and deductibles.

The cost to workers continues to escalate. According to a recent survey by the Kaiser Family Foundation, the average annual premium for employer-sponsored health insurance in 2023 was $23,968 for family coverage—an increase of 7% over the previous year and an increase of 22% over the last five years. On average, workers pay 29% of the premium for family coverage, and 38% for family coverage in small plans. And premiums are only one aspect of the out-of-control health care costs. Workers also contribute directly to the cost of their health care through deductibles, co-payments and other forms of out-of-pocket expenses.[4] All of these costs are increasing.

While the cost of employer-sponsored health care for workers have risen dramatically in the past years, workers and their families have not received the health care benefits they deserve. The rising cost of health care under ERISA plans has a negative impact on workers' physical and financial health. A 2019 survey found that 33% of people with employer-sponsored insurance put off or postpone needed care due to costs and 18% did not fill prescriptions, rationed doses, or skipped doses of medicine.[5] Moreover, significant numbers of employees with employer sponsored health insurance carry substantial amounts of medical debt.[6]

Reigning in the middlemen will help control these costs, but Congress must also make employers accountable by clarifying the definition of plan assets and making ERISA's fiduciary duties applicable to all that manage money contributed by employees to the cost of health care. ERISA was passed to protect the interests of workers "by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts." 29 U.S.C. § 1001(b). Participants, however, have not had easy access to the courts and while some strides have been made in providing participants with meaningful remedies, courts are beginning to

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[4] https://www.kff.org/report-section/ehbs-2023-summary-of-findings/#:~:text=HEALTH%20INSURANCE%20PREMIUMS%20AND%20WORKER,and%20%2423%2C968%20for%20family%20coverage.

[5] https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers.

[6] https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey.

cut back on the availability of those remedies. The fundamental purpose of ERISA will not be served if cost savings are achieved by denying participants the very care that has been promised.

A case in point is *Rose v. PSA Airlines*, 80 F.4th 488 (4th Cir. 2023) where doctors for a 27-year-old flight attendant named Kyree attempted to obtain prior authorization from a self-funded plan for an immediate heart transplant necessary to save Kyree's life. Pre-approval was denied because Kyree did not meet certain alcohol-abuse criteria allegedly required by the plan. Kyree's doctors sought an expedited external claim review required by law to be completed within seventy-two hours. The external reviewer, however, treated the request as a standard review to be completed within 45 days despite the urgency of the request. Kyree died a little over a week after submitting the external review application—five days after a decision should have been rendered. Eventually, the external reviewer overturned the previous claims denials, finding that the plan document did not contain the alcohol abuse exception, but by that time Kyree had been dead for almost a month. The administrator of Kyree's estate sued seeking equitable relief for disgorgement of the amount the defendants saved by mismanaging Kyree's claim under ERISA's equitable relief provision, but the district court and the Fourth Circuit determined that ERISA did not provide for such relief, despite two previous Fourth Circuit decisions holding that such relief was available. Thus, those who administered the plan escaped any liability for using false criteria to deny the claim and for negligently failing to expedite review of the claim.

While Congress should make necessary statutory reforms, it should be cautious in making any change to broaden preemption. After struggling with preemption questions for almost 50 years, the courts have established guiding principles that, in general, properly balance employers' desire to have a uniform benefit structure and administration with the states' interest in exercising authority in areas of traditional state regulation. One such important principle is that state and local laws (including regulations) that merely increase costs or alter financial incentives for ERISA plans, but do not require plans to adopt any particular scheme of substantive coverage, are not preempted. This allows states to exercise their traditional authority over consumer and patient protection through regulation of service providers and their business practices designed to protect the interests of participants and beneficiaries under ERISA plans in the same manner as other health care consumers.

II. Suggested Changes to Strengthen ERISA's Fiduciary Standards

ERISA requires plan fiduciaries to discharge their duties prudently, "solely in the interests of participants and beneficiaries" and "for the exclusive purpose of (i)

providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104. ERISA Section 406 (a)(1)(C) and (D) prohibit "the provision of services, goods, or facilities between a plan and a party in interest" and "the transfer to, or use by or for the benefit of a party in interest, of any assets of the plan." 29 U.S.C. § 1106(a)(1)(C) and (D). A party in interest is defined in ERISA Section 3(14) to include a fiduciary and a "a person providing services to the plan" and affiliates of these entities. 29 U.S.C. § 1002(14). ERISA Section 408(b)(2) exempts contracting with a service provider from these prohibited transaction rules if the arrangement is "necessary for the establishment or operation of the plan" and the compensation is "reasonable." 29 U.S.C. § 1108(b)(2). The CAA requires certain service providers to health care plans to disclose a description of services provided, all direct and indirect compensation, the way the compensation will be received, and whether the service provider expects to be a plan fiduciary.

These basic fiduciary duty provisions of ERISA should not be changed. Instead, Congress should clarify the circumstances under which these duties apply by defining the term "plan assets" in a health plan and clarifying the circumstances under which service providers become fiduciaries to an ERISA health plan.

A. Congress should define what constitutes plan assets and who is a fiduciary in the health plan context.

ERISA Section 3(21), 29 U.S.C.§ 1002(21), broadly defines the term "fiduciary" to include, among others, persons with any discretionary authority or discretionary control respecting management of a plan, persons who exercise any authority or control respecting management or disposition of its assets, or persons who have any discretionary authority or discretionary responsibility in the administration of such plan.

There are see two major problems that arise in construing the term "fiduciary" in the context of group health plans. First, whether assets used to pay health benefits are plan assets is unclear from the statute, Department of Labor (DOL) guidance and ERISA case law. Second, courts have construed this definition in the context of group health plans to exclude most insurance companies, third party administrators and pharmacy benefit managers when they administer benefits under contracts with group health plans. This narrow construction has allowed the persons and entities that are primarily responsible for managing and administering health plans, including by designing and administering health care provider networks and plan drug formularies and deciding benefit claims, to operate outside of ERISA's protective regulatory scheme.

1. Define what constitutes plan assets in a Health Plan

Because ERISA does not define the term "plan assets," it is sometimes difficult to determine whether money used to pay health benefits is a plan asset and, consequently, whether a person is a fiduciary because it exercises any authority or control over plan assets. Unless defined by regulation, what constitutes plan assets is generally determined using ordinary notions of property rights under non-ERISA law. Generally, courts have concluded that assets of a health plan include any property, tangible or intangible, in which a plan has a beneficial ownership interest. *See, e.g.*, Secretary *of Labor v. Doyle*, 675 F.3d 187, 203 (3d Cir. 2012), citing DOL Advisory Op. No. 93-14A. Assets that are held in trust to pay plan benefits (for example, through a Voluntary Employee Benefit Association (VEBA) or Taft-Hartley Trust) are clearly plan assets, and those who exercise discretionary authority or control over the assets are fiduciaries. Employee contributions are, by regulation, considered to be plan assets either at the time they would otherwise be paid to the employee or within 90 days. 29 C.F.R. § 2510.3-102(a)(1). Employee contributions are plan assets even when they are not segregated from employer assets. DOL Adv. Op. 92-24A.

Although DOL has given guidance as to when employer assets used to pay for health benefits (whether segregated from employer accounts or not) are plan assets, there is general lack of clarity on this issue. DOL has advised the following: (1) assets held in a revocable trust under which the employer maintains control are not plan assets (DOL Adv. Op. 93-114A); (2) assets held in an account in the name of an employer "to be used exclusively in administering the plan would not create a beneficial interest in the plan" unless there were "other actions or representations which would manifest an intent to contribute assets to a welfare plan" (DOL Adv. Op. 92-24A); (3) segregated funds held in a bank account "in the name of the plan" are plan assets (DOL Adv. Op. 93-31A); (4) employer funds are plan assets when contracts and other legal instruments give the plan a beneficial interest in the funds (DOL Adv. Op. 99-08A), and (5) employer funds can become plan assets if the employer representants to participants that the funds will be used exclusively to pay for plan benefits (DOL Adv. Op. 93-14A).

DOL guidance does not fully address whether there are plan assets when employee contributions are used, together with employer contributions, to pay plan benefits. Most employers require substantial employee contributions to the cost of health plan benefits, and these are plan assets which ordinarily should be held in trust. In DOL Technical Release 92-01, DOL stated that it would not enforce the trust requirements where (1) employee contributions are used for the payment of premiums for certain fully insured plans and (2) where employee contributions are made under a cafeteria

plan and benefits are paid directly out of the general assets of the employer. No guidance has been issued with respect to the trust requirements when employee contributions are used, together with employee contributions, to pay for plan benefits and administration, which is the usual scenario with ERISA covered self-funded plans.

This lack of clarity has the potential to harm the interests of plan participants and beneficiaries because employers often do not believe that they are required to comply with ERISA's fiduciary standards unless the money to pay benefits is held in trust. When a recent lawsuit was filed against Johnson & Johnson concerning the failure to administer its pharmacy benefit program consistent with ERISA's fiduciary standards, employers were advised by many benefit consultants that they could avoid fiduciary liability if they paid benefits out of their general assets rather than using a trust.

It is also unclear whether accounts held by TPAs to pay plan claims in self-funded plans are plan assets, even where the accounts hold money from Taft-Hartley trusts or VEBAs. DOL has stated that these accounts may constitute plan assets if they "suggest to participants that there is an independent source of funds securing payments of their benefits under the plan." DOL Adv. Op. 92-24A. *See also* DOL amicus brief in *Massachusetts Laborers' Health and Welfare Fund v. Blue Cross Blue Shield of Massachusetts*, 66 F. 4th 307 (1st Cir. 2023) (stating that funds remitted to Blue Cross as working capital were plan assets). This is a recurring issue in litigation against TPAs who generally argue that these accounts do not hold plan assets and, therefore, the TPA is not a plan fiduciary.

2. Define when a service provider to a health plan is a fiduciary.

Participants and beneficiaries are also harmed when a TPA or other service providers deny that they are fiduciaries based on an old DOL interpretive bulletin carving out those who perform certain "ministerial functions" from ERISA's otherwise broad functional fiduciary reach. 29 C.F.R. § 2509.75-8. The interpretive bulletin was designed to ensure that lower-level employees assigned administrative tasks with respect to a plan could do their jobs without concern about possible fiduciary liability. The bulletin states that persons who perform "purely ministerial functions" are not fiduciaries to the extent that they have "no power to make any decisions as to plan policy, interpretations, practices or procedures" and perform their functions "within a framework of policies, interpretations, rules, practices and procedures made by other persons." *Id*. When the person performing ministerial functions is subject to another person's rules, the person "is not a fiduciary because such person does not have discretionary authority or discretionary control respecting

management of the plan [and] does not exercise any authority or control respecting management and disposition of assets of the plan." *Id*.

This interpretive bulletin is routinely cited by TPAs and other service providers to avoid fiduciary liability when the plan fiduciaries retain ultimate authority to decide a benefit claim although few, if any, of the claim decisions ever reach that level of review. Instead, the TPA makes the final claims decision in almost all instances. TPAs also routinely rely upon this interpretive bulletin to argue that the TPA is not a fiduciary because the plan adopted the TPA's internal practices and procedures when it signed the administrative service agreement (ASA). Thus, the TPA argues, it has no discretion because it is performing its functions "within a framework of policies, interpretations, rules, practices and procedures" made by the plan itself.

The plan, however, has very little bargaining power when it negotiates an ASA with a TPA, and the terms are often vague as to how the TPA will administer the plan. Some ASAs promise that the TPA will pay benefits at the network negotiated discount, but the plan is not informed what the discount is. ASAs vaguely state that benefits may be paid pursuant to other provisions in provider contracts without revealing what those provisions are. ASAs sometimes state that providers may be paid more than the billed amount but do not explain the circumstances under which that occurs. Any attempt to obtain clarification before the ASA is signed is met with the response that the internal methods of the TPA and its contracts with network providers are proprietary. And when plans attempt to obtain claims data that would reveal how the TPA prices claims, and under what internal TPA procedures, policies, and rules the price is determined, the TPA refuses to give the plan the information on the grounds that the information is proprietary. Thus, the TPA thwarts the plan's attempt to monitor its behavior on the grounds that its internal policies and procedures are proprietary while avoiding liability as a fiduciary by arguing that these policies and procedures have been adopted by the plan as its own and the TPA it is simply performing the ministerial function of following them.

3. <u>Strengthen the ability of health plan fiduciaries to monitor their service providers.</u>

ERISA's fiduciary duties have been applicable to those who administer health plans since ERISA's enactment. Based on our experiences, however, many employers and those advising them were not aware that they had fiduciary duties relating to how their TPAs, PBMs and other vendors were selected or that they have an ongoing duty to monitor those service providers until passage of the the CAA's gag clause prohibition and service provider fee disclosure. Many employers who have fiduciary committees for their pension and retirement plans do not have similar committees

for their health plans and rely on human resources departments to administer their plans with little or no oversight. Some employers believe that their TPAs are ensuring compliance with various ERISA requirements, such as MHPAEA, when in fact they are not.

While some employers state that they need additional guidance on their duties with respect to managing their health plans, the same fiduciary standards that apply to selecting and monitoring pension plan service providers apply equally to health plan fiduciaries, and the substantial body of law relating to pension plans should provide sufficient guidance. Moreover, DOL provided guidance to health plan fiduciaries in its publication "Tips for Selecting and Monitoring Service Providers for Your Employee Benefit Plan." [7]

As DOL notes, "[t]he process of selecting service providers will vary depending on the plan and services to be provided." *Id*. DOL advises that soliciting bids among service providers is not required but it is a way in which the responsible fiduciary can obtain the necessary information relevant to the decision-making process. *Id*. DOL informs health plan fiduciaries to obtain information from more than one provider and give each service provider under consideration, "complete and identical information about the plan and the services you are looking for so that you can make a meaningful comparison." [8] DOL informs health plan fiduciaries that they should compare the firms based on the same information, "such as services offered, experience, cost, etc." and obtain "information about the firm itself, including its financial condition and its experience with group health plans of similar size and complexity. *Id*.

DOL also makes clear that health plan fiduciaries, like pension plan fiduciaries, are required to monitor their service providers. Plan fiduciaries should establish a formal review process and follow it at reasonable intervals to decide whether to continue with the service provider or seek a replacement. DOL states that employers should act to ensure that the service providers are performing the agreed upon services including, among other things, reviewing the service providers performance, checking actual fees charged, asking about policies and practices (such as a TPA's

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[7] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/tips-for-selecting-and-monitoring-service-providers.pdf.

[8] https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf.

claims processing systems, ensuring proper maintenance of plan records and following up on participants' complaints). *Id*.

Many employers and Taft-Hartley plan trustees are well-aware of their fiduciary responsibilities to monitor their service providers but are stonewalled by those service providers. Health plan fiduciaries, however, cannot properly monitor their service providers without unfettered access to the contracts, policies, procedures and claims data of the service providers. Both the CAA's gag clause prohibition and the fee disclosure provisions are problematic because they require plan fiduciaries to terminate contracts with their service providers if their service providers do not provide required disclosures or agree to eliminate gag clauses from contracts. However, in many cases, there are no alternative service provider in the plan's geographic area, or the alternative service provider is no better than the service provider the plan currently has, making it impossible for the plan fiduciary to find a prudent alternative.

Requiring service providers to give plans access to their claims data (with no or limited conditions) would be more effective than prohibiting gag clauses in contracts. ERISA could be amended to require service providers to provide access to claims data and other information necessary for plan fiduciaries to do their jobs, enforced through a meaningful civil money penalty directly imposed by the DOL on service providers that do not fully and promptly comply.

Another approach would be to amend ERISA requirements in section 408 for reasonable arrangements between plans and service providers. A "reasonable arrangement" between a plan and a service provider under Section 408(b)(2) of ERISA could be defined to require that the plan have sufficient access to any claims data in the control of such service provider as well as any software used by such service provider that would be helpful in making such data intelligible and auditable, subject to HIPAAs' protections for personally identifiable health information. The amendment could provide that contracts between a group health plan and a claims payment service provider may not limit the number of claims that the plan may audit. In addition, the amendment could make clear that the plan is entitled to documents of the service provider that are reasonably necessary for the plan to determine compliance with the contract. Service providers could request the plan to enter into a confidentiality agreement to protect proprietary information and could charge the plan for the reasonable costs it incurs in connection with such audits. Plans, however, should not be prevented from hiring outside experts to help in analyzing data provided by the service providers. Similar to the current version of Section 408(b)(2), this approach will not be effective if plan fiduciaries do not have other

available service provider options if their current service provider refuses to give the information.

ERISA could also be amended to provide that information created or used by pharmacy benefit managers and third-party administrators in providing administration or management services for an employee benefit plan are assets of the plan, subject to any restrictions allowed under Section 724(a)(2) of ERISA, 29 U.S.C. § 1185m. Contract provisions purporting to limit or charge the plan for the plan's use of this data could be held void.

Treating claims data as a plan asset, alone, would not solve the problems of meaningful access for several reasons. First, plan fiduciaries can contract away any rights with respect to any plan asset, including claims data. Because of the uneven bargaining power between plan fiduciaries and network service providers, plan fiduciaries will likely be required to bargain away access to the data to enter into network service provider agreements. Plan fiduciaries will only have bargaining power if such agreements are also prohibited or if there are other available networks that allow access (unlikely among the big nationwide network providers) or there are alternatives to the networks. Second, to allow plan fiduciaries to fully understand fees and costs, they would need access to the underlying network contracts which apply to all plans within the network, making it difficult to treat the underlying provider contracts as a particular plan's asset.

Plan fiduciaries must also be given access to provider contracts. Without access to the provider contracts, plan fiduciaries cannot adequately evaluate the claims data to determine whether claims are being paid properly or whether there are hidden fees. Some plan fiduciaries who have been able to obtain access to claims data have found that the amount paid to network providers does not match the provider's published rates (and sometimes far exceeds the network rates) allegedly because of other provisions in the contracts that give the service provider significant discretion in determining how much the provider will be paid and allow the service provider to collect additional fees.

III. Congress should strengthen the rights and remedies of participants and beneficiaries.

Currently DOL oversees and enforces ERISA on behalf of two million group health plans covering 136.5 million individuals, 700,000+ retirement plans holding more than $10 trillion in assets, and the many other benefit plans DOL is charged with regulating (*i.e.*, dental plans, vision plans, wellness plans, short-term disability plans, long-term disability plans, severance plans). For this reason, it is imperative that

Congress strengthen the rights of participants and beneficiaries to protect their own interests in their ERISA-covered employee benefit plans. While the statute was enacted explicitly for this purpose, the following issues have all served to weaken the rights of participants and beneficiaries and have made it more difficult for them to protect their own interests, placing an even greater burden on DOL to enforce ERISA.

A. Discretionary Clauses

Since the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch,*[9] most employee benefit plans grant insurance companies and others deciding benefit claims broad discretion to determine eligibility for benefits and to interpret the terms of the plan, resulting in application of a *de novo* standard of review. This standard severely limits the scope of discovery in a benefit suit and makes it extremely difficult for health plan participants to obtain promised benefits even when the court determines that it would decide the matter differently under a *de novo* standard. This unfairly disadvantages sick, retired, and disabled individuals challenging benefit denials. Congress should consider banning discretionary clauses in ERISA plans.

B. Arbitration Clauses

Plan sponsors increasingly include provisions in their plans requiring participants to arbitrate benefit and fiduciary breach claims instead of suing in federal court as permitted under ERISA. Some prohibit participants from informing other participants of the alleged fiduciary breaches,[10] And other plans prohibit participants from bringing actions against the plan or its fiduciaries as class actions or as representatives of the plan. These restrictions are designed to discourage participants who have small claims from obtaining redress even if the alleged violation is systemic and many other participants have similar claims that could be addressed on a class or representative basis. Congress should ban this practice.

C. Article III Standing

ERISA Section 502(a)(2), 29 U.S.C. § 1132(a)(2), expressly gives plan participants and beneficiaries a cause of action for fiduciary breaches that impact a plan and

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[9] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 1010 (1989).

[10] *See, e.g., California Commerce Club, Inc*., 369 NLRB No. 106 (June 19, 2020) (The National Labor Relations Board (NLRB) held that confidentiality language in an arbitration agreement an employer required its employees to sign as a condition of employment was a lawful action).

provides for appropriate relief to the plan for those breaches under Section 409 of the Act, 29 U.S.C. § 1109.

In *Thole v. U.S. Bank*,[11] the Supreme Court ruled that a plan participant lacked Article III standing to assert fiduciary breach claims involving a defined benefit pension plan where the participant continues to receive vested benefits. *Thole* has been applied to deny Article III standing to health plan participants seeking to correct fiduciary breaches. Even though plan participants contribute to the cost of their own benefits through premium deductions, deductibles and co-payments, courts have held that they do not have Article III standing to challenge fiduciary breaches in the management of their health plans that increase costs unless they have been denied a benefit because of the wrongdoing.[12] Congress should consider amending ERISA to provide a qui tam remedy for a participant bringing these lawsuits in order to meet Article III's standing requirements.

D. Anti-Assignment Provisions

Some plans prohibit participants from assigning their health care claims to their medical providers.[13] The medical provider, however, has the knowledge and resources to pursue claims on behalf of the participant. TPAs generally prefer to deal directly with providers so that they can reprice claims or recover what the TPA unilaterally determines is an overpayment. But where a plan prohibits assignment, the provider does not have standing to dispute a repriced claim or overpayment recovery. When a participant challenges the TPA's practices, however, the TPA argues that the participant does not have Article III standing unless he has been balanced billed by the provider. Congress should outlaw anti-assignment provisions.

E. Attorney's Fees for Participants and Beneficiaries that Prevail in Actions for Benefits

In many disputes over benefits, the participant must retain legal counsel and other experts to analyze the difficult legal, medical and contractual issues that arise during

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[11] 140 S. Ct. 1615 (2020).

[12] *See, e.g., Scott v. UnitedHealth Group, Inc*., 540 F. Supp. 3d 857 (D. Minn. 2021); *Winsor v. Sequoia Benefits & Ins. Services, Inc.,* No. 21-cv-00227-JSC, 2021 WL 5053087 (N.D. Cal. Nov. 2, 2021).

[13] *See, e.g., Davidowitz v. Delta Dental Plan of Calif., Inc*., 946 F.2d 1476, 1481 (9th Cir. 1991).

the plan's internal claims process. Because claimants generally are forbidden from supplementing the plan's claims procedure file with additional pertinent evidence during the lawsuit, it is essential that the administrative record contains complete information necessary to establish the claim. Courts have interpreted ERISA section 502(g), which authorizes a court to award reasonable attorney's fees and cost, to exclude fees for that portion of the attorney's work and fees incurred in the pre-judicial claims process. [14] This makes it more difficult for claimants to retain legal counsel, particularly in cases with relatively small claims, and results in unfair claims denials. In addition, some courts do not allow a prevailing party's expert witness fees incurred in the court action to be included as a cost under Section 502(g).[15]

F. Venue

Section 502(e)(2) of ERISA, 29 U.S.C. § 1132(e)(2), allows ERISA suits to be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found. Some employee benefit plans require that participants agree to bring any such suits in a particular federal district, such as where the plan is administered, and courts have upheld these plan provisions.[16] In effect, this requires participants to bring ERISA claims in courts that may be hundreds or even thousands of miles from where they live or work, making it inconvenient and expensive for the participant and discourages participants from enforcing their rights under ERISA. Congress should outlaw venue provisions in plans.

G. Statute of Limitations for Benefit Claims

ERISA contains a statute of limitations for suits to enforce ERISA's fiduciary requirements but does not contain a statute of limitations for suits to recover benefits or for other relief pursuant Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Courts

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[14] *See, e.g., Cann v. Carpenters' Pension Trust for N. Calif.*, 989 F.2d 313, 317 (9th Cir. 1993); *Anderson v. Procter & Gamble Co.*, 220 F.3d 449 (6th Cir. 2000).

[15] *See, e.g., Agredano v. Mut. of Omaha Companies*, 75 F.3d 541, 542 (9th Cir. 1996) (affirming district court order denying plaintiff's request for expert witness fees, in which it stated that "[t]here is no right to expert witness fees under ERISA"); *Holland v. Valhi, Inc*., 22 F.3d 968, 979–80 (10th Cir.1994) (holding that section 502(g)(1) does not authorize courts to shift expert witness fees except to the extent allowed by 28 U.S.C. §§ 1920 and 1821).

[16] *See, e.g., Smith v. Aegon Cos. Pension Plan,* 769 F.3d 922 (6th Cir. 2014); In re Mathias, 867 F.3d 727 (7th Cir. 2017).

generally apply whatever time limits the plan provides, or in the absence of a plan provision that has been disclosed to the claimant in the final adverse determination, the statutes of limitations applicable to similar claims under state law in the district where the suit is brought.[17] These courts do not always agree about the analogous state law and the statutory periods can vary greatly even with respect to the same kind of state-law claim. In addition, courts disagree about when claims accrue. This harms participants who have meritorious claims but, despite due diligence, file their lawsuit out of time. ERISA should be amended to provide for a uniform statute of limitations for denial of benefits claims that also defines when a claim accrues.

H. Exculpatory Provisions

Plan fiduciaries sometimes agree to contractual provisions in service provider agreements that require the plan to hold harmless or reimburse the TPA or other plan service provider if they have been found liable for illegal conduct. These provisions are essentially contracts of adhesion and result in ERISA plan fiduciaries spending plan assets meant to pay for plan benefits on reimbursing the illegal conduct of their service providers. Those acting on behalf of employee benefit plans often lack the bargaining power or will to restrict these provisions which should be made illegal.

I. Exhaustion of Fiduciary Breach Claims

The majority of courts hold that participants alleging that plan fiduciaries violated ERISA's fiduciary duties may file suit without having to exhaust internal plan procedures such as those that are designed to resolve benefit claims.[18] Some courts, however, including the Seventh and Eleventh Circuits, require plan participants to first exhaust any plan procedures, even when plan fiduciaries alleged to have violated ERISA are the decisionmakers and liable for the fiduciary breach.[19] This

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[17] *See, e.g., Patterson v. Chrysler Grp., LLC*, 845 F.3d 756, 762–63 (6th Cir. 2017); *Castaldi v. River Ave. Contracting Corp.*, No. 14-CV-5435, 2015 WL 3929691, at *8 (S.D.N.Y. June 22, 2015) *Syed v. Hercules Inc*., 214 F.3d 155, 166 (3d Cir. 2000)*; Lang v. Aetna Life Ins. Co*., 196 F.3d 1102, 1104 (10th Cir. 1999).

[18] *See, e.g., Zipf v. AT&T Co.,* 799 F.2d 889 (3d Cir. 1986); *Smith v. Syndor,* 184 F.3d 356 (4th Cir. 1999); *Chailland v. Brown & Root, Inc.,* 45 F.3d 947 (5th Cir. 1995); *Hitchcock v. Cumberland Univ.,* 851 F.3d 552 (6th Cir. 2017); *Horan v. Kaiser Steel Ret. Plan,* 947 F.2d 1412 (9th Cir. 1991); *Held v. Hanover Leasing Corp.,* 912 F.2d 1197 (10th Cir. 1990); *Stephens v. PBGC,* 755 F.3d 959 (D.C. Cir. 2014).

[19] *See, e.g., Lindemann v. Mobil Oil Corp*., 79 F.3d 647 (7th Cir. 1996); *Lanfear v. Home Depot, Inc*., 536 F.3d 1217 (11th Cir. 2008).

sets up an unfair and unnecessary obstacle to court access for workers seeking redress for fiduciary breaches. ERISA should be amended to clarify that participants and beneficiaries are not required to exhaust internal plan procedures before bringing fiduciary breach lawsuits.

J. Disclosure of Documents

ERISA requires plans to disclose certain documents to participants upon request, including "other instruments under which the plan is established or operated." ERISA Section 104(b), 29 U.S.C. § 1024(b). Amending ERISA to clarify that any contract with a covered service provider under which the service provider determines benefits (such as ASAs between TPAs and plans), are required to be produced in response to a request made pursuant to Section 104(b).

K. MHPAEA Applicability to Disability Insurance

Because the MHPAEA applies only to health insurance, discrimination against mental illness persists in group disability insurance. Most group policies limit coverage of disability due to behavioral health conditions to 24 months while these same policies pay benefits for physical conditions until retirement age. People suffering mental health conditions, however, are usually disabled far longer than 24 months. The prohibition of discrimination against mental illness is a matter of recognized public policy, and Congress should make the MHPAEA applicable to disability insurance.

IV. Hypothetical Explaining Need for Technical Changes

The technical aspects of ERISA can seem abstract, but they have very real impacts on workers and their families who are denied benefits and face daunting barriers to asserting their rights. The following hypothetical scenario illustrates how these technical issues, described above, impact an ERISA plan participant seeking benefits and relief for fiduciary breaches:

Gary is employed as a sale's clerk for a large national retail company based in California in one of its rural Georgia stores. He receives his health care through his employer's self-funded plan administered by Big Name Insurance (BNI). His plan is a prototype plan purchased by his employer from BNI.

Gary suffers serious injuries in a car accident, is prescribed opioids to help him deal with the pain and becomes addicted. Gary seeks treatment but discovers that BNI has very few in-network providers who treat substance use disorders, that those who

are in-network receive low quality ratings and that the closest in-network provider is 100 miles away.

Gary decides to go to a nearby provider that is out-of-network, but BNI rejects his pre-authorization request. Because his plan has an anti-assignment provision, his chosen provider cannot appeal the claim denial for him.[20] His chosen provider is unwilling to provide treatment without pre-authorization because Gary cannot pay the out-of-pocket cost.

Gary goes to the only lawyer in town who is familiar with ERISA. She tells Gary that he must exhaust his internal plan remedies before filing suit, but she cannot assist him because courts do not award fees for pre-filing work.[21]

Gary appeals his benefit denial as described in his summary plan description, putting in some evidence that the requested treatment is consistent with generally accepted standards of care (GASC) and thus medically necessary.

After several months, BNI denies his last appeal, stating that, under its interpretation of the plan document, it is not required to provide treatment consistent with GASC.

Gary does not see anything in his summary plan description that informs him when he must file suit. At this point Gary's substance use disorder is out of control and he does not go back to his lawyer until 13 months after he gets his final denial. She tells him that it is probably too late to file a lawsuit challenging the benefit denial because the most analogous state statute (which governs ERISA benefit claims) requires him to file within one year.[22]

Gary's lawyer decides to take the case, despite the statute of limitations problem, and files in the nearby Georgia federal district court because ERISA allows Gary to bring suit where he resides. BNI immediately seeks to move the case to California, citing the plan's venue provision requiring participants to bring suit in California where the plan is administered. The court agrees with BNI that the plan provision governs because it is not inconsistent with ERISA's venue provisions which also

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[20] *See, e.g., American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018) (collecting cases).
[21] *See, e.g., Cann v. Carpenters' Pension Trust for N. Calif.*, 989 F.2d 313 (9th Cir. 1993); *Anderson v. Proctor & Gamble Co.*, 220 F.3d 449 (6th Cir. 2000).
[22] *See, e.g., Adamson v. Armco, Inc.*, 44 F.3d 650, 652 (8th Cir. 1995).

provides that suit may be brought where the plan is administered.[23] Gary's lawyer tells him that she is not licensed to practice law in California and will not be able to represent him.

Despite living on the other side of the country, Gary finds a lawyer in California who will represent him. Gary's California attorney is disturbed that Gary did not include some available evidence in the administrative record and seeks to supplement the record with additional evidence. The court denies his request to supplement the record because, with very few exceptions, ERISA benefit cases are decided solely on the administrative record. [24]

The court never reaches the statute of limitations defense but rules in favor of BNI on the merits. The court concludes that Gary has the better argument, but notes that because Gary's plan document gives discretion to BNI to interpret the plan, he must uphold the benefit denial on the grounds that BNI's interpretation that the plan does not require treatment consistent with GASC was not unreasonable.

Gary has by this time lost his job and moved in with his parents who live near an in-network provider from whom he is receiving treatment. Gary decides to bring a class action on behalf of all participants in plans administered by BNI challenging BNI's pre-authorization requirements as inconsistent with MHPAEA.

The court grants BNI's motion to dismiss holding that Gary does not have Article III standing to bring the claim because he is now receiving treatment from an in-network provider and cannot show that he has an injury that can be redressed by the lawsuit. [25]

Gary becomes very depressed about the judicial system and relapses. His parents get a second mortgage on their house to pay out-of-pocket for a qualified out-of-network provider which BNI now agrees to cover. Because the provider is out-of-network and Gary's claim cannot be assigned to the provider, BNI pays Gary directly for the

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[23] *See, e.g., Smith v. Aegon Cos. Pension Plan*, 769 F. 3d 922 (6th Cir. 2014); *In re Mattias*, 867 F.3d 727 (7th Cir. 2017).

[24] *See, e.g., Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1989) (collecting cases).

[25] *See, e.g., Ryan S. v. UnitedHealth Group, Inc*., 2022 WL 883743 (9th Cir. Mar. 24, 2022).

cost of treatment rather than the provider. Gary uses the money to buy opioids, overdoses and dies.[26]

V. Conclusion

Thank you for inviting me to testify today and allowing me to bring these important issues to your attention. I would be happy to answer any questions you have about my testimony and to work with you and your staff on addressing these serious challenges for plan sponsors, plan fiduciaries, and most importantly, plan participants and their families.

[26] https://www.cnn.com/2019/03/01/health/anthem-insurance-payments-patients-eprise/index.html.