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Class Action Lawsuit Accuses Employer of Failing to Negotiate Lower Prescription Drug Prices

In a lawsuit filed in district court in early February, a class action plaintiff alleges that a large employer violated its ERISA fiduciary duties to group health plan participants by paying excessive prices to its pharmacy benefit manager ("PBM") for managing its prescription drug program, which resulted in higher costs for health plan participants. This case could be a sign of a future wave of ERISA excessive fee litigation targeting health plans.

Overview of Lawsuit

On February 5, 2024, a plaintiff filed a complaint in the U.S. District Court for the District of New Jersey against a large employer, which sponsors multiple ERISA-governed health plans that provide medical benefits for its current and former employees and their family members. The lawsuit alleges that both the company (in its capacity as the sponsor of the plans) and the plans' pension and benefits committee breached their fiduciary duties under ERISA by mismanaging the company's prescription drug benefits program. ERISA requires fiduciaries to discharge their duties solely in the interest of, and for the exclusive purpose of providing benefits to, the plans' participants and beneficiaries and to act with care and prudence.

In the complaint, the plaintiff argues that the primary way in which the company mismanaged the program was by agreeing to pay a PBM – which administers the plans' prescription drug benefits – significantly higher prices for many generic drugs that are allegedly available at much lower prices. The complaint outlines the ways in which this practice allegedly cost the company's plans and their employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, and higher coinsurance. For example, the complaint alleges that the company's plans have in some cases paid prices upwards of 250 times higher for certain drugs than what is available if an individual walked into a pharmacy and paid out-of-pocket. According to the complaint, the company failed to supervise the PBM or review the PBM's actions in violation of ERISA, which led to the excessive payments. In particular, the plan fiduciaries allegedly failed to make an effort to compare the offerings of alternative service providers for the prescription drug program, seek the lowest level of costs for the services, and monitor plan expenses to ensure that they were reasonable.

As with all class action lawsuits, the complaint asks the court to "certify" the class of plaintiffs in order for the case to move forward. The class would consist of participants in one or more of the company's health plans during the time period at issue.

Implications of Case

While this case is only in the very beginning stages, and the employer has yet to submit its reply to the complaint, many are seeing this case as a sign that group health plans may now be subject to the same excessive fee lawsuits which have become more and more common among ERISA-governed retirement plans over the last decade. Some estimates have put the number of excessive 401(k) fee lawsuits filed each year in the hundreds. In light of this development, health plan fiduciaries may want to review their own policies for selecting and monitoring their third-party service providers, and especially PBMs.

The lawsuit also casts even more scrutiny on PBMs, which have drawn the ire of Congress and state policymakers amidst the rising costs of prescription drugs. In November 2023, for example, the Senate Finance Committee voted nearly unanimously to advance the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act (S. 3430), which includes heightened transparency rules and other regulations for PBMs. The House approved a similar bill (H.R. 5378, the "Lower Costs, More Transparency Act") late last year by an overwhelmingly bipartisan 320-71 margin.

States Attorneys General Call on Congress to Enact PBM Reform

Arguing that states alone cannot do enough to effectively regulate PBMs, 41 states' attorneys general (plus the attorneys general of the District of Columbia and the U.S. Virgin Islands) sent a letter to Congressional leaders to enact legislation to "hold PBMs accountable and improve the country's healthcare system overall."

Acknowledging the historical role PBMs have played in helping employers and health plans negotiate prescription drug prices with pharmaceutical manufacturers, the letter argues that, "in recent years, the PBMs have only made the pharmaceutical market more opaque and have been a cause of rising drug prices." Part of the problem, according to the letter, is that "significant market power" is now concentrated in a small number of PBMs.

State Attempts to Regulate PBMs Face Obstacles

As the letter points out, a number of states have enacted reforms targeting PBMs in various ways. For example, Ohio and Arkansas have enacted legislation to ban "spread-pricing" – the practice of PBMs charging health plans more for a drug than the PBM is paying for it and pocketing the difference. However, many of these efforts have been frustrated by ERISA preemption litigation and, according to the letter, PBMs trying to "evade" state law and regulation by "refusing to disclose data to state regulators as well as their own clients …."

To address these and other issues, the letter argues that Congress should enact legislation to "reform PBM practices to curtail their ability to unreasonably raise the price of drugs and to require greater transparency." Specifically, the letter says PBMs should be required to "produce pricing data to health plans and federal and state regulators in a standardized format," with the goal of enabling health plans to "negotiate better deals" with PBMs and allowing "regulators to better hold PBMs accountable."

Outlook for Federal Legislation

The letter favorably references the PBM reform bills that the House recently passed, and that could – along with two Senate bills – form the basis for a compromise package of health-related provisions to possibly be included on an omnibus spending package for the balance of fiscal year 2024. However, Congressional negotiators reportedly are struggling to find common ground

among the different reform proposals. But given the bipartisan, bicameral interest in these issues, some legislation addressing PBMs may well be enacted in 2024 – although possibly not until after the November elections.

IRS Releases Updated ACA Employer Shared Responsibility Penalties for 2025

On February 12, 2024, the Internal Revenue Service ("IRS") announced the new inflation-adjusted amounts for employer shared responsibility payments under the Affordable Care Act. These amounts will be effective for calendar year 2025.

Background

Under Internal Revenue Code ("Code") section 4980H, large employers with at least 50 full-time employees are subject to employer shared responsibility payments ("ESRPs") payable to the IRS if they fail to offer those employees the opportunity to enroll in minimum essential coverage, or if the coverage they offer is not "affordable" or doesn't provide "minimum value." These penalty amounts are subject to annual adjustment for inflation.

Updated ESRP Amounts

On February 12, 2024, the IRS released Revenue Procedure 2024-14, which provides adjusted ESRP amounts, relying on data provided by the Department of Health and Human Services. Effective for the 2025 calendar year:

- The adjusted ESRP under Code section 4980H(a)(1) (for employers that fail to offer minimum essential coverage to 95% of full-time employees and their dependents) is $2,900.
- The adjusted ESRP under Code section 4980H(b)(1) (for employers that have at least one employee with respect to which the premium tax credit or a cost-sharing reduction is permitted) is $4,350.

Note that these penalty amounts represent a reduction from $2,970 and $4,460, respectively, for 2024.

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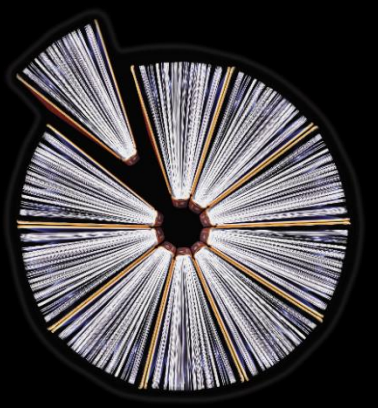

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