

Negotiating Third-Party Administrator Agreements for Health Plans: Essential Provisions and Strategic Considerations

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Agenda

- The Independent Dispute Resolution (IDR) process
- “Shared Savings” fee arrangements
- Identifying and addressing ancillary fees
- Medical rebate provisions
- Performance guarantees
- Additional provisions, including artificial intelligence safeguards, data access rights, limitation of liability, and indemnification clauses

Why this topic?

- Health plan costs are skyrocketing
- To assist with limiting the cost increases, plan sponsors need to understand the fees being charged by third-party administrators (TPAs) and insurance carriers
- This webinar focuses on changes that a plan sponsor can try to negotiate for a self-funded plan
- However, most of the fees explained in this webinar apply to all plans

The Independent Dispute Resolution (IDR) Process

Basic Overview

- The No Surprises Act (NSA) created protections against surprise billing
- The NSA generally prohibits surprise billing in group health plans and individual health insurance, and limits the cost sharing to the individual for certain items and services
 - This webinar will focus on the rules for group health plans
 - We will refer to everyone covered under a group health plan as “participants”
- Surprise billing occurs when an out-of-network (OON) provider or facility unexpectedly bills a participant for the uncovered balance remaining on the bill
- Participants are more likely to receive a surprise bill when they don’t have the chance to select an in-network provider in advance, such as during a medical emergency

Basic Overview

- The NSA prohibits surprise bills for:
 - Most emergency services provided by an OON provider
 - Non-emergency services from an OON provider delivered with respect to a patient's visit to certain types of in-network health care facilities (unless the OON provider provided a notice of waiver of rights and received consent from the patient)
 - Covered services from OON providers of air ambulance services
- Although participants cannot receive surprise bills in these instances, they still may have some cost-sharing responsibility
- However, the participant's cost-sharing requirements for OON items or services cannot be greater than in-network cost-sharing requirements

The IDR Process

- When the health plan receives a claim that is subject to the NSA, the health plan must make an initial payment or issue a notice of denial of payment within 30 days after the provider submits the bill
 - We generally assume that the plan will pay the qualifying payment amount (QPA), or something close to it, which is the median of the plan's contracted rates with participating providers for the item or service in the geographic region
- Beginning on the date the OON provider receives the initial payment or denial, the provider has 30 days to initiate the open negotiation period
- The parties are required to complete the full 30-day open negotiation period before either side may initiate the IDR process
- Within four business days after the close of the open negotiation period, either party may initiate the IDR process by submitting a Notice of IDR Initiation to the Departments of the Treasury, Labor, and Health and Human Services (the "Departments")
- An IDR entity is then selected for the claim

The IDR Process

- No later than 10 business days after the IDR entity's selection is finalized, both parties must submit their payment offers
- The IDR entity then has 30 business days to issue a payment determination and notify both the parties and the Departments of its decision
- Any payment owed pursuant to the IDR determination must be issued within 30 calendar days after the arbitrator's decision
- A key issue is that the IDR process is a "baseball-style" arbitration system
- Baseball-style arbitration is a dispute resolution method where both sides submit their final proposed figures to an arbitrator. The arbitrator must choose exactly one of the two proposals without modification. There is no compromise or "splitting the difference."

Some Problems

- Both dispute volume and the typical size of the awards made by IDR entities have experienced massive year-to-year increases
- Detailed information has been reported by Georgetown University, Center on Health Insurance Reform
 - Spending On IDR Process Pushes No Surprises Act Costs To More Than \$22.4 Billion Over Just Four Years | Center on Health Insurance Reforms
- The dispute volume was up 77 percent from 2024 to 2025 and total awards rose by 264%
- In 2025, providers initiated 2.6 million new disputes
- Note that the Departments originally estimated approximately 22,000 disputes a year

Some Problems

- Georgetown University, Center on Health Insurance Reform, reports that in 2025:
 - over three-fourths of resolved dispute lines came from the following three organizations:
 - Radiology Partners (30 percent), a large national radiology practice group with private-equity backing;
 - HaloMD (27 percent), a middleman organization that files disputes on behalf of providers; and
 - TeamHealth (20 percent), a multispecialty provider group with private-equity backing
 - Providers prevailed in approximately 85% of all disputes
 - When providers prevailed, they won a median award of 445% of QPA

Some Problems

- There are a large number of claims that are being determined in the IDR process that are not eligible for that process
- Note that IDR entities are paid on a per-dispute basis. They do not receive any pay for ineligible disputes
- Georgetown University, Center on Health Insurance Reform, reports that in 2025, health plans challenged eligibility in 41% of disputes, and IDR entities ruled 18% of disputes ineligible
- We now seem some third-party administrators (TPAs) asking clients if they will approve the TPA not paying IDR awards for claims that the TPA has determined are ineligible for the IDR process
 - We also see those same TPAs stating that if the employer approves paying the IDR awards for these “ineligible” claims, that the amount of the award over the QPA will not be covered by stop-loss
 - It is unclear on how this will get resolved, as the law requires that any payment owed pursuant to the IDR determination must be issued within 30 calendar days after the arbitrator’s decision

Example of An Issue

TPA Not Negotiating During the Open Negotiation Period.

- As explained above, the NSA established a 30-business-day open negotiation period to provide payers and providers with an opportunity to agree on an appropriate payment rate without resorting to the IDR process. However, if the parties cannot agree, they can proceed to the IDR process. Because this is baseball style arbitration, if one party does not make an offer, then the other party automatically is awarded their offer.
- We have begun to see issues when the TPA for the plan fails to make an offer in the IDR process, and the OON provider wins an award for an amount that exceeded the original (very high) billed amount.
- For example, assume the claim was for a surgery. The OON provider sent a bill of \$50,000 and the plan made a low offer of \$3,000.
- When the OON provider went to IDR, his offer was \$65,000 and the TPA failed to respond. The OON provider was awarded \$65,000—more than the originally billed amount!

Limits

- How can we limit this kind of cost? We can take some steps, but the IDR process is broken, and Congress needs to enact legislation to fix this
- Consider adding a provision that if the TPA does not make an offer in the IDR process, that the employer will pay no more than the QPA. Essentially, the plan will not pay for the mistake of the TPA
- We have been successful in adding this kind of provision to TPA agreements
- However, this is something that should also be addressed in Request for Proposal (RFP) documents. It is hard to add to an existing agreement.

“Shared Savings” and the IDR Process

Basic Overview

- TPA agreements often include a “shared savings” program, with the fee being somewhere between 15%-35% of the “savings”
- For example, assume that the OON provider submits a bill for \$100,000—a price that no one would pay for the service
- The TPA gets the OON provider to accept a payment of \$30,000—which is something closer to the QPA
- The plan pays the \$30,000 claim. Assume that the shared savings program is 35%. In this case, the plan will ALSO pay 35% of the \$70,000 that was “saved”—or \$24,500
- These programs create some of the highest costs for plans

Basic Overview

- A New York Times article from 2024 stated that for OON claims, many TPAs consult MultiPlan, which typically recommends paying less than the provider billed—and the TPA agreements include shared savings programs
 - *Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill* (published April 7, 2024)
- The article stated, “In recent years, the nation’s largest insurer by revenue, UnitedHealthcare, has reaped an annual windfall of about \$1 billion in fees from out-of-network savings programs, including its work with MultiPlan, according to testimony by two of its executives.”
- It also stated, “Court records show, for example, that Cigna took in nearly \$4.47 million from employers for processing claims from eight addiction treatment centers in California, while the centers received \$2.56 million. MultiPlan pocketed \$1.22 million.”
- The point—shared savings programs can be costly for plans

Shared Savings and the IDR Process

- We have seen costly outcomes related to the IDR process and the shared savings program
- For example, an OON provider submits a claim for \$200,000 and the plan offered \$6,000. It went to the IDR process.
- The OON provider then offered \$150,000 and the plan offered \$10,000 (which was under even the Medicare reimbursement rates)
- The arbitrator awarded the \$150,000, even though that was far over the QPA
- In this example, it seems as if the TPA did a bad job negotiating the claim. Now the plan pays the higher amount awarded in the IDR process and is charged a savings fee due to the \$50,000 decrease in what the provider first offered versus what was awarded in the IDR process.

Shared Savings—What Can You Do?

- Decrease the shared savings fee—35% is too high!
- Consider putting the fee on a scale, such as the shared savings fee percentage shall be: (a) XX% for claims where the billed charge is \$50,000 or less; (b) XX% for claims where the billed charge exceeds \$50,000 but is \$250,000 or less; and (c) XX% for claims where the billed charge exceeds \$250,000
- Add a maximum annual cap to the shared savings fee—we have seen large employers negotiate this
- There are numerous ways to cap this fee. We have seen clients be very creative in solving for this issue
- When running an RFP, the consultant should be proposing various ways to cap this fee

Shared Savings

Require disclose

- Add a provision that the TPA must disclose in writing to the plan sponsor: (a) whether the TPA negotiates directly with OON providers or uses a repricing vendor; (b) the identity of any such vendor and the terms of its compensation arrangement with the TPA; (c) any indirect compensation arrangement; and (d) any ownership or financial interest the TPA holds in any subcontractor performing the repricing services
- Require the TPA to provide annual reporting on: (a) the total number of OON claims subject to the shared savings program; (b) the aggregate billed charges, negotiated amounts, and shared savings fees; (c) a comparison of negotiated amounts to the applicable QPA; and (d) identification of any claims where the shared savings fee exceeded \$XXX.
- Include the right to audit and what happens if the audit reveals overpayment of shared savings fees (money returned to the plan and TPA pays all audit costs)

Shared Savings

- We understand that employers want to protect participants from large balance bills and they implement these programs so that the OON provider will accept that the bill has been paid—and not balance bill the participant
- Consider other plan designs, given that participants are protected from “surprise billing” for most claims in which they cannot pick the provider (such as in an emergency or the in-network facility uses an OON provider)
- Maybe the plan simply states that for OON claims, the maximum that the plan will pay (outside of claims covered by the NSA) is 200% of Medicare rates
- If a participant elects to go OON, they may be stuck with a large bill

Audits

- We have seen audits conducted by consultants that essentially state that 98% of the claims were paid correctly
- Push back on that!
- Have them audit the claims in the IDR process
 - How often did the TPA not make an offer and the provider received a default award
 - How often did the TPA make an offer that was under the Medicare reimbursement rate and then the provider received a huge award in the IDR process

Identifying and Addressing Ancillary Fees

So Many Fees

- There are many TPA-generated revenue streams that sit outside of fixed administrative fees
- These may be poorly disclosed and/or uncapped
- These revenues are typically embedded in operational aspects of the agreement such as claims processing, network administration, recoveries, settlements, incentives, etc.
- In many cases, these revenue streams exceed the TPA's administrative fee
- We often see consultants focus on these main fees:
 - Network discounts
 - PEPM admin fees
 - Performance Guarantees
- Employers needs to understand—and negotiate—all fees

So Many Fees

The types of fees could include the following:

- Pre-Payment Payment Integrity Fees (fees charged for pre-pay claim edits, such as coding and bundling)
- Post-Payment Overpayment Recovery Fees (fees for payment of recovered dollars)
- Shared Savings
- Network Fees
- IDR Fees & Settlements
- Subrogation Fees
- Retention by the TPA of Medical Rebates
- Provider Incentive Payments
- Spread Pricing

So Many Fees

- We have asked TPAs to provide a single list of all fees, on one schedule—and if the fee is not on that schedule, the employer does not owe it
 - This is very hard to obtain
- The consultant running the RFP and negotiating the agreement should be able to create the list

So Many Fees

- The agreement should have provisions that state that the TPA cannot profit from its mistakes. All error recoveries and overpayments are returned to the plan sponsor—100%
 - There are several cases that claim that certain TPAs inflated claims up-front and collected inappropriate recovery fees from the plan when it later corrected its own errors

So Many Fees

Tiara Yachts Inc. v. Blue Cross Blue Shield of Michigan (6th Cir. May 21, 2025)

- Tiara Yachts alleged that BCBSM systematically overpaid claims submitted by medical providers
- Tiara Yachts alleged that BCBSM processed claims using an intentional design called 'flip logic' in order to overpay out-of-state providers. Essentially, the allegation is that BCBSM allowed providers to bill and get fully reimbursed for highly inflated costs of service
- Tiara Yachts also alleged that BCBSM improperly profited from this design through its shared savings program. BCBSM recovered a portion of the overpaid money but pocketed 30% of the recovered amount

So Many Fees

- TPA agreements often have provisions about how the plan must pay for provider incentives
- These are payments the plan makes to in-network or OON providers — on top of the negotiated claim payment — to reward providers for meeting cost, quality, or utilization target
- While value-based care is important, the plan sponsor often has limited visibility into how these incentive pools are structured, funded, and distributed
- Often times there is no cap on these fees

So Many Fees

- Consider how you can cap these fees. For example, state that the total provider incentive payments for any Plan Year shall not exceed []% of total Plan claims paid during such Plan Year
- Require outcomes. For example, state that the provider incentive payments are based on verified, actuarially documented savings to the Plan resulting from the provider's participation in the applicable incentive program. "Verified savings" shall mean the difference between (a) the expected cost of the applicable services, as determined by reference to the Plan's prior [12]-month claims experience for the same or similar services, and (b) the actual cost of such services during the measurement period.

So Many Fees

- Add that there cannot be a conflict.
- For example, state that the TPA shall not enter into, or cause the Plan to pay, any provider incentive payment arrangement in which: (a) the TPA has a direct or indirect financial interest in the provider receiving the incentive payment; or (b) the TPA receives any fee, commission, or other compensation from the provider that is contingent upon the provider's receipt of a provider incentive payment from the plan
- These kinds of caps and limitations need to be included in the RFP—they are very hard to negotiate later, although we have been successful in doing that

Medical Rebates

Medical Rebates

- “Medical Rebates” apply to drugs covered under the medical benefit (not prescription drug benefit)
- These drugs are administered by a healthcare provider in a clinical setting such as a doctor’s office or hospital
 - Many oncology drugs fall into this category
- The rebate is paid by an entity such as the pharmaceutical company to the TPA (not the Pharmaceutical Benefits Manager)
- While Employers know to ask for a pass through of pharmaceutical rebates, the same attention is often not paid to medical rebates
- Employers should ask for a pass through of Medical Rebates!

Medical Rebates, Cont'd

- Employers should include similar language regarding medical rebates in their TPA agreement as they do for prescription drug rebates in agreements with PBMS
- Definition of what constitutes a “medical rebate” should be as broad and as encompassing as possible to avoid the TPA recharacterizing the rebate as something else
- TPAs should provide a detailed disclosure to the Employer of all medical rebates received over the year (regardless of the source of the payment)
- Employers should ask for audit rights with respect to the medical rebates to ensure the amounts received by the employer are accurate

Performance Guarantees

Performance Guarantees

- Make sure you understand how these work
- Assume that the performance guarantees (PGs) promise a 95% accuracy rate on claims paid. An issue with that is that all claims are treated the same. A \$100 copay miscoding and an \$800,000 surgical claim paid at the wrong rate are each counted as "1 error."
- The TPA hitting 95% payment incidence accuracy could be getting numerous high-dollar claims wrong while processing low-dollar office visits correctly
- Consider if this PG should be broken out by standard claims and high dollar claims.
- For example, the minimum guarantee for Standard Claims shall be [XX]% incidence accuracy. The minimum guarantee for High-Dollar Claims shall be [XX]% incidence accuracy. For purposes of calculating the penalty for High-Dollar Claim errors, create a formula where each error is weighted by the dollar amount of the error

PGs

- The TPA samples its own claims, applies an "industry accepted methodology," and reports its own score
- Consider if there should be provisions that state that the financial accuracy is measured by an independent auditor, using a statistically valid random sample of no fewer than XX claims per measurement period, stratified by claim dollar amount to ensure adequate representation of claims above \$[XX].
- You will need to include permitted auditors, as that can also be a fight

PGs

- Do you know what is being measured? It is just the claims and services in your plan or is it measured over a book of business?
- If it is across all employer plans administered by the TPA, that could mean for one of the plans, its own claims could be the worst-performing in the book of business, but the TPA could still report 95% accuracy because other employers' claims carried the average
- Consider if the TPA agreement should state that all performance guarantees are measured solely on the basis of claims processed under the Plan during the applicable measurement period. Results from other employer plans or any blended or aggregated population shall not be included in the measurement.

PGs

- Assume that there is a guarantee on the “turnaround time” for when a claim must be processed, such as within 15 days
- What does that mean?
- Consider if that should be defined. For example, add a provision that states that the turnaround time is measured from the date of receipt of a clean claim to the date on which the claim is finally adjudicated (paid, denied) and an explanation of benefits (EOB) is issued to the participant
- A claim that is pended, suspended, or placed in a holding status is not considered “processed”
- Consider how “reworked” claims are treated. For example, add that all claims, including reworked, reprocessed, adjusted, or corrected claims, are included in the turnaround time calculation. For reworked claims, turnaround time shall be measured from the date the original clean claim was received to the date of final correct adjudication.

Additional Provisions, including Artificial Intelligence Safeguards, Data Access Rights, Limitation of Liability, and Indemnification Clauses

Additional Provisions

- In this section we will discuss various important additional provisions in TPA Agreements that are rarely addressed in the RFP process:
 - AI safeguards
 - Data Access Rights
 - Limitation of Liability
 - Indemnification

Artificial Intelligence Safeguards

- Request that the TPA disclose how it is using or incorporating AI models in its administration of the Plan and request other details necessary to assess the models being used.
- Prohibit the use of using employer data for purposes of AI model training, fine tuning, etc.
- Ensure that provisions regarding data protection, confidentiality, HIPAA and information security expressly apply to TPA's use of AI models

Artificial Intelligence Safeguards, Cont'd

- Understand how the TPA is using AI in claims processing
- Ensure that TPA is following the ERISA claims procedure regulations regardless of its use of AI
 - Internal rules, guidelines and protocols must be disclosed in an adverse benefit determination
 - Plans must maintain “administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents”
 - Appeals must be decided by an “appropriate named fiduciary”
- Use of AI in benefit determinations is a growing area of litigation

Data Access Rights

- Employer's should insist on contract language that gives them access to their own data!
- TPAs will often block employer's request for data on the basis that the data is proprietary
- Include language that unequivocally states that all plan records belong to the plan sponsor not the TPA
- Agreement should grant the employer access to all claims-level data and specify the format of that data
- Upon termination TPA should be required to cooperate in the transfer of records to a successor TPA

Limitation of Liability

- Standard ASA language often includes a limitation of liability that caps the TPA's liability to one year of "administrative fees"
- Employees should push back on this language
- Often, "administrative fees" in this context are not defined. Make sure they include ALL fees the employer pays (remember the "So Many Fees" slides from earlier in the presentation)
- Ask for more than one year
- Ask that the cap on liability not apply to certain things (gross negligence, willful misconduct, HIPAA breaches, other data breaches etc.,)

Indemnification

- Standard indemnification language is often one-sided in the TPA's favor
- Always ask for mutual indemnification, but don't simply mirror the language the TPA included, ensure it captures the kinds of harm that can be caused by the TPA
- Carve certain acts out from indemnification such as losses resulting from TPA's gross negligence or misconduct or from HIPAA breaches, IP infringement
- Ensure the indemnification provisions survive termination of the agreement (particularly during the claims runout period)

Suggested Action Items

Suggested Action Items

- Educate leadership on the issues so you can have a real budget for the RFP—health plans are one of the largest costs for a company
- Put together a comprehensive RFP that includes the items discussed in this webinar and require the TPA candidates to agree to specific contract language as part of their bid.
- This is a team effort -- work with a good consultant and benefits lawyer from the beginning of the RFP process through contract negotiations.

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