ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

ERISA IMPLICATIONS FROM DOL ACTIVITY IN BCBS ANTI-TRUST LITIGATION

BACKGROUND

As a result of recent action, certain larger self-funded group health plans impacted by the *Blue Cross Blue Shield Antitrust Litigation* have until May 2, 2022, to re-evaluate their settlement decision.

Regardless of whether a plan is impacted by this specific decision, the DOL action in this area provides a clear warning (and complicated roadmap) to explore with regard to similar plan settlement activity.

As background, a settlement was reached on October 16, 2020, arising from a class action antitrust lawsuit *In re: Blue Cross Blue Shield Antitrust Litigation MDL 2406*, N.D. Ala. Master File No. 2:13-cv-20000-RDP (the "Settlement").

The class action claimants asserted that the Blue Cross Blue Shield Association and its licensees (collectively "Settling Defendants") engaged in anti-competitive market practices that resulted in inflated premiums for fully insured health plans and stop loss policies, as well as higher ASO fees for self-funded agreements.

The Settling Defendants denied all allegations of wrongdoing and the parties agreed to settle. The Settlement will establish a $2.67 billion fund and the Settling Defendants will also agree to make changes in the way they do business to increase the opportunities for competition in the market for health insurance. More information is available at https://www.bcbssettlement.com.

After the Settlement, the court approved a proposed plan of distribution on March 12, 2021. The proposed distribution plan contemplates a $1.9 billion net settlement fund for distribution between the class members. Class members are individuals and companies that purchased or received health insurance provided or administered by BCBS during the following periods:

- Individuals **and** insured groups: **February 7, 2008, through October 16, 2020**.
- **Self-Funded Accounts: September 1, 2015, through October 16, 2020**.

Notice to class members was provided on May 31, 2021, and the deadline to file a claim was November 5, 2021. Most governmental accounts are excluded from the settlement.

WHAT IS NEW?

Although the deadline for claims filing has passed, the Court in February 2022 opened a new "opt-out" period for *self-funded entity* accounts in order to clarify that an opt-out election from the damages class also takes the account out of the injunctive relief class for "Second Blue Bids."

The "Second Blue Bid" portion of the Settlement was designed to enable large, geographically dispersed, self-funded national employers (5,000 or more employees) to have the opportunity to receive a second bid from a settling individual BCBS plan in addition to the employer's local settling individual BCBS plan.

A Second Blue Bid is unavailable to employers headquartered in areas where there are already two licensed settling individual BCBS plans.

For purposes of the new opt-out period, a "self-funded entity account" is

- an account that purchased or was enrolled in a Blue Cross and/or Blue Shield administrative services plan at any point in time between September 1, 2015 and October 16, 2020; and
- any account, employer, health benefit plan, ERISA plan, non-ERISA plan, or group that purchased, were covered by, participated in, or were enrolled in a "self-funded health benefit plan."

A self-funded entity account does not include sponsors, administrators, fiduciaries, or members of a self-funded account. A "self-funded health benefit plan" is any commercial health benefit

product other than commercial health insurance, including administrative services only contracts or accounts, administrative services contracts or accounts, and jointly administered administrative services contracts or accounts.

A self-funded entity account has until **May 2, 2022**, to take one of the following actions:

- Withdraw a previously filed damage claim and elect to opt out (an opt out will exclude the account from the settlement damages class, and individualized injunctive relief, including the right to request a Second Blue Bid); or
- Withdraw a previous opt out and remain in the damages class; or
- Do not respond and leave the previous election in place. If the account did not file a claim earlier, it will remain part of the settlement class but not be entitled to damages.

A copy of the updated notice is available at https://www.bcbssettlement.com/admin/services/connectedapps.cms.extensions/1.0.0.0/asset?id=74891eaa-4806-4718-ad9e-078d084313a7&languageId=1033&inline=true

If the account opts out, it will keep its right to sue BCBS and its settling affiliates for monetary damages and individualized injunctive relief related to the claims in this case.

The ability to sue depends on the individual facts and circumstances surrounding the account's claim, e.g. venue, applicable statute of limitations, amount of fees at issue, etc.

Injunctive relief may include the right to pursue in litigation more than one BCBS bid based upon the account's individual facts and circumstances.

POTENTIAL ISSUES UNDER ERISA

Given the structure of settlement relief, there are potential prohibited transaction and fiduciary issues for ERISA covered plans as a portion of the settlement fund may be considered ERISA plan assets. ERISA plan sponsors should take heed that similar issues are likely to arise in connection with future settlements (especially those involving ongoing service providers).

According to the U.S. Department of Labor (DOL) in its Statement of Interest Brief filed with the court on October 19, 2021, a group health plan's cause of action against the Settling Defendants due to paying inflated service fees is itself an ERISA plan asset.

The DOL reasons that the ERISA plan is a legal entity distinct from the employer under 29 U.S.C. § 1132(d) as the plan can sue and be sued and has a separate and independent legal claim against the Settling Defendants.

The DOL also identifies other potential sources of plan assets as the employee portion of prior premiums or contributions paid (despite the independent right of employees to receive a portion of the Settlement proceeds on an individual basis) as well as trust assets if the plan is funded.

Thus, the DOL views the decision of whether to accept the Settlement or opt-out as an exercise of "authority or control respecting management or disposition of assets" and a fiduciary decision.

As a result of the DOL's brief identifying a potential "cascade of ERISA violations depending on the facts and circumstances of each case," the opportunity for the second opt-out may give eligible plans and their fiduciaries the ability to address the potential fiduciary issues outlined in the DOL's brief.

These fiduciary issues differ depending on whether a Settling Defendant is a current plan service provider. If so, then the Settling Defendant is a party on interest under ERISA § 406(a). Based on the DOL's brief, the acceptance of the Settlement by the Settling Defendant could be a Prohibited transaction in the DOL's view unless an exemption applies.

In its brief, the DOL cites PTE 2003-39 as a possible exemption for plan fiduciaries. Under PTE 2003-39, a fiduciary acting on behalf of the plan must acknowledge in writing that it is a fiduciary with respect to the settlement of the litigation on behalf of the plan.

Such fiduciary must not have any relationship to or interest in any of the parties involved in the settlement, other than the plan, that might affect the exercise of such person's best judgment as a fiduciary. This provision may require

use of an independent fiduciary as the employer will also have an interest in the Settlement since the proposed settlement distribution considers the employer, not the plan, as the class member.

The plan fiduciary must then document its process of evaluating the settlement to determine, among other things if the terms of the Settlement are reasonable in light of the plan's likelihood of full recovery, the risks and cost of litigation, value of claims foregone if opt out, etc.

One important factor under PTE 2003-39 is that settlement must be no less favorable to the plan than comparable arm's-length terms and conditions that would have been agreed to by unrelated parties in similar circumstances.

If the plan no longer uses a Settling Defendant as a current service provider, there still may be potential fiduciary issues. Further, there are several unanswered questions for plans and their fiduciaries based on existing guidance dealing with the use of demutualization proceeds and MLR rebates:

- If there are no independent sources of ERISA plan assets, (no employee or trust contributions) does the plan's settlement right alone implicate fiduciary concerns?
- Does a plan fiduciary have to formally evaluate whether it is reasonable in light of the plan's likelihood of recovery for the plan to accept the Settlement or can the employer merely opt out to avoid potential ERISA issues as employees have their own rights to file a claim?
- Do ERISA plans have an obligation to file a claim to seek damages if the fiduciary determines that the terms of the Settlement are reasonable?
- What is the time frame to use the allocations if plan assets?

Employers and plan administrators should consider and discuss these issues with counsel in connection with this or any future plan settlement situation. ■