Effective health plan governance: A path to lower costs

Navigating the complex world of health plan governance and cost containment is more critical than ever. Regulatory changes, increased transparency demands, and fiduciary responsibilities are reshaping the health plan landscape. This article, featuring insights from KPMG Benefits Services LLC professionals, highlights key concerns and strategies for chief financial officers (CFOs) and financial leaders to help ensure compliance and financial efficiency in their healthcare plans.

Building a strong foundation for fiduciary governance and compliance

Health plan sponsors, much like retirement plan sponsors, are bound by fiduciary duties, including the duty of loyalty, prudence, and the exclusive benefit rule. The Consolidated Appropriations Act of 2021 (CAA) has introduced new transparency requirements, such as the No Surprises Act and the disclosure of broker and consultant compensation. These changes have led to a surge in government investigations and participant litigation, underscoring the importance of robust fiduciary governance. Here are steps organizations can take:

- **Establish a health plan committee:** Form a dedicated committee to mitigate fiduciary responsibility for senior management and ensure that all governance practices are well-documented and referenced in plan documents.
- **Analyze fee disclosures:** Regularly review and analyze broker and consultant fee disclosures to identify any potential conflicts of interest and ensure transparency.
- **Monitor service providers:** Continuously monitor health plan service providers to ensure they meet the health plan's standards and regulatory requirements.
- **Conduct independent audits:** Perform independent claims audits and contract compliance reviews to maintain the integrity of the health plan and address any issues proactively.

Ensuring mental health parity and MHPAEA compliance

The Mental Health Parity and Addiction Equity Act (MHPAEA) mandates that health plans ensure coverage limitations for mental health and substance use disorder (MHSUD) benefits are no more restrictive than those for medical and surgical (M/S) benefits. Compliance with MHPAEA is measured through a review of quantitative treatment limitations (QTLs), which are financial requirements such as copays and coinsurance, and nonquantitative treatment limitations (NQTLs), which are protocols that limit the scope or duration of benefits an individual can receive, such as prior authorization requirements.

Recent regulations have increased scrutiny on NQTLs and network adequacy. Plan sponsors must conduct comprehensive assessments to ensure compliance, inclusive of the following steps:

- **Data collection:** Gather medical and prescription drug data from all relevant vendors and administrators that oversee treatment limitations.
- **QTL assessment:** Review of copays, coinsurance, and other financial requirements for MHSUD and M/S benefits as written in the plan documents and applied in operations through a series of tests on claims-level data.
- **NQTL assessment:** Evaluate how NQTLs are applied to MH/SUD and M/S benefits, including a review of the factors, sources, and evidentiary standards relied upon to develop the NQTLs.

Following conclusion of the assessment, plan sponsors must maintain thorough documentation and establish an ongoing monitoring plan to stay compliant and prepare for Department of Labor audits or participant requests for information.

Cost containment strategies

As fiduciaries, health plan sponsors must offer cost-competitive programs while ensuring the financial health of the plan. Effective cost containment strategies are essential to achieving these goals:

- **Full-scope health plan assessments:** Conduct periodic, comprehensive assessments to identify inefficiencies and opportunities for improvement.
- **Provider payment comparisons:** Compare provider payment data to Medicare rates and other commercial plans to ensure competitive pricing and avoid overpayment.
- **Vendor incentive alignment:** Evaluate the alignment of vendor incentives with plan goals, including brokers, to ensure they are working in the best interest of the plan.
- **Transparent PBMs:** Consider transparent or pass-through PBMs to avoid conflicts of interest and achieve significant cost savings.
- **Formulary design:** Review formulary design to prioritize lower-cost drugs and minimize reliance on rebates, which can sometimes obscure the true cost of medications.

Pharmacy benefit management

Pharmacy benefit managers (PBMs) are under increased scrutiny for practices that may conflict with fiduciary duties. CFOs should be aware of the following considerations:

- **Clinical health outcomes:** Ensure that the PBM prioritizes clinical health outcomes and lowest costs over profit, aligning with the plan's goals for participant well-being.
- **Transparency in earnings:** Understand how much the PBM earns and how they earn it, particularly through spread pricing and rebates.
- **Transparent PBMs:** Consider transparent or pass-through PBMs that do not combine discount guarantees, do not own specialty pharmacies, and are not paid on spread pricing as these can offer clearer and more cost-effective solutions.
- **Cost comparisons:** Compare gross costs to the National Average Drug Acquisition Cost to identify potential savings and ensure competitive pricing.

Data management and transparency

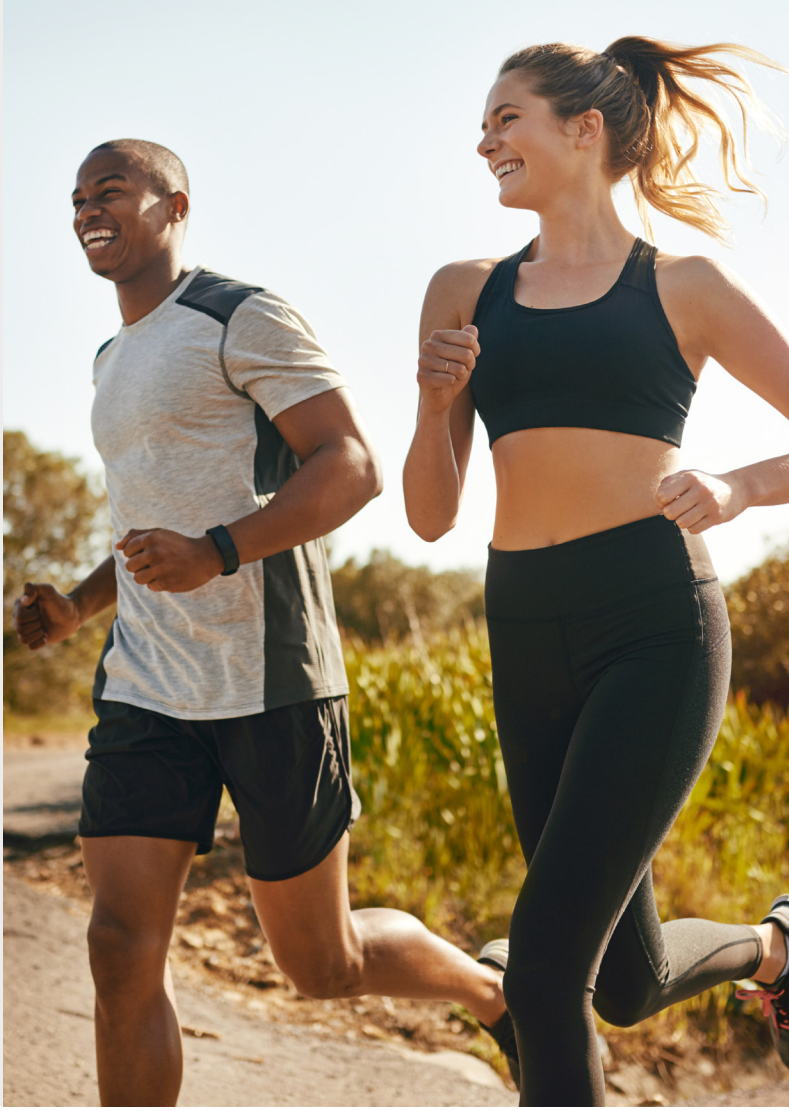
Data transparency is crucial for effective health plan governance. The CAA's gag clause attestation requires healthcare providers to provide de-identified claims data for third-party audits. CFOs should focus on the following:

- **Compliant contractual language:** Review and update contractual language to ensure compliance with gag clause requirements and facilitate data sharing.
- **Centralized data management:** Centralize and manage data to facilitate accurate and timely reporting, enhancing your ability to make informed decisions.
- **Data utilization:** Leverage data to identify and address gaps in care and cost inefficiencies, improving the overall financial health of the plan.

Conclusion

In today's competitive business environment, organizations must optimize financial performance and manage costs without compromising quality or service. Robust governance and cost containment strategies are essential for maintaining profitability and meeting financial goals. Staying ahead of regulatory changes and ensuring compliance with transparency requirements helps avoid penalties and reputational damage. Aligning financial strategies with overall business goals supports growth and profitability, while accurate and timely financial reporting, bolstered by effective data management, strengthens investor confidence. Additionally, identifying and mitigating financial risks, including market, credit, and operational risks, is crucial for long-term stability and success.

In the dynamic landscape of health plan governance and cost containment, CFOs and financial leaders must prioritize fiduciary duties and regulatory compliance. By forming dedicated health plan committees, conducting thorough assessments, and partnering with aligned vendors, organizations can effectively mitigate risks, reduce costs, and ensure the financial well-being of their plan participants.



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