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Employee Benefit Plan Review

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Columns

Feature Articles

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FEATURE ARTICLES

COLUMNS

PBMs

We are seeing an increasing willingness of state regulators to scrutinize the practices of pharmacy benefit managers (PBMs) through detailed conduct examinations. When combined with the Department of Labor's proposed PBM fee disclosure rule, PBMs are a particular emphasis of articles in this issue of *Employee Benefit Plan Review*. Other articles focus on notable state law developments – and we have more!

Medical Debt

The lead feature article in this issue, titled, "The Missing Piece in Employee Financial Wellness: Medical Debt Demands Employer Action," is by Christine Cooper, the founder and chief executive officer of aequum LLC.

In this article, the author explains that while traditional financial wellness programs focus on predictable budgeting, medical debt remains a primary driver of employee instability. The author argues that employers must move beyond financial education to actively assist in medical bill resolution. The author concludes that, by addressing billing errors and advocacy gaps, employers fulfill fiduciary duties, enhance workforce productivity and provide the comprehensive protection necessary for true financial peace of mind.

The States

We have three articles highlighting state law developments of interest.

The first, titled, "Delaware Court of Chancery Rules Workplace Sexual Misconduct Oversight Failures Can Support Shareholder Breach of Fiduciary Duty Claims," is by Kerry E. Berchem and Robert G. Lian, Jr., partners in Akin Gump Strauss Hauer & Feld LLP.

In this article, the authors examine a precedent-setting decision by the Delaware Court of Chancery holding that a board of directors' and senior officers' failure to respond in good faith to clear red flags of workplace sexual misconduct may give rise to viable breach of fiduciary duty claims under Delaware law.

The next article, titled, "West Virginia Insurance Commissioner Assesses $1.5 Million Penalty to Settle Allegations of PBM Compliance Violations," is by Jonathan L. Swichar, Bradley A. Wasser and Nikki Baniewicz, attorneys with Duane Morris LLP.

In this article, the authors discuss the administrative order entered by West Virginia's insurance commissioner, agreed to by Express Scripts Administrators LLC, assessing a $1.5 million administrative penalty against the PBM. The order followed a market conduct examination that identified multiple violations of West Virginia laws governing PBMs. The authors observe that several states, including West Virginia, have heightened scrutiny regarding reimbursement practices, rebate administration and relationships with pharmacies and health plans.

Denise M. Keyser, Louis L. Chodoff and Michelle Solari, attorneys with Ballard Spahr LLP, follow with their article, titled, "New Jersey Dramatically Expands State Family Leave Act and Employee Leave Protections." Here, the authors explain that the scope and application of the New Jersey Family Leave Act has been dramatically expanded. Under A3451/S2950, effective July 17, 2026, more employers are subject to the law, and more employees qualify for job-protected leave.

The DOL

It is not just state authorities increasing their examination of PBMs and employee benefits – the U.S. Department of Labor is acting, as well.

In the article titled, "What Pharmacy Benefit Managers and Group Health Plans Need to Know About the Department of Labor's Proposed PBM Fee Disclosure Rule," Theresa C. Carnegie and Hassan Shaikh, attorneys with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., provide an initial summary of a proposed rule released by the Labor Department that would end long-running confusion about how ERISA disclosure obligations apply to PBMs under the Consolidated Appropriations Act, 2021, and that would give fiduciaries of ERISA-covered self-insured group health plans significantly expanded visibility into PBM services and compensation.

Special Reports

We also have two special reports for you in this issue, both by Andy Barbeau, the founder and chief executive officer of Managerial & Organizational Resilience, LLC. They are

titled, "Managing for Impact" and "Understanding Your People Problem."

Enjoy the issue!

Victoria Prussen Spears*
Co-Editor-in-Chief
June 2026

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What Pharmacy Benefit Managers and Group Health Plans Need to Know About the Department of Labor's Proposed PBM Fee Disclosure Rule

By Theresa C. Carnegie and Hassan Shaikh

The Department of Labor has released a proposed rule (Proposed Rule)[1] that would end long-running confusion about how ERISA disclosure obligations apply to pharmacy benefit managers (PBMs) under the Consolidated Appropriations Act, 2021, and give fiduciaries of ERISA-covered self-insured group health plans significantly expanded visibility into PBM services and compensation. The proposal pairs broad compensation transparency with comprehensive audit rights covering PBMs and their affiliates, agents, and subcontractors, including PBM-affiliated brokers and consultants.

The Proposed Rule and the Consolidated Appropriations Act, 2026[2] will materially impact the PBM industry, particularly PBM's arrangements with their plan clients. This article provides an initial summary of the Proposed Rule's key provisions and discusses its anticipated impact on PBMs, self-insured group health plans, and other stakeholders.

Effective Date and Comment Period

If finalized, the rule would take effect 60 days after publication, and apply to plan years beginning on or after July 1, 2026. Comments to the Proposed Rule were due by March 31, 2026.

Scope and Applicability

- Applicable to Self-Insured Group Health Plans Only. The Proposed Rule applies only to ERISA-covered self-insured group health plans. Fully insured group health plans are excluded from the Proposed Rule, but DOL has reserved future rulemaking to address fully insured plan arrangements.
- Scope of "Covered Service Providers". Covered service providers include (i) entities that directly contract with self-insured group health plans to provide PBM services (i.e., typically the PBM), and (ii) PBM-affiliated brokers and consultants who provide advice, recommendations, or referrals regarding PBM services.
- Non-affiliated brokers and consultants remain subject to the disclosures required under the Consolidated Appropriations Act, 2021.
- Definition of PBM Services. PBM services are broadly defined to include services necessary to manage or administer a plan's prescription drug benefit (including drugs covered under the medical benefit), such as rebate aggregation, claims processing, and utilization management (e.g., prior authorization and step therapy).
- Inapplicable to Medical Claims. TPAs, health insurers, and other entities involved in the administration of a self-insured group health plan's *medical* claims are excluded from the Proposed Rule, though DOL has requested comment on whether the disclosures of the Proposed Rule should be extended to such entities.

Key Provisions

Covered service providers are responsible for making compensation disclosures to plan fiduciaries and allowing plan fiduciaries to audit those disclosures for accuracy under the Proposed Rule. As an extension of their disclosure responsibilities, covered service providers are also required to make compensation disclosures on behalf of all affiliates, agents, and subcontractors that provide PBM services to the plan under a PBM arrangement but are not directly contracted with the plan. DOL specifically notes that the term "agent" is intended to capture, for example, rebate aggregators or GPOs outside of the laws of the U.S.

Disclosure Requirements

The proposed disclosures are intended to make clear to plan fiduciaries (i) the PBM services that will be provided to the plan, and (ii) all compensation expected to be received by the covered service provider (or any affiliate, agent, or subcontractor) in connection with the arrangement. Disclosures are required prior to the self-insured group health plan entering into a contract or arrangement with a covered service provider and on a semi-annual basis thereafter. Semi-annual disclosures are due within 30 days after each six-month period of the contract term and must detail actual compensation received by category, explain material overages of 5% or more versus initial estimates, and restate audit rights.

Disclosures must contain sufficient specificity to permit plan fiduciaries to determine reasonableness, which includes requiring compensation to be expressed as monetary amounts, and allowing estimates only if actual figures are not reasonably ascertainable. The following written disclosures must be provided to applicable plan fiduciaries:

- *Description of PBM Services.* Full disclosure of PBM services to be provided. DOL notes that, absent full disclosure of services, questions may arise regarding whether the covered service provider is providing services within parameters established by the plan or if the covered service provider is taking discretionary behavior (which would then implicate the covered service provider as a fiduciary to the plan under ERISA).
- *Direct Compensation.* Aggregate and service-level breakdowns of all compensation that the covered service provider or an affiliate, agent, or subcontractor reasonably expects to receive on a quarterly basis from the self-insured group health plan or plan sponsor in connection with the arrangement.
- *Manufacturer Payments (Rebates and Other Remuneration).* Disclosure of all payments (including rebates, administrative fees, and price protection fees) reasonably expected to be received by the covered service provider or an affiliate, agent, or subcontractor from drug manufacturers, rebate aggregators, or other similar entities. This disclosure must be made on an aggregate and per-formulary drug basis and expressed as a dollar amount reasonably expected to be paid on a quarterly basis, and must specify the amounts that will be passed through to the plan and the amounts that will be retained by the covered service provider, or an affiliate, agent, or subcontractor.
- *Spread Compensation.* Aggregate, channel-level, and formulary drug-level disclosures of the dollar amounts of spread compensation the covered service provider, or an affiliate, agent, or subcontractor reasonably expects to earn under the arrangement.
- *Copay Claw-backs.* Disclosure of the reasonably expected amounts of compensation earned by the covered service provider or an affiliate, agent, or subcontractor for clawing back copayments made to the pharmacy at the point of sale.
- *Termination Compensation.* Disclosure of any compensation the covered service provider or an affiliate, agent, or subcontractor expects to receive in connection with contract termination, including an explanation of how rebates will be treated upon termination.
- *Other Compensation.* Catch-all disclosure of any additional compensation not otherwise disclosed, but reasonably expected to be received by the covered service provider or an affiliate, agent, or subcontractor in connection with the contract or arrangement.
- *Formulary Placement Arrangements.* Explanation of arrangements and incentives with manufacturers affecting formulary design, including a description of how such incentives impact services provided to the plan and otherwise align with plan and member interests, and identification of reasonably available therapeutic alternatives to on-formulary drugs (and if applicable, explanations of why such alternatives are omitted from the formulary). For covered service providers who retain authority to modify the formulary, this disclosure must also explain why the covered service provider (or its affiliate, agent, or subcontractor) is retaining such authority and the expected frequency of changes to the formulary.
- *Drug Pricing Methodology.* Disclosure of net cost to the plan for each formulary drug on a per-channel basis.

The Proposed Rule establishes annual audit rights for self-insured group health plans to audit their covered service providers.

Audit Rights

The Proposed Rule establishes annual audit rights for self-insured group health plans to audit their covered service providers to, at

minimum, verify the accuracy of the covered service provider's disclosures (though the scope of the audit may be expanded upon the parties' mutual agreement). To minimize barriers to audits, the Proposed Rule also:

(i) requires that audit costs be shared between the parties;
(ii) gives the plan sole authority to select the auditor without limitations or interference by a covered service provider, and
(iii) broadly prohibits covered service providers from imposing restrictive conditions on the auditor, such as traveling to the covered service provider's office to conduct the audit or limiting the number of records that will be provided.

Additional Provisions

- *Enforcement and Penalties*. Noncompliance can render the arrangement a prohibited transaction under ERISA, exposing service providers and fiduciaries to DOL enforcement and civil penalties. Fiduciaries must report non-compliance to the DOL and may be required to terminate contracts if failures are not remedied within 90 days.
- *Fiduciary Status*. Covered service providers must disclose if they (or their affiliates, agents, or subcontractors) will serve as ERISA fiduciaries to a plan. Although DOL does not deem PBMs fiduciaries in the Proposed Rule per se, it notes that any entity exercising discretionary authority or control over plan management, administration, or assets may be a fiduciary. Accordingly, PBMs should ensure that the services they provide (and those provided by their affiliates, agents, and subcontractors) are not discretionary but instead operate within the parameters disclosed to and approved by the plan fiduciary.

Implications for PBMs and Self-Insured Group Health Plans

The Proposed Rule introduces a comprehensive framework for PBM fee and compensation disclosure, designed to enhance oversight and enable plan fiduciaries to more fairly assess the reasonableness of PBM contracts and arrangements. While the Proposed Rule may increase PBM compensation transparency, the benefits may (especially in the short-term) be outweighed by the compliance costs that are likely to fall on PBMs, plans, and other services providers as they work to implement the Proposed Rule's requirements.

Notes

1. https://public-inspection.federalregister.gov/2026-01907.pdf.
2. https://www.congress.gov/bill/119th-congress/house-bill/7148.

The authors, attorneys with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., may be contacted at tccarnegie@mintz.com and hshaikh@mintz.com, respectively.

The Missing Piece in Employee Financial Wellness: Medical Debt Demands Employer Action

By Christine Cooper

Financial wellness has become an integral part of today's employee benefit packages, as more employers are investing in financial literacy education and financial management tools to assist employees with managing debt, building savings and preparing for the future. Despite all of this employer investment, medical debt remains one of the largest contributors to financial instability.

Medical debt is one of the primary drivers of financial instability[1] for working Americans. Healthcare costs are not simply another financial obligation – they represent a long-term financial burden that may actually undermine the exact objectives that employer sponsored financial wellness programs seek to resolve.

For self-insured employers this is not just an employee issue. It is a plan-level and fiduciary concern. Therefore, if the goal of employer sponsored financial wellness programs is to protect employees' financial health, then employers need to consider how to resolve medical bills for their employees as well.

The Magnitude of Medical Debt

The amount of medical debt owed by Americans is staggering. In fact, according to the Consumer Financial Protection Bureau (CFPB) over 15 million[2] American adults owe medical debt greater than $500 that is older than one year. Collectively, these debts total tens of billions of dollars. However, what is equally important as the sheer volume of medical debt is the lasting negative effect that it has on consumers financially.

Medical debt is different from other forms of debt because it is often unexpected, delayed and difficult to verify. Consumers may be charged for services months after receiving them and may be billed by providers with whom they had no choice regarding their participation. Additionally, billing errors, duplicate charges and unclear pricing are commonplace. When unpaid, these medical bills can quickly be sent to collections.

Consequently, medical debt can significantly affect consumers' ability to obtain other forms of credit or loans or mortgages and may require consumers to deplete their savings accounts, take on additional debt, or delay making significant financial decisions. The effects of medical debt on a consumer's financial stability can last for years. This is not just a consumer finance issue. It directly affects workforce stability, productivity and overall plan value.

A Regulatory Gap Leaves Employees Vulnerable

Regulators have taken some steps to address the growing concern of medical debt. However, a large gap remains in the regulations currently available to protect consumers from being negatively impacted by medical debt. Recently the CFPB issued a final rule[3] prohibiting most medical debt from appearing on credit reports and preventing creditors from using it to make credit decisions. The CFPB noted that medical debt is a poor indicator of a person's ability to pay back a creditor.

Unfortunately, a federal judge vacated this rule, leaving medical debt to appear on credit reports and allowing creditors to continue pursuing medical debtors even if the underlying medical debt is either inaccurate or in dispute. Furthermore, while there exist additional protections for consumers relative to surprise medical billing under the No Surprises Act,[4] the implementation and enforcement of this law continues to evolve.

This creates a meaningful gap between regulatory intent and real-world outcomes. Employees remain exposed to billing practices that can damage their financial standing, even when protections technically exist. Moreover, the lack of certainty with respect to regulatory protections creates operational and fiduciary risk for employers sponsoring these plans.

Traditional Financial Wellness Programs Fall Short

Employers have invested heavily in providing financial wellness resources to their employees,

including education about Health Savings Accounts (HSAs), student loan repayment assistance, retirement planning and financial budgeting tools. While these employer sponsored financial wellness programs are beneficial, they suffer from a fundamental flaw: they are designed primarily for employees to make predictable financial decisions.

Medical debt does not follow predictable patterns. It is often unexpected, complex and driven by billing practices outside the employee's control.

Unlike other types of debt that can be managed through education or budgeting tools, medical debt typically arises unexpectedly and is difficult to manage without first resolving the underlying billing error or dispute. Regardless of whether an employee was properly prepared financially prior to receiving a medical bill or charge, the process required to resolve the billing issue will ultimately determine whether the employee achieves financial stability.

Therefore, traditional financial wellness programs do not provide adequate support for employees struggling with medical debt. Without addressing resolution, these programs leave a critical gap in overall financial protection.

Impact of Medical Debt on Employer Sponsored Group Health Plans

For employers, especially those sponsoring group health plans with high levels of self-insured medical debt creates problems that extend beyond individual employee hardships. Specifically, medical debt can negatively affect employee productivity, workforce performance, plan design effectiveness and fiduciary responsibilities.

When employees experience financial strain resulting from unresolved or unpaid medical bills, their productivity decreases and they may take more days off work or leave their employer altogether. Financial stress tied to healthcare costs shows up directly in workforce performance and retention.

Even effective health plans may expose their employees to unforeseen billing disputes or provider errors.

Even effective health plans may expose their employees to unforeseen billing disputes or provider errors. Coverage alone does not guarantee financial protection when billing practices are inconsistent or unclear.

Additionally, fiduciary responsibilities are becoming more stringent. Employers are not only expected to sponsor a quality health care plan but also ensure that plan participants are protected within the context of that plan. This includes ensuring that plan processes do not unintentionally contribute to financial harm through unresolved billing issues.

An adverse experience with regard to billing also reduces an employee's perception of their overall financial wellness programs and damages employee confidence and trust in their employer.

How Employers Can Address Medical Debt

There are multiple ways employers can respond proactively and comprehensively to the challenges presented by medical debt:

1. Identify areas within your organization where your employees are most vulnerable to unexpected expenses, such as participating providers outside their network or billing confusion.
2. Increase monitoring of billing and claims data in order to identify errors earlier in the process and avoid escalating issues.
3. Expand existing financial wellness programs to include specific support mechanisms that enable employees to resolve medical-related billing disputes, such as advocating on behalf of an employee with a healthcare provider or assisting an employee in disputing charges.
4. Ensure that vendors and administrators working on your behalf prioritize fairness, accuracy and transparency in billing practices and employee protection.
5. Stay informed about new laws and regulations governing billing, credit reporting and dispute resolution procedures.
6. Demonstrate good faith in dealings with employees through open communication, accessible support and equitable billing practices. These actions reinforce trust and improve overall plan engagement.

The Future of Financial Wellness: From Education to Protection

Financial wellness cannot depend solely upon educating employees. Rather, it depends upon identifying the real obstacles that exist, determining how they interfere with achieving financial stability and addressing these issues with solutions. Medical debt is clearly among those obstacles and must be incorporated into the strategy if financial wellness is the goal.

By developing a comprehensive strategy that includes integration of medical bill resolution and protection into employer-sponsored health plan options and pairing the strategy with employee communications regarding accessing affordable care when

needed, employers can minimize financial stress on their employees. These initiatives promote better workforce outcomes and enhance the perceived value of health plan options.

Addressing medical debt is not just a support function. It is a necessary step in delivering a benefits strategy that protects both employees and the long-term performance of the plan.

Notes

1. https://pmc.ncbi.nlm.nih.gov/articles/PMC11918610/.
2. https://www.consumerfinance.gov/about-us/newsroom/cfpb-finds-15-million-americans-have-medical-bills-on-their-credit-reports/.
3. See https://www.congress.gov/crs-product/IF12169.
4. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/avoid-surprise-healthcare-expenses.

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Delaware Court of Chancery Rules Workplace Sexual Misconduct Oversight Failures Can Support Shareholder Breach of Fiduciary Duty Claims

BY KERRY E. BERCHEM AND ROBERT G. LIAN, JR.

In a precedent-setting derivative decision in *Los Angeles City Employees' Retirement System v. Glenn Sanford*,[1] the Delaware Court of Chancery held that a board of directors' and senior officers' failure to respond in good faith to clear red flags of workplace sexual misconduct may give rise to viable breach of fiduciary duty claims under Delaware law.

In an opinion[2] penned by Chancellor Kathleen J. McCormick, the court denied motions to dismiss claims against certain directors and officers of eXp World Holdings Inc., ruling that the plaintiffs had pled sufficient facts to support allegations that the company's fiduciaries had breached their oversight obligations and that the chief executive officer (CEO) had breached his duty of loyalty by concealing information and retaining employees implicated in the alleged misconduct.

KEY HOLDINGS

Oversight Obligations Extend to Alleged Sexual Misconduct Risks

In *Los Angeles City Employees' Retirement System v. Sanford*, the court confirmed that directors and officers may owe fiduciary duties to monitor and respond to credible reports of workplace sexual assault and misconduct. Allegations that fiduciaries ignored red flags or failed to implement effective reporting systems once the fiduciaries became aware of the allegations (i.e., allowing a so-called "rape culture" to persist), were sufficient to survive a motion to dismiss.

Duty of Oversight / *Caremark* Framework Applies

The court relied heavily on the *Caremark* doctrine, which provides the foundational framework for director oversight liability under Delaware law.[3] Specifically, *Caremark* held that corporate directors may be liable for breach of the duty of loyalty if they fail to implement or monitor systems designed to ensure a company's compliance with law and to inform the board of directors of risks. For a plaintiff to successfully make a *Caremark* claim, particularized facts showing bad faith must be pled, typically through one of two theories:

- Sustained or systemic failure of a board of directors to exercise oversight, such as the utter failure to attempt to assure reasonable information and reporting systems exist.[4]
- Having implemented such systems, the board of directors failed to monitor or oversee them, thereby disabling itself from being informed of risks or problems requiring attention.

Caremark claims are considered "possibly the most difficult theory in corporation law upon which a plaintiff might hope to win a judgment"[5] because liability requires a showing of sustained or systemic failure of oversight—not mere negligence or poor judgment.

While grounded in the traditional *Caremark* oversight doctrine, the court in *Los Angeles City Employees' Retirement System* emphasized that, in addition to avoiding negligent inaction, once a board of directors or senior management becomes aware of a credible claim of workplace sexual assault, proactive action must be taken, specifically:

- Fiduciaries must make a good-faith effort to establish reasonable information and reporting systems to identify misconduct risks.
- If red flags arise, the board and officers must respond in good faith—nominal or superficial actions that do not address the problem may be insufficient.

Breach of Loyalty for Concealment

The *Los Angeles City Employees' Retirement System v. Sanford* complaint went beyond alleging passive oversight failures and squarely

accused the company's CEO of active misconduct implicating the duty of loyalty. Specifically, plaintiffs alleged that the CEO:

- Knowingly concealed credible reports of sexual assault and harassment.
- Failed to escalate those issues to the board or implement remedial measures.
- Retained high-producing agents accused of misconduct because they generated substantial revenue for the company.

According to the complaint, these decisions were not merely negligent or inattentive, but were motivated by a desire to preserve the company's growth narrative and the CEO's personal financial interests, including equity value and compensation tied to performance.

The court found these allegations "reasonably conceivable" and sufficient to survive a motion to dismiss.

The court found these allegations "reasonably conceivable" and sufficient to survive a motion to dismiss because, if proven, they would support an inference that the CEO placed his own financial considerations and self-interests above the corporation's legal and ethical obligations. That distinction is critical under Delaware law: while claims sounding in negligence or poor judgment are often dismissed under *Caremark's* demanding standard, allegations of intentional concealment, bad faith or knowing toleration of unlawful conduct fall within the core of the duty of loyalty and are not protected by exculpatory charter provisions under Section 102(b)(7) of the Delaware General Corporate Law.[6] As a result, the court treated the CEO's alleged conduct as qualitatively different from mere oversight lapses, exposing him to potential personal liability and allowing the claims to proceed to discovery.

Action Steps: Crisis & Compliance Management

In light of *Los Angeles City Employees' Retirement System v. Sanford*, boards of directors should adopt and consistently implement the following:

- Ensure enterprise risk management and compliance systems are designed to and actually can capture and escalate reports of misconduct up the chain to the full board or appropriate committee.
- Commission independent investigations (often with outside counsel) rather than limited internal reviews when credible allegations of serious misconduct arise.
- Document board and committee discussions and decisions concerning misconduct allegations, including both factual analyses and corrective action plans, where appropriate or advisable.
- Regularly evaluate policies on sexual misconduct, harassment, retaliations and whistleblower protections to ensure they are enforced and understood across the organization.
- Provide directors with periodic training on identifying and responding to non-financial governance risks, including workplace safety and culture issues.

Broader Implications

The *Los Angeles City Employees' Retirement System v. Sanford* decision, among the first of decisions of its kind but certainly not the first to give rise to allegations of this nature, calls for board oversight and obligations that encompass a broader array of corporate risks than might be obvious upon first reading.

M&A Transactions

Sexual misconduct in the workplace—known, unknown, potential, real or perceived—creates economic risks that should be carefully assessed and addressed by both sellers and acquirers in mergers and acquisitions (M&A). In M&A due diligence, parties look beyond financial statements to be able to put a price on intangible risks and assets. Any threatened or pending litigation or insurance claims, including over sexual harassment, can and should be reviewed and considered during pricing discussions. Due diligence of social issues typically covers everything from employee reviews to social media policies and should include a clear-eyed assessment of whether a company's human resources department and policies allow for a culture permissive of sexual harassment. Boards and management must be on the lookout for red flags, including:

- Documented patterns of misconduct.
- Employment agreements that do not include "moral turpitude" or similar "for cause" provisions, or otherwise provide severance packages regardless of a finding of sexual misconduct.
- Separation or settlement agreements that relate to sexual harassment and contain nondisclosure agreements.
- Difficulty recruiting or retaining women, particularly at senior levels.
- Complaints about work culture or specific individuals.
- Evidence that serious allegations are not made to human resources.
- Prior claims or charges for harassment, discrimination, or similar misconduct.
- Suppressed or unaddressed allegations of sexual harassment.

In the world of M&A, "don't ask, don't tell" should not be an option for either seller or buyer.

Due diligence should assess workplace culture and misconduct risk.

SEC Disclosure and Regulatory

Under *Caremark* and its progeny, the board's obligation is not necessarily to prevent all misconduct, but to exercise good-faith oversight to ensure that there is a solid system to surface material risks, including risks arising from workplace misconduct and culture. Sexual assault or harassment issues generally become disclosure matters only when they are material to investors; however, for *Caremark* purposes, the board's focus is whether it has ensured the existence and functioning of reporting, escalation and response mechanisms capable of identifying such risks before they create legal, financial or reputational harm.

In *Los Angeles City Employees' Retirement System v. Sanford*, the court reinforced that oversight risk increases where boards receive—or should receive—credible internal information about systemic workplace issues, but where the company's public disclosures about culture, compliance or employee safety are materially inconsistent with those company assertions. Even where individual incidents are not themselves disclosable, affirmative statements portraying a strong culture, effective controls or a safe workplace may give rise to liability if they are misleading in light of known internal concerns. In this context, inaccurate or overly optimistic workforce-culture disclosures can support claims not only under federal securities law, but also under state fiduciary duty principles tied to board oversight failures.

The principal risk is not the presence of misconduct alone, but a breakdown between internal reporting and external disclosure. Boards face heightened exposure where red flags (e.g., repeated complaints, regulatory inquiries, executive involvement or internal investigation findings) are not adequately monitored, documented or reflected in elevation procedures or disclosure controls. This risk is amplified when the company makes broad or aspirational statements about culture or compliance that are contradicted by internal data.

Accordingly, best practice for the board is to ensure:

- Reliable mechanisms for reporting and escalating workplace misconduct and culture risks.
- Ensuring competent and effective staffing of human resources and other management functions responsible for overseeing implementation and oversight of policies.
- Regular board-level visibility into those issues (e.g., through periodic reporting).
- Alignment between what management knows internally and what the company communicates publicly.

A disciplined, materiality-based disclosure approach, focused on actual practices with respect to governance, controls and remediation, remains critical to mitigating both *Caremark* oversight risk and potential securities disclosure liability.

Notably, companies face direct regulatory exposure for false or misleading statements in Securities and Exchange Commission (SEC) filings, even where the underlying subject matter—such as workplace culture or misconduct—would not otherwise require disclosure. The SEC may bring enforcement actions under Rule 10b-5, Section 17(a), and periodic reporting rules for materially inaccurate statements or misleading half-truths, including aspirational or reputational statements that are contradicted by internal information. Liability can arise where disclosures about culture, compliance or controls are inconsistent with known complaints, investigations, or systemic issues. Consequences may include civil penalties, cease-and-desist orders, mandated compliance undertakings, and potential officer or director liability, often accompanied by shareholder litigation. For boards of directors, the principal risk is misalignment between what management and the board know internally and what the company says publicly.

D&O Insurance

The court's ruling in *Los Angeles City Employees' Retirement System v. Sanford* may have meaningful implications for director and officer (D&O) insurance coverage, particularly for oversight and fiduciary-duty claims arising from alleged corporate misconduct. By allowing derivative claims based on board-level failures to address serious internal misconduct to survive a motion to dismiss, the decision underscores the potential for significant personal exposure to directors and officers even in the absence of adjudications. Insurers may respond by more aggressively scrutinizing whether such allegations fall within policy definitions of "wrongful acts" or instead implicate exclusions for intentional misconduct, bad faith or improper personal benefit.

The case is also likely to increase coverage disputes over defense-cost advancement and indemnification in derivative actions.

The case is also likely to increase coverage disputes over defense-cost advancement and indemnification in derivative actions, especially where insurers argue that sustained oversight failures suggest non-covered conduct. At the same time, the decision may drive heightened underwriting scrutiny and encourage insureds to seek clearer policy language

addressing oversight risk, cultural and compliance failures and derivative-suit coverage. Overall, the *Los Angeles City Employees' Retirement System v. Sanford* ruling signals a more complex and contested directors and officers coverage landscape for claims alleging systemic governance breakdowns.

Shareholder Activism

Workplace cultures perceived to tolerate or inadequately address sexual misconduct claims can lead to targeted campaigns by shareholder activists, pension funds, unions and advocacy groups. Typically, these campaigns are framed as efforts to address material governance risks, coupled with, in these specific cases, an argument that permissive culture creates legal, reputational and financial risk, and that boards that ignore red flags, fail to enforce accountability at senior levels or allow public statements should immediately remediate or, potentially, be replaced.

For instance, Mercy Investment Services (Mercy), the faith-based investment ministry, has been an active proponent of corporate reform on social and ethical issues. The organization frequently co-files shareholder proposals through coalitions of religious investors, often under the umbrella of the Interfaith Center on Corporate Responsibility, and leverages exempt solicitation statements to build broader investor backing. Its advocacy has spanned human rights in supply chains, pharmaceutical pricing practices and climate risk mitigation. In recent campaigns, Mercy has circulated exempt solicitation letters encouraging shareholders to support enhanced board oversight of workplace sexual harassment risks.

Likewise, SOC Investment Group (formerly known as CtW Investment Group), has garnered a reputation for submitting and/or supporting shareholder proposals that seek to hold boards and management accountable for social and ethical concerns, including in relation to sexual misconduct.

Relatedly, during the 2023–2025 proxy seasons, the New York State and New York City Comptrollers led sustained shareholder activism campaigns pressing the Wells Fargo board on workplace harassment and discrimination oversight, including issues tied to sexual misconduct risks as part of broader governance concerns. In 2023, a proposal filed by New York State Comptroller Thomas DiNapoli and New York City Comptroller Brad Lander asking the board to prepare a public annual report on the effectiveness of its efforts to prevent harassment and discrimination, including data on complaints, settlements, arbitration clauses and concealment clauses, won majority support (i.e., approximately 55% of the vote) from shareholders, signaling investor demand for transparency and accountability on these matters.[7]

The court's ruling in *Los Angeles City Employees' Retirement System v. Sanford* underscores the need and legal obligation of boards and senior officers to promptly and proactively address credible sexual misconduct allegations.

Earlier this year, the New York State Comptroller submitted a shareholder proposal[8] urging Uber to prepare a public report on sexual misconduct incidents and the board's role in overseeing safety and harassment prevention, responding to thousands of reported abuses and pressing leadership accountability at the governance level.

Additionally, earlier activism efforts such as mass employee walkouts, open letters and shareholder demands at companies like Activision Blizzard[9] spotlighted failure of oversight and mishandling of sexual harassment claims, pushing for board accountability and disclosures. While direct sexual misconduct or workplace harassment proposals declined in sheer number in 2025 following an SEC rule changes that made it easier for companies to exclude shareholder proposals from proxy ballots, the recent proxy landscape still reflects investor concern about human capital risks, which encompasses harassment and discrimination oversight.

High-profile campaigns can lead to board scrutiny, executive departures, governance reforms, shareholder litigation and regulatory attention. Notably, activists often succeed without proving that specific incidents were independently disclosable under SEC rules; instead, they emphasize systemic issues, misleading culture disclosures and inadequate *Caremark*-style oversight. For boards, the key activist risk lies in perceived tolerance of misconduct or inconsistency between internal knowledge and external messaging, which can undermine credibility and invite sustained shareholder and public pressure.

Conclusion

The court's ruling in *Los Angeles City Employees' Retirement System v. Sanford* underscores the need and legal obligation of boards and senior officers to promptly and proactively address credible sexual misconduct allegations. Once aware of a potentially credible allegation, boards and senior management must investigate, monitor and remediate risks to satisfy fiduciary duties under Delaware law. The *Los Angeles City Employees' Retirement System v. Sanford* decision serves as an important reminder that fiduciaries are obligated to shape governance frameworks and to reinforce that oversight obligations extend well beyond financial reporting into workplace culture and employee safety.

Notes

1. Los Angeles City Employees' Retirement System v. Glenn Sanford, et al., C.A. No. 2024-0998-KSM (Del. Ch. Jan. 16, 2026).
2. https://cases.justia.com/delaware/court-of-chancery/2026-c-a-no-2024-0998-ksjm.pdf?ts=1768595635.
3. See In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Del. Ch. 1996), and Stone v. Ritter, 911 A.2d 362 (Del. 2006) (which clarified that Caremark liability is a subset of the duty of loyalty, because it requires a showing of bad faith).
4. From Caremark: "Generally where a claim of directorial liability for corporate loss is predicated upon ignorance of liability creating activities within the corporation, as in Graham or in this case, in my opinion only a sustained or systematic failure of the board to exercise oversight such as an utter failure to attempt to assure a reasonable information and reporting system exits will establish the lack of good faith that is a necessary condition to liability. Such a test of liability lack of good faith as evidenced by sustained or systematic failure of a director to exercise reasonable oversight is quite high. But, a demanding test of liability in the oversight context is probably beneficial to corporate shareholders as a class, as it is in the board decision context, since it makes board service by qualified persons more likely, while continuing to act as a stimulus to good faith performance of duty by such directors." In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Del. Ch. 1996).
5. In re Caremark International Inc. Derivative Litigation, 698 A.2d 959 (Del. Ch. 1996).
6. See Del. Code Ann. tit. 8, § 102(b)(7).
7. https://www.osc.ny.gov/press/releases/2023/05/dinapoli-landers-proposal-calling-wells-fargo-board-report-efforts-prevent-discrimination-and.
8. https://www.osc.ny.gov/press/releases/2026/01/dinapoli-uber-needs-explain-what-it-doing-protect-riders-sexual-assault.
9. See, e.g., Shareholders call on Activision Blizzard CEO to resign after employee walkout, available at https://www.theguardian.com/technology/2021/nov/17/activision-vision-bobby-kotick-shareholders-employee-walkout. Microsoft Corporation closed its acquisition of Activision Blizzard in October 2023.

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West Virginia Insurance Commissioner Assesses $1.5 Million Penalty to Settle Allegations of PBM Compliance Violations

BY JONATHAN L. SWICHAR, BRADLEY A. WASSER AND NIKKI BANIEWICZ

West Virginia's insurance commissioner has entered an administrative order, agreed to by Express Scripts Administrators LLC, assessing a $1.5 million administrative penalty against the pharmacy benefit manager (PBM). The March 2, 2026, order followed a market conduct examination that identified multiple violations of West Virginia laws governing PBMs. The enforcement action reflects increasing regulatory scrutiny of PBMs by state authorities. Several states, including West Virginia, have heightened scrutiny regarding reimbursement practices, rebate administration and relationships with pharmacies and health plans.

The administrative order follows a detailed market conduct examination conducted by the West Virginia Offices of the Insurance Commissioner that reviewed Express Scripts' compliance with state law. Express Scripts was investigated for conduct taking place between January 1, 2023, through June 1, 2024.

The examination analyzed multiple aspects of the company's PBM operations including, but not limited to, pharmacy reimbursement, pharmacy audits, network adequacy, complaint handling, rebate administration and formulary design.

After reviewing the examination findings and Express Scripts' responses, the insurance commissioner determined that several practices violated state statutes regulating PBMs. Although Express Scripts disputed certain findings, the company agreed to resolve the matter without admitting liability to avoid extended litigation and administrative proceedings.

Pharmacy Reimbursement Violations

A central focus of the findings involved pharmacy reimbursement practices. West Virginia law requires PBMs to reimburse pharmacies for filling prescription medications at the National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $10.49, or alternatively, the wholesale acquisition cost plus the same dispensing fee when NADAC data is unavailable.

The examination concluded that Express Scripts failed to reimburse pharmacies at the required statutory level for a substantial number of claims. Regulators determined that more than 19,500 claims in 2023 and nearly 10,000 claims during the first half of 2024 were reimbursed below the state-mandated level. According to the examination report, these practices resulted in significant underpayments to West Virginia pharmacies.

Preferential Reimbursement to PBM-Affiliated Pharmacies

The examination also found that Express Scripts reimbursed affiliated pharmacies (those pharmacies which Express Scripts owns or has a financial interest in) at higher rates than nonaffiliated pharmacies for numerous prescription drugs. West Virginia law prohibits its PBMs from favoring affiliated pharmacies within their networks when reimbursing claims.

Regulators concluded that Express Scripts used a reimbursement methodology for affiliated entities, such as Express Scripts' mail-order and specialty pharmacies, that substantially differed from the methodology applied to other retail pharmacies in the state, greatly favoring Express Scripts. This practice violates statutory requirements and could lead to higher overall costs for health plans and consumers when prescriptions are filled through PBM-affiliated pharmacies rather than independent pharmacies.

Rebate Pass-Through and 340B Issues

The commissioner also identified compliance issues related to manufacturer rebate

administration. Under West Virginia law, PBMs are required to pass through 100 percent of manufacturer rebates, discounts and other remuneration received in connection with prescription drug dispensing. This means consumers must see the entire benefit of manufacture rebates, and PBMs cannot use the rebates to boost their bottom line. The examination found that Express Scripts failed to demonstrate that all rebates were passed through at the point of sale as required by state statute.

In addition, Express Scripts used contractual provisions excluding certain rebates when prescriptions were dispensed through 340B pharmacies, even when the claims themselves were not 340B transactions. West Virginia law requires 340B pharmacy providers that bill claims using pharmaceutical inventory purchased under Section 340B pricing to identify the claims using National Council for Prescription Drug Programs values. The report concluded that Express Scripts' Network Provider Manual outlines specific details related to general claims submission and the requirements to submit a 340B drug that do not align with West Virginia code. These actions could prevent patients from receiving the full benefit of manufacturer rebates—and could actually disadvantage pharmacies participating in the federal 340B program.

Pharmacy Audit Practices

Another significant component of the examination involved the PBM's pharmacy audit procedures. West Virginia law permits PBMs to recoup funds from pharmacies when claims are improperly submitted, but limits recoupments to the amount of actual financial harm associated with the claim.

Regulators determined that Express Scripts maintained audit policies allowing recoupments that exceeded the actual financial harm related to the dispensed prescription. The report also found that the PBM assessed noncompliance fees and initiated recoupments before pharmacies had completed the appeal process for audit findings. According to the commissioner, these practices violated statutory limitations governing pharmacy audit procedures.

Fees Charged to Pharmacies

The examination also focused on fees assessed against pharmacy providers. The report found that Express Scripts required independent pharmacies to pay credentialing and recredentialing fees to participate in certain health plan networks. The fee assessed was nonrefundable regardless of denial or approval of the application. Furthermore, every three years independent pharmacies were required to pay additional fees to Express Scripts based on the timeline to recredential. Express Scripts also assessed transaction fees for the use of its claims transmission system.

West Virginia law explicitly prohibits PBMs from deriving revenue from pharmacies in connection with the performance of PBM services. Regulators concluded that these fees violated statutory provisions governing PBM compensation and pharmacy network participation.

Consumer Cost-Sharing Violations

The examination further identified violations affecting health plan members, particularly with respect to insulin cost-sharing. West Virginia law caps cost-sharing for insulin at $35 per 30-day supply, regardless of the type or quantity of insulin prescribed.

The commissioner found that Express Scripts assessed cost-sharing amounts exceeding the statutory limit in 191 claims affecting 79 members, resulting in more than $10,000 in overpayments by consumers. The report also noted that refunds to affected members were issued months after the prescriptions were dispensed and did not adequately explain the reason for the payment.

Network Adequacy and Transparency Issues

The examination also identified deficiencies related to network adequacy and pharmacy directory transparency. West Virginia law requires PBMs to maintain accurate provider directories and update those directories regularly.

Express Scripts failed to demonstrate that its pharmacy directories were updated monthly and failed to provide evidence that periodic audits of the directories were conducted.

Regulators determined that Express Scripts failed to demonstrate that its pharmacy directories were updated monthly and failed to provide evidence that periodic audits of the directories were conducted. The report further concluded that the PBM did not provide required written notice to pharmacies regarding new health benefit plans entering certain geographic areas, potentially limiting pharmacies' ability to participate in those networks.

Corrective Action and Enforcement Measures

To resolve the matter, Express Scripts agreed to an administrative penalty of $1.5 million and to implement corrective measures designed to bring its operations into compliance with each of the above

components of West Virginia law. In addition, the PBM must review affected claims and reimburse pharmacies for underpayments identified during the examination, including interest.

The order also requires the company to submit a corrective action plan detailing changes to its internal policies and procedures to address the violations identified in the examination. The plan must be submitted to the commissioner for approval and implemented after regulatory review.

What This Means for Pharmacy Benefit Managers, Pharmacies and Health Plans

The West Virginia enforcement action reflects the increasing willingness of state regulators to scrutinize PBM practices through detailed conduct examinations. The order highlights several compliance issues that regulators are likely to continue focusing on across jurisdictions:

- Compliance with state pharmacy reimbursement formulas, particularly NADAC-based reimbursement requirements;
- Rebate transparency and statutory obligations to pass-through manufacturer rebates;
- Pharmacy audit practices and limitations on recoupment amounts;
- PBM relationships with affiliated pharmacies and potential preferential reimbursement structures;
- Compliance with statutory caps on patient cost-sharing for certain medications; and
- Transparency and accuracy of pharmacy network design.

As state regulation continues to expand, enforcement actions such as this one illustrate the growing regulatory attention directed at PBMs. Of interest to independent and community pharmacies, the West Virginia action highlights the increasing willingness of state regulators to investigate PBM conduct and enforce statutory protections.

Pharmacies operating in jurisdictions with robust PBM regulatory frameworks should remain attentive to these developments and may wish to review whether their contracts, reimbursement arrangements and audit interactions with PBMs to ensure compliance with applicable state laws. Increased regulatory scrutiny may also provide pharmacies with additional avenues to raise compliance concerns with regulators when PBM practices appear inconsistent with state statutory requirements. ❂

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New Jersey Dramatically Expands State Family Leave Act and Employee Leave Protections

BY DENISE M. KEYSER, LOUIS L. CHODOFF AND MICHELLE SOLARI

The scope and application of the New Jersey Family Leave Act (NJFLA) has been dramatically expanded. Under A3451/S2950,[1] effective July 17, 2026, more employers are subject to the law, and more employees qualify for job-protected leave.

In addition, the amendments address the receipt of Temporary Disability Benefits (TDB) and Family Leave Insurance (FLI) and may provide job-protected leave for those who receive these benefits—though questions remain and further guidance is expected on this point.

While further guidance and clarification are anticipated, all New Jersey employers—even those with only a single employee in the State—should review their leave and PTO practices and policies and begin taking steps to bring those policies and practices into compliance with the changes.

CURRENT LAW

The NJFLA provides qualifying New Jersey employees with 12 weeks of job-protected leave during a 24-month period. The eligibility for leave is triggered by certain qualifying events. Under the law's current iteration, to qualify for leave, an employee must work for a covered employer for at least 12 months and have worked at least 1,000 hours in the preceding 12 months for that employer. Employers are covered if they employ at least 30 employees for 20 workweeks in the current or preceding calendar year.

Out-of-state employers are covered if they meet this 30-employee threshold and employ at least one employee working in New Jersey.

Qualifying employees of covered employers are eligible for NJFLA leave:

(1) to care for or bond with a child within one year of the child's birth, placement for adoption, or foster care;
(2) to care for a family member with a serious health condition or who has been isolated or quarantined because of exposure to a communicable disease during a state of emergency; or
(3) to provide care for a child if the child's school or place of care is closed by order of a public official due to an epidemic of a communicable disease or other public health emergency.

Notably, unlike its federal corollary, the Family and Medical Leave Act (FMLA), the NJFLA does not provide leave for an employee's own disabling health condition. Under current state law, employees requesting job protected leave because they themselves are unable to work for medical reasons generally must seek leave under the FMLA or as a reasonable accommodation under the Americans with Disabilities Act (ADA) or the New Jersey Law Against Discrimination (NJLAD).

Notably, unlike its federal corollary, the Family and Medical Leave Act (FMLA), the NJFLA does not provide leave for an employee's own disabling health condition.

NJFLA leave may be taken intermittently or consecutively. Although NJFLA leave is unpaid, employees may apply for FLI and receive partial wage replacement.

THE NJFLA CHANGES

Under the amendments, the NJFLA will continue to provide 12 weeks of job-protected leave during a 24-month period, and the qualifying purposes for the leave remain unchanged. However, effective July 17, 2026, the definitions for qualifying employees and covered employers will change significantly and, as a result, the law potentially will apply far more broadly than it does now. The former Governor's press release estimates that an additional 400,000 New Jersey employees will now

be eligible to receive NJFLA protection. Rather than having to meet the 12-month/1,000-hour requirements currently in place, under the amendments, employees will instead be eligible for NJFLA leave if they are employed by a covered employer for at least three months and have worked at least 250 hours for that covered employer in the last 12 months. Thus, many part-time workers, recent hires, and even probationary employees will be entitled to job-protected leave.

The amendments also expand coverage of smaller employers. A "covered employer" will include those with at least 15 employees, employed during each of 20 or more calendar workweeks in the current or preceding calendar year.

The twin expansions of who may take leave and who must grant it mean that the NJFLA changes will impact employers of almost all sizes, across the entire State.

Additional Changes

The new legislation also amends the law governing receipt of TDB and FLI, although the scope and impact of these changes are not as clearly described in the legislation. To review, an employee may qualify for TDB if the employee is unable to work for medical reasons and may qualify for FLI if the employee is needed to care for a family member or for other specified family-related reasons. As currently written, these laws provide partial wage replacement but do not require employers to provide job-protected leave during receipt of those benefits. Under current law, an employee's leave rights are found elsewhere, for example, in the NJFLA, FMLA, ADA, or NJLAD.

This may change, too. The amendments to the TDB and FLI laws provide that an employee receiving those benefits, upon return from leave, will be "entitled to be restored by the employer to the position held by the employee when the leave commenced or to an equivalent position of like seniority, status, employment benefits, pay, and other terms and conditions of employment." This is unquestionably broad language and potentially extends job-protected leave rights to all employees who receive TDB or FLI payments.

If this is the intent of the law, the ranks of employees eligible for job-protected leave have been greatly expanded—far beyond the NJFLA changes themselves. And, because of the broad coverage of the TBI and FLI laws, this change would affect virtually all employers with employees working in New Jersey. The impact of such a change would be remarkably far-reaching. An employee may receive up to 26 weeks of TDB payments; the amendments, thus, could provide job-protected leave for this entire period, more than double the 12 weeks the FMLA provides. In the unusual situation where an employee would be eligible for TDB and then later for FLI (or vice versa), this period could extend even further.

But this language appears to contradict limiting language elsewhere, which advises that nothing in the amendments should be construed as "increasing, reducing, or otherwise modifying any [NJFLA] entitlement" to be restored to employment after a period of leave. It is difficult to square this point with the broader statement seemingly entitling employees to be restored to their former positions after a leave in which they receive TDB or FLI. Given the lack of clarity on how these provisions interact, the New Jersey employer community is hopeful that the state's new Administration will issue formal or informal guidance in the coming months and before the changes' July effective date.

Finally, the amendments also will grant employees the option of using New Jersey Earned Sick Leave (NJESL) or receiving TDB or FLI benefits, and employees may choose the order in which they use these benefits—with explicit allowance for and increasing likelihood that these benefits will be "stacked." And, employees "shall not receive more than one kind of paid leave simultaneously during any period of time." This provision may bar employees from supplementing TDB or FLI benefits with available paid leave (whether NJESL or employer provided PTO) to remain whole during time off.

In Summary

On January 17, 2026, outgoing Governor Phil Murphy signed A3451/S2950, which will expand dramatically the scope and application of the NJFLA. More employers will be subject to the law, and more employees will qualify for job-protected leave. These changes are effective July 17, 2026.

In addition to these changes, the amendments address the receipt of TDB and FLI and may provide job protected leave for those who receive these benefits, although questions remain on this point and further guidance is expected.

Conclusion

While the recent amendments plainly will expand significantly the number of employees eligible for NJFLA job-protected leave, and the number of employers who are subject to the law, the precise contours of the TDB/FLI changes as well as employees' control over the use of NJESL, TDB, and FLI remain far less clear. While further guidance is anticipated, at this point, all New Jersey employers—including those with only a single employee in the State—should review their leave and PTO practices and policies and begin to take steps to bring those policies and practices into compliance with the coming changes.

Note

1. https://legiscan.com/NJ/bill/A3451/2024.

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By Andy Barbeau

Managing for Impact

Despite years of research demonstrating that high employee engagement drives higher organization performance, global management practices have yet to rise to the challenge. Ongoing research by Gallup[1] shows that 68% of employees in the U.S. are not engaged (i.e., not involved or enthusiastic) in their work or organization. In central Europe, dis-engagement levels across multiple countries average out at around 90%, and in Japan the dis-engagement level is an astonishing 93%. What this says about the health of our organizations is alarming. Translated into medical terms, most organizations have a diagnosis of stage four cancer – where apathy and negativity rob employees of their creative energies, crowd out healthy behaviors, and disrupt normal functioning.

Employee engagement is one of the most misunderstood and underappreciated components of both day-to-day operational performance and overall organizational success. Unraveling the root causes behind these extremely low levels of employee engagement, we learn that likely contributors include:

- Widespread failure to provide gratifying work experiences.
- Lack of managers who value, respect, and trust employees.
- Shortage of opportunities to grow, excel, and advance careers.[2]

It is no wonder that so many average employees report being dissatisfied, disengaged, and ready to quit. Ignoring these impacts comes at the peril of productivity, quality, customer satisfaction, and more. It is time to redefine the role of management as creating and maintaining the environmental conditions that allow employees to flourish.

How did things get so bad? What lead to this situation and what can we do about it? Answering these questions requires a brief history lesson into classic management thinking. Dating back to the early industrial revolution – and still intact today – classic management mindsets are based on very pessimistic beliefs about front-line workers:

- They cannot be trusted.
- They do not have the skills to solve problems or make effective decisions.
- They do not have the organization's best interests in mind.

These predispositions result in an us-versus-them way of thinking that portrays management as providing all the thinking, while workers provide the doing. Management's job, therefore, is to ensure the compliance of workers in following instructions, leaving little to no room for intellectual contribution. The truth is that while our understandings of management have progressed considerably, our day-to-day practices have not,[3] and the resulting manager-worker tension is a primary reason for low levels of employee engagement and retention.

As Einstein said, "we cannot continue with the same behavior and expect a different outcome." This has been known, but not implemented, since the early 1900s when Mary Parker Follett called for "power with, not over, the people" and clarified that "the creative power of the individual appears not when one dominates others, but when all unite in a working whole."[4] Follet's 100-year-old ideas are still very relevant and badly needed today. All we need to do is change our ways of thinking about the role of management and the importance of front-line employee engagement.

Instead of managing for strict compliance with someone else's instructions, we must manage such that we promote the commitment of employees through close collaboration.

Rather than assuming the worst, managers and leaders should assume that all workers, especially knowledge workers, want to use their brains, have a say in what and how work is done, innovate and problem solve, learn and grow, etc. Therefore, instead of managing for strict compliance with someone else's instructions, we must manage such that we promote the commitment of employees through close collaboration.

Allowing workers to engage in, and have an influence over, how work is done is a powerful

motivator[5] and is desperately needed in every type of organization and wherever we apply the tool of management. It is only through changing the environmental conditions of employees that we will be able to improve their day-to-day experiences, earn their commitment, and reap the benefits of their improved engagement.

Recommendations

Achieving the right environmental conditions to engage and motivate workers to commit to their organization requires changes to the entire employee journey, including the following:

- *Hiring*: Gallup[6] recommends ensuring a "high degree of alignment between the needs of the organization and each worker's natural talents (i.e., patterns of: thoughts, feelings, and behaviors that can be productively applied)." It is important to look for tendencies like motivation, workstyle, initiation, and collaboration. Current screening methods such as keyword matching between resumes and job descriptions will not achieve the right level of fit and will set employees up for failure. You're not hiring a list of skills, you're hiring a human being with thoughts, feelings, and behaviors that should align with and advance the objectives of the organization.
- *Orientation*: Provide a thorough and clear description of the organization's overall purpose, how it realizes that purpose through value creation for customers, and where and how new recruits will contribute to both. Set expectations by communicating the company's focus on the ends, not the means. "Great managers define outcomes and trust workers to determine how to achieve them."[7] Limiting orientations to a narrow, departmental focus prevents true innovation and problem-solving.
- *On the Job*: Gallup's research[8] represents a shift away from a command-and-control, top-down approach, towards more engaging experiences with workers in their day-to-day duties to ensure the following:
    - "Less bossing, and more coaching. When management moves from the role of boss to the role of coach, it increases employee engagement and performance."
    - Closer personal connections with coaches including "expressions of care and concern, leveraging of strengths, tough love, and early and direct confrontation of poor performance."
    - Stronger engagement through "solicitation of opinions and recommendations, involvement in decision-making and problem-solving, and opportunities to learn and grow."

Formal performance management systems and tools which rate or rank employees should be discarded in favor of personalized guidance on what each employee needs.

    - Sharing of knowledge and changing expectations, "training on new materials and equipment, opportunities for employees to do their best work, recognition, care, and encouragement."
    - Strong team relationships. "There is a global and universal connection between strong team engagements and superior performance."
    - Regular check-ins with employees to understand current sentiments and address issues early before they impact performance. Do not dismiss or underestimate the importance of reported problems as only a few will report them, but many will likely experience them.
- *Advancement*: Gallup[9] suggests candid and frequent face-to-face conversations with employees regarding advancement. Formal performance management systems and tools which rate or rank employees should be discarded in favor of personalized guidance on what each employee needs. Seek out creative ideas to introduce:
    - Other ways to advance or earn gratitude besides climbing the corporate hierarchy; every role is deserving of dignity and recognition.
    - Opportunities across the organization to try different job roles, obtain new skills, make a difference, leverage strengths, and/or achieve a personal career objective.
    - Realistic ways to utilize every employee's personal passions and interests to find the true win-win for the organization and the individual.

Conclusion

Successful managers will be those who embrace and develop every worker's undeniable human nature by allowing them to actively

contribute to a larger cause through collaborative, intellectual engagement in a nourishing environment. A healthier environment for employees will lead to higher levels of engagement that, in-turn, drive better productivity, quality, customer satisfaction, and overall performance.

Notes

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5. Pfeffer, Jeffery. 2018. "Dying for a Paycheck: How Modern Management Harms Employee Health and Company Performance and What We Can Do About It." Harper Business.
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7. Gallup 2019.
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9. Id.

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By Andy Barbeau

Understanding Your People Problem

The so-called "Great Resignation" as well as "quiet quitting," stress, burnout, turnover, and other workplace/management issues negatively affect organizational performance. These issues all have one thing in common: poor employee experiences, especially at lower levels, which is examined in this article.

To resolve the self-inflicted wounds of poor employee experience, employers must first understand and then correct for the single greatest hidden root cause problem leading to these visible symptoms. This will require seismic shifts in how employers think about the organizational system if they want employees to thrive and their organizations to survive. This is due to the very definition of "understanding your people problem" as cited by Larry Kokkelenberg and Regan Miller[1] in their 2022 book *OD for the Accidental Practitioner:* "System influences may well be the strongest influence on human behavior."

"Structuring" People

The single most destructive mistake most organizations make today involves how they structure their people. The ubiquitous "org chart" visually represents two critical dynamics that negatively influence employee experience: specialization, i.e., functions or departments, and hierarchy, i.e., multileveled command and control. Research by Chris Argyris,[2] Nick Obolensky,[3] Johanna Pregmark and Michael Beer,[4] and Sophia Town et al.[5] demonstrates how this centuries-old approach to structuring people often leads to several debilitating outcomes, including:

- *Siloed thinking and action*. Each departmental manager advocates for their own interests, processes, technologies, and unique ways of managing. This can lead to organizational islands with defensive borders.
- *Process complacency*. Siloed managers and employees focus only on their tasks and are ignorant of, and/or apathetic to, overall value-creating processes. This can result in inadequate process execution and outcomes.
- *Process ownership*. Siloed organizations rely on cross-functional processes that require multiple groups to work collaboratively, making ownership and responsibility of those processes difficult to determine.
- *Decision-making*. Hierarchical, top-down decisions occur slowly and are also frequently uninformed by frontline context, which demotivates all levels below, destroying trust and engagement, and paralyzing action.
- *Miscommunication*. Organizational islands and hierarchical levels can motivate both manipulation and distortion of important and urgent information, tainting the resulting understandings, decisions, and outcomes.
- *Organizational silence:* To maintain control, save face, or ensure a win, leaders may dismiss or cover up information that they deem threatening, deafening organizational learning and corrective actions.
- *Suboptimization*. Here, siloed managers pursue optimization strategies that make logical sense locally but are also prejudiced against overall value creation, thus suboptimizing overall organizational operations.
- *Value creation*. Hierarchy attracts employee attention and loyalty away from value creation, requiring additional time, effort, and cost to reintegrate and coordinate the efforts of siloed teams.

The structure of most organizations is a significant, and usually hidden, root cause problem, i.e., the "why" of the people problem.

What does all this really mean? Simply that the structure of most organizations is a significant, and usually hidden, root cause problem, i.e., the "why" of the people problem. Although most managers are not consciously aware of this, many nonetheless attempt to mitigate its effects. Cross-functional teams, matrix structures, servant leadership, team building, etc. are all, in fact, attempts to overcome the misalignment of people and process, according to Kokkelenberg and Miller.[6] Yet the only effective

way to address the real root cause of the people problem is to simplify the structure in a way that creates closer and stronger process relationships.

Recommendations

Anyone can advocate for understanding and addressing the people problem, regardless of their area of responsibility or organizational level. Recall that structures based on specialization and hierarchy actually detract from value creation, so the ideal objective is a unified environment based primarily on processes in the realm of "process orientation." This means an orientation offering a much more simplified, employee-centric structure that aligns with process execution, creating closer and stronger process relationships, and attracting employee attention back to value creation and customers. Done well, process orientation will unify structure and process into a holistic, systems-based model. Thus, the negative effects of specialization and hierarchy will be greatly reduced or eliminated, and operational and customer-facing outcomes will be improved. This involves major change and requires executive management support to complete.

If, however, process orientation is not an option, consider alternatives that enhance understandings of why the organization exists, what its ultimate purpose is, and how its customers define value in terms of the desired products, services, and most importantly, experiences and outcomes. Specifically:

- Identify the overall end-to-end process flow to achieve outputs and outcomes. View the whole organization and its relationships across all teams. A physical product would flow from raw materials, through the production process, to finished goods, and finally, to happy customers.
- Define an operational vision of each team's role in terms of how they will productively contribute, directly or indirectly, to the end-to-end value creation flow to drive customer outputs and outcomes.
- Share this vision with all teams and ask them to enhance and improve it. Work with them until they see themselves as part of the larger objectives so they can commit to being a part of it. Have each team use the vision to define their own performance measures.
- With each team on board, share this vision with executive leadership for implementation. Advocating for a strong focus on value creation and customer outcomes should logically resonate with owners, chief executive officers, and boards.
- To build momentum, constantly look and advocate for opportunities to improve the overall system of value creation and customer outcomes, not just a specific team. Look beyond local borders when problem-solving and solutioning.

Conclusion

Only by moving forward together as a whole will organizations thrive and survive in this complex world.

But the good news is: It can be done!

Notes

1. Kokkelenberg, Larry, and Regan Miller. 2022. OD for the Accidental Practitioner: A Book Written by Practitioners, for Practitioners. Parker Publishers (hereinafter Kokkelenberg Miller).
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6. Kokkelenberg Miller, supra n. 1.

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