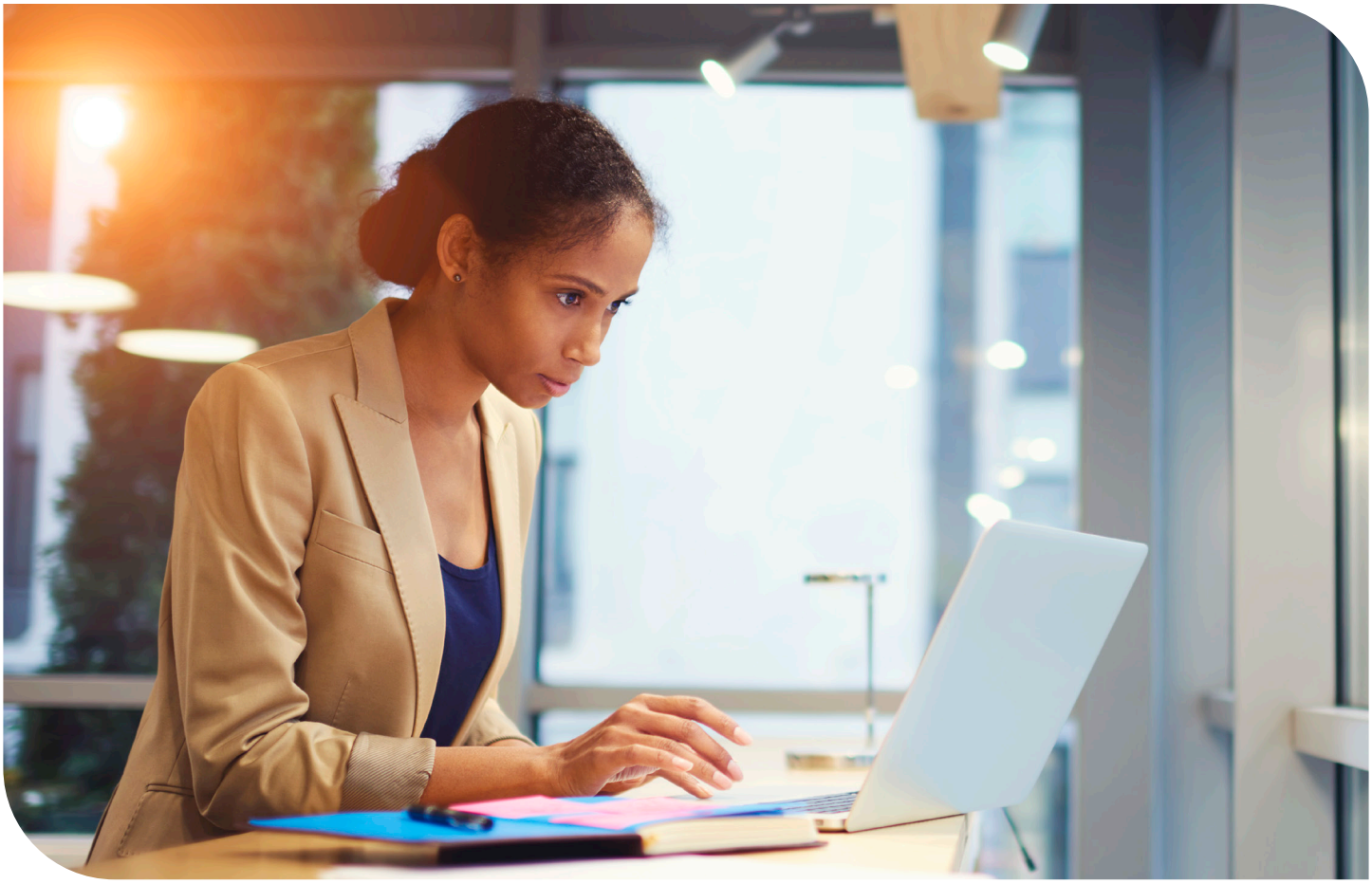


August 16, 2022

A CFO's Guide to Health Plan Fiduciary Leadership

How to Establish a Strategic Fiduciary Framework to Enhance the Value of Employee Health Benefits

PBGH Purchaser Business Group on Health

Introduction

Finally, employers can evaluate the cost and quality of services they are purchasing from providers and other vendors and make informed procurement decisions.

Recent passage and implementation of the Consolidated Appropriations Act (CAA) of 2021 creates new risks and opportunities for employers who self-insure their health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). The CAA mandates employer access to new and critically important insights into the prices they're paying for employee health care services – details they have been unable to previously obtain from vendors to whom they pay millions of dollars each year to negotiate on their behalf. Finally, employers can evaluate the cost and quality of services they are purchasing from providers and other vendors and make informed procurement decisions. In fact, the law requires employers to demonstrate that the health care services they buy for their employees are cost-effective, high-quality and meet mental health parity and pharmacy benefit requirements. This means that employers must take steps to establish oversight procedures and processes to document their efforts to comply with the CAA as fiduciaries, similar to the governance practices employers have already established for their 401(k) and retirement plans.

Implementing an effective health plan oversight and audit framework, with documented procurement processes, can substantially reduce corporate exposure for companies and individual directors, officers and employees. Many employers currently lack adequate controls in their existing service agreements, have historically tolerated unreasonably high fees and costs and often rely upon financially conflicted intermediaries for advice. It is because of these systemic barriers to compliance that CFO leadership is particularly needed to guide corrective action. Compliance may very likely require companies to adopt new business practices, amend existing health benefit contracts and ensure insurance policies for Directors and Officers cover claims involving employee health plans.

The heightened fiduciary risk of being a health plan manager is occurring at a time of increasing health plan expenses, economic pressures, workforce recruitment and retention challenges and a seemingly insatiable employee demand for immediate, personalized solutions that foster overall well-being. CFOs who embrace a health plan fiduciary framework to mitigate litigation risk may find that compliance opens new opportunities to reduce wasteful health care spending, improve predictability and enable better support for the health and wellbeing of their employees and families. The same health plan data that can help CFOs mitigate fiduciary risk can also unlock opportunities for human resource and benefit leaders to better address workforce health challenges and manage delegated services and vendors. Fiduciary leadership that is aligned across finance, human resources and benefit teams can catalyze a transformation of employee health benefits from a liability to a valuable, strategic asset.

Assessing Health Plan Fiduciary Risk

Fiduciary Duties Defined

Both the passage of the CAA and recent ERISA case law have helped define the scope of liabilities for health plan fiduciaries. The following chart identifies the principal duties, audit standard and risks that may exist for many employers.

Principal Fiduciary Duty	Audit Standard	Risk Areas
Act solely in the best interests of plan participants and beneficiaries	Actions must be for the exclusive purpose of providing benefits. Disclose and avoid all conflicts of interest.	Undisclosed financial conflicts of interests may lead to actions that do not benefit plan beneficiaries.
Carry out duties with prudence	Exercise skill, care and diligence in responsibilities. Document process for all health benefit decisions. Ensure adequate expertise for plan decisions or hire competent professionals.	Lack of formal, documented governance and procurement practices can lead to misinformed, or relationship-driven decision making.
Follow plan documents	Plan documents serve as a basis for plan operational and management decisions and should not be deviated from.	Failure to conduct independent testing of third-party handling of eligibility and claims processing can lead to overpayment.
Hold plan assets in trust	Anything defined as a plan asset must be held in trust, with some exceptions. Plan assets include all participant and beneficiary contributions paid to the employer or withheld from the employee, as well as rebates, refunds, dividends, and medical loss ratio returns in most cases.	Delegation of premium accounts without robust accounting and audit oversight can create opportunity for self-dealing and misappropriation of plan resources.
Ensure that Plan Expenses Are Reasonable	Investigate, analyze, hire and monitor plan service providers for reasonableness of fees for all expenses paid for with plan assets (above).	Limited analysis of service provider data for reasonableness of charges, including outlier analysis and service cost benchmarking, can lead to overpayments and medically inappropriate care. ***This is the single largest area of exposure for health plan fiduciaries under the CAA.***

Identifying Internal Fiduciary Roles and Actions

An individual within a company can be found to be a health plan fiduciary based on the responsibility of their role, or the activities they engage in, regardless of their title. Any individual who exercises control or discretionary decision-making over their company's employee health benefit plan is a plan fiduciary. Following are fiduciary roles that officers and employees of self-insured health plans often oversee or perform:

Any individual who exercises control or discretionary decision-making over their company's employee health benefit plan is a plan fiduciary.

- **Plan Oversight:** Selecting, monitoring, and benchmarking performance of expert advisors and service providers that accept fiduciary responsibility. The act of selecting a health plan administrator (TPA/ASO) for an employee health plan is a fiduciary act, similar to the selection of a recordkeeper for a 401(k) plan.
- **Asset Management:** Determining plan contributions, receiving and holding plan contributions, accounting and monitoring of contribution collection and recovery of overdue or delinquent payments, rebates, refunds, dividends, and medical loss ratio returns, with some exceptions.
- **Plan Operations:** Signing the annual employee benefit plan return/report, IRS Form 5500, educating employees, implementing vendors, communicating to employees and service providers, and retaining and managing an auditor.

While certain plan advisory or administrative functions may be outsourced to third-party service providers, the employer retains ultimate fiduciary responsibility - even with express acceptance of fiduciary responsibility by the third party. Business decisions relating to formation/design rather than the administration/management of a plan are not subject to ERISA's fiduciary rules. These are called "settlor" functions under ERISA. This includes decisions, for example, to establish a medical plan, amend a medical plan (e.g., to add a covered benefit) and to terminate a medical plan. Activities that follow a business decision (implementation activities) are subject to ERISA's fiduciary rules.

Best Practices for Compliant Health Plan Oversight

CFOs must be involved in health care purchasing from the standpoint of risk management, financial planning and organizational stability. Despite the complexity of the healthcare industry and complicated nature of the contractual relationships at issue, there are simple and straightforward actions that every CFO can undertake to remain in compliance and within a safe harbor protected from fiduciary liability.

Establish a Health Plan Fiduciary Committee

Conducting a health plan fiduciary risk assessment, or internal audit, enables companies to efficiently assess risk and develop a roadmap for action.

Similar to the formation of 401(k) or retirement plan administrative committees, the establishment of an internal health plan committee, while not required by the Department of Labor (DOL) or Internal Revenue Service (IRS), is a good fiduciary practice for plan sponsors. Not only does it help establish clear roles and responsibilities for plan oversight, it also provides much-needed checks and balances to help the plan remain in compliance and within a safe harbor protected from fiduciary liability. To establish a health plan fiduciary committee:

1. Identify fiduciary activities occurring within the company and the individuals responsible for those activities.
2. Form a committee that includes all internal fiduciary decision makers.
3. Establish good governance practices, including adoption of a charter, regular meetings, documented minutes and appropriate utilization of expert advisors.

Conduct a Health Plan Risk Assessment

Conducting a health plan fiduciary risk assessment, or internal audit, enables companies to efficiently assess risk and develop a roadmap for action. The checklist below offers a starting point that any self-insured health plan sponsor can use to assess their fiduciary risk and take action in three critical areas:

1. Plan governance and oversight
2. Third-party administrative agreements
3. Expert advisor relationships

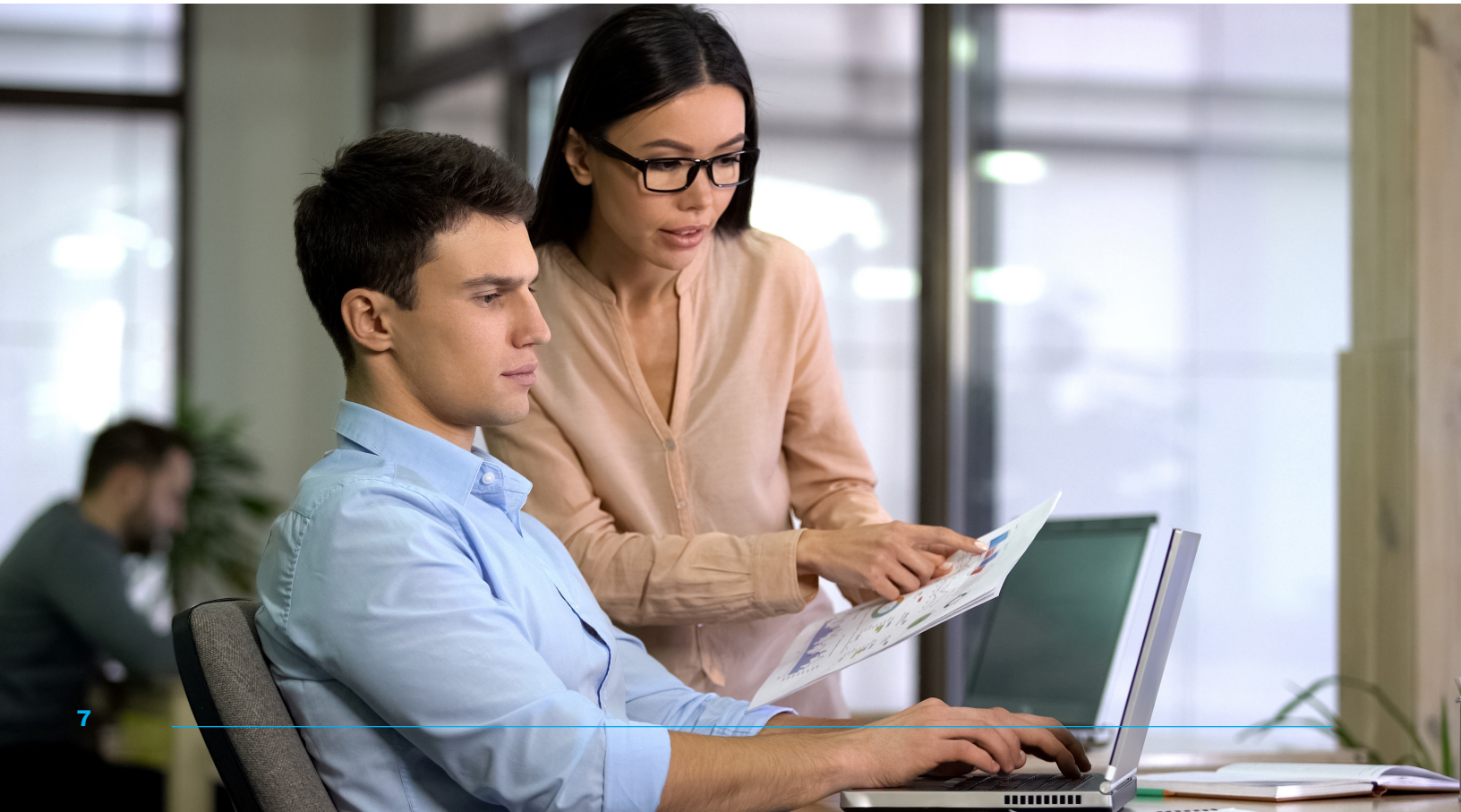
An internal health plan fiduciary committee can help prioritize corrective action based on the degree of risk, cost and alignment with strategic corporate objectives. Once a baseline of compliance is established, oversight efforts can shift to data-driven analysis of health care service costs and quality, which can illuminate new opportunities for action.

Plan Governance and Oversight	Yes	No
Have you identified and named all plan fiduciaries in writing?	☐	☐
Have you adopted standard health plan procurement standards that document unacceptable practices?	☐	☐
Do you have a documented process for interviewing and hiring appropriate third-party service providers?	☐	☐
Have you created and documented all policies and procedures with respect to evaluation of third-party services providers?	☐	☐
Have you ensured that those responsible for health care purchasing decisions have the skill and expertise needed to undertake these duties, and if not, have you engaged an expert?	☐	☐
Have you adopted a written “fiduciary conflict of interest” policy that applies to all individuals and entities with responsibility for advising, recommending and making health care purchasing decisions?	☐	☐
Do you have access to all health care claims data and pharmaceutical data?	☐	☐
Have you developed a means to independently analyze and assess plan expenses for reasonableness and value?	☐	☐
Do you collect and review vendor performance to ensure efficacy, engagement, and overall value to health plan participants?	☐	☐

You must answer yes to the questions above to comply with ERISA.

Expert Advisor Relationships (broker/consultant)	Yes	No
Have you identified external advisors who are subject to the new fee disclosure rules set forth in the CAA 2021?	☐	☐
Have you identified and assigned internal responsibility for soliciting and evaluating the required information?	☐	☐
Have you developed and documented the means to evaluate the information received, both in terms of completeness, relevance and reasonableness?	☐	☐
Have you introduced contractual obligations on external advisors to provide the required information – for all new, renewed, or extended contractual arrangements?	☐	☐
Have you conducted an assessment of whether the compensation is reasonable and whether the information provided presents any other concerns that may need to be further investigated?	☐	☐
For expert advisors with access to plan data and reports, have they created a triaged problem list to guide fiduciary oversight and action?	☐	☐

If you answered no to any of the questions above, there is a significant risk of fiduciary liability for failure to comply with CAA, Section 202.

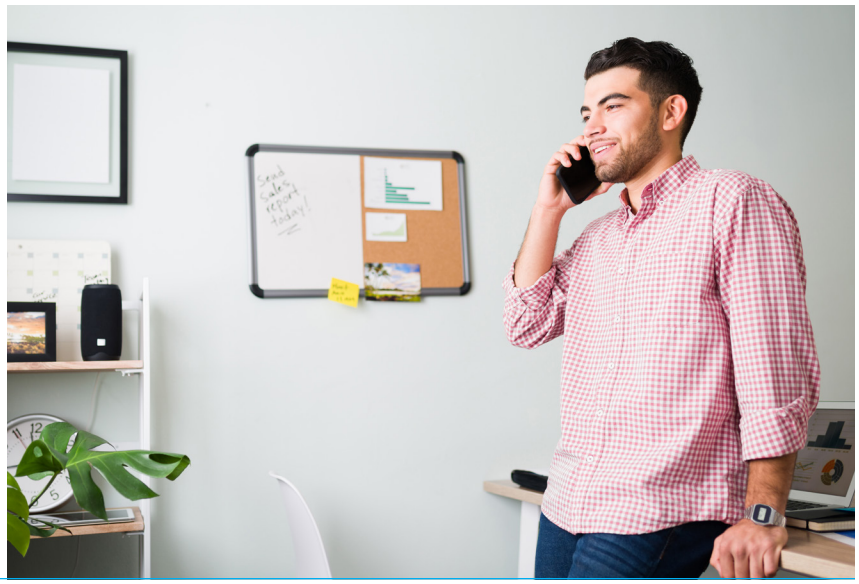


Third-Party Administrative Agreements (TPA/ASO/PBM)	Yes	No
Do your third-party administration agreements include the following language?	☐	☐
Restrictions on employer access to health plan data, including any claim or encounter information	☐	☐
Restrictions on employer ability to share health plan data with third-party business associates	☐	☐
Limitations on audit rights for claims processing, claims payment, or provider contracts	☐	☐
Limitations on recovery rights for claims (i.e., carrier retains discretion to recover overpayments)	☐	☐

If you answered yes to any of the questions above, the agreement restricts your ability to fulfill your fiduciary obligations.

Does the contract restrict use of plan assets for sole and exclusive benefit of plan participants?	☐	☐
Has the third-party administrator attested to having no conflicts of interest, including any financial interest in provider organizations or other third party service providers?	☐	☐
Does the third-party administrator disclose all fees, direct and indirect, derived from the contractual relationship?	☐	☐

If you answered no to any of the questions above, there are significant risks of fiduciary liability for failure to (1) carry out duties prudently, (2) hold assets in trust, and (3) act solely in the best interest of plan participants.



Use Data to Evaluate and Manage Plan Performance

The first and most basic element of a data-driven approach to health care purchasing is to have access to all of the health plan's data, including health care claims data in its most unaltered form. Access to de-identified claims data, as well as provider-specific cost and quality data, is not only prudent, it is required by law under the CAA of 2021 (IRS Code 26 Sec 9824). This data gives the employer the ability to independently analyze and assess plan expenses for reasonableness and value. The need for independent analysis is also supported by case law, and plan sponsors should be careful not to rely solely on aggregated third-party reports to assess reasonableness of fees and expenses (See Tibble v. Edison Int'l, C.D. Cal., No. CV 07-5359 SVW (AGRx), 7/8/10).

This data gives the employer the ability to independently analyze and assess plan expenses for reasonableness and value.

Companies can insource or outsource data collection and analysis, but it should be directed by plan fiduciaries, based on risk, and according to the procurement standards and metrics set by the health plan fiduciary committee. To get started, all self-insured employers should have access to outlier and benchmark reporting at a service level:

1. Identify high-cost and high-demand services areas for beneficiaries.
2. Set cost and quality benchmarks, using health plan and market data.
3. Identify deviations from benchmarks by service provider and beneficiary subgroups.
4. Implement and oversee corrective action to reduce deviations in cost and quality.

With data in hand, including insight into the variability in cost and quality of health care services that are being purchased, CFO's can craft health benefits and procurement strategies that align with the fiduciary principles set forth above.

Translating Fiduciary Risk into a Strategic Plan for Health

With a clear fiduciary mandate, disclosure requirements and new access to health services data, CFOs have a unique opportunity to catalyze internal realignment of health benefits with broader corporate health priorities. CFOs can sponsor implementation of a new strategic framework for health by enabling and supporting change across their organization through corporate health budgeting and financial planning. Key tenants to enable a shift from reactive sick care to proactive well care, include:

1. Develop a unified corporate budget for health that includes all health-related spending across the company, including but not limited to health insurance, ancillary insurance, occupational health and workers compensation.

2. Align budget authority and resource allocation to reflect corporate priorities.

3. Set cross-departmental performance metrics that leverage all available health data.

4. Measure and reward departmental and cross-functional outcomes.

While fiduciary health plan leadership can come from many places, the real value will accrue to organizations that embrace their fiduciary role, align outcomes with corporate objectives, and empower staff at all levels to take coordinated action to apply the information and data that is now available under the CAA of 2021.

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