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Contract Language May Cost Health Plans ERISA Fiduciary Protections

The United States Court of Appeals for the Seventh Circuit in *Chicago District Council of Carpenters Welfare Fund v. Caremark, Inc*. has found that contract language matters,[1] and ERISA health plans should take heed. According to the decision, the fiduciary status of a self-insured health fund's pharmacy benefit manager (**"PBM"**) may turn on the analysis of a few provisions in a lengthy contract between a health fund and its PBM. In light of the fiduciary nature of what so many PBMs provide for health plans, the decision is important, and provides a primer on what *not* to include in a PBM agreement.

Regardless of what might be written in a particular PBM management agreement, as a practical matter health plans typically rely heavily on PBMs to serve their best interests in the complex arena of prescription drug reimbursement. And health plan executives almost always grant PBMs broad discretion to deliver clinically appropriate prescription drug benefits at reasonable prices. They do this because the tasks involved in pharmacy benefit management are highly specialized, multifaceted, and not always well-understood by corporate health benefits departments or union health plans.

Accordingly, PBMs generally perform a cluster of expert services on behalf of ERISA health plan customers: forming credentialed networks of retail pharmacies; negotiating prices with retail pharmacies and pharmaceutical manufacturers on behalf of health plans; designing restricted drug formularies (often with drug switching and prior authorization components) to encourage both economy and good care; determining appeals; and establishing and administering a multitude of discount, rebate and price guarantee arrangements that often involve complex collection and reconciliation processes, with payments flowing both to and from health plans.

Generally, an entity is considered a fiduciary for the purposes of ERISA if it has or exercises discretionary authority or discretionary control over the management or administration of a plan or its assets.[2] The determination is usually based on all of the facts and circumstances. An entity need not be a "named" fiduciary under the health plan to be considered a fiduciary under ERISA, and such an entity would be a fiduciary to the extent it performs fiduciary functions.[3]

The Dispute between the Chicago District Council of Carpenters Welfare Fund and Caremark centered on the Fund's claim that Caremark breached its fiduciary duties under ERISA. Whether or not a PBM is a fiduciary under ERISA is important because ERISA imposes certain limitations on fiduciaries of employee benefit plans with regard to self-dealing and conflicts of interest. Specifically, under ERISA, a fiduciary cannot:

> (1) deal with the assets of the plan in his own interest or for his own account, (2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or (3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.[4]

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1 474 F.3d 463 (7th Cir. Jan. 19, 2007).

2 29 U.S.C. § 1002(21)(A); 29 CFR § 2509.75-8: D-2.

3 See 29 CFR § 2509.75-8: FR-16.

4 29 U.S.C. § 1106(b).

A fiduciary who breaches these duties may be liable to restore to the plan any profits gained through the breach.[5]

In light of typical PBM activities, it would seem obvious that a PBM would have or exercise discretion over at least some services and plan assets. Indeed, in a different federal appeals case involving the PBM AdvancePCS Inc. — which was taken over by Caremark — the United States Court of Appeals for the Ninth Circuit found the question to be straightforward, stating: "AdvancePCS easily fits this definition [of fiduciary]. In choosing whether to fill a prescription or shift a participant to a different drug, it exercises discretion over the plans' assets."[6]

Yet, while PBM management agreements usually will state that the PBM is responsible for these various expert tasks, it is not unusual for these agreements to also include a sentence or two in apparent contradiction of this allocation of responsibility. These sentences will state, for example, that the ERISA health plan, not the PBM, maintains "sole discretion and authority" over these tasks, and that the PBM is "not a fiduciary."

In *Caremark*, the Seventh Circuit found that the existence of this type of language, when combined with certain other contract language suggesting an absence of PBM discretion, was a sufficient basis for concluding that Caremark had no discretion and was not a fiduciary. Notably, the court reached this conclusion on a motion to dismiss based on the language of the contracts alone—without the benefit of any fact-finding through discovery or trial to enable it to consider whether Caremark actually exercised any discretion.

It is very important to note that the Seventh Circuit's approach is at odds with the typical analysis engaged in by courts in deciding whether an entity is a fiduciary under ERISA.[7] Generally, courts confronted with this kind of issue look beyond how an entity is described in a plan document, such as a PBM agreement, and permit an examination all of the relevant facts and circumstances to reach a conclusion as to whether the entity exercised any discretion.[8] Nonetheless, the presence of this new Seventh Circuit opinion suggests that it would be prudent for health plans to take steps to help assure that their PBM management agreement language is consistent with the level of discretion actually granted to their PBMs.

The Decision

Affirming a district court decision dismissing the Chicago District Council of Carpenters Welfare Fund's (the **"Health Plan"**) suit alleging that Caremark breached its fiduciary duties under the Employee Retirement Income Security Act of 1974 (**"ERISA"**), the Seventh Circuit ruled that Caremark was not a fiduciary under ERISA and thus not subject to the limitations placed on ERISA fiduciaries. The court's ruling analyzed three contracts between Caremark and the Health Plan. The ruling rested on two main bases. First, the court focused on the economics of the arrangements as described in the contracts, whereby the contracts did not require Caremark to pass along to the Health Plan the benefit of negotiated rates and discounts with pharmacy retailers and drug manufacturers. Second, the court emphasized that certain contractual language consistently stated that Caremark had no discretion, and was not a fiduciary.

The Health Plan had contended that under the contracts, Caremark was a fiduciary because it exercised discretion in four areas. First, the Health Plan claimed that Caremark had discretion to negotiate drug prices with retailers and was authorized to adjust those prices unilaterally on the occurrence of certain events. Second, the Health Plan argued that Caremark exercised discretion in negotiating the prices that the Health Plan paid to manufacturers and the rebates that the Health Plan would receive for its purchases. Third, the Health Plan contended that Caremark exercised discretion through its role in designing and administering the Health Plan's prescription drug formulary. Finally, the Health Plan claimed that Caremark had discretion in its management of the Health Plan formulary's drug-switching program.

Beginning its analysis by highlighting that each contract stated that "Caremark was not a fiduciary . . . . and that the [Health Plan] possessed the sole authority to control and administer the plan," the court went on to analyze additional contract language to determine the intent of the parties, and to reject the Health Plan's arguments.

With regard to Caremark's role in negotiating retail pricing, the court took the view that because the contracts contained no obligation to pass through retail-pharmacy cost savings, Caremark had no ERISA "discretion." Despite the Health Plan's understanding of the nature of the services furnished by Caremark (which was based on contract language expressly describing Caremark's obligation to "use its best commercially reasonable efforts to negotiate" discount rates with retail pharmacies), the court found that under the contracts, there was no obvious linkage between the actual retail prices paid by Caremark to retailers, and the prices paid by the Health Fund to Caremark. Instead, the Health Plan paid a retail price to Caremark that was established in the contracts (e.g., a discount off of Average Wholesale Price). The court also found that regardless of the Health Plan's impression of the matter, the

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5 29 U.S.C. § 1109(a).

6 *Glanton v. AdvancePCS Inc.,* 465 F.3d 1123 (9th Cir. 2006) (C.J. Kozinski). Notwithstanding the holding that AdvancePCS was a fiduciary under ERISA, the case was dismissed because the plaintiffs, plan participants and beneficiaries lacked standing.

7 *See e.g. See e.g. Bouboulis v. Transp. Workers Union of Am.*, 442 F.3d 55, 63-65 (2d Cir. 2006); *NYSA-ILA Medical & Clinical Services Fund v. Catucci,* 60 F. Supp. 2d 194, 202 (S.D.N.Y. 1999).

8 *Id.*

contracts did not empower Caremark to unilaterally change the prices charged to the Health Fund, because any change required the signature of "both parties."

The Court similarly rejected the Health Plan's argument concerning rebates. The court explained that pursuant to the contracts, Caremark had no obligation to pass through any portion of the rebates negotiated with manufacturers. Instead, the payment received by the Health Plan and termed a "rebate" payment, was rather a fixed amount for each prescription filled, and there was no obvious linkage between the "rebate" payments paid by Caremark to the Health Plan, and the actual rebate amounts received by Caremark from manufacturers.

Turning to the Health Plan's argument concerning Caremark's role in designing and managing the Health Plan formulary and in administering the drug switching program, the court dismissed the Health Plan's contentions, finding that Caremark lacked discretion in both areas simply because each of the three contracts between the parties provided that the Health Plan retained "sole authority to control and administer the plan." Thus, the court explained, the Health Plan was the "final arbiter of the content of the formulary and any drug-switching decisions," and Caremark's role was akin to that of a claims administrator. The Health Plan countered, to no avail, that in practice the Health Plan always relied on Caremark and adopted Caremark's formulary.

Impact for Health Plans

The lesson provided is that health plans must take care to assure that their contracts with PBMs and other third-party administrators reflect the reality of the arrangement. If a health plan is relying upon the discretion and expertise of a PBM in an area about which it has little or no expertise (such as formulary arrangements, with their therapeutic interchange and prior authorization components), then the contract between the parties should be hammered out to reflect that reality.[9] Although the narrow focus on the language of the contracts is a departure from the approach of other courts,[10] and may not be followed outside of the Seventh Circuit, it would nonetheless be prudent to accurately set forth the understanding of the parties in the agreement.

It also should be noted that with respect to the economics of arrangements established in PBM contracts, and described in *Caremark*, plan administrators and others responsible for assuring that service providers are paid reasonable compensation and that health plans contain costs, arguably are entitled to be kept apprised of actual manufacturer rebates paid on health plan utilization, and on the spreads being earned by PBMs for retail prescriptions. Contracts can and should be drafted to accomplish these goals, and to assure that health plans fairly enjoy the benefits of the discount and rebate arrangements that PBMs currently are expected to accomplish on behalf of health plans.

Ellen H. Moskowitz, 212.969.3232
emoskowitz@proskauer.com

Roger A. Cohen, 212.969.3114
rcohen@proskauer.com

[9] Notably, with respect to determining claims appeals for group health plans, ERISA and the United States Department of Labor claims procedures require that where PBMs are retained to handle appeals, the PBM must fulfill that responsibility as a fiduciary. 29 CFR § 2560.503-1(h)(3).

[10] *See e.g. Boubouli*, 442 F.3d at 63-65; *NYSA-ILA Medical*, 60 F. Supp. 2d at 202.

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Client Alert

Proskauer's Health Care Department includes over 30 attorneys with significant and diverse health care experience. The following individuals serve as contact persons and would welcome any questions you might have:

Ellen H. Moskowitz	212.969.3232	emoskowitz@proskauer.com
Marcy Hahn-Saperstein	561.995.4774	mhahn-saperstein@proskauer.com
Sara Krauss	212.969.3049	skrauss@proskauer.com

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