FEATURE

TPAs Tackle High-Cost Claims

Written By
Laura Carabello



When a single claim can eclipse six or seven figures, self-insured employers don't have the luxury of finding out after the fact. High-cost claims, from complex cancer treatments and rare disease therapies to catastrophic injuries, are rising in both frequency and severity, and they're reshaping how plan sponsors think about risk.

The scale of this challenge is downright jarring as employers face another tough year. Aon projects employer health casts to increase 9.5% next year to more than $19,000 per employee.

According to WTW's 2025 Best Practices in Healthcare Survey, what once qualified as a "high-cost" claim at $50,000 now often starts at $100,000, with multimillion-dollar claims increasingly common, driven by advanced treatments like gene therapy or complex conditions such as congenital disorders and transplants.

Analysts state that just 5% of members drive 56% of total healthcare spending, with the top 1% alone responsible for 28% of costs, as 5% of members account for 56% of total spending, while just 1% are responsible for 28% of the costs.

Claims exceeding $1 million have grown even more dramatically, with QBE North America's 2026 Accident & Health Market Report finding that the frequency of million-dollar claims has nearly tripled over the past five years, with average severity in 2025 running 10% above prior-year averages. Cancer remains the single largest driver, followed by nervous system diseases and newborn care.

- Tumors alone account for 31% to 36% of stop-loss claim reimbursements across all years studied
- Blood cancers carry an outsized share of that burden at a $1 million deductible threshold, with per-employee monthly costs for blood cancers rising more than 70% in 2025.
- Hematologic malignancies represent more than half of all neoplasm claims

For third-party administrators (TPAs), this isn't simply a claims processing challenge. It's a real-world test of whether they can move from reactive administration to proactive cost containment. The TPAs winning this battle aren't the ones with the fastest turnaround times (although that's important!); they're the ones catching high-cost claims before they spiral, armed with data, clinical insight and negotiation strategies that protect both the plan and the patient.



Lori Daugherty

As employers challenge broad assumptions about savings and pose more difficult pharmacy benefit questions, TPAs must be prepared to provide greater understanding of exactly what their clients are paying for, where dollars are being spent and how to realistically change the results.

Lori Daugherty, CEO, RxLogic, says, "TPAs are under tremendous pressure to respond to these issues, especially when there is a PBM involved that really controls the pharmacy model. That is why TPAs need a partner with independent technology that can help them take more ownership of pharmacy operations and provide a transparent picture of the pharmacy spend, rebate structure, utilization patterns and plan performance. This also impacts formulary and clinical decisions, enabling TPAs to influence pharmacy cost and member experience, such as introducing programs like prescription drug discount cards."

As TPAs shift the pharmacy focus from an administrative obligation to a business growth strategy, Daugherty explains that they may already be managing several aspects of pharmacy operations – managing enrollment, answering inquiries, fulfilling data reports and demystifying pharmacy benefit manager (PBM) operations for employers.

"Taking control of pharmacy benefits shifts the TPA business model," she explains. "Rather than treating pharmacy as a standard vendor pass-through, TPAs build a branded solution. This helps employer clients, strengthens broker ties, and unlocks pharmacy administration revenue. Reshaping the pharmacy benefit model turns a simple vendor relationship into a branded TPA asset."

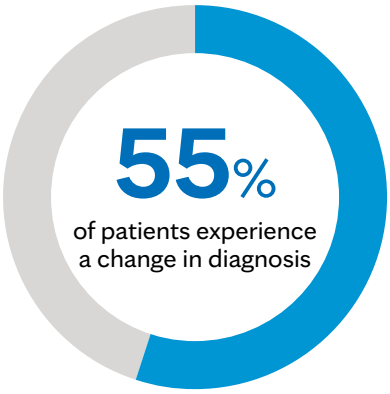
Standing-out in the self-insured market has become a priority for TPAs that seek a unique edge to stand out from competitors.

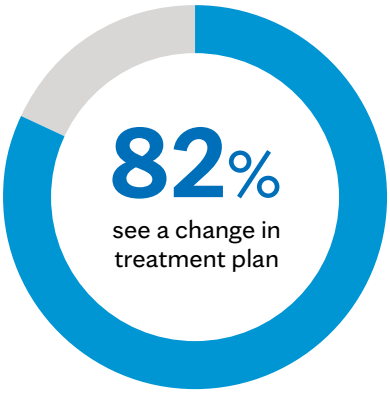
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"Saving money for clients is now a major way to win business," she adds. "Brokers and employers want more than basic claims processing -- they want a strategic partner who can lower costs and improve health results. That's the value of an independent technology platform and a key ingredient of the RxLogic value proposition."

Jason Hines, CEO and co-founder, Gigasheet, a price intelligence platform, observes, "TPAs abilities in managing high-cost claims vary widely. We work with a number of different organizations that use hospital and payer price transparency data to identify claims that are outside norms and provide evidence of market rates for negotiations."

Hines sees some TPAs beginning to incorporate this data into payment integrity, repricing, and complex claims workflows, noting, "But anecdotally, adoption still appears limited. There is also a need for greater transparency around percentage-of-savings fees."

He suspects that savings baselines can be inflated or difficult to verify, adding, "This can make a large fee look justified even when the final price is still above a fair market rate." That makes it harder for employers to understand their actual savings and whether the intervention delivered a good value."



Phil LeFevre

WHAT'S WORKING

TPAs are making strides in tackling high-cost claims using price transparency data to re-imagine Reference-Based Pricing (RBP), Out-of-Network (OON) negotiations and member navigation inside networks.

Phil LeFevre, vice president, Business Development, Denniston Data Inc. (DDI), says his clients are leveraging both market reimbursement data (across all payers and providers), as well as line-level pricing by NPI and payer.

"The biggest shift is away from Medicare multiples (1.4x Medicare) to a MLCR (pronounced "Mil-Sir"), the Median Local Commercial Reimbursement," he explains. "MLCR is slightly higher than 1.4x Medicare (~1.75x) but fluctuates by market and procedure to reflect a fair and defensible reimbursement amount, just as intended by the No Surprises Act for the Qualifying Payment Amount (QPA)."



Todd Martin

LeFevre maintains that this makes negotiations much easier, improves access and reduces disputes and balance billing, adding, "We are also helping TPAs surface NPI level network rates combined with provider quality data to leverage massive opportunities in their own network to optimize for low cost and high quality – anomalies that should not exist in most markets but are ample in all the big healthcare networks. By surfacing these opportunities using Smart Scores through tiering, steering or a member shopping experience, TPAs are creating big savings for employers while protecting their roles as fiduciaries."

Strong TPAs should be leveraging claims editing software prior to processing a claim, looking for errors in the bill, upcoding and unbundling.

That's the recommendation of Todd Martin, chief sales officer, Nova Health, saying, "In addition, TPAs with in-house medical management programs allow for early detection of potential high-cost claimants at which time the member can be engaged with a nurse to help navigate the most cost-effective and quality care. Once someone has a high dollar claim, there should be Case Management support to help with the transition of care, treatment plan compliance and gaps in care."

He points to a recent example from Nova's medical management team which conducted a transplant contract review for a member.

"As a TPA, Nova conducts transplant contract comparisons to get the employer the best rate across multiple vendors, rather than just using network rates," he explains. "Some clients with ASO models don't realize they can go outside the network -- but a TPA can do so and achieve cost savings."

Moreover, in a PPO network arrangement, there can often be restrictions on the ability to audit claims, as they could be providing the TPA with a simple repriced claims file without the ability to see a lot of detail surrounding the claim.

"Itemized bills can be requested from the provider or facility, but this is often challenging to succeed," continues. "There is definitely a large transition amongst many employers to a Reference Based Pricing model as many of the BUCA solutions are just no longer sustainable. Some employers are doing this in lieu of a network 100% or just transitioning out-of-network claims to this form of reimbursement."

Interventions, especially early on, are helping to improve outcomes, which ultimately help reduce the cost of the claims.

"Early detection and guidance can help conditions be managed before they turn into a high dollar situation," he adds. "Managing gaps in care and supporting with treatment plan performance will ultimately reduce admissions, in-patient stays and readmissions for non-compliance."



Jakki Lynch

Ultimately, the TPA should be a partner to the consultant and employer.

"TPAs work with many point solutions, and we have the experience of seeing what works and what doesn't work," he avers. "When TPAs identify point solutions that can control cost with payment integrity packed with improved outcomes, it makes for a strong partnership and more long-term clients."

Jakki Lynch, RN, CCM, CMAS, CCFA, director, Cost Containment, Carbon Stop Loss Solutions, underscores that while interventions can mitigate the financial impact of catastrophic medical events, they cannot prevent the events themselves.

"They can help identify, manage, and potentially reduce the cost of high-dollar claims such as cancer, major trauma, organ transplants, premature neonates, extended hospital stays resulting from hospital-acquired events, and other complex or catastrophic conditions," says Lynch. "However, these events may still occur regardless of the cost-containment strategy. Therefore, these interventions should be viewed as financial risk-mitigation tools that help preserve plan resources and minimize excessive or avoidable spending—not as mechanisms that eliminate catastrophic medical risk."

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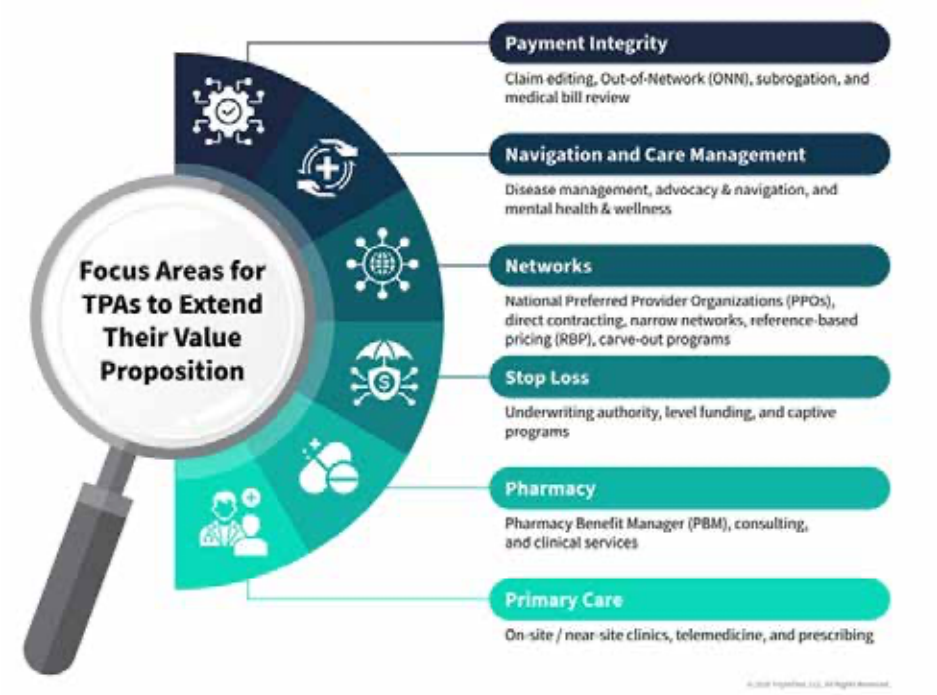
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Jim Carlson, VP and head of Business Development, Self-Funded, Evidium, attests that complex claims management, reference-based pricing and aggressive out-of-network negotiation all do real work, but they're triggered by a claim that's already in motion.

"By the time a TPA is negotiating a six or seven-figure oncology or gene therapy claim, the cost trajectory was largely set months earlier," he says, emphasizing that most tools available to TPAs today only offer a claims-based risk score, which tells you what happened, not why or what's coming next.

"Evidium models each member's actual clinical journey, so plan sponsors get real visibility into emerging high-cost conditions before they escalate, and underwriting teams get sharper stop-loss precision going into renewal," says Carlson. "Every insight that is generated is explainable and auditable, not a number without reasoning behind it, which matters when a plan sponsor has to defend a fiduciary decision."



Source: 2026 Triple Tree, LLC

Carlson adds that kind of clinical grounding is exactly what specialty drug management, re-pricing and chronic condition programs need to be effective.

"On fees, plan sponsors need to look closely at percentage-of-savings arrangements," he advises. "If a vendor's compensation rises when claims costs rise, that's worth scrutinizing before assuming it's aligned with cost containment."

There is room for improvement in complex claims management, concedes Lynch. "Reference-based pricing and aggressive negotiations with out-of-network providers are a good start, but if the underlying bill contains inappropriate or erroneous charges, negotiating a discount off the billed amount may not capture the full value available. The key is selecting a payment integrity partner that thoroughly reviews the bill and medical record, identifies unsupported or inappropriate charges, ties findings to regulatory and plan requirements, and develops creative, provider-acceptable solutions."

She says it is also optimal to partner closely with the reinsurer, given its exposure to a high volume of complex claims and its expertise in identifying effective solutions.

"Combining the reinsurer's insights with strong clinical, claims, and payment integrity expertise can ensure the claim is accurately evaluated, and negotiations begin from the right starting point," says Lynch.

High-cost claims are not always the result of catastrophic medical events alone.

Larry Castle, director, Clearinghouse Operations, Smart Data Solutions, contends, "They are often amplified by administrative friction that delays intervention, obscures emerging risks, and limits visibility



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Larry Castle

into cost drivers. Fragmented data across eligibility, claims, medical records, prior authorization, and payment workflows makes it difficult for TPAs and employers to identify issues early enough to influence outcomes."

He says the most effective TPAs are adopting data-driven strategies that aggregate and normalize information across the healthcare ecosystem, enabling earlier detection of high-risk cases, stronger payment integrity controls, improved specialty drug oversight, and more informed reimbursement decisions. These capabilities help employers better protect plan assets while improving member experiences and health outcomes.

"At Smart Data Solutions, we see firsthand how improved data accessibility and workflow efficiency help TPAs gain greater visibility into emerging risks and cost drivers," Castle adds. "As healthcare costs continue to rise, reducing administrative friction, increasing transparency, and providing a clearer understanding of how savings are generated will be critical to helping employers manage high-cost claims and build a more sustainable healthcare ecosystem."


David Ostrowsky

TPAS PROVIDE COMMUNICATIONS, GUIDANCE AND RESOURCES

For the sake of positioning themselves well in a very competitive industry and providing optimal value to self-insured employers, TPAs can certainly generate guidance and resources for specialty drug management, re-pricing, payment integrity and chronic condition management.

"In terms of specialty drug management, it's no secret that highly specialized medications account for a massive portion of a given employer's total healthcare spending," attests David Ostrowsky, manager, Corporate Communications, The Phia Group, LLC. "Regarding re-pricing, many TPAs have the background and experience to offer guidance on reference-based pricing models that some self-funded plans may otherwise be unfamiliar with. And lastly, for chronic condition management, many self-funded plans do have a very small number of members who suffer from chronic—and often severe—illnesses that prove to be massive cost drivers. Subsequently, many TPAs are able to introduce digital health tools and AI-driven analytics that self-funded plans can adopt for such members to use."

VALUE OF COLLABORATION

In the self-funded world, cost containment is the risk management tool employers feel directly. For a smaller group, one member on novel cancer therapies can outpace a quarter's financial planning. Mitigating that risk requires TPA and stop-loss partners aligned on the plan's financial goals and open with information, then bringing the employer, TPA, and carrier together at the outset of a complex claim.

Early collaboration helps manage high-cost claims and protect self-funded plans from unexpected exposure," says Tanya Arrowsmith, senior vice president, A&H, Crum & Forster. "Engaging the stop-loss carrier at inception allows the parties to align strategy, evaluate cost-containment opportunities, obtain documentation, and present a unified position in provider negotiations. This supports timely, favorable outcomes while protecting plan assets and stop-loss reimbursement."



Tanya Arrowsmith

She says the impact reaches renewal. Proactive cost management clarifies claim experience and future exposure, supporting informed underwriting and competitive stop-loss pricing.

"Coordination among the employer, TPA, and stop-loss carrier is especially important when managing out-of-network claims," continues Arrowsmith. "In August, the Fifth Circuit struck down parts of the No Surprises Act rules governing QPA calculations. Although existing QPAs may remain temporarily, recalculation may create uncertainty for plan forecasting and compound exposure in federal IDR. Bringing all three parties together early in the claim offers the best opportunity for a collaborative, timely resolution."

TURNING METABOLIC HEALTH INTO A PROACTIVE TPA STRATEGY

The metabolic health crisis has reached a tipping point, fueling a healthcare crisis that directly threatens employer bottom lines through skyrocketing claims and lost productivity. TPA's now have a tremendous opportunity to work with employers to change this paradigm. Diabetes, cardiovascular disease, and cancer rank among the top 5 highest claims and are driven by poor metabolic health. Containing these costs requires a proactive approach—one prioritizing early detection and targeted intervention to deliver better clinical outcomes, substantial savings, and a resilient workforce.



This metabolic crisis hits hardest in the liver, where silent disease is rapidly accelerating one of the most expensive threats to workforce productivity. Metabolic dysfunction-associated steatotic liver disease (MASLD) and its progressive form, MASH (steatohepatitis), affect an estimated 1 in 3 adults—most undiagnosed. Left unchecked, MASLD silently progresses to cardiovascular disease, diabetes, cirrhosis, and some cancers, driving high-cost claims. For TPAs, this is a chance to differentiate: proactively packaging early detection into the programs you bring clients, rather than waiting for costs to surface downstream.

"The issue isn't lack of concern—it's lack of early visibility," says Shawn McGinnis, director, Employer Markets, Echosens. "Non-invasive point-of-care liver health screening using FibroScan® for risk stratification can change that equation by identifying liver fat and stiffness before disease progression."

She says we need to prioritize programs that address whole-person health, not treat one disease at a time in a silo, adding, "Early detection through preventive screening is the best way to catch disease before it progresses to a higher, more costly disease burden."

Deployed in onsite clinics, employer screening events, or other direct primary care settings, rapid risk stratification enables care teams to apply timely, cost-effective interventions, including smarter utilization of advanced therapies. TPAs can help employers generate positive outcomes:

- Lower Costs:
    - Reduce ER visits and admissions
    - Avoid unnecessary specialist referrals and advanced imaging
    - Strategically deploy pharmacy interventions
    - Delay or reverse costly disease progression – diabetes, CVD, cirrhosis, and certain cancers
    - Mitigate catastrophic stop-loss claims
- Streamline Care:
    - Primary care manages early disease - avoiding unnecessary referrals to specialists
- Boost Productivity: Reduce employee absenteeism, presenteeism, and turnover

Targeting and treating isolated conditions isn't enough. For TPAs, bringing this kind of proactive screening to clients gives employers a viable tool to bridge the metabolic health gap before it escalates.

McGinnis shares, "This is a tangible way for TPAs to bring value to clients by providing better outcomes while reducing costs."

DATA ACCESS MATTERS

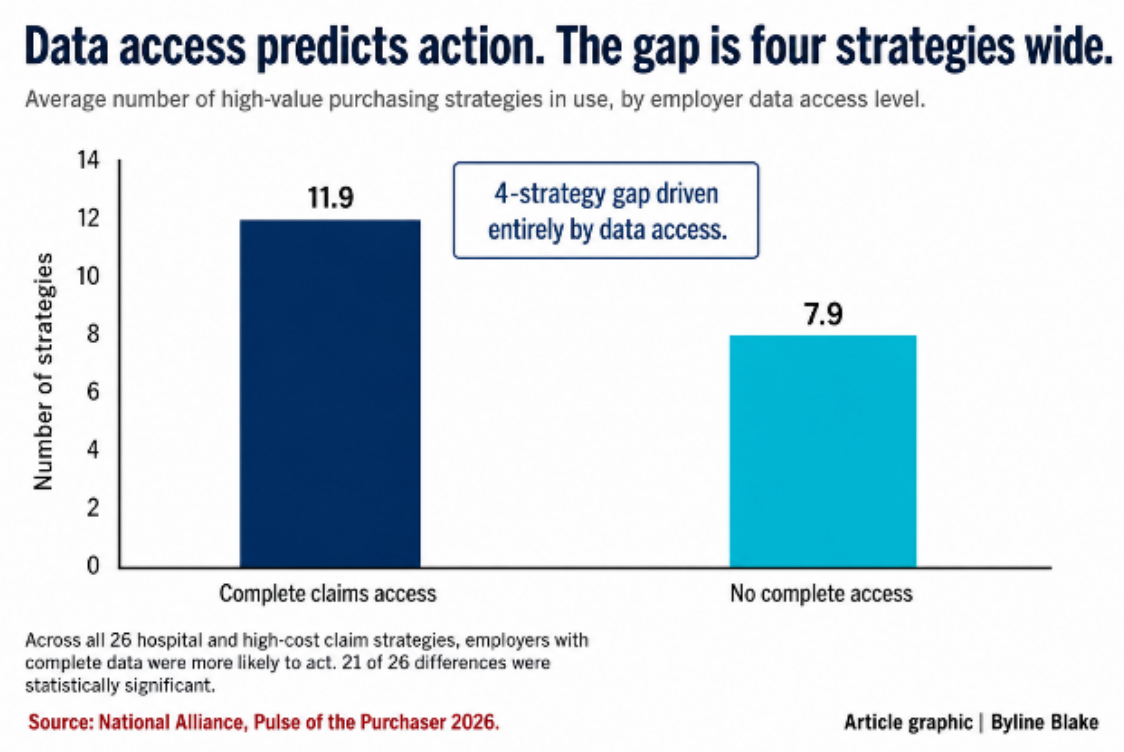
TPAs that are actually managing the health plan spend are paying closer attention to data access.

The alarm sounded when the National Alliance of Healthcare Purchaser Coalitions recently released its 2026 Pulse of the Purchaser survey revealing that employers with complete claim-level access to their medical data are running an average of 11.9 high-value purchasing strategies.

Employers without that access are running 7.9, a significant difference driven entirely by whether the employer can see what is happening inside its own plan. Across all 26 hospital and high-cost claim strategies measured in the survey, employers with complete claims data were more likely to be taking action.

Access is necessary but not sufficient, as employers also need the operational support to translate claims intelligence into purchasing decisions. Roughly one in three employers in the survey report they do not have complete claim-level access to their medical data, and only about three in five are confident they can audit their own complete files.

According to Asad Shoostry, chief technology officer, AscellaHealth, "Access to claims data is only the first step. For increasingly complex treatments, the real challenge is connecting medical and pharmacy data that may arrive at different times, through different systems, and under different billing structures. Employers need an integrated, longitudinal view that can match those events together and turn fragmented claims into actionable insight; otherwise, having the data does not necessarily mean you can use it to make better purchasing or benefit decisions."



It also appears that where the data is stored matters: three-quarters of employers keep claims with their health plan or TPA, and that group reports the lowest access rates. Employers using an independent data warehouse report access rates above 84%.

TPAs are paying attention since the real implication is straightforward: If the self-insured health plan claims data resides inside the same TPA vendor relationship that is being evaluated, the plan is less likely to have unrestricted access to it. Without access, taking action is a challenge.

TPAS AND PHARMACY

TPAs have an opportunity to play a larger role in pharmacy and help their employer clients achieve greater transparency, better cost control, and a more connected benefits experience. For many self-insured employers, pharmacy benefit operations have moved from a line-item to a C-suite level concern. As costs increase and specialty drugs – including GLP1s – create new risk, plan sponsors are asking harder questions about transparency, PBM rebates and data access.

This often puts TPAs in a difficult position as they are typically the first call when an employer wants explanations and answers. However, the pharmacy benefit may still sit with a separate PBM partner that controls key parts of the economics, reporting, and member experience. TPAs are becoming more accountable, taking on some responsibility for whether the pharmacy benefit is delivering value. This level of accountability avoids surprises when the spend keeps rising, and the system just keeps getting renewed.

Closing these gaps creates a new opportunity for TPAs to start taking more ownership of the pharmacy benefit. This does not mean they need to immediately become a full-service PBM, but it should trigger them to build or private-label PBM capabilities that give them real control and flexibility over margin, data and clinical strategy.

"The most effective TPAs are no longer treating high-cost drug claims as a back-end problem," says Jake Velie, CPT, chairman & CEO, National Integrative Health (NIH). "They're integrating specialized pharmacy strategy directly into the pre-certification/prior authorization/case management process, so that by the time a specialty, orphan, REMS-restricted, or infusion therapy is approved, the lowest-net-cost sourcing, site-of-care optimization and clinical alternatives have already been explored."

He stresses that TPAs don't have to wait to build out a full integration.

"Single case agreements on active high-cost claimants offer an immediate path to savings and give plan sponsors tangible results they can see right away," he explains. "Those already taking this approach are seeing meaningful reductions in plan spend and improved stop-loss renewal performance. When paired with cost-plus fee transparency rather than percentage-of-savings arrangements, this upstream approach to high-cost Rx is quickly becoming what distinguishes the TPAs winning new business from those standing still."

Johanna van Nijkerk, vice president of business development, AscellaHealth who has worked on the plan sponsor side, observes that the specialty drug pipeline represents one of the most significant financial threats facing health plans and employers today.

"As more high-cost therapies enter the market, organizations can no longer rely on traditional approaches to manage spend," says van Nijkerk. "Success depends upon having the visibility, clinical expertise, and proactive management strategies needed to control costs while preserving patient access."

She offers this cautionary advice: "I've seen specialty drug management evolve into a significant fiduciary and compliance challenge. Organizations are increasingly expected to justify not only what they spend, but also how those decisions are made. Without transparency, oversight, and accountability, they face growing financial, regulatory and reputational risk."



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GLP1 COVERAGE CHALLENGES



Bruce Roffe

Leaders at the Business Group on Health attest that GLP-1s have been a significant factor in that affordability equation, and for many employers, they're having to make some hard decisions about maintaining the viability of their overall plan and whether or not they can do so while still continuing GLP-1s. Dr. Bruce Roffe, Registered Pharmacist, president and CEO, H.H.C. Group offers solid recommendations for managing GLP1 utilization, saying TPAs can help health plans to avoid crude coverage restrictions alone and instead use a combination of eligibility controls, outcomes management and contracting.

"The plans that are most successful are generally trying to ensure GLP-1s are used for the highest-value members while limiting long-term use among members who are not achieving meaningful clinical benefit," says Roffe. "For example, TPAs can support their clients by recommending tight prior authorization criteria that require FDA-labeled BMI criteria, documentation of obesity-related comorbidities, participation in a structured weight management program, failure of lifestyle intervention for a defined period and prescribing by or consultation with appropriate providers."

Given his interaction with TPAs across the country to achieve optimal cost containment through cost management initiatives, Roffe observes that many are suggesting participation in a weight management program as well as continuation criteria.

"The latter may be the single biggest opportunity, with the recommendation to approve treatment initially for 3-6 months and then require evidence of meaningful weight loss (for example ≥5% at a specified interval), medication adherence and ongoing participation in care management," he explains. "Members who are not responding clinically may not be permitted to continue coverage, preventing plans from paying indefinitely for low-value treatment."

TPAs are increasingly tasked to offer strategies that help plan sponsors control costs, including negotiating aggressive rebates and outcomes-based contracts.

"In their advisory role, TPAs are addressing a major issue: many patients remain on therapy long term, creating recurring costs," says Roffe. "Managing the duration of therapy should include defining maintenance protocols, monitoring long-term effectiveness and reassessing eligibility periodically. The financial challenge is often not initiation of therapy but indefinite continuation."

Roffe emphasizes that a TPA can help clients measure the total cost of care, not simply the pharmacy spend, adding, "The smartest plans evaluate hospital admissions, diabetes costs, cardiovascular events, bariatric surgery avoidance and overall medical spend. A member generating $15,000 to $20,000 of annual GLP-1 cost may still be economically attractive if medical costs decline significantly."

TPAS AND MENTAL HEALTH

TPAs are deploying real cost-containment strategies, and across most medical spend those strategies work. But in behavioral health, Trevor Colhoun, CEO, TPN.health affirms that TPAs don't have the capability to find the efficient and effective process for a covered life, because the variable driving cost in high-acuity behavioral health isn't price — it's whether the member is matched to the right provider.

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"That's the work we do at TPN.health," he explains. "We go deep on the provider: understanding the specialty of each high-acuity provider, and how their quality of care matches their value. Credentialing and claims are part of that same picture, not a separate administrative exercise."



Trevor Colhoun

Colhoun says that at scale, that knowledge produces better rates and better outcomes at once: "….through high-acuity care navigation up front, clinically informed matching and personality scoring, and a scale of offerings that delivers value of service matched to what the member actually needs rather than what happens to be available."

ARTIFICIAL INTELLIGENCE (AI) TO THE RESCUE

AI is rapidly becoming the difference-maker. Rather than waiting for a claim to hit six figures before intervening, AI-powered predictive models can flag high-risk members weeks or months earlier, scanning patterns in diagnosis codes, prior utilization and social determinants of health that a human reviewer might overlook. This represents a palpable shift from hindsight to foresight, allowing TPAs to loop in case managers, negotiate provider rates or guide members toward centers of excellence before costs spiral out of control. The result isn't just savings; it's better-coordinated care that leads to better outcomes.



Barbora P. Howell

"Generative AI can fundamentally change how TPAs manage high-cost claims," asserts Barbora Howell, co-founder and CEO of TrueClaim. "Instead of relying upon retrospective audits, AI can review every claim, surface anomalies and payment-integrity issues and give claims teams the context to intervene before payment.

She points to an example at her organization, "We use AI to review 100% of claims and flag issues such as duplicate charges, medically unlikely edits, and upcoding for human validation. This allows experts to focus their attention where it matters most while saving the plan 7% of claims costs."

Equally important, Howell says the economics should be transparent, adding, "Employers should know exactly how every vendor and TPA is compensated. TrueClaim charges a transparent administrative fee, passes vendor costs through without markup and returns shared-savings incentives to the employer."

TPAS FACE LEGAL CHALLENGES

It's not a bed of roses for the national TPAs as they face mounting legal challenges and scrutiny over high-cost claims. These employer lawsuits are driven by issues spanning hidden fees, aggressive claim denials using automated tools, data-access restrictions, and heavy backlogs and high provider win rates in federal independent dispute resolution (IDR) processes under the No Surprises Act.

Advisors at Withum maintain that rising medical claim denials are no longer a back-office nuisance; they represent a direct fiduciary risk under the Employee Retirement Income Security Act of 1974 (ERISA). They impart that every denial that delays care or reimbursement can expose plan sponsors to financial volatility, regulatory scrutiny and litigation, and as fiduciaries, employers must act prudently and solely in the interest of plan participants. Failure to monitor claim adjudication processes, especially those delegated

to third-party services providers, such as TPAs and PBMs, can result in breaches of ERISA duties and reputational harm.

While many denials are clinically or contractually appropriate, Withum contends that the variability and frequency of denials across payers signal broader systemic issues that contribute to the rise in claim denials.

FIDUCIARY AND LEGAL RISK

Under ERISA, plan sponsors must ensure claims are processed fairly and in compliance with plan terms. As claim denials continue to draw scrutiny, courts are increasingly clarifying how ERISA's fiduciary standards apply to modern claims administration, especially when TPAs rely upon automation, algorithms or insufficient human review.

Recent cases offer insight into how judges are evaluating these practices and the legal exposure that can arise when oversight is inadequate:

- ***Aramark v. Blue Cross and QCC Insurance Company***

Most recently, a federal court case in Pennsylvania could show benefits managers and benefits advisors how the courts will handle employer plan suits based on the results of plan audits.

A ruling lets Aramark — a food services and facilities management giant — move forward with some of the arguments it made in a suit against a health plan administrator.

According to documents, Aramark based the suit on the results of an audit of some of its self-insured health plans. The list of defendants included Independence Blue Cross and QCC Insurance Company, an Independence Blue subsidiary that administers employer health plans.

Aramark accused the defendants of breaching their fiduciary duty to the plan participants under ERISA and of engaging in transactions prohibited by ERISA.

Aramark charges that the plans' TPA paid about 5,000 duplicate claims; hundreds of claims for telehealth services and other services excluded from coverage; and hundreds of claims with missing, invalid or unlisted claim codes. The company reportedly made plausible claims that the health plans' TPA now has "money wrongly held," and that QCC "had discretionary authority and responsibility in plan administration."

- ***K.D. v. Anthem Blue Cross and Blue Shield***

The court found violations of the Mental Health Parity and Addiction Equity Act (MHPAEA) and ERISA when Anthem failed to provide adequate review for denied mental health claims. The ruling reinforced that plan sponsors must actively oversee appeals to avoid fiduciary breaches.

- ***Kisting-Leung et al. v. Cigna Corporation***

Plaintiffs, consumers in California, filed a class action complaint alleging Cigna used an algorithm to deny claims in seconds without medical review. The court ruled that delegating medical necessity determinations to an algorithm violated plan terms and constituted an abuse of discretion, allowing fiduciary breach claims under ERISA to move forward.

PLAN SPONSORS STRENGTHEN TPA OVERSIGHT

Denied claims aren't just paperwork headaches as they carry real fiduciary weight. When self-insured employers get this wrong, they risk regulatory scrutiny, lawsuits and damage to their reputation.

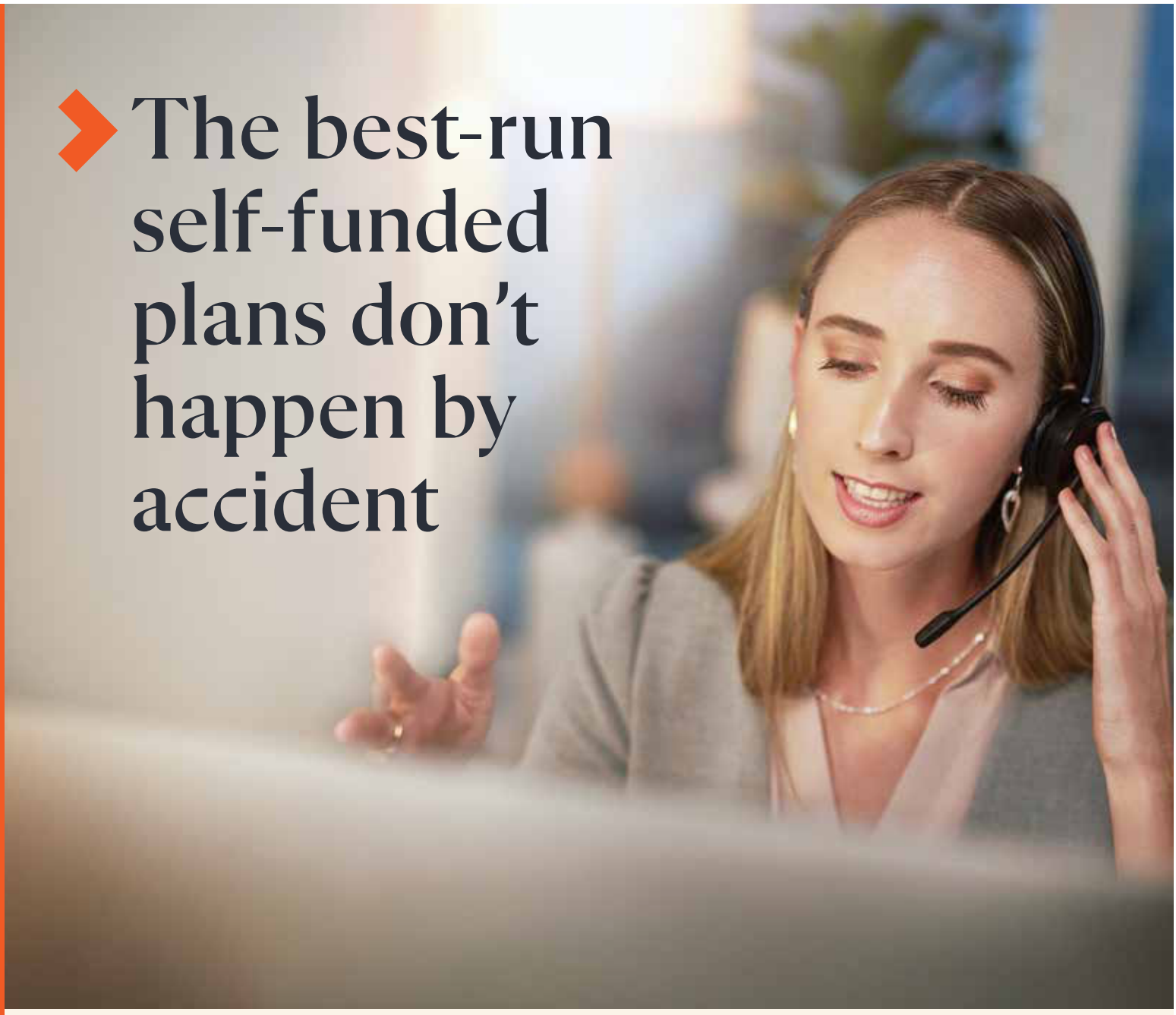
ERISA puts plan sponsors on the hook for acting prudently and putting participants' interests first, and that duty doesn't disappear just because claims processing gets outsourced to a TPA. Relegating the day-to-day work isn't the same as handing off responsibility: Employers still need to stay engaged, tracking how denials are handled, auditing the claims process and confirming appeals meet the federal standard of a "full and fair review." Omitting this oversight isn't just precarious from a legal standpoint; it erodes the trust employees place in their benefits.

Strong governance is what keeps a health plan sustainable over the long run. When employers invest in independent audits, push TPAs for transparent reporting, and lean on data to guide decisions, they can catch problems early, before small issues turn into systemic challenges. A positive outcome goes beyond staying compliant.

This level of oversight builds employee trust and repositions health benefits as a strategic advantage rather than just a line-item expense. For self-insured employers, treating accountability and member advocacy as priorities serves a dual purpose: it protects the plan and signals a real commitment to employees, a key ingredient for maintaining and attracting top talent.

Martin at Nova Health suggests, “An ethical TPA should be disclosing all of their fees within their proposals and administrative service agreements. Fees can get buried in many places such as subrogation, out-of-network negotiations, PBM per-script commissions, as well as behind-the-scenes stop-loss overrides.”





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CALLING FOR ACCOUNTABILITY

Litigation over fiduciary breaches and employer lawsuits against TPAs over hidden administrative charges, "shared savings" overpayment fees, and a lack of pricing transparency on expensive medical claims have prompted greater plan sponsor oversight and demands for accountability.

Advisors at Withum offer some guidelines for employers: "Self-insured health plans can take proactive steps to strengthen oversight of their TPAs, who are often responsible for processing claims and managing provider networks. TPA oversight is important to reduce legal exposure, improve employee satisfaction, and fulfill their fiduciary duty to act in the best interest of plan members."

- Establish clear performance benchmarks: Metrics such as denial rates, appeal success, and adjudication timelines should be reviewed regularly and incorporated into quarterly performance evaluations to identify trends and areas for improvement.
- Demand transparency: Require detailed reporting on denials and appeals, including justifications and resolution outcomes.
- Audit regularly: Independent audits can help uncover patterns of inappropriate denials and ensure ERISA compliance.

They recommend using data to drive governance and should consider adopting a proactive, data-driven approach to manage risk and improve outcomes. This includes analyzing claims data, utilization patterns, and denial rates to identify trends and systemic issues, as well as applying predictive modeling to forecast high-cost claims and adjust benefit design. As with all AI-driven initiatives, they recommend monitoring AI-driven adjudication for compliance and fairness.

THE VALUE OF REPUTABLE TPAS

While many observers raise legitimate concerns about transparency, incentives and conflicts of interest, much of the strongest criticism of TPAs relies on allegations and selected examples from lawsuits rather than established industry-wide evidence and findings. The most productive approach for employers is not assuming all TPAs are good or bad, but demanding rigorous transparency, conflicts of interest, audit rights, claims-level data access and disclosure of all compensation streams. TPAs provide significant operational value, and employers should focus on these metrics rather than assuming misconduct.

Dr. Roffe emphasizes, "A sophisticated TPA would likely agree that transparency and accountability are important, but I – along with many colleagues -- would challenge several conclusions made by critics. Some faultfinders claim that TPAs are the medical equivalent of PBMs and profit by increasing costs. In reality, most TPAs are primarily administrative entities, and it is the PBM that often directly influences drug pricing and pharmacy reimbursement."

Self-funded employers typically hire TPAs because they lack the infrastructure to adjudicate millions of claims, maintain provider networks, ensure regulatory compliance or manage customer service and appeals.

"TPA fees are usually a small fraction of total health plan spending," Roffe points out. "Respected industry sources affirm that the overwhelming majority of costs come from medical claims, provider pricing, specialty drugs and utilization trends. It's a fact that TPAs generally do not bear the medical claims risk in self-funded plans – it's the employers that do, and that is undisputed."

While some observers claim that network contracts are deliberately hidden, Roffe asserts, "Provider contracts often contain confidentiality clauses demanded by providers, not solely by insurers. Hospitals and physician systems frequently consider negotiated rates proprietary, and revealing all network contracts could undermine future negotiations and reduce network competitiveness. Employers often receive limited access to complete provider contracts, but this does not automatically indicate abusive pricing."

In response to criticisms that TPAs steer patients toward affiliated providers to increase profits, Dr. Roffe rebuts, "Many steering programs are designed around quality metrics, value-based care arrangements, narrow-network strategies and designated Centers of Excellence. There is growing consensus that integrated organizations can better coordinate care, improve outcomes and reduce unnecessary utilization."

Roffe states that out-of-network claims are notoriously difficult to manage, and TPAs require an experienced partner that can effectively combine PPO network agreements, attorney-led negotiations and detailed line-item bill reviews to support lower medical spend for their clients.




Mike Lanza

"This is an area where decades of experience can save employers substantial amounts that otherwise would have been paid at billed charges," says Roffe. "The goal is to get providers to accept discounted rates on out-of-network claims as a defensible payment in full for their services. The key is fast turnaround and an expert negotiating team that uses real people who are supported by AI and technologies."

TPA CLAIM REVIEW AND PLAN COMPLIANCE

TPAs are essentially caught between two competing responsibilities: maintaining provider networks and discounts while also properly administering the Plan document.

Michael Lanza, Senior Vice President, USBenefits Insurance Services, advises that provider contracts can restrict the ability to conduct claim-review audits, which can have a significant impact on the management of high-cost claims.

"TPAs must have a comprehensive claim-review process that applies to both in-network and out-of-network claims and ensures claims are covered under the terms of the Plan," says Lanza. "Reviews should address medical necessity, experimental or investigational treatment, exclusions, limitations, billing accuracy, and other coverage provisions."

Payment of a claim that is not covered by the Plan creates compliance, fiduciary, financial, and contractual risks.

"Ultimately, an effective claim-review program is not simply a cost-containment strategy," cautions Lanza. "It is an essential component of proper Plan administration, adherence to the Plan document, fiduciary oversight and protection of Plan assets."■

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