RISK strategies CONSULTING

WHITE PAPER

Disclosure, Transparency, and Fiduciary Responsibility in Healthcare

Revised June 2025

Revisions to this white paper highlight updates to various lawsuits that have been filed pertaining to fiduciary responsibility.

Several industry lawsuits pertaining to fiduciary responsibility have been filed recently. The outcomes are varied. The merits of these cases are best left to the litigants and their respective counsel. This is an opportunity to emphasize the importance of **enhanced disclosure**, **robust diligence, and enhanced audit practices** enforced by **well-written contracts** to ensure **alignment and accountability** among key health industry stakeholders. Risk Strategies Consulting highly recommends that healthcare stakeholders change the underlying dynamic to one of transparency. The industry simply cannot achieve truly collaborative outcomes if we cannot trust one another and advocate for full disclosure in regards to our specific areas of focus.

There is an amplified level of frustration over the lack of transparency, clarity, and understanding of how healthcare services and access are selected, managed, financed, and made available to employees (i.e., patients). These sentiments are evidenced through growing consumer transparency regulations over recent years including the Transparency in Coverage Rule.[1]

Fiduciary Responsibility and Government Legislation

Recent suits focus on fiduciary responsibility associated with regulations stemming from the Employee Retirement Income Security Act of 1974 ("ERISA") and the Consolidated Appropriations Act of 2021 ("CAA"). ERISA governs most employee benefit plans. ERISA's main objective was to reduce abuse in voluntary benefits and overall health plans in the private industry. In 2006, the Pension Protection Act extended employer fiduciary requirements through minimum funding standards of pensions.[2]

Although ERISA does not apply to state and local government health and welfare and pension plans, state and local governments are prohibited from regulating private employer-sponsored health plan benefits (via employer, self-funded plans). ERISA generally prohibits states and localities from forcing employers to create or amend an employee benefit plan or from enacting statutes or ordinances controlling the administration of an employee benefit plan established under ERISA.[3]

Since ERISA was enacted, federal legislators have frequently considered altering ERISA preemption to provide states greater flexibility and latitude. Proponents of this view suggest that because nearly 155 million people get coverage through employer-sponsored plans, ERISA preemption impedes state health reforms, from incremental improvements such as claims data collection, all the way to comprehensive proposals for state single-payer systems.[2] They also claim that state laws (rather than federal laws) are biased to insurance claimants and allow them to sue insurance companies for breach of contract, insurance bad faith, and punitive damages.[4] Proponents of ERISA preemption maintain that multistate employers cannot provide quality, affordable benefits to working families if they must comply with fragmented recordkeeping, reporting, or other state and locally imposed mandates on ERISA plans in addition to federal rules. They assert the consequences would adversely affect labor markets, disadvantage employees based on where they live or work, prompt employers to cut back on benefit coverage, and raise the cost of health insurance and retirement plans — ultimately pricing some employees and their families out of the market, undermining their health and financial well-being.[5]

Specific Health and Welfare Cases

Section 404 of ERISA mandates fundamental fiduciary duties as summarized below.[6]

- Regularly monitor plan service providers including third-party administrators ("TPAs") and pharmacy benefit managers ("PBMs").
- Payment for plan expenses must be reasonable and necessary for plan operation.
- Act solely in the interest of plan participants and their beneficiaries, with the exclusive purpose of providing benefits to them.
- As a fiduciary, all duties must be carried out in a prudent manner.
- Conform plan documents with ERISA mandates.
- Hold plan assets, if applicable, in trust.

Recent lawsuits question plan sponsor and administrator fiduciary performance. These cases have generated significant attention in the media, yet little, if any, legal recourse has come out of these actions. Due to broad interpretation of applicable law, we expect the pace of litigation to continue and that numerous perspectives, and interpretations will be utilized in pursuit of a favorable verdict. Risk Strategies Consulting is not a law firm, and we offer no opinion on the validity of the cases, or perceived ill-intent or error on the part of plan sponsors or insurers. We believe these cases are a direct reflection of the need for examination and focus on the facts, cadence of controls, and communications instead.

1. Johnson and Johnson (J&J)[7]

Last year, the J&J class action lawsuit was filed on February 5, 2024, in federal court in New Jersey. The suit alleged breach of fiduciary duty under ERISA for mismanagement of J&J's pharmacy benefits plan, purportedly resulting in the plan and plan participants overspending millions of dollars. The case was novel as it appeared to be the first of its kind on the health plan fiduciary side. Until J&J, suits generally involved employer health plan sponsors suing third-party administrators (TPAs) for breaches of fiduciary duties imposed by ERISA.

On January 24, 2025, the United States District Court for the District of New Jersey dismissed the action.[8] The court dismissed the plaintiff's claims for breach of fiduciary duty under ERISA, finding that the plaintiff failed to adequately allege constitutional (Article III) standing.

The court concluded that the plaintiff's failure to satisfy the requirements for standing warranted dismissal. Specifically, the court found that the plaintiff's purported injury — the payment of higher premiums — was speculative and hypothetical and that the plaintiff failed to allege that the employer's "specific conduct" resulted in the plaintiff's payment of higher premiums.

Notably, the court recognized that the plaintiff's allegations of paying higher prices for specific drugs as a result of the employer's alleged fiduciary breaches was a concrete injury-in-fact that was traceable to the employer's alleged ERISA violations. The court held that the plaintiff failed to demonstrate that her injury was redressable because she had already reached her prescription drug cap for each year. Thus, a favorable decision would not be able to compensate the plaintiff for the money she already paid.

Although the J&J case was dismissed, the court did not close the door on ERISA fiduciary breach claims. The District Court left open the possibility for another plaintiff to establish Constitutional standing to the extent they have a redressable injury.

2. Bricklayers and Allied Craftworkers Local[1] Fund, et. al. vs. Anthem[9]

This class action was filed in federal court in Connecticut alleging that network access provider, Anthem, (now Elevance Health), unlawfully refused to allow self-funded health plans, with which they contract, to access their plan claims data in violation of federal laws. Plaintiffs separately negotiated with Elevance to attempt to gain access to their health plan claims data, as they are required to periodically review to fulfill their monitoring function imposed by ERISA. Elevance allegedly refused access to claims data, notwithstanding the fact that the Transparency in Coverage Final Rule requires plans to publish in-network provider rates for covered items and services. Additionally, the Hospital Price Transparency Final Rule requires hospitals to publish payer-specific negotiated rates. Further, the CAA prohibits plans from entering into agreements with service providers that offer access to a provider network if their agreement directly or indirectly restricts the plan from obtaining electronic access to claim and encounter data for all plan participants.[1]

The Bricklayers also alleged that Elevance engaged in prohibited transactions and failed to manage claims prudently, all in violation of ERISA.

The case was dismissed on April 24, 2024, for failure to state a claim. The court found that the plaintiffs failed to plausibly allege that any defendant is an ERISA fiduciary.

To state a claim for breach of fiduciary duties under ERISA, plaintiffs must first plausibly allege that defendants are plan fiduciaries with respect to the challenged conduct. In order to be a fiduciary under ERISA, one must be either a named fiduciary, with the authority to control and manage the operation and administration of the plan, or a "functional fiduciary" with discretionary authority in the management of the plan.

In assessing whether or not defendants are plan fiduciaries with respect to the challenged conduct, the court found that plaintiffs failed to plausibly allege that defendants exercised or possessed the discretionary authority required to be an ERISA fiduciary nor were they a named fiduciary. As a result, the case was dismissed for failure to state a claim.

Plaintiffs have since filed an amended complaint and a motion to dismiss the amended complaint is still pending as of the release of this updated white paper.

3. Navarro v. Wells Fargo[10]

On July 30, 2024, a class action lawsuit was filed against Wells Fargo by former employees, alleging that the company breached its fiduciary duties under ERISA. The plaintiffs allege that Wells Fargo failed to conduct a diligent search for a Pharmacy Benefit Manager (PBM), failed to use its bargaining power to negotiate better contracts, failed to retain a pass-through or alternative model PBM, and failed to steer participants toward lower cost specialty drug alternatives.

The case was dismissed on March 24, 2025, for lack of Constitutional standing.[11] Applying a similar analysis to that in the Johnson and Johnson case, the court concluded that the plaintiff's alleged injuries were "speculative and, ultimately, not redressable." As a result, the case was dismissed.

4. Stern v. JP Morgan Chase Bank[12]

On March 13, 2025, a class action lawsuit was filed against JP Morgan, asserting claims similar to those in the Johnson & Johnson and Wells Fargo cases. Plaintiffs allege that JP Morgan breached its fiduciary duties under ERISA mismanagement of the prescription drug benefits under the plan, failed to exercise prudence in overseeing and selecting a PBM, and that these failures resulted in price discrepancies and increased costs for prescription drugs and other services under the plan. This case differs from Johnson & Johnson and Wells Fargo because plaintiffs allege that all the generic drugs in the formulary compared with publicly available National Average Drug Acquisition Cost (NADAC) information were overpriced, rather than just some.

Plaintiffs also allege that defendants breached their fiduciary duty by allowing such price increases because of the business relationship between JP Morgan and the PBM (CVS/Caremark). Plaintiffs allege that JP Morgan was willing to cause their participants to pay higher prescription drug prices in order to strengthen the relationship between JP Morgan and Caremark.

Among other allegations, plaintiffs claim that:

- Defendants breached their fiduciary duties by agreeing to grossly inflated prescription drug prices, costing the JP Morgan plan and its participants millions of dollars through higher payments for prescription drugs, higher premiums, higher out-of-pocket costs, higher deductibles, higher coinsurance, higher copays, and suppressed wages.
- Defendants agreed or allowed prescription drug prices up to 560 times higher than comparable online prices.
- The formulary included a 211% average markup on 366 generic drugs.
- Defendants failed to take reasonable steps to reduce drug costs, monitor PBM performance, or use their bargaining power to obtain better terms.
- Defendants breached their duty of loyalty and their duty of prudence by placing their own business interests ahead of those of the plan and its participants in letting matters slide with respect to the plan's PBM and prescription drug program, and the costs of that program.
- Defendants violated ERISA's prohibited transaction provisions in failing to show that the compensation paid to Caremark was "reasonable" and failing to identify any other prohibited transaction exemption.

JP Morgan intends to file a motion to dismiss the complaint and the matter remains pending at the time of the release of this white paper.

5. Kraft versus Aetna[13]

Kraft Heinz hired Aetna to administer their medical and dental plans for employees, retirees, and their family members. Allegedly, Aetna leveraged its role as the TPA to enrich itself to Kraft Heinz's detriment. Although the matter was widely published when it was filed, Kraft ultimately dismissed the case, and the parties agreed to arbitrate the dispute.

6. Mass Laborer Health and Welfare Fund (Fund) vs. Blue Cross Blue Shield of Massachusetts (BCBSMA)[14]

The Fund alleged that BCBSMA had paid providers in amounts exceeding contractually negotiated amounts. The Fund made these claims against BCBSMA, under ERISA, with each claim dependent upon BCBSMA's status as a fiduciary. The District Court granted BCBSMA's motion to dismiss finding that the Fund had not made sufficient allegations that BCBSMA was an ERISA fiduciary.[15]

On appeal, the Circuit Court affirmed dismissal, holding that BCBSMA was not an ERISA fiduciary. The Court noted that fiduciary status under ERISA arises in two ways: being a named fiduciary on a plan insurant or being a "functional fiduciary" by exercising discretionary authority or control, rendering investment advice for a fee with respect to plan assets, or having discretionary authority in administration of the plan.

In an extensive opinion, the Circuit Court determined that BCBSMA was not a fiduciary under ERISA and affirmed dismissal of the Funds suit.[14] The discussion is an important one for TPAs; however, it was anchored in the contractual obligations agreed to by the parties and emphasizes the need for careful contractual planning and language among TPAs and Plans.

7. Owens & Minor vs. Elevance Health[16]

Owens & Minor, a medical-equipment supplier, sued a unit of Elevance Health in federal court in Virginia, alleging the insurer blocked the company's attempt to get its health plan data. The matter is similar to the Bricklayers matter and focuses primarily on the "gag clause" prohibition found in § 201 of the CAA.

The parties agreed to dismiss this case in August of 2023, presumably as a result of Owens & Minor receiving its health plan data. However, after receiving this data, Owens & Minor has since initiated a new lawsuit[17] against Anthem Health Plans of Virginia alleging that Anthem breached its fiduciary duties resulting in significant losses to the plan paid for by employees and the company itself. Because a motion to dismiss the case has been filed, the matter remains pending as of the release of this white paper.

8. SMO et al. v. Mayo Clinic, U.S. Dist. Ct., Dist. of MN[18]

An Arizona Mayo Clinic hospital worker filed a purported class action lawsuit against the health system and insurer, Medica. The suit was filed on April 2, 2024, and alleges that Mayo employees were saddled with enormous healthcare bills after their claims were "systemically underpaid."[19] Mayo Clinic employees claim to have racked up more than $10,000 in healthcare costs a year and that they avoided going to the doctor for fear of the cost, all while working for one of the world's most prestigious healthcare organizations. The Defendant claims that Medica uses "deceptive, misleading, arbitrary" pricing methods that leave plan members in the dark about costs and allow for inconsistent reimbursement rates, all in violation of federal law and Medica's fiduciary responsibilities. Medica's provider portal, which is intended to direct workers to in-network doctors and other healthcare professionals is heavily criticized because Medica allegedly provided false and misleading information about providers in the portal, as the plaintiff found no in-network providers when using the portal, leading to believe she could have care covered by out-of-network providers. Additional allegations involve a lack of transparency in the explanation of benefits, so members do not have enough information to understand or appeal Medica's coverage determinations. Finally, Mayo's remote workers must find providers that are part of a third-party network to receive the most affordable care; however, workers claim that clinicians who are a part of this network are not taking new patients, no longer accept the insurance, or have retired.[19]

A motion to dismiss the case has been filed, and the matter remains pending as of the release of this white paper.

Healthcare Stakeholder Implications

Risk Strategies Consulting offers no opinions or legal advice; however, we believe issues raised in suits such as the examples cited, usually can, and should be solved by *changes in the practices by those involved* rather than by litigation. By "practices," this is referring to healthier ways to run a business through *enhanced disclosure and clarity, deep diligence,* and *stronger audit practices, enforced by well-written contracts, to ensure alignment and accountability* that is made available to all relevant stakeholders.

Plan Sponsor and Payor Implications

Plan sponsors are charged with the duty of managing administration, compliance, finances, and strategy in a highly complex and ever-evolving world of statutes and regulations. One could ask why a plan sponsor would purposefully overpay for benefits when they incur the cost of half to two-thirds of the benefit plans themselves? They are essentially attempting to improve the **value and quality** of the provision of healthcare as well as the **customer service** to plan participants. Value and quality are variable terms, driven by market conditions and the goals and objectives of the plan sponsor; yet the complexity of achieving plan goals is ever necessary. Because of this, plan sponsors hire consultants as subject matter experts that lend objectivity, advice, and recommendations. Unfortunately, and frequently, consultants lack tested diligence methodologies and are often financially conflicted. For example, consultants may own PBM coalitions, may have created required clinical management packages for use by carriers and for which they are reimbursed, and may have innovation and transformation groups, which seemingly bring new solutions forward, but for which they receive revenue streams or backend bonuses. Risk Strategies Consulting believes these conditions violate their fiduciary responsibilities and constitute a prohibited transaction under ERISA, if they act as an ERISA fiduciary.

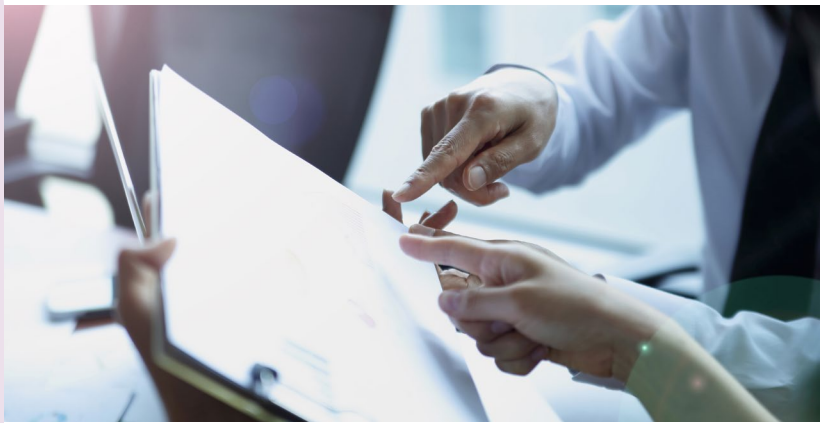
Regardless of any delegation of fiduciary duties, plan sponsors are advised to consider, in collaboration with legal counsel and benefits consultants, the following **action items as proactive measures that may mitigate potential liability.**[6]

- Establish protocols for consistent monitoring of plan service providers.
- Ensure consistent and regular interval tracking of plan expenses to ensure they are reasonable under the circumstances.
- Implement RFPs and market check exercises at regular intervals for all plan service providers including TPAs and PBMs.
- Complete regular internal claim audits that monitor plan service provider performance and plan expenses.
- Engage legal counsel to create a formal benefits committee.
- Conduct committee meetings consistently and provide ERISA fiduciary training for committee members.
- Carefully document all plan fiduciary-related actions and the decisions of the committee.

Risk Strategies Consulting emphasizes that the level of diligence performed by the industry is short of best practice standards. The use of Uniform Data and Discount Specifications to reveal a carrier network discount position is a prime example of an insufficient representation of the overarching network discount for a carrier in a given geography.

How can the industry do better?

For starters, RFPs need to focus on obtaining more precise disclosure of revenue streams, costs, fees, and how vertical or vendor-supplied benefits are positioned, financed, incentivized, and integrated into the total plan offering. Plan sponsors rarely require carriers to outline the details of their direct and non-direct revenue streams. Having undisclosed revenue streams is not helpful and can culminate in distrust, volatility, and legal activity.



Divulging them and their underlying incentive structure that drive certain processes and practices could help explain strategies and decision-making choices made by key healthcare stakeholders that impact plan sponsors and their membership. The multitude of potential revenue streams may be demonstrated through vertically held services such as payment integrity and clinical management, value-based reimbursement risk share, out-of-network negotiation savings, network access fees, and others. Furthermore, and inopportunely, audit models do not illuminate detail around non-claim charges in the claim file or charges that flow differently through the bank account.

To consistently capture carrier financial status, Risk Strategies Consulting has developed a Financial Disclosure Questionnaire tool that can be utilized to conduct a side-by-side comparison of carrier bidders in an RFP, to support development of a more panoramic view of total costs and value for a plan sponsor, and to aid carriers in identifying and consolidating fragmented cost and savings streams. The ultimate objective of the questionnaire is to clarify the types, amounts, frequency, transmission methods, and purposes of any disclosed or undisclosed costs and revenue streams that impact cost or value of healthcare for a self-funded plan sponsor. Ensuring transparency and clarity of the content and impact of all direct and non-direct carrier revenue that impacts plan sponsors is highly important for them to responsibly understand, manage, and make strategic decisions regarding healthcare benefit administration on behalf of their employees. Revenue types are categorized into the following high-level categories:

- Administrative Fees
- Clinical Fees
- Pass Through Savings
- PBM-specific
- Affiiated Organizations

Within each of the categories, we elicit per employee or member per month amounts, frequency, transmission method, purpose, any dollars withheld from the plan sponsor, and a comparison to book of business averages. We also invite carriers to elaborate on any fees or savings not explicitly requested via the tool.

In our experience, plan sponsors typically neglect to ask key RFP questions in follow-up with questions relating to pertinent information that was not asked and answered in the body of the RFP as well as the distinguishing features their models and solutions bring — along with how these may be qualitatively and quantitatively measured for outcomes performance. As an illustration of the importance of outcomes measurement, since carriers are paid to sell volume, the present process allows them to “sell up” solutions or programs that are not necessarily beneficial to the plan sponsor and their covered population. Because having access to quality care is deemed essential for all, programs presented as high quality are frequently highly charged... ***We can do better.***

Different levels of direct fiduciary oversight exist when the plan is fully insured by a carrier as opposed to self-funded by an employer. For self-funded plans, the size and sophistication of the plan sponsor is a significant factor, which will drive many of these decisions. Typically, in fully insured arrangements, the payor owns significant elements of claims and financial responsibility. Alternatively, in employer-sponsored plans, meeting fiduciary responsibilities and liabilities is part of the plan sponsor role. And while the payor still mostly owns the claims fiduciary responsibility for employer-sponsored plans, the plan sponsor usually retains the financial elements unless they sell off these aspects (but this is less common). Depending on the size of the plan sponsor and access to funding, differing levels of control may be exhibited for procurement, contract management, and vendor selection and management. Plan sponsors may also hold carriers partially responsible through requests for performance guarantees, and again, this is leveraged primarily through the size and influence of the larger plan sponsors that are attractive sales targets to carriers. Ultimately, plan sponsors may decide to transfer partial fiduciary responsibility to others, but not full responsibility.

Having a robust system of checks and balances, overseen by formal committees to ensure quality performance and accountability from vendors, is indispensable for plan sponsors. They usually need health benefit advice and counsel from legal, financial, and procurement professionals as well as from an independent fiduciary and an agnostic health and welfare benefit consultant. No one entity can offer the totality of controls a plan sponsor needs for employee benefit plan management and accountability in determining market standard or market-leading practices and performance. To reiterate, maintaining audit rights to ensure administrative functions, clinical decision-making, financials, and plan designs are congruent and responsibly administered on a day-to-day basis is essential. Creation and implementation of these four functions would adequately address all fiduciary responsibility concerns. We illustrate, not to point fingers or insinuate ill motive, rather to acknowledge that the complexities of healthcare administration make it nearly impossible to know all vulnerabilities within systemic processes and that business workflows and revenue streams can sometimes lead to unintended consequences. Only in rare instances have we (Risk Strategies Consulting) had a payor withhold information from us regarding their practices when we ask the right questions about their approaches. Regardless, having transparent, unbiased, comprehensive valuation is crucial to fortify the industry with integrity and best practices for all stakeholders, especially consumers of healthcare. Not holding, these types of conversations place all stakeholders at risk of bombardment with undue questioning over perceived, or actual, failures as a fiduciary.

Consultant Implications

Consultants play a critical role in facilitating efficient and diligent auditing processes. They bring expertise and experience to help healthcare providers, carriers, and plan sponsors navigate this crucial undertaking. Traditional audits are limited because they typically allot only about two hundred fifty randomly stratified claims. This limitation makes determining underlying patterns that illuminate foundational flaws and issues nearly impossible.

We recommend that plan sponsors and carriers set expectations that consultants need to be transparent and to steer clear of consulting relationships where disclosure of professional relationships, which may present conflicts of interest, is not prioritized in transparent communication. Because consultants are the distribution channel for carriers, this sometimes results in their becoming a customer of sorts, whose needs, like any customer's, must be met. This can essentially usurp the standing of the actual customer, the plan sponsor.

Unlike our competitors, Risk Strategies Consulting does not receive direct or indirect third-party monies tied to any project, client, or book of business. This ensures our objectivity and avoids the perception or appearance of any conflicts of interest. Additionally, we do not sell any services other than consulting, and we have no preferred arrangements with anyone in any market segment. For instance, while we are employed by a highly prestigious employer-owned pharmacy coalition, we do not own a pharmacy coalition. This fact distinguishes us from nearly all of our competitors and ensures our objectivity, while also enabling us to avoid any appearance of conflict of interest. Similarly, we research, examine, and evaluate emerging and distinctive players/potential vendors in a number of market segments, which relate to the needs of our clients. Although we are well-versed and have a deep understanding of these offerings, Risk Strategies Consulting does not own or have an equity interest in any solution. This differentiates us from the market standard within the consulting industry, whereby often, some form of remuneration occurs between the consultant and the vendor when the vendor is selected to serve a client.

Essentially, forward-thinking consultants like Risk Strategies Consulting advise adopting new and innovative auditing approaches to help healthcare organizations deal with outdated systems and to mitigate potential difficulties. This includes not only ensuring the depth and integrity of the data, but also involves evaluation of all supporting policy and documentation, as well as consideration of the use of automation and customized practices. Leveraging a combination of **technology-fortified and human capital solutions** may significantly benefit healthcare entities. Risk Strategies Consulting also employs proprietary tools designed to enhance claim workflow, process, dashboards, and data dissemination. Use of these **core solutions** empowers us to focus on a multitude of in-demand and client-centric product offerings.

Advanced Data Analytics Tools

These tools enable auditors to efficiently process vast amounts of healthcare data and can identify patterns, anomalies, and trends within claims and medical records faster than people. By analyzing this data, auditors can uncover potential errors and help prioritize which claims to investigate more thoroughly, making the process more focused and cost-effective.

Survey Analysis

This is an important ingredient within the auditing framework to assess usability, performance perceptions, and efficiencies, and may contain qualitative and/or quantitative aspects. The sample size is significant to ascertain appropriate weighting and benchmarking, and trends over time can signal an issue that is gaining momentum (helpfully or detrimentally).

Generative Machine-based Learning (ML) Models

These models assess and help manage the financial and clinical risks associated with healthcare claims, reimbursement, and related expenses. They enable auditors to make data-driven observations, identify potential areas of concern, and develop financial sustainability as well as compliance strategies.

Clinical Knowledge and Expertise

Having subject matter experts ensures auditors can more accurately assess the clinical efficacy of healthcare claims and services. This expertise contributes to error identification, clinical standards compliance, care quality assessment, and the promotion of efficient, patient-centered, healthcare practices.

Business Plan

This is the underpinning to the successful use and deployment of all the elements outlined in this white paper, and is critically aligned to a robust project plan containing high-level deliverables that culminate in the audit function, which also is a crucial, ongoing exercise. The team ensures that **administrative, clinical, financial, contractual, compliance, and regulatory aspects** of the initiative being audited are incorporated including:

- Success definition
- Discovery
- Specifications and requirements
- Reporting and analytics
- Audit

Consultants must be held to the highest possible standards, including being able to examine alignment between plan sponsor, payor, and vendor objectively. Determining if this alignment coincides with the purpose, mission, and definitions of success needs to be front and center when making recommendations and offering guidance. Lack of alignment is one cause of a multitude of industry emotions at the moment such as the concerns over spread pricing amidst pharmacy-medical entities and pricing. Another area that is not always clear to plan sponsors is how fee-for-service and value-based reimbursement coincide or complement the quality and savings value propositions of payor networks and vendor-contracted solutions. Payor use of antiquated, disconnected claims systems; the existence of tired business processes; and the growing array of specialty and pharmaceutical codes that are variably utilized by carriers are less than optimal and generally detrimental.

Risk Strategies Consulting believes these factors, amongst many others, need to be addressed head-on. Best-in-class consultants must focus their questions to ensure they are adeptly asking the *right* questions, while also illuminating those they have not asked but *should* ask. Although none of these questions are particularly complicated, they are positioned to be direct, probing, and curious.

- What do we need to learn, and how are we going to learn?
- What data and other assets do we need to ingest?
- What are we trying to answer?
- What do we need to do with this information?
- What have we not considered?
- What is the client distinctly qualified to perform versus those areas of opportunity?
- Are contractual, plan terms, and regulatory obligations appropriately fulfilled?
- Are the benefit plan outcomes consistent with the plan terms and plan sponsor values?

The Risk Strategies Consulting auditing framework is laser focused on claim line level detail and also takes an integrated and longitudinal view throughout the member/patient's journey within their healthcare ecosystem and across the provider and payer environments. While this approach may be atypical, the process is vitally important. Viewing the claims, pricing, and reimbursements methodology on a single, claim by claim method renders important findings, but viewing longitudinally reveals a contextual perspective of care activity over time. Furthermore, other dimensions crucial to claims adjudication and reimbursements are factored in such as carrier and employer policies, clinical management program inputs, local and federal legislation by plan/offering type, and provider-specific contract provisions and reimbursement clauses. These aspects apply regardless of the audit subject at hand. In order to accomplish this more holistic evaluation, the technology and data elements below, coupled with **auditing and clinical professionals**, are imperative for dynamic auditing validation.

- Data logistics and management
- Technical frameworks
- Machine-based learning, informed algorithms
- Predictive analytics

These tools and approaches position us to deliver considerably higher rates of recovery, operational efficiency, financial value, reduced abrasion, predictable revenue cycle management, and causal interception for efficiencies in recovery. This further helps to address the fragmented, antiquated systems that are currently being used to navigate data management and support complex reimbursement models and specialty drugs. Having a transformative partnership with our clients redefines audit, shifting downstream impact to upstream solutions, creating value beyond a traditional recovery focus and allowing for an alignment of incentives.

In Conclusion

Plan sponsors, carriers, and consultants have important and distinct responsibilities in ensuring compliance with fiduciary requirements and accountability. ERISA, CAA, and the Transparency and Coverage Rule require diligent adherence to standards and regulations designed to protect employees and ensure they are provided sufficient support when accessing healthcare and services. The landscape of compliance is ever-changing, and carriers and plan sponsors have different responsibilities, depending upon whom bears the title of insurer (fully insured versus self-funded) and what components are delegated to others and with discretion exercised.

Carriers and plan sponsors have enormous responsibility to promote a dynamic where transparency is expected and to insert appropriate checks, balances, controls, auditing, and committee oversite as well as legal and consultant advisement. While we express no opinion on the validity, or lack thereof, with respect to recent lawsuits, we do note that they have raised awareness within the industry, and strongly support objective, diligent, consistent, fact-facing, probing evaluation and auditing practices that foster transparency and reveal direct and non-direct revenue streams. Promoting such business practices amongst constituents and offering an evaluation of how these bring value to consumers as imperatives is critical to future success. This includes a multifaceted assessment of *administrative, clinical, financial, contractual, and regulatory* dimensions.

Citations

1. Transparency in Coverage, 85 FR 72158 (2020). https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage
2. Raval, A. (2023, October 17). Why government plans are exempt from Erisa. Berg Plummer Johnson & Raval, LLP. https://bergplummer.com/blog/disability-insurance/why-government-plans-are-exempt-from-erisa/
3. McCuskey, E. Y. (2023, February 9). Reforming ERISA to help states control health care costs. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2023/feb/reforming-erisa-help-states-control-health-care-costs
4. Waddill, K. (2023, February 23). How to fix ERISA waivers to pursue employer sponsored Health Plan Reform. HealthPayerIntelligence. https://healthpayerintelligence.com/news/how-to-fix-erisa-waivers-to-pursue-employer-sponsored-health-plan-reform
5. Protecting ERISA Preemption. The ERISA Industry Committee. (n.d.). https://www.eric.org/protecting-erisa-preemption/
6. Honig, E. (2024, February 23). New Group Health Plan Fiduciary Lawsuit Draws Attention. Risk Strategies. https://www.risk-strategies.com/blog/new-group-health-plan-fiduciary-lawsuit-draws-attention
7. Lewandowski v. Johnson and Johnson et al., 1:2024cv00671 (D. N.J. 2024)
8. Lewandowski v. Johnson and Johnson et al., 3:2024cv00671 (D. N.J. 2025)
9. Trustees of the International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund et al v. Elevance, Inc. et al, 3:2022cv01541 (2nd Cir. 2023)
10. Navarro v. Wells Fargo & Co. et al., 24-cv-3043 (D. MN 2024).
11. Navarro v. Wells Fargo & Co. et al., 24-cv-3042 (D. MN 2025).
12. Stern v. JP Morgan Chase & Co. et al., 1:25-cv-02097-JLR (S.D. N.Y. 2025)
13. Kraft Heinz Company Employee Benefits Administration Board et al v. AETNA Life Insurance Company, 2:2023cv00317. (5th Cir. 2023)
14. Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass., 66 F.4th 307 (1st Cir. 2023)
15. Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass., Civil Action 21-10523-FDS (D. Mass. Mar. 30, 2022)
16. Owens & Minor, Inc. v. Anthem Health Plans of Virginia, Inc., 3:23-cv-00115, (E.D. Va.2023)
17. Owens & Minor, Inc. v. Anthem Health Plans of Virginia, Inc., 3:24-cv-820, (E.D. Va. 2024)
18. S.M.O. v. Mayo Clinic et al., No. 0:2024cv01124 (8th Cir. 2024)
19. Nesterak, M. (2024, April 3). Mayo Clinic employee files class action lawsuit over High Health Care Costs . Minnesota Reformer. https://minnesotareformer.com/2024/04/03/mayo-clinic-employee-files-class-action-lawsuit-over-high-health-care-costs/

Get to know us.

Risk Strategies Consulting is comprised of experienced consultants, actuaries, data scientists, auditors, pharmacists, accountants, and other experts able to help payers, providers, and plan sponsors clearly understand the risks of their business and ways to minimize and manage them.

As a national consulting and actuarial services business, Risk Strategies Consulting provides high-touch consulting and state-of-the-art analytics services including strategy and consulting (encompassing health and welfare with deep pharmacy expertise, as well as mergers and acquisitions); actuarial services for plan sponsors, providers, and insurers; and benefit and claim audit services. Services are provided for a wide variety of industry segments including government entities, manufacturing and distribution, and self-funded organizations including corporations and trusts, healthcare organizations, national and regional insurance companies, and private equity firms, among others.

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