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ERISA Fiduciary Governance Part 2: Let's Talk Transparency Obligations

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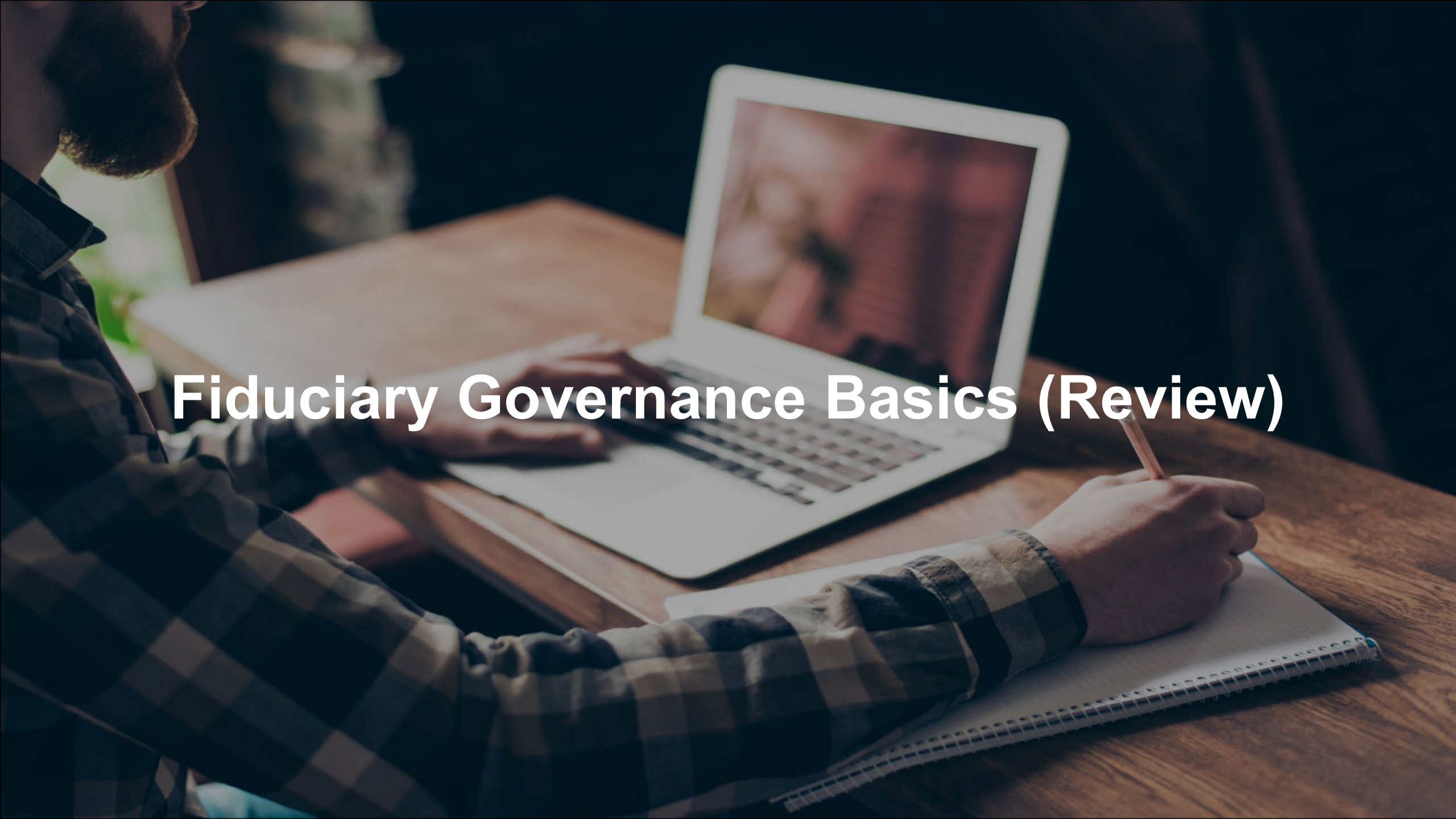
Please note that the following is intended to be used for general guidance purposes only — it is not intended to constitute tax or legal advice. Any question of application of the law should be addressed to legal or tax counsel. The information is current as of May 21, 2025.

Agenda

Let's Talk Transparency Obligations

- Introduction
- ERISA Fiduciary Governance Basics (Quick Review)
- Group Health Plan Transparency Obligations (Overview)
- CAA 2021 Transparency Requirements: 2025 Update
  - Gag clause prohibition
  - MHPAEA NQTL comparative analysis
  - RxDC reporting
  - § 408(b)(2) disclosures
- Fiduciary Breach Litigation
- TiC Rule Requirements: 2025 Update
- Cost Containment Strategies and Tools for Plan Fiduciaries
- Key Takeaways
- NFP Publications and Resources



Fiduciary Governance Basics (Review)

ERISA Fiduciary Governance Basics (Review)

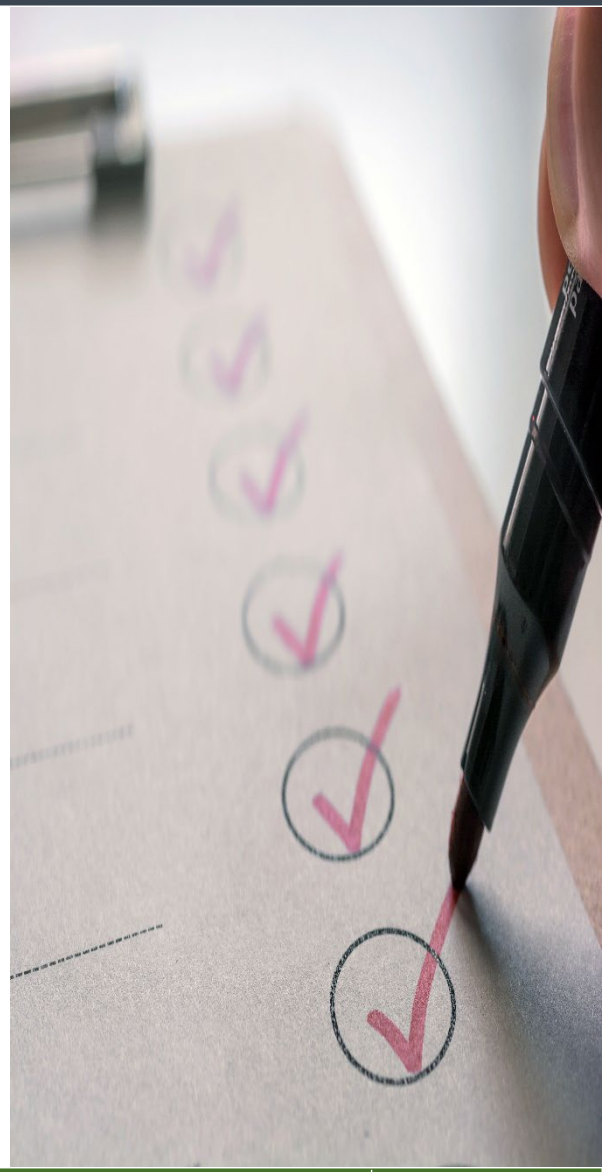
General Steps

- Employers should take a proactive approach to fiduciary governance.
- ERISA's application is not one-size-fits all; each organization's governance structure, policies, and procedures should be tailored to their size, needs, and the complexity of their benefit plans.
- Consulting with experienced ERISA counsel is always advisable for exact direction.

Specific Practical Steps in Establishing a Fiduciary Governance Program:

1. Identify plan fiduciaries.
    - A fiduciary is any party with discretionary authority over the plan or plan assets.
    - Employers should carefully consider who will fulfill plan administrator/named fiduciary role and ensure this appointment is documented.

2. Ensure plan fiduciaries understand the basic ERISA standards for fiduciary conduct.
    - A fiduciary must follow the plan document terms and act solely in the interest of participants (duty of loyalty), and with the care, skill, prudence and diligence of a prudent expert (duty of prudence)
    - Importantly, the duty of prudence focuses on how fiduciary decisions are made and engagement in a prudent decision-making process.



ERISA Fiduciary Governance Basics (Review)

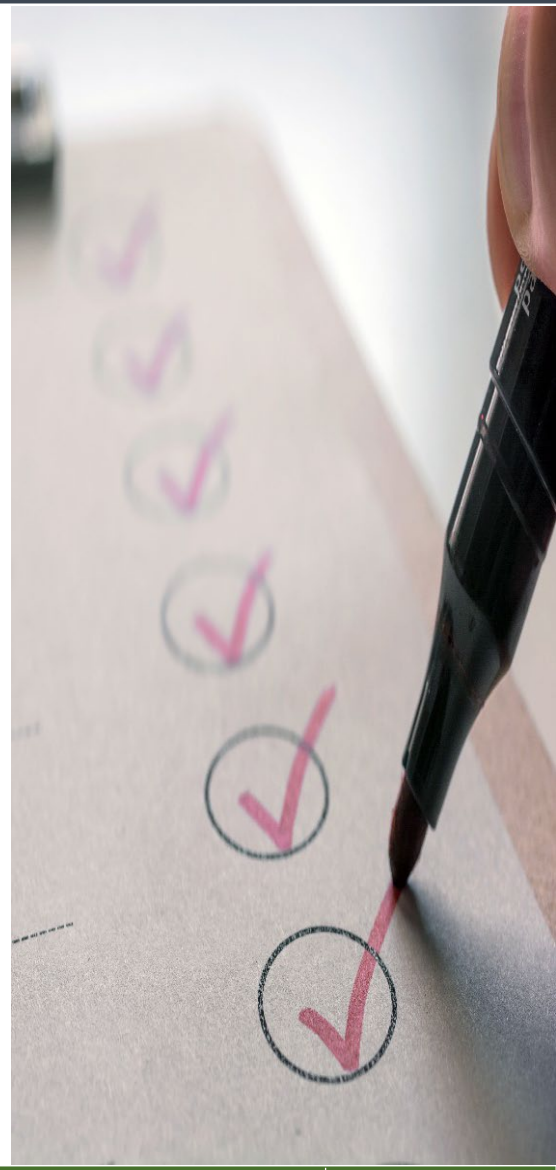
Specific Practical Steps in Establishing a Fiduciary Governance Program:

3. Review the fiduciary governance structure and consider establishing a committee.
   - A committee is not required for any plan but may help employers to facilitate and document a prudent decision-making process.
   - A committee can also help to limit fiduciary liability exposure of employer and board of directors.

4. Adopt prudent processes for making and documenting fiduciary decisions.
   - Fiduciaries should meet regularly to discuss benefit issues, document decisions, engage independent experts as needed and ensure all serving as fiduciaries undergo regular training.

5. Recognize that selecting and monitoring service providers is a fiduciary function.
   - Employers should engage in a prudent documented process (whether via an RFP or otherwise) that considers the service provider's services, total fees/compensation, cybersecurity practices, and proposed contract terms.

6. Consider fiduciary liability insurance and indemnification to protect plan fiduciaries from potential liabilities.



Fully Insured vs. Self-Insured Employers

Fiduciary Duties Apply to Both; Heightened Responsibility & Additional Tasks for Self-Insured

- **Fully Insured Employer**
  - Fiduciary duties shared with carrier
  - Carrier plays a significant role in compliance with fiduciary obligations
  - Primary Concerns:
    - Identifying and training fiduciaries, prudent decision-making process, documentation of decisions, and overseeing/monitoring carrier (and other vendor) performance/cost/quality.

- **Self-Insured Employer**
  - Bears more fiduciary responsibility due to increased involvement in plan decision-making and therefore need to take more steps to develop appropriate governance program.
  - Employer plays primary role in compliance; but needs to work even more closely w/ TPAs and vendors
  - Primary Concerns:
    - Identifying/training fiduciaries, forming a committee, prudent decision-making process, keeping meeting minutes, documentation of decisions, overseeing/monitoring TPA/vendor performance/cost/quality, fiduciary liability insurance.

Group Health Plan Transparency Obligations – Overview

Transparency Laws:

- Hospital Price Transparency Rule
- Transparency in Coverage Rule
- CAA 2021, Title II
- Why were these law enacted?

Address sharply rising healthcare costs and the lack of information available to plans and participants to make informed healthcare choices.

Remove barriers to obtaining network rates, quality of care information and access to mental health benefits.

Promote greater transparency in healthcare pricing and prevent surprise bills.

Create a more competitive healthcare marketplace, narrow price dispersions and put downward pressure on prices.

Group Health Plan Transparency Obligations

Why is transparency important for group health plan sponsors?

The lack of transparency has made it difficult for plan sponsors to obtain accurate information about healthcare costs to make informed decisions about plan benefits.

Under ERISA, the employer as plan administrator has a fiduciary duty to:

- Ensure plan assets are administered prudently and solely in the interest of participants;
- Monitor the performance of plan service providers; and
- Verify that their service providers' compensation is reasonable.

To fulfill these duties, plans need access to healthcare costs, claims data and service provider compensation.

This is particularly for self-insured plans, where the employer assumes greater financial responsibility and a higher level of fiduciary obligations.

Good news is that because of transparency laws, comparison tools are now available that use the publicly disclosed healthcare pricing data to help fiduciaries manage costs and reduce risks!

Group Health Plan Transparency Obligations

Which group health plan transparency laws are we focusing on?

Transparency in Coverage Final Rule (TiC) (enacted in November 2020)

- Applies to non-grandfathered group health plans
- Mandates public posting of machine-readable files (MRFs) with plan INN rates and OON historical amounts (2022) and prescription drug prices (still waiting for implementation date...)
- Requires participant internet-self service tool to compare health care costs (2023-4)

The Consolidated Appropriations Act, 2021 (CAA 2021) (enacted in December 2020)

- **Transparency (Title II) – includes numerous requirements with varying enforcement dates**
  - Prohibits gag clauses in contracts (December 27, 2020)
  - Imposes mental health parity written NQTL comparative analysis requirement (February 10, 2021)
  - Mandates service provider compensation disclosures (December 27, 2021)
  - Requires new prescription drug data collection (RxDC) reporting (December 27, 2022)

CAA 2021 Transparency Requirements: 2025 Update

CAA 2021 Transparency Requirements: Removal of Gag Clauses

Background

- Plan fiduciaries must ensure they do not agree to contract terms with providers, networks or TPAs that restrict:
  - Accessing provider-specific cost and quality of care information and providing the information to participants.
  - Electronically accessing de-identified participant claims data that reflects costs related to claims (consistent with HIPAA, ADA and GINA).
  - Sharing this information with a HIPAA business associate.
- Plans must submit an annual attestation to CMS to certify compliance by December 31 each year.
- Purpose is to ensure plan sponsors have access to cost and claim data to fulfill their fiduciary functions (e.g., by performing a claims audit or analysis).

2025 Update

- FAQs Part 69 issued in January 2025, clarified group health plan obligations and prohibited clauses.
- Explain plan's gag clause prohibition includes "downstream agreements" (e.g., between a TPA and network provider).
  - Sponsor should request written confirmation (e.g., in service contract) that TPA has not entered network contracts with gag clauses.
- Provide examples of prohibited restrictions on a plan's ability to share de-identified claims data with a business associate.
  - E.g., sharing is at TPA's discretion or limited in scope, scale or frequency.
- Instruct plans to report noncompliant contract clauses in "Additional Information" box of attestation.
  - Advisable for sponsor to review with counsel!

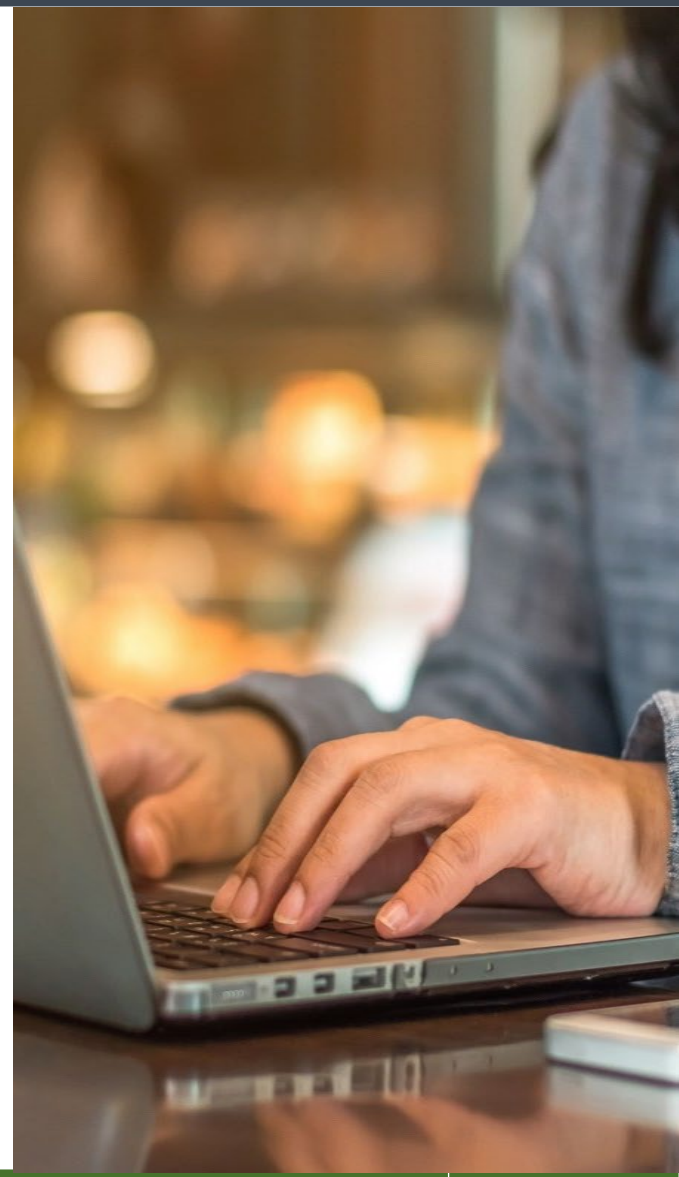
CAA 2021 Transparency Requirements: MHPAEA Comparative Analysis

Background

- CAA 2021 enhanced MHPAEA requirements, with a focus on non-quantitative treatment limitations (NQTLs), such as preauthorization requirements, step therapy protocols, and experimental treatment exclusions.
- Plans must perform and document a written analysis of the design and application of NQTLs imposed on mental health and substance use disorder benefits as compared to NQTLs imposed on medical and surgical benefits (to show parity). Analysis must be provided to regulators or participants upon request.
- In 2024, MHPAEA final rules were issued, requiring, among other items, a certification by a plan fiduciary that they engaged in a prudent process to select a qualified service provider to perform the analysis.

2025 Update

- In January, the ERISA Industry Committee (ERIC), a trade association representing about 100 large employers sued the federal government, claiming the 2024 MHPAEA final regulations exceeded the administration's authority, would increase costs, and risked reducing the quality of care.
- On May 12, a judge granted the Trump administration's request to pause the ERIC lawsuit while the administration reviews the 2024 MHPAEA regulations, potentially rescinding or modifying them. In a statement issued on May 15, the administration said it will not enforce the new rules in the interim.
- However, plan fiduciaries should understand MHPAEA, and the CAA 2021 NQTL comparative analysis requirement remain in effect, even if the new rules and fiduciary certification will not be enforced.



CAA Transparency Requirements: RxDC Reporting

Background

- Group health plans and insurers must submit detailed data about prescription drug and healthcare spending to CMS.
- Reporting is due to CMS **annually by June 1** and must be submitted in specific files through the HIOS data collection portal.
- Plan sponsors typically coordinate and contract with insurers, TPAs, PBMs and other vendors to submit most required data on the plan's behalf but need to provide certain info (e.g., employer/employee premium split).
- Regulators must review and compile collected data (in de-identified format) into a publicly available biannual report on prescription drug reimbursements, pricing trends, and the role of drug costs in contributing to premium rates.

2025 Update

- HHS issued the first (long overdue) report of 2020-1 data to Congress in November 2024. See our article.
- Unfortunately, report covered nationwide prescription drug trends but didn't provide plan-level insight into Rx drug pricing, in part because of how data was aggregated.
- Few conclusions could be drawn due to data limitations, such as the role of Rx price changes on premium rates.
- Departments are considering ways to make data more useful, so stay tuned for possible reporting updates.

CAA Transparency Requirements: Service Provider Compensation Disclosures

Background

Prior to a contract or renewal date, parties providing brokerage or consulting services to group health plans must provide a written disclosure to the plan fiduciary of any compensation (direct or indirect) they will receive for plan services.

- Applies if service provider receives $1,000 or more in compensation.
- Disclosure must state plan services (including, if applicable, fiduciary services) and all expected compensation (transaction-based, an incentive, etc.).
- Notice of changes to fees or services generally required within 60 days.
- No regulations issued yet but DOL FAB 2021-03 provides informal guidance.

Importantly, disclosures are designed to assist plan fiduciary in fulfilling their fiduciary obligation under ERISA §408(b)(2) to determine if the service provider's compensation is reasonable and for necessary plan services and identify potential conflicts of interest.

- Otherwise, transaction is prohibited.
- If disclosure is not received, sponsor has engaged in a prohibited transaction!

CAA Transparency Requirements: Service Provider Compensation Disclosures

2025 Update

On April 15, 2025, the Trump Administration issued an executive order that requires the DOL to propose regulations within 180 days to provide greater clarity for health plan fiduciaries regarding compensation received by PBMs. It's unclear if the regulations will address other types of brokerage and consulting compensation covered by the §408(b)(2) disclosures.

Fiduciary breach lawsuits have also focused on service provider compensation, alleging that sponsors caused the plan to engage in a prohibited transaction by overpaying service providers.

Employers must ensure they have a prudent process in place for ongoing §408(b)(2) compliance.

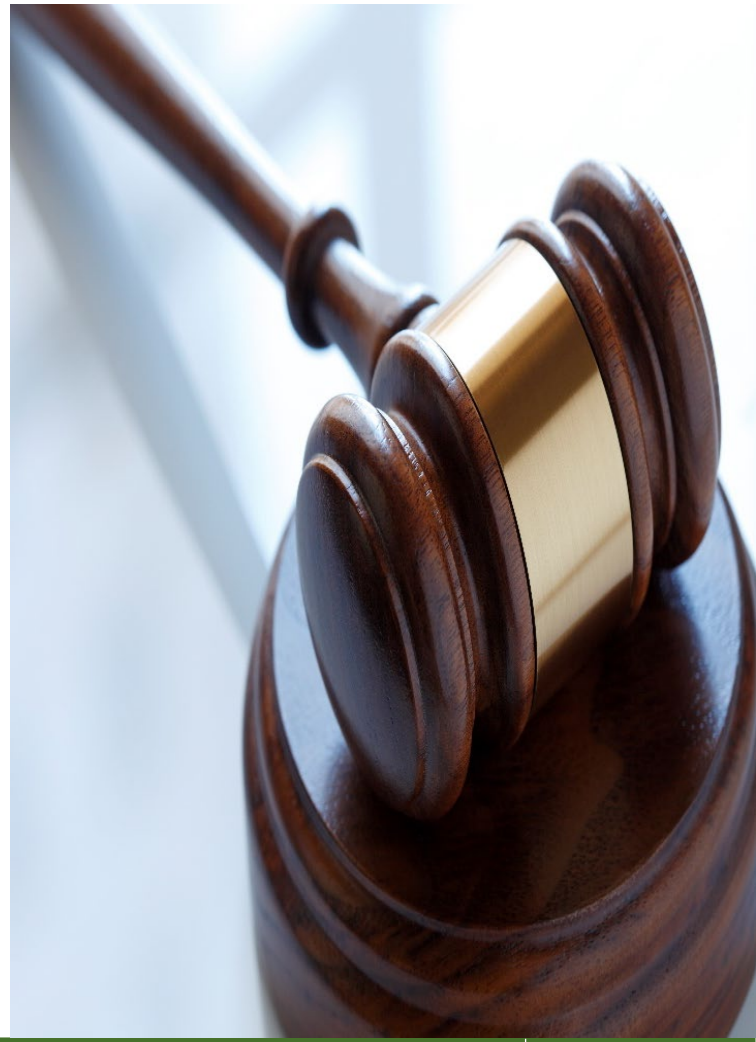
- Review existing service provider contracts to determine the renewal or extension date.
- Request compensation disclosure if not provided before entering, extending, or renewing a contract.
- Review disclosure and fees for accuracy and reasonableness, and if needed, send written request to provider for clarification.
- Engage independent experts as necessary to evaluate proposed fees and contract terms.
- Document the process and retain a copy of disclosure for fiduciary recordkeeping purposes.


Fiduciary Breach Litigation

Fiduciary Breach Litigation Update

How are the fiduciary breach lawsuits connected to transparency laws?

- The availability of data raises the bar for plan sponsors in terms of fulfilling their fiduciary obligations.
- Since more data is now publicly available, class action law firms (on behalf of participants) have used it to sue plan sponsors for alleged breaches of their ERISA fiduciary duties, particularly regarding prescription drug plans.
- In several high-profile cases, participants have asserted plan fiduciaries failed to prudently manage the plans, negotiate better prescription drug pricing, and select and monitor their PBM and the PBM's compensation.
- Participants generally assert these alleged breaches caused them to pay more in premiums and OOP costs then they would have absent the defendant fiduciaries' mismanagement.
- Thus far, participants have not been successful in showing they have suffered a personal and concrete injury, as required to establish "standing" to proceed with a case.
- But the lawsuits are expected to continue and present numerous legal risk and potential liabilities for group health plan sponsors.



Fiduciary Breach Litigation Update

Recent Group Health Plan Participant Class Action Lawsuits;

More Likely to Follow

Lewandowski v. Johnson and Johnson, et al., U.S. District Court of New Jersey

- Class action lawsuit filed in February 2024, alleging J&J breached ERISA fiduciary duties by mismanaging their prescription drug plan and overpaying PBM for drugs, which harmed participants by increasing their premiums and cost-sharing.
- Court dismissed claims in January 2025 for lack of standing; plaintiff didn't show concrete injury and reached OOP max (and thus would have paid same amount regardless of alleged breach). See our January 28, 2025 article.
- New plaintiff (who had not reached OOP max) added and amended complaint filed March 2025.
- Awaiting court to rule on J&J's motion to dismiss amended complaint…

Navarro et al., v. Wells Fargo et al., U.S. District Court of Minnesota

- Class action litigation filed in July 2024 alleging breach of ERISA fiduciary duties like J&J case and that fiduciaries engaged in prohibited transactions by causing the plan to pay excessive PBM fees.
- Court dismissed claims in March 2025, finding participants did not suffer a concrete injury clearly traceable to the defendant's conduct; the allegations of harm were speculative; see our April 9, 2025 article.
- But plaintiff filed amended complaint on May 8, 2025.

Seth Stern et al., v. JPMorgan Chase & Co. et al., New York Southern District Court

- Class action lawsuit filed in March 2025, alleging JPMorgan Chase mismanaged prescription drug plan, overpaid for generic drugs. failed to prudently select a PBM and evaluate potential conflicts of interest. Complaint points out that Caremark, the plan's PBM vendor is vertically integrated with CVS Specialty, its mail order pharmacy.
- Defendant JPMorgan Chase expected to file a motion to dismiss by June 3, 2025.

Fiduciary Breach Litigation Update

SCOTUS

Cunningham Ruling

How will it impact group health plans?

Cunningham v. Cornell University, U.S. Supreme Court

- Class action involving participants in Cornell University's defined contribution retirement plan who alleged Cornell and other plan fiduciaries caused the plans to engage in prohibited transactions by paying too much for recordkeeping services with TIAA and Fidelity.
- A contract or transaction between an ERISA plan and a service provider is a prohibited transaction. However, an exemption under ERISA §408(b)(2) applies if the services are necessary for the plan and the service provider's compensation is reasonable.
- Case focuses on what plaintiffs must plead when bringing a prohibited transaction claim.
- On April 17, 2025, the Court unanimously held that participants alleging a fiduciary breach need only plead that a prohibited transaction occurred (e.g., the plan entered a transaction with a service provider). The burden then shifts to plan fiduciaries to assert and prove that an exemption applies (the services were necessary and the compensation reasonable).
- The decision makes it easy for participants to bring prohibited transaction claims and get to discovery and may increase litigation brought against ERISA plan fiduciaries.
- The Court acknowledged the defendant's concern regarding a potential "avalanche of meritless litigation."
- Not clear how this may impact group health plan litigation but highlights need for sponsors to ensure they receive and carefully review service provider compensation disclosures.
- Please see our May 6, 2025 article.

Transparency in Coverage Rule
2025 Update

Transparency in Coverage Rule Requirements

Background – 2 Basic Requirements (applicable to non-grandfathered group health plans)

1. Public Disclosure of Pricing Data

- Plans and insurers must disclose:
  - Negotiated rates for in-network covered items and services
  - Historical out-of-network billed charged and payments
  - **Prescription drug negotiated rates and historical net prices**

- Required format is machine-readable files that must be posted monthly on a public website.
- Insurer/TPA can post for plan, but self-funded plan remains responsible for disclosures.
- Goal is to make plan pricing available to data analytics folks who can collect data across plans and create price comparison tools for plan sponsors.

2. Internet Cost-Sharing Tool

- Plans and insurers must:
  - Provide participants with personalized out-of-pocket (OOP) cost information for covered items and services prior to receiving care through an online self-service tool.
  - The “EOB in advance” must include actual negotiated rates, real-time accumulated amounts towards deductibles and OOP maximums.
  - Disclosure is intended to provide participants with estimates of their cost-sharing liability with different providers, so they can better compare costs.

Transparency in Coverage Rule Requirements

2025 Update

Trump Administration Healthcare Price Transparency Executive Order

- On February 25, 2025, President Trump signed an executive order focused on healthcare price transparency. Please see our March 4, 2025 article.

- The order expands upon Trump's prior efforts to increase transparency in healthcare pricing by hospitals and health plans, initiated in 2019 with the Hospital Transparency and TiC rules.

- The order directs the DOL, HHS, and IRS to take certain steps within 90 days (**by May 26, 2025**) to improve and enforce existing price transparency requirements by:
  - Issuing updated guidance that ensures pricing information is standardized and easily comparable across health plans.
  - Updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data. This includes rules that would require disclosure of the actual prices of items and services (not just estimates).

- Many anticipate the new guidance will expedite the implementation of the prescription drug MRF posting requirement, which was not initially enforced (in part due to litigation). The agencies announced the end of their non-enforcement policy in 2023 (see our October 10, 2023, article) but never set an implementation timeline.

- Healthcare pricing transparency is clearly a focus of the Trump Administration, and plan fiduciaries should pay close attention to develops in this area (especially this week)!

Cost Containment Strategies and Tools

Mitigating Fiduciary Risk

through

Price Transparency Tools and Resources

Data Analytics

Design and implement a structured evaluation process for the health and welfare strategy.

Vendor Financial Stability

Establish process for evaluation financial stability and reasonability of fees.

Validate Vendor and Provider Performance

Integrated data analytics to establish quantitative and qualitative analytics: identifying utilization patterns; monitor quality metrics and outcomes; with real time price transparency cost comparison.

Monitor Plan Effectiveness and Reasonability of Fees

Modern analytic platforms provide ease of monitoring inefficiencies, fraud, outlier fees and emerging trends.

Industry Trends

- **Enhanced Focus in Health & Welfare Evaluation/ Documentation Process**
- **Complex Data, Simplified**
- **Growth in Value-Based Competition**
- **Making Data Actionable**

NIH National Library of Medicine
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Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward

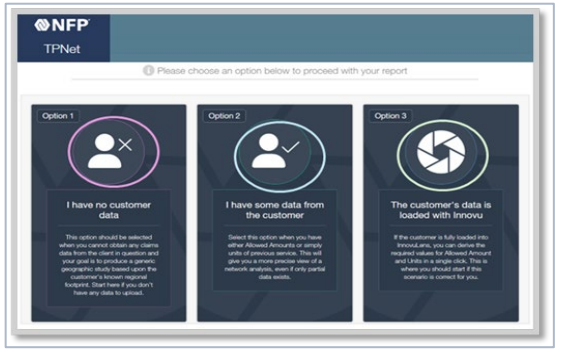
Abstract

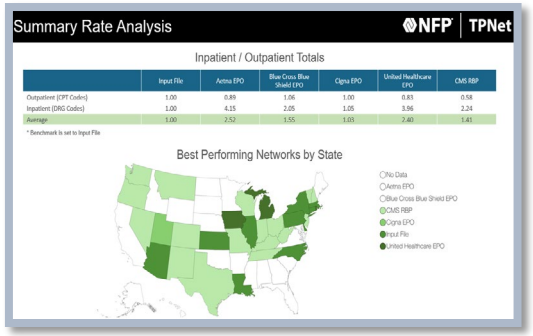
Health care price transparency is **gaining momentum** as a tangible policy intervention that can unleash market principles to **increase competition, help begin to decrease U.S. health care expenditures,** and **provide Americans with access to affordable, high-quality health care.** Indeed, pricing reform is required to facilitate patient shopping in health care.

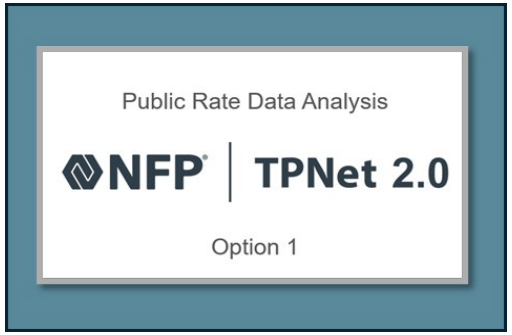
Transparent Pricing Network Analysis - TPNet™

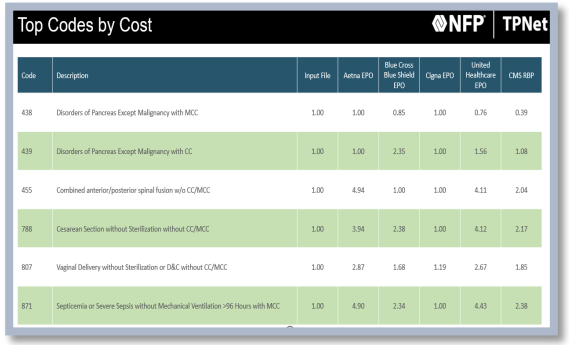
- **NFP Proprietary Tool**
- **Industry accepted methodology** – Top 700 procedural codes, mapped to client utilization data.
- **Underlying data** – Both hospital/payer price transparency data set; CMS and enhanced data set.
- **All National Networks** – PPO, EPO, HMO, RBP.
- **Output** – Index to Medicare or Actual Costs.
- **Network Performance Report** – Summary Rate Analysis; Best Performing Network by State; Top Clinical Categories by Service Line/Cost; Top Procedural Codes by Cost; Top Procedural Code Level by Network.
- **Option** – Regional networks through custom data queries.

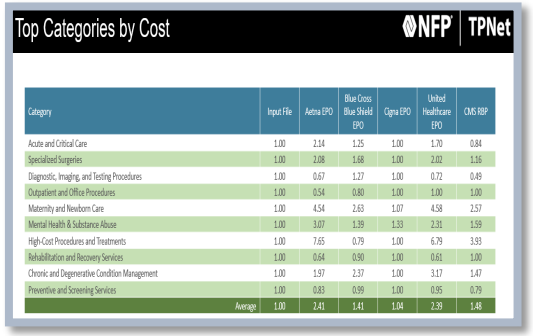
Comprehensive 14-page Report









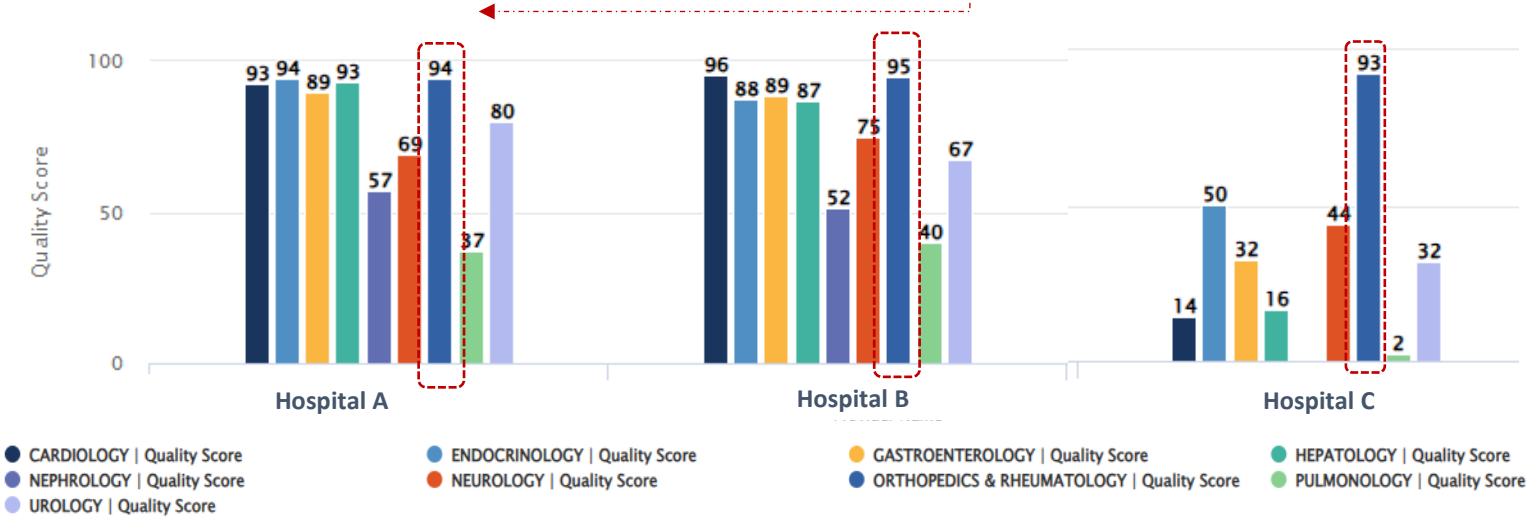


Consumer Access to Cost of Care in Advance of Procedure

470

MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC

Payer Name	Aetna		Cigna		Blue Cross Blue Shield		United Healthcare	
Provider	Average Posted Rate	Medicare Rate	Average Posted Rate	Medicare Rate	Average Posted Rate	Medicare Rate	Average Posted Rate	Medicare Rate
Hospital A	$32,407	$18,794	$32,150	$15,342	$22,855	$15,342	$26,914	$15,342
Hospital B	$38,124	$18,794	$30,872	$15,608	$47,427	$18,610	$26,914	$13,396
Hospital C	$58,846	$16,097	$38,133	$14,654	$34,584	$16,097	$35,008	$18,794
Diff. v Highest Cost	($26,439)		($7,261)		($24,572)		($8,094)	



Value-Based Cost Containment Strategies

Next Generation Health Plans

Control Benefit Spend

Actionable Data – Accurate and Reliable

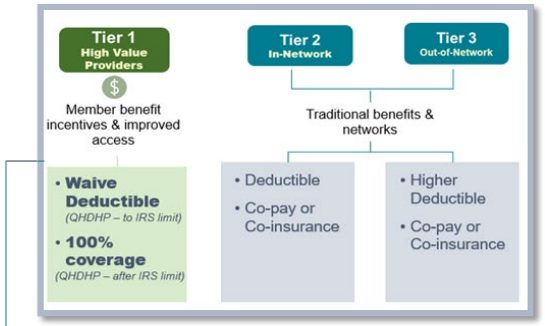
Address Point Solution Fatigue

High Performance Narrow Networks

There are next generation of health plans, using price transparency tools to reduce cost, eliminate waste, and improve efficiencies through state-of-the art technologies.

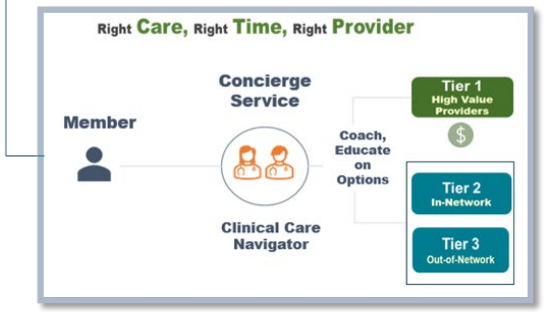
Improve Quality ● **Improve Access** ● **Reduce Costs**

Tiering of Benefits
Align Member Benefit Incentives



Optimal Success

Steering to Providers
High Quality/Low and Reasonable Cost Providers



Key Takeaways for Employers

Final Takeaways

What are the key takeaways for employers?

- Employers should expect a heightened focus on healthcare price transparency.

- As plan fiduciaries, employers should:

    - Ensure they are fulfilling the CAA gag clause attestation, RxDC reporting and MHPEA NQTL comparative analyses requirements.
    - Carefully review and evaluate § 408(b)(2) service provider compensation disclosures and document the process.
    - Monitor fiduciary breach litigation.
    - Expect new guidance regarding TiC reporting and enforcement **very soon** and be prepared to implement any required updates.
    - Understand that cost containment tools are now available to help sponsors compare healthcare prices and fulfill their fiduciary duties, including the duty to prudently select service providers.
    - Expect greater enforcement of transparency laws, which will hopefully result in a more competitive marketplace and lower prices!

NFP Publications and Resources

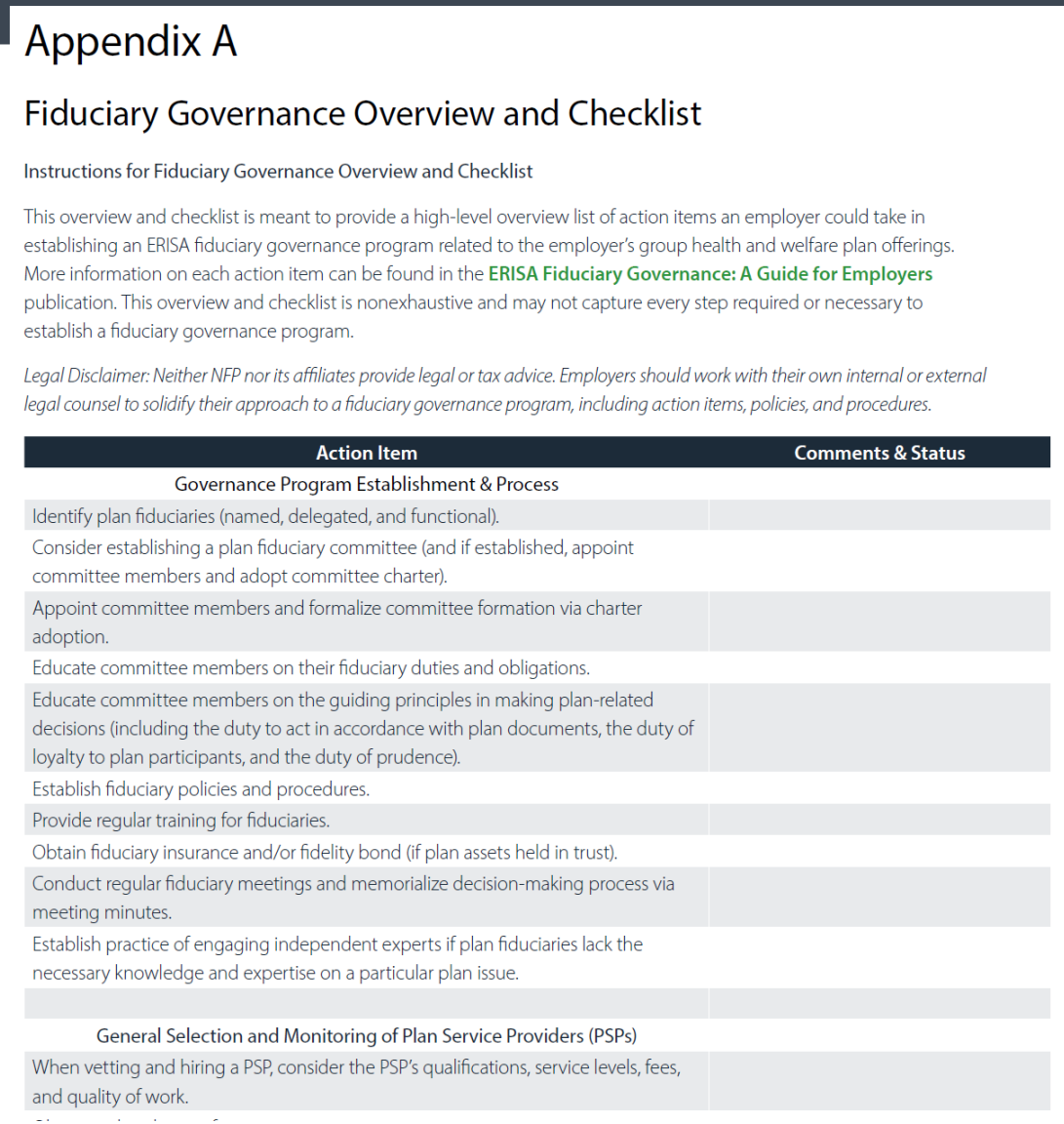
NFP Resources

Publication

For further information on the topics discussed during the presentation, please ask your broker or consultant for a copy of the NFP publication **ERISA Fiduciary Governance: A Guide for Employers**.

Publication includes:

- Detailed description of employer steps
- Overview and Checklist
- Sample documents
  - Board resolution/charter
  - Summary of Committee Duties and Responsibilities
  - Committee Appointment Letter and Notice of Acknowledgment
  - Meeting Minutes



Appendix A

Fiduciary Governance Overview and Checklist

Instructions for Fiduciary Governance Overview and Checklist

This overview and checklist is meant to provide a high-level overview list of action items an employer could take in establishing an ERISA fiduciary governance program related to the employer's group health and welfare plan offerings. More information on each action item can be found in the ERISA Fiduciary Governance: A Guide for Employers publication. This overview and checklist is nonexhaustive and may not capture every step required or necessary to establish a fiduciary governance program.

Legal Disclaimer: Neither NFP nor its affiliates provide legal or tax advice. Employers should work with their own internal or external legal counsel to solidify their approach to a fiduciary governance program, including action items, policies, and procedures.

Action Item	Comments & Status
Governance Program Establishment & Process	
Identify plan fiduciaries (named, delegated, and functional).	
Consider establishing a plan fiduciary committee (and if established, appoint committee members and adopt committee charter).	
Appoint committee members and formalize committee formation via charter adoption.	
Educate committee members on their fiduciary duties and obligations.	
Educate committee members on the guiding principles in making plan-related decisions (including the duty to act in accordance with plan documents, the duty of loyalty to plan participants, and the duty of prudence).	
Establish fiduciary policies and procedures.	
Provide regular training for fiduciaries.	
Obtain fiduciary insurance and/or fidelity bond (if plan assets held in trust).	
Conduct regular fiduciary meetings and memorialize decision-making process via meeting minutes.	
Establish practice of engaging independent experts if plan fiduciaries lack the necessary knowledge and expertise on a particular plan issue.	
General Selection and Monitoring of Plan Service Providers (PSPs)	
When vetting and hiring a PSP, consider the PSP's qualifications, service levels, fees, and quality of work.	

NFP Resources

Please Join Us for Our Upcoming Fiduciary-Focused Webinars!

- **Fiduciary-Focused Get Wise Wednesdays Webinar Series – Save the Dates**
  - July 16, 2025
  - September 17, 2025
  - (All occur at 3:00 p.m. ET. More information will be distributed closer to each date.)

- **Additional Communications**
  - We will continue to communicate any updates on fiduciary governance and transparency obligations through our biweekly newsletter, *Compliance Corner*, our webinars, and our various publications.


Questions?
Thank you for joining us!