RISK strategies CONSULTING

WHITE PAPER

Disclosure, Transparency, and Fiduciary Responsibility in Healthcare

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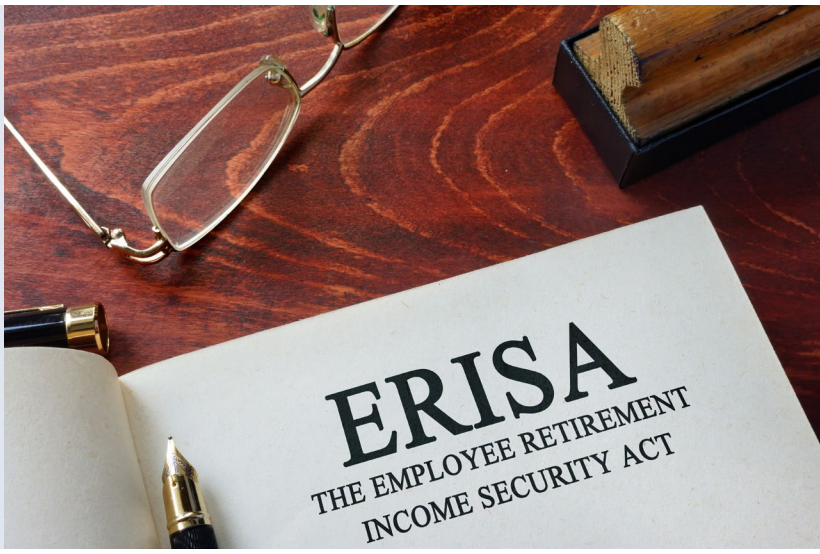
Several healthcare industry lawsuits pertaining to fiduciary responsibility have been filed recently; the outcomes have varied. It is not our intention to weigh in on the merits of these cases; that is best left to the litigants and their respective counsels. Rather, we will use this opportunity to emphasize the importance of **enhanced disclosure, robust diligence, and enhanced audit practices** that are enforced by **well-written contracts** to ensure **alignment and accountability** among key health industry stakeholders. Risk Strategies Consulting strongly advocates 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.

Recent litigation is a reflection of an amplified level of frustration over 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 legislation 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 is a federal law that governs *most* employee benefit plans, and its main objective when created 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]



While ERISA does not apply to state and local government health and welfare and pension plans, state and local governments are prevented from regulating private employer-sponsored health plan benefits (via employer, self-insured plans). ERISA preempts and *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 the ERISA preemption to provide states greater flexibility and latitude. Proponents of this view opine 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 (versus federal/ERISA laws) are fairer 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 are of the view 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, thus undermining their health and financial well-being.[5]

Specific Health and Welfare Cases

ERISA, Section 404, 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.

The following 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. Instead, we believe these cases are a direct reflection of the need for examination and focus on the facts versus the emotions – and asking about the cadence of controls and communications instead.

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

The suit fresh on most everyone's mind is the J&J class action, filed on February 5, 2024, in federal court in New Jersey. The suit alleges breach of fiduciary duty under ERISA for mismanagement of J&J's pharmacy benefits plan, purportedly resulting in plan and plan participants overspending millions of dollars. Defendants include J&J, in its capacity as an employee plan sponsor, J&J's Pension and Benefits Committee, and several Pension and Benefits Committee members individually.

The case is novel as it appears to be the first of its kind on the *health plan* fiduciary side. Until J&J, suits generally involved employer health plan sponsors *suing TPAs* for breaches of fiduciary duties imposed by ERISA. Allegations involve improper handling of claims payments, failure to provide claims data, cross-plan offsetting, and others. The J&J lawsuit also resembles long-occurring ERISA retirement plan fiduciary breach, class action lawsuits, which typically involve employees filing lawsuits against their employer retirement plan sponsors for excessive fees and imprudent monitoring of plan service providers. Highlights of the J&J plaintiffs include the failure to:

- Obtain competitive bids for PBM services at regular intervals by an RFP process.
- Negotiate favorable terms with PBMs.
- Continually supervise PBM actions to ensure that the plan is minimizing costs and maximizing outcomes for beneficiaries.
- Periodically attempt to renegotiate PBM contracts, and/or conduct an open RFP process to solicit proposals from other PBMs.
- Adequately negotiate the PBM contract terms, given J&J's bargaining power as a Fortune 50 employer.
- Independently assess the PBM's formulary placement of each prescription drug, and closely supervise the PBM's formulary management to ensure the plan is paying only reasonable amounts for each prescription drug.
- Properly steer plan participants towards the most affordable access point for drugs.
- Contemplate carving out their specialty-drug program from their broader PBM contract to obtain more favorable pricing.
- Protect plan assets.

J&J has yet to respond to the allegations, and we expect them to mount a robust defense.

2. Bricklayers and Allied Craftworkers Local [1] Fund, et. al. vs. Anthem[8]

A class action was filed in federal court in Connecticut *alleging* that network access provider, Anthem, (now Elevance Health), unlawfully refused to allow self-funded (self-insured) health plans, with which they contract, to access their own plan claims data in violation of federal laws. Plaintiffs separately negotiated with Elevance to attempt to gain access to their own 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, and 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 allege that Elevance engaged in prohibited transactions and failed to manage claims prudently, all in violation of ERISA.

The Bricklayers case has matured to the motion stage and, as expected, Elevance has sought dismissal of the complaint. The legal arguments are complicated and dense and rest on the following theories:

- The Defendants are not ERISA fiduciaries because they lack discretion or control over the Bricklayers plan as to designated functions, arguing that Elevance is merely a contractor that provides services to the actual ERISA fiduciaries – i.e., the Plaintiffs.
- The parties' contract defines the scope of Elevance's duties with respect to data reporting, and audits do not violate ERISA's "gag-clause" provision.
- The complaint fails because Defendants fail to allege any actual "harm" from the purported ERISA violations because they rely on differences among certain sets of claims, data, and rates posted by others on the internet.

In turn, the Bricklayers claim that they were required to sue Elevance under ERISA because Elevance's refusal to provide the plan "… with their own claims data, unless the Plans agreed to severely restrict the use of the date.," violates ERISA's prohibition of "gag clauses" in service provider contracts.[9]

The Bricklayers rely on the gag clause prohibition found in § 201 of the CAA, §724 of ERISA, as ardently as Anthem seeks to disavow its application. In simplest terms, the "gag clause prohibition" prohibits plans from agreeing with plan vendors (i.e., TPAs, as vendors offering access to healthcare networks) that would prevent plan access to cost and quality data. Under §201, Plans must annually attest to compliance with the gag clause prohibition by filing an attestation with the Centers for Medicare and Medicaid Services.[10]

The Bricklayers' Court has scheduled argument of Elevance's motion to dismiss for later this month. While both parties have extensively briefed the relevant ERISA arguments, the possibility remains that the Court will not reach the core legal issues because there is a question as to whether the Defendants have legal "standing" to assert a claim.

Notwithstanding, the case is illustrative of the need for plans and TPAs to dig deeper into contractual and compliance issues related to ERISA, the ACA, and related regulations.

3. Kraft versus Aetna[11]

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 partner agreed to binding arbitration.

4. Mass Laborer Health and Welfare Fund (Fund) vs. Blue Cross Blue Shield of Massachusetts (BCBSMA)[12]

Pending in federal court in Massachusetts, 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.[13]

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.[12] 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.

5. Owens & Minor vs. Elevance Health[14]

Pending in federal court in Virginia. Owner & Minor, a medical-equipment supplier, sued a unit of Elevance Health in federal court in the Eastern District of 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 matter is pending, and one should expect Elevance to assert the same defenses raised in Bricklayers.

6. SMO et al. v. Mayo Clinic, U.S. Dist. Ct., Dist. of MN[15]

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."[16] 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. 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.[16]

The matter is pending, and Mayo has not responded to the allegations.

Healthcare Stakeholder Implications

Again, we offer no opinions or legal advice, however, we believe issues raised on recent suits such as the examples cited above usually can, and should, be solved by *changes in the practices by those involved* rather than by litigation. By "practices," we are specifically 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 law and regulation. 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 the 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 would be 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 at regular intervals 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 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.

Indeed, 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-insured 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 the 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 to the client—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-insured by an employer. For self-insured 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 to amalgamate 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 say that the complexities of healthcare administration make knowing all vulnerabilities within systemic processes nearly impossible and that business workflows and revenue streams can sometimes lead to unintended consequences. Only in rare instances have we 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 places 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 clients navigate this crucial undertaking. Traditional audits are limited because they typically allot only about 250 randomly stratified claims. This limitation makes determining underlying patterns that elucidate foundational flaws and issues nearly impossible.

We recommend that clients 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. Moreover, 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, which can essentially usurp the standing of *the actual customer*, the plan sponsor. Unlike our competitors, we do 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 such as 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 and consideration of the use of automation and customized practices. Moreover, leveraging a combination of t***echnology-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 above elements and is critically aligned to a robust project plan containing the below 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.

- 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. Moreover, determining if this alignment coincides with the purpose, mission, and definitions of success of the client 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 clients, vendors, and carriers 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 embodied with a laser focus on the 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 in 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. Indeed, 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 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- versus self-insured) and what components are delegated to others and with discretion exercised. Nevertheless, 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 successes. This includes a multifaceted assessment of *administrative, clinical, financial, contractual, and regulatory* dimensions.

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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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