Subcommittee on Health, Employment, Labor and Pensions Hearing
"ERISA's 50th Anniversary: the Path to Higher Quality, Lower Cost Health Care"
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10:15 a.m. EDT

Supplemental Testimony of Karen Handorf
In response to questions from
Representative Mark DeSaulnier (D. CA)

1. A recent New York Times investigation described the compensation practices of a data analytics firm called MultiPlan, which works with third-party administrators of employer-sponsored health plans to identify so-called "savings" in the form of low reimbursements for out-of-network care. The investigation found that MultiPlan and the third-party administrators were allowed to charge employers excessive fees and leave plan participants with exorbitant out-of-pocket expenses. What barriers do plan fiduciaries face in accessing the data described in the CAA?

Plan fiduciaries face substantial barriers when seeking access to the data described in the CAA that would reveal information concerning the amount paid to providers and hidden and excessive fees. Plan fiduciaries have very little bargaining power when they negotiate an administrative service agreement ("ASA") with a third-party administrator ("TPA"). In many cases, there is no alternative TPA in the plan's geographic area, or the alternative TPA engages in the same types of behaviors as the plan's current TPA, making the change to a different TPA not worth the disruption and expense.

The ASA is usually vague as to how the TPA will administer claims. Some ASAs provide that claims will be paid at the discount that the TPA has negotiated with the medical providers in its network, but the plan is not informed what the discount is. ASAs often vaguely state that the TPA will pay benefits under the plan pursuant to other provisions in medical provider contracts without revealing what those provisions are or to whom they apply. ASAs sometimes state that in some cases providers may be paid more than the billed amount but do not explain the circumstances under which that occurs. Requests for clarification of those terms before the ASA is signed are often met with the response that the internal methods of the TPA and its contracts with network medical providers are proprietary.

Similarly, it is very difficult for plan fiduciaries to nail down whether TPAs consider certain provisions in ASAs to be gag clauses. Rather than identifying gag clause provisions, TPAs may point to general ASA language declaring that any illegal terms are null and void.

Moreover, when plan fiduciaries seek data, TPAs almost always insist on non-disclosure agreements ("NDAs") that limit the plan's ability to use the data. NDAs, for example, prohibit use of the data for (a) benchmarking and comingling claims data from multiple companies; (b) developing or using any type of price transparency tool; (c) creating any type of health care comparison data base; (d) making any cross-carrier comparisons; (e) running any type of RFP or RFI process to shop for TPA services; (f) contracting with business coalitions, accountable care organizations, or centers of excellence; (g) "steering" plan participants between providers of the same service type or category; (h) performing certain analytical procedures on claims data, such as reverse engineering of pricing, margins, etc.; (i) disclosing claims data to any employees who are involved in provider network development or negotiating pricing and terms on behalf of any coalition or collective; and (j) maintaining the plan's own historical claims data or sharing historical claims data with the plan's new TPA or consultants. It is not uncommon for TPAs to restrict review of the claims data to its own chosen vendors and to prohibit plans from retaining a claim reviewer on a contingency fee basis.[1]

[1] A sample NDA reads as follows: "Company expressly agrees to refrain from disclosing, utilizing or aggregating account specific claims data for the purpose of providing Consumer Engagement Services. For purposes of this Agreement, the term 'Consumer Engagement Services' includes, but is not limited to, services to be provided by Company or their vendors for which the Company provides information pertaining to: (a) health advocacy, which includes but is not limited to, using Company's specific claims data to provide members with information to make health care decisions through concierge services; and/or (bi) network advocacy, which includes but is not limited to, using Company's specific claims data to lower cost to Company for services by negotiating deeper discounts; and/or (c) transparency of health care services and costs, which includes but is not limited to, quality of care, member experience, or claims cost estimates for future health care services based in part or in whole on Company's specific claims data which are aggregated with that of: i) multiple employer groups; ii) other plans issued by same Carrier; and iii) other payors, providers, or service vendors."

Some large plan fiduciaries are able to obtain claims data with the assistance of legal counsel or others, but usually the plan fiduciaries' only recourse is to sue the TPA in court for the data. There the TPA often argues that the CAA does not require it to produce the data; it only prohibits plan fiduciaries from entering contracts that contain gag clauses.

Even if plan fiduciaries obtain claims data, they often find it difficult to analyze the data without access to the contracts between the TPA and the network medical providers. As noted above, the ASAs are generally vaguely worded to give the TPA maximum flexibility in negotiating reimbursement arrangements with network providers, resulting in contract terms that allow fee-for-service payments at a discounted rate, value-based payments, and diagnosis related group ("DRG") payments, and give the TPA permission to pay more than the billed amount without explaining the circumstances. In addition, the TPA may have revenue neutrality agreements with providers guaranteeing them a certain amount per year, which may cause the TPA to pay more for some plan claims than the agreed upon rate to make up a shortfall.

Without full access to the claims data, it is even more difficult for plan fiduciaries to monitor claims payments to out-of-network medical providers. Many ASAs do not define how the price paid to out-of-network providers will be determined or the ASA gives the TPA broad discretion to choose among different payment options. Similar vague language is in plan documents. This ambiguity gives TPAs broad discretion to pay out-of-network providers any dollar amount without limit, as the New York Times article described. This discretion, together with savings programs and cross-plan offsetting (see below), allows a TPA to collect unreasonable fees and to transfer plan assets of self-funded (*i.e.*, non-insured) plans to itself.

a) How widespread are arrangements such as the one described by the New York Times? Are there similar examples that have not reached the public's eye yet?

<u>Prevalence of "savings" fee arrangements</u>

The arrangement described by the New York Times article involves the use of MultiPlan and Data iSight (referred to as "repricers") by the major insurers, acting as TPAs for self-funded health care plans, to price out-of-network claims at low rates and take a percentage of the difference between the billed rate and the sum actually paid as a "savings" fee. As the article accurately reports, this program incentivizes

low payments to out-of-network providers to maximize the savings fee and often results in the plan participant being financially obligated to pay the balance of the bill.

Because the "savings" fee is often disguised as part of the benefit payment and not reported separately to the plan, it is difficult to determine how widespread these arrangements are, although they have been the subject of recent lawsuits.[2] As the article states, MultiPlan and Data iSight are used by the largest TPAs: UnitedHealth, Cigna, Aetna, Kaiser Permanente, Humana and some of the Blues. A recently filed lawsuit filed by W.W. Grainger against Aetna claims that Aetna uses Zelis Healthcare Corp. and Global Claims Services in addition to MulitPlan to reprice claims. According to the W.W Grainger complaint, Aetna takes money from a self-funded plan to pay a claim and then sends the claim to repricers to negotiate it down. According to the complaint, "The repricing companies have one job: to delay payment until the provider's biller relents and agrees to accept an amount well below the billed amount and well below what Aetna wrongfully obtained from the Plans. If one repricing company is not making headway with a provider, then Aetna shifted the claim to another repricing company, and then another, and then another." [3]

Cross-Plan offsetting practices

The larger TPAs also engage in a practice called cross-plan offsetting. With cross-plan offsetting a TPA recovers an overpayment to a health care provider under one health plan that it administers by underpaying or "offsetting" an amount owed to the same provider under a different health plan it administers.[4] Often the TPA takes money from self-funded plans to reimburse itself for overpayments it made to the provider in its insured plans, thus putting self-funded plan assets in its corporate

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[2] *See Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan*, No. 1:22-cv-603 (W.D. Mich.) (dismissed Feb. 27, 2023) (appeal pending); *Popovchak v. UnitedHealth Group, Inc.*, No. 22-CV-10756, 2023 WL 612550 (S.D.N.Y. Sept. 19, 2023).

[3] *W.W. Grainger, Inc. et al. v. Aetna Life Ins. Co*., No. 2:24-cv-00352 (E.D. Tex., filed May 10, 2024).

[4] *See W.W. Grainger, id.; Tiara Yachts, supra*; *Smith v. UnitedHealth Group, Inc*., No. 0:2022 cv 01658, dismissed for lack of Article III standing, 2023 WL 3855425 (D. Minn. May 4, 2023) (appeal pending).

accounts with no third party involved.[5] Along the way, the TPA may collect "savings" fees from self-funded plans for collecting the overpayments it made in the first place.

The plans are not consulted when a cross-plan offset is taken. The participant whose claim is subject to a cross-plan offset is not informed that part of the participant's benefit payment (if not all) has been used to reimburse a different plan for mistakes the TPA made in allegedly overpaying the provider. And when the medical provider bills the participant for the balance of its fee, the participant may have no benefit claim to pursue because, as described above, the plan often contains no specific reimbursement rate for out-of-network providers. Even if the provider does not balance bill the participant, the provider has provided medical services to the participant for which he has not been fully compensated which, in turn, may upset the doctor-patient relationship and inhibit the participant from seeking further medical care.

The provider, who is prevented from pursing the claim because of plan provisions which prohibit the participant from assigning a claim to the provider, has no opportunity to contest the alleged claim of overpayment. As one court stated, in effectuating cross-plan offsets, the TPA acts as "judge, jury and executioner."[6] Thus, the TPA's use of cross-plan offsetting becomes almost immune from challenge.[7]

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[5] A typical cross-plan offsetting scenario is as follows. A participant in a self-funded health plan received health care services from an out-of-network provider who, in turn, submitted a claim to United on her behalf for $34,000. United decided the "allowed amount" was only $14,040 and, after applying the participant's deductible and co-insurance, represented to her that a total of $8,015 in benefits were due which it had paid directly to her provider on her behalf. United, however, never paid this amount to her provider but instead informed him that it had previously overpaid him for services provided to a different patient in another employer's insured plan. To collect the overpayment made by the insured plan, United used the money from the participant's plan and transferred it to its own corporate accounts.

[6] *Peterson v. UnitedHealth Grp*., 242 F. Supp. 3d 834, 838 (D. Minn. 2017).

[7] When the participant is not balance billed, the TPA claims that she has no Article III standing because she has not suffered an injury. *See Smith v. UnitedHealth Group, Inc.*, No. 0:2022 cv 01658,2023 WL 3855425 (D. Minn. May 4, 2023) (appeal pending).

DOL has stated that cross-plan offsetting violates ERISA's rule under 29 U.S.C. § 1104(a) that a plan fiduciary shall discharge its duties with respect to a plan solely in the interest of the participants and beneficiaries. DOL also asserts that a fiduciary engaging in cross-plan offsetting is acting on both sides of a transaction in violation of 29 U.S.C. § 1106(b)(2) and, where the offset amount benefits the TPA's insured plans, is dealing with plan assets in its own interest or for its own account in violation of 29 U.S.C. § 1106(b)(1).[8] DOL recently settled a lawsuit against EmblemHealth requiring it to cease the practice.[9] At least one court has held the practice to be illegal,[10] and another has held that the practice, if not illegal, is in serious tension with ERISA and questionable.[11] The practice, however, continues with substantial numbers of recoveries through offsets likely used to reimburse TPAs for alleged over-payments made in insured plans.

Hidden fees and other alleged self-dealing practices

A review of complaints filed in courts over the past several years reveals other alleged TPA practices that result in higher costs to self-funded plans which lead to higher premiums and deductibles even if they do not result in balance billing the participants:

- TPAs taking money from self-funded plans in an amount close to the provider-billed amount or the amount owed pursuant to an in-network agreement and then reprocessing the claim to a lower amount and keeping the difference.[12]

- TPAs employing "exclusion lists" to induce medical providers to join their network by promising that they will provide no scrutiny or limited scrutiny to their claims without informing plans of such exclusion lists.[13]

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[8] *See* DOL Amicus Brief in Support of Plaintiffs*, Peterson v. UnitedHealth Grp*., 2017 WL 3994970 (8th Cir. Sept. 7, 2017).
[9] https://www.dol.gov/newsroom/releases/ebsa/ebsa20231005.
[10] *Lutz Surgical Partners PLLC v. Aetna*, No. 3:15-cv-02595, 2021 WL 2549343 (D.N.J. June 21, 2021).
[11] *Peterson v. UnitedHealth Grp*., 913 F.3d 769, 777 (8th Cir. 2019).
[12] *See W.W. Grainger v. Aetna, supra*.
[13] *See W.W. Grainger v. Aetna, supra*.

- TPAs using subcontractors to provide services and paying the additional fees to them from plan assets without the plans' knowledge and contrary to the contract terms by using "dummy" codes.[14]

- TPAs passing on a provider state tax to plans without disclosing that it was doing so.[15]

Insurers market their "savings" and cross-plan offsetting practices as necessary to contain provider fraud and abuse, but the practices are used to collect fees and money from self-funded plans in addition to the per member/per month fee collected for plan administration. Lawsuits by plans against TPAs have revealed that TPAs may make little effort to detect and prevent fraudulent payments and have paid millions of dollars of plan assets on claims that never should have been paid and were paid automatically, almost immediately, with no human review. When plans independently discover fraud and mistakes, TPAs are often slow to act and may prohibit plans from recovering the mistaken payments to providers.

b) How are existing rules under ERISA and related laws, such as the claim denials and appeals regulations, insufficient to combat this issue?

There are multiple reasons why the existing rules under ERISA are not sufficient to combat these issues.

Barriers to bringing benefit claims.

Plan documents and ASAs are often vague as to the amount that out-of-network providers will be reimbursed or may even give TPAs complete discretion to choose among various methods for reimbursement. While contracts between TPAs and medical providers usually prohibit balance billing, there is nothing prohibiting balance billing when the medical provider is out-of-network. Courts faced with challenges to provider suits against TPAs for the amount promised for medical procedures have held that ERISA protects a person's benefit entitlement but does

[14] *Peters v. Aetna Inc*., 2 F.4th 199 (4th Cir. 2021).
[15] *Su v. BCBSM*, 0:2024 cv 00099 (D. Minn. Feb. 26, 2024).

not govern the rate of payment.[16] Thus, a participant who is balance billed by an out-of-network provider cannot allege that she was denied a benefit under the plan. Taken to an extreme, a plan participant could have a covered claim for which the TPA has paid the provider $10 for a billed amount of $100,000, and the participant would be unable to point to anything in the plan documents to justify a higher payment.

Usually, the plan participant is not involved in the payment or negotiation process. TPAs generally require plans to include anti-assignment provisions in plan documents that prevent participants from assigning their benefit claims to providers who do not otherwise have standing under ERISA to challenge benefit denials. It is the provider, however, who obtains pre-certification and negotiates with the TPA with respect to the amount the provider will be paid, and the TPA will generally pay the participant's benefits directly to the provider. This gives the TPA ample opportunity to collect "savings" fees and to cross-plan offset without detection and makes it difficult, if not impossible, to challenge TPA practices. Thus, the providers, who are not ERISA regulated parties, and the TPAs, who are minimally regulated by ERISA, determine the reimbursement rate for millions of dollars of claims without input from the plans, their fiduciaries, or their participants.

If a plan participant has a coverage claim that does not involve the rate of payment, it is extremely difficult for the participant to successfully appeal a benefit denial or bring litigation to challenge the denial. There are very few ERISA attorneys who handle health care benefit denials in general, and most cannot afford to take a case where the amount recovered will be minimal. Although courts generally limit their review of benefit denials to the administrative record, attorneys generally are not compensated for the pre-filing work necessary to build the record. Often the participant does not seek representation until the internal appeals process is completed. At that point, the record may be inadequate to challenge a denial in court or the participant may have missed statute of limitations requirements in the plan document that makes the litigation untimely. As discussed in my testimony, other procedural barriers also stand in the way of participants successfully challenging benefit denials such as venue and arbitration provisions.

[16] *See, e.g., Jenkins v. Aetna*, No. 23 Civ 9470, 2024 WL 1795488 (S.D.N.Y. Apr. 25, 2024).

The most significant barriers, however, are the discretionary standard of review afforded by the courts to benefit denials and the lack of meaningful remedies when benefits are improperly denied. Under the discretionary standard of review, a court will not overturn the benefit denial if it is reasonable, even if the court would have reached a different conclusion. And, if a court overturns the benefit denial, the worse that will happen for the plan, the TPA or insurer is that the plan will have to pay the benefit because ERISA does not provide for punitive damages or other compensatory ("make whole") relief for the improper denial of benefits.

As my written testimony explained, even when the TPA does not comply with time deadlines and denies claims based on non-existent plan language, there may be no remedy even if the participant dies or suffers significant medical and financial consequences. Only where the participant still needs the medical treatment or was able to pay out of pocket and seeks reimbursement will any remedy be available and then it will be nothing more than what should have been paid to begin with. The financial incentives thus encourage unjustified denials or delays -- working against the interests of participants and beneficiaries whom ERISA is intended to protect and favoring those who disregard their fiduciary obligations by absolving them of any responsibility.

Barriers to bringing fiduciary breach claims.

Substantial barriers also stand in the way of participants suing plan fiduciaries and TPAs for breaches of fiduciary duty and prohibited transactions.

Court interpretations of Article III of the Constitution have created a major barrier to participants seeking to hold plan fiduciaries and TPAs accountable. Participants challenging breaches of fiduciary duties by health plan fiduciaries must establish that they have been injured by the practice being challenged to show standing under Article III. Courts have held that participants challenging plan-wide practices that result in excessive fees, cross-plan offsetting and the mismanagement of health plan assets do not have Article III standing if they have not lost plan benefits because of the challenged activity. They rely on *Thole v. U.S. Bank*, 590 U.S. 538 (2020), where the Supreme Court held that plan participants lacked Article III standing to assert fiduciary breaches for mismanagement of a defined benefit pension plan assets because the participants continued to receive vested benefits. Courts that deny participants Article III standing hold that self-funded health care plans are like

defined benefit pension plans, and the plaintiff has not been injured unless she alleges facts showing that the challenged activity negatively impacted her benefits. These courts note that health plan premium costs are fixed, and the employer sponsor bears the financial risk of any shortfall. It is not enough to allege that the participant, who contributed to plan costs through premium payments, was injured by the mismanagement by being charged premiums or copayments that in actual dollar amounts were higher than they should have been absent the mismanagement.[17]

The courts conclude that it is purely speculation that absent fiduciary mismanagement, the plan sponsor would have reduced co-pays and co-insurance or that plan participants would have received a proportionate distribution of assets.

c) Do you believe that DOL has adequate resources to ensure that there is meaningful oversight of group health plans and their service providers?

No. According to its most recent budget request, the Employee Benefits Security Administration ("EBSA"), which carries out DOL's responsibilities under ERISA, employs less than 850 people and is responsible for protecting more than 153 million workers, retirees and their families who are covered by approximately 765,000 private retirement plans, 2.8 million health plans, and 619,000 other welfare benefit plans that together hold estimated assets of $12.7 trillion.[18] EBSA is estimated to have one investigator for every 16,000 plans.

EBSA's budget has remained flat over the past decade (taking into consideration inflation) other than occasional supplemental funding, but its responsibilities have increased in both the retirement and health plan areas. The CAA amended ERISA in

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[17] *See Gonzales de Fuente v. Preferred Home Care of New York LLC*, 858 F. App'x. 432 (2d Cir. 2021) (finding that participants who alleged misappropriation of employer contributions to the plan which should have been used to provide them a superior plan lacked Article III standing because they had not lost benefits); *Scott v. UnitedHealth Group,* 540 F.Supp.3d 857 (D. Minn. 2021) (holding that participants, who paid substantial premiums toward their healthcare, did not have Article III standing to challenge cross-plan offsetting because they had not lost benefits as a result of the practice); *Knudsen v. Metlife Group, Inc.*, 2023 WL 4580406 (D. N.J. July 18, 2023) (holding that participants did not have Article III standing to challenge cross-plan offsetting based on their payment of excessive out-of-pocket costs because they received their benefits) (appeal pending).

[18] www.dol.gov/sites/dolgov/files/general/budget/2025/CBJ-2025-V2-01.pdf.

significant and permanent ways that gave DOL substantial ongoing enforcement, regulatory, outreach, and reporting responsibilities with respect to the CAA. DOL received supplemental funding to implement these responsibilities but the funding expires at the end of FY 2024. Similarly, DOL received supplemental appropriations for additional investigators and attorneys for Mental Health Parity and Addiction Equity Act ("MHPAEA") enforcement, but that funding also expires at the end of FY 2024. As the most recent report to Congress states, EBSA continues to see significant non-compliance with MHPAEA, and investigations are resource-intensive and time-consuming.[19] Without additional supplemental funding, EBSA will lose substantial expertise in this complicated area of the law. MHPAEA investigations also reveal other health care plan failures, so the loss of personnel will not only impact enforcement of MHPAEA but also enforcement of fiduciary standards related to health plans in general.

While Congressional interest in enforcing MHPAEA is admirable and warranted, enforcement of MHPAEA without enforcement of fiduciary rules with respect to management and administration of health plans in general is misplaced. It is well-established that many American workers cannot afford the high premiums and high deductibles that result from overpriced health care which, in turn, leads to other health problems and medical debt. If workers and their families cannot afford the high premiums or are forced to ration medical care because of high deductibles, it does not matter whether their health plans are compliant with MHPAEA because participants will not be able to access their mental health benefits in the first place.

EBSA also needs additional resources because health plan investigations are complex and document intensive. Data produced by insurers, TPAs and PBMs to comply with price transparency rules is difficult and time-consuming to analyze. The transparency rules have made it evident that different discounts apply within hospital systems depending on whether the plan is insured or self-funded. The disclosed discounts do not tell the entire story because the TPAs and providers have other payment methods that apply other than discounted rates, requiring analysis of the underlying contracts between the providers and the TPA. Following the money in a cross-plan offset alone would take significant time and resources.

Giving DOL significant resources to police TPAs is even more important now because market forces have created an unequal balance of power between plans and TPAs. Plan fiduciaries cannot get plan data or the underlying provider contracts to

[19] https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.

effectively monitor TPAs, and plan participants face significant roadblocks, as described above, preventing them from effectively protecting their interests. EBSA has subpoena power and can more effectively determine how TPAs are exercising their power.

As is evident from the testimony of others at the hearing, employers are looking for additional guidance from DOL with respect to the gag clause prohibition, the Section 408(b)(2) disclosure rules and their general duties to manage their plans prudently and loyally. DOL should also review its position on putting health plan assets in trust and issue guidance concerning the fiduciary status of health plan service providers. These tasks are difficult and time consuming, and DOL should be given adequate resources to provide proper guidance to the regulated public and to protect the interests of participants and beneficiaries.

d) What are some legislative solutions to address this and similar practices by service providers?

I am a member of a group of former Department of Labor employees who worked on enforcement and interpretation of ERISA at DOL ("the group").[20] As I described in my written testimony, I conferred with the group in preparing my written testimony. The group has met over the past several years to develop legislative proposals for enhancing the effectiveness of ERISA, some of which address issues concerning group health plans and their administrative service providers. The group also submitted a response to the Request for Information on ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage. To the extent that proposed legislative solutions have been addressed by the group, I have noted it below. To the extent that proposed legislative solutions have not been fully addressed by the group, the group would be pleased to work with the Committee to develop solutions.

The following legislative proposals would address health plan administrative service provider problems:

[20] Other members of the group are Phyllis Borzi, Elizabeth Hopkins, Daniel Maguire, Marc Machiz and William Taylor. Their biographies are included in footnote 1 of my written testimony.

1. **Amend ERISA's fiduciary definition to make TPAs and PBMs fiduciaries.**

As discussed in my written testimony, TPAs and pharmacy benefit managers ("PBMs") assert that they are not fiduciaries because, among other things, (1) they are performing non-discretionary, ministerial functions within a framework of policies, practices and procedures adopted by plans pursuant to ASAs; and (2) many of their functions are industry-wide practices that are not unique to one plan but are instead performed by the TPA or PBM in its business capacity and not in its fiduciary capacity.

The group believes that this problem could be addressed if Congress amend the definition of a fiduciary, 29 U.S.C. § 1002(21), to add provisions designating PBMs and TPAs (including any insurance issuers providing services under an ASA) as ERISA fiduciaries to the extent they provide certain defined services to group health plans, either directly or through a third party.

With respect to PBMs, the definition of fiduciary could be amended to provide that such service providers are fiduciaries to the extent that they provide any of the following services:

(1) negotiating terms and conditions of prescription drug coverage for payers including rebates and price concessions, without regard to whether these negotiations occur before or after such terms and conditions are applied to coverage under the plan;
(2) managing the prescription drug benefits provided by the health plan, coverage, or payer, including formulary design and management, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, and the adjudication of appeals, regardless of whether any such activities are ratified or adopted by any other fiduciary of the plan; or
(3) causing or approving the expenditure of plan assets or the payment of plan benefits regardless of whether such activities are ratified or adopted by any other fiduciary of the plan.

With respect to TPAs, the definition of fiduciary could be amended to provide that such service providers are fiduciaries to the extent that they provide any of the following services:

(1) selecting the health providers for whose services the participants may receive coverage under the plan; or
(2) managing the processing and payment of claims, the performance of utilization review, the processing of prior authorization requests and the adjudication of appeals, regardless of whether any such activities are ratified or adopted by any other fiduciary of the plan.

To avoid subjecting lower-level employees of such service providers to personal liability, the employer of such employees should be required to indemnify them for any liability they incur merely for acting within the scope of their employment with respect to these fiduciary duties.

2. **Amend ERISA to give plans access to claims data**.

As discussed above, plan fiduciaries face significant barriers when they attempt to access their claims data. Experience shows that the CAA's gag clause prohibition is not having its intended effect. When plan fiduciaries attempt to obtain claims data, they are often required to sign NDAs severely limiting the use of the claims data. Legislation should require service providers to give plans access to their claims data (with no or limited conditions) rather than to prohibit gag clauses in contracts. In addition, plan fiduciaries cannot adequately evaluate the claims data to determine whether claims are being paid properly or whether there are hidden fees without access to the underlying network provider agreements.

Congress could address this problem by amending ERISA to state that data created or used by PBMs and TPAs in providing administration or management services for an employee benefit plan is an asset of the plan, subject to any restrictions allowed under section 724(a)(2) of ERISA, 29 U.S.C. § 1185m. Plan fiduciaries should be prohibited from bargaining away access to the claims data in their network service provider agreements, and contract provisions purporting to limit or charge the plan for the plan's use of this data should be held void.

In addition, a "reasonable arrangement" between a plan and a service provider under section 408(b)(2) of ERISA, 29 U.S.C. § 1108(b)(2), 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 provider agreements relevant to the plan's claims, and any software used by such service provider that would be helpful in making such data intelligible and auditable, subject to HIPAA's protection for personally identifiable health information.

Our group has not fully developed a legislative solution to this problem but would be pleased to work with the Committee to draft appropriate legislative language.

3. **Amend ERISA to require health care plans to specify the basis upon which benefit payments are made from the plan.**

As discussed above, TPAs often dictate the benefit terms of plans to allow them to pay claims at any rate in their discretion. This harms participants because TPAs may pay out-of-network providers minimal amounts to collect large savings fees, as described in the New York Times article, forcing the provider to balance bill the participant to recoup its costs. The participant, however, would likely not succeed in bringing a benefit claim for additional money because the plan does not promise a specific payment rate or process for determining it (such as "usual and customary"). Requiring health plans to state the reimbursement rate would minimize opportunities for TPAs to collect additional fees and for participants to be balance billed.

Our group has not developed a legislative solution to this problem but would be pleased to work with the Committee to draft appropriate legislative language.

4. **Amend ERISA to ban cross-plan offsetting**.

As discussed above, DOL and the courts have held that cross-plan offsetting violates the exclusive purpose and prohibited transaction provisions of ERISA, but TPAs continue to use this wide-spread and often abusive practice. It is generally not disclosed or is misrepresented when plans contract with TPAs, making it difficult for plan fiduciaries to opt out of or monitor the program.

Our group has not developed a legislative solution to this problem but would be pleased to work with the Committee to draft appropriate legislative language.

5. **Amend ERISA to prohibit anti-assignment provisions**.

Many health plans prohibit participants or beneficiaries from assigning their claims for health care benefits to others, including their medical providers. Even though the TPA usually deals directly with the provider during the claim's payment process, and the provider has the knowledge and greater resources to pursue a disputed claim in court, the provider cannot do so because of the anti-assignment provision. By paying the provider directly and dealing with the provider as if he was the participant, the TPA can cross-plan offset and obtain savings fees without the provider having recourse in court. When participants challenge such practices, the

TPA argues that the participant has no Article III standing unless the participant can show balance billing. Thus, the TPA avoids any accountability for its self-dealing unless challenged by the plan or DOL.

The group has studied this problem and believes it could be addressed by amending Section 502(a) of ERISA to add a new paragraph (12) to read as follows:

> by any assignee who has received an assignment from a participant or beneficiary of a group health plan for the purpose of recovering benefits under the plan, regardless of any plan provision that purports to prohibit or limit such assignments.

e) How would improving remedies under ERISA and related laws help workers protect their rights?

In enacting ERISA, Congress intended for plan participants to have fulsome remedies and ready access to the Federal Courts to protect their own interests. Unfortunately, the courts have severely limited the scope of ERISA's remedial provisions. This has allowed TPAs to engage in costly and unfair practices without fear of ever being held accountable. This problem is exacerbated by EBSA's lack of resources to investigate and litigate cases against TPAs and plan fiduciaries inability to obtain claims data to hold TPAs accountable.

In addition to outlawing anti-assignment provisions, the following changes to ERISA would assist workers in protecting their rights:

1. **<u>Amend ERISA to give participants and beneficiaries Article III standing.</u>**

As discussed above, a major barrier to participants protecting their own interests is court interpretations of Article III standing. Court decisions hold that a participant does not have Article III standing unless he has suffered a personal injury because of the challenged practice and do not consider alleged increases in premium payments and deductibles to constitute injury for Article III purposes.

Our group has studied this issue and determined that one possible way of addressing it is to give participants a monetary stake in litigation like the monetary stake of a relator in a *qui tam* action, which the Supreme Court has held to have Article III

standing.[21] It would do so by adding employee benefit plans to the list of persons that can sue for relief under section 409 of the Act, 29 U.S.C. § 1109. The proposed amendment would also amend section 502(d) of ERISA, 29 USC 1132(d) (which now permits plans to sue and be sued in their own name), to expressly provide that plan participants and beneficiaries may bring an action as the plan's assignee under section 502(a)(2) for relief to the plan under section 409, provided that the plan has not already brought an action involving substantially the same allegations or claims in its own name, and they serve the plan with a copy of the complaint. The participants or beneficiaries who sue as the plan's assignee are to receive a partial assignment of the plan's claim: an amount of any recovery is designated for such plaintiffs, at least .5% and no more than 1%. To avoid a multiplicity of actions, plaintiffs filing a claim as assignees of an employee benefit plan are required to seek consolidation of such actions and must seek a transfer of venue where necessary for consolidation.

The proposed changes are as follows:

> (1) Section 502(a)(2) of the Act is amended to add "a plan," before "a participant"
>
> [It will read: "(2) by the Secretary, or by a plan, a participant, beneficiary or fiduciary for appropriate relief under section 409;"]
>
> (2) Section 502(d) is amended by adding at the end a new paragraph (3) to read as follows:
>
> > (3)(i) A participant or beneficiary may file suit as assignee for his or her employee benefit plan pursuant to section 502(a)(2) for appropriate relief pursuant to section 409, provided that the plan has not previously filed a claim involving substantially the same allegations or claims in its own name. The action shall be brought in the name of the plan and the plaintiffs must serve a copy of the complaint on the employee benefit plan that will receive or benefit from any relief that may be obtained.
> >
> > (ii) The participant or beneficiary who has brought such a suit shall receive at least .5% but not to exceed 1% of the proceeds of

[21] *See Vermont Agency of Natural Resources v. United States ex. rel. Stevens*, 529 U.S. 765 (2000)

any action or settlement of the claim in addition to any other relief, including attorney's fees and costs, the court may award to the plaintiff or plaintiffs.

(iii) If there is more than one participant or beneficiary who has filed suit on the same claim, then the court shall distribute the amount equitably so that each plaintiff in such a suit that is not brought as a class action and each named plaintiff in a case that is brought as a class action shall receive some portion of the mandated percentage recovery.

(iv) Any participant or beneficiary filing a claim as assignee for a plan when such claim is already pending in another action shall promptly move for consolidation with such action, moving first for a transfer of venue pursuant to 28 U.S.C. 1404 where such transfer is necessary to facilitate such motion.

2. <u>Amend ERISA to ban discretionary clauses.</u>

The deferential standard of review of benefit claims makes it extremely difficult for plan participants challenging health care or disability denials to have a court overturn a denial even if the court determines that it would decide the matter differently if the deferential standard of review did not apply. Many states have banned these clauses in insurance policies issued in their states, and Congress should ban such clauses in ERISA plans as well.

The group believes that this problem could be addressed by amending ERISA to add a new section 522, to read as follows:

SEC. 522. Prohibition on Discretionary Clauses. (a) In General. No employee benefit plan shall contain any language purporting to confer or reserve discretionary authority on any person in interpreting plan provisions or deciding claims for benefits under the plan.

(b) Voidability. Any provision described in subsection (a), above, shall be void and unenforceable.
(c) For purposes of this section, the term "discretionary authority" shall mean any provision that has the effect of conferring discretion on any person to determine entitlement to

benefits or interpret plan language that could lead to deferential review by any reviewing court.

3. **Amend ERISA to allow participants to recover attorneys' fees for their attorneys' work during the claim procedure**.

As discussed above, participants challenging benefit denials cannot recover attorneys' fees and costs for work pursuing benefits during the internal claim procedures prior to filing suit even though the record on review by the court is limited to the record developed during the internal appeals procedure.

The group believes this issue could be addressed by amending Section 502(g)(1) of ERISA to read as follows:

> In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee, expert witness fees, and costs of the action to either party. In any action under subparagraph (a)(1)(B) of this section, the court in its discretion may also allow the plaintiff a reasonable attorney's fee, and costs (including expert's and consultant's fees) incurred in the course of exhausting the plan's claims procedures prior to filing suit.

4. **Amend ERISA to prevent plans from limiting the right of participants to bring enforcement actions under ERISA in any federal court specified under the current language in the statute**.

Although ERISA currently allows plan participants to bring suit in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, courts have upheld plan provisions requiring participants to bring suits in a particular federal district, often where the plan is administered. This makes it extremely difficult for participants who may be thousands of miles from the designated federal court to obtain counsel and pursue the claim.

The group believes that this can be addressed by amending Section 502(e)(2) of ERISA as follows:

> (e) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is

administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found. No plan provision or other agreement or arrangement shall be enforced to limit the right of a plaintiff to bring or maintain an action in the court of the plaintiff's choosing as permitted by this paragraph.

5. **<u>Amend ERISA to allow participants to sue for fiduciary breaches without exhausting plan procedures.</u>**

Most courts hold that participants are not required to exhaust internal plan procedures before bringing suit for breach of fiduciary duty, correctly noting that the procedures are designed to resolve benefit claims. The Seventh and the Eleventh Circuits, however, require exhaustion of fiduciary breach claims before suing in court, setting up an unnecessary obstacle to participants' court access.

The group believes this issue can be addressed by amending Section 502 of ERISA to add a new subsection (n) entitled "Exhaustion of Plan Procedures," as follows:

> (1) The exhaustion of any internal plan procedure shall not be required before a civil action may be filed under paragraph (2), (3), (10) or (11) of subsection (a), or under subsection (c), of this section.

2. The Department of Labor consults with a body called the Advisory Council on Employee Welfare and Pension Benefit Plans, commonly known as the ERISA Advisory Council. The Council has released a number of reports that have helped inform the Department in issuing guidance and regulations under ERISA. However, the majority of the Council's efforts have focused on pensions, and generally have not examined health care issues as frequently. As you note in your testimony, DOL has jurisdiction over millions of health plans that cover more than 130 million Americans.

a) Are there ways that the Council could be improved to ensure that issues relating to health care are more prominently considered?

If the current composition of the Council is changed, as discussed below, it is more likely that issues relating to health care would be more prominently considered.

b) Do you think the membership of the Council adequately represents the interests of plan participants and beneficiaries? Would you recommend changes to the Council's membership?

The current composition of the Advisory Council does not adequately represent the whole of the employee benefits stakeholder community. The statutory categories for membership on the Council should be expanded to give greater representation to those representing the interests of the plan participants and beneficiaries. In addition, reducing the number seats allocated to service providers and making sure those service provider categories represent both the retirement and health plan constituencies would be useful.

Given the current composition of the Council as described in ERISA, the Council is top-heavy with service providers, particularly those in the retirement plan industry. The Council has run into problems in the past with its ability to focus on health plan topics since few members of the group have expertise in the health and welfare plan area.

The Council consists of 15 members appointed by the Secretary of Labor. Three members are representatives of employee organizations (at least one of whom represents an organization whose members are participants in a multiemployer plan). Three members are representatives of employers (at least one of whom represents employers maintaining or contributing to multiemployer plans). Three members are representatives of the general public. There is one representative each from the fields of insurance, corporate trust, actuarial counseling, investment counseling, investment management, and accounting.

As you can readily see, no seat is earmarked for participants and beneficiaries and in practice, they have been strikingly underrepresented and even in the categories that one might think could be reserved for those representing their interests (such as "General Public"). Often individuals who would be qualified for other categories are slotted in these General Public seats. For instance, the fact that an individual has just retired after a long career as a service provider or benefits professional should not qualify that individual to serve in a Council seat reserved for the General Public because he or she is now a retiree. And there is no specific seat earmarked for "Retirees." Yet there are earmarked seats for insurance, banking (corporate trust), actuarial counseling, accounting and one each for investment counseling and investment management.

A fairer way of allocating seats might be by revising the categories to reflect:

- plan sponsors (3 – including one representing contributing employers in multiemployer plans),
- active employees in collectively bargained plans or their representatives (2 – including one representing participants in a multiemployer plan),
- active employees in non-collectively bargained plans or their representatives (1),
- retirees or their representatives (2),
- gig workers (1).
- service providers (3 – two with no specific delineation of which ones and at least 1 service provider uniquely servicing health plans), and
- the general public (3 – but they must be subject matter experts who do not qualify in any of the other categories).