Governance That Wins

Strengthening Self-Funded Welfare Plan Governance for Greater Savings and Reduced Exposure

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- *We would be happy to discuss these materials or topics with your fiduciary committee or others at your company, should that be helpful, and at no cost to you or your company.*

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Focusing on the representation of public company and private equity portfolio borrowers in cash-flow and asset-based financings, Kim partners with CFOs, treasurers, controllers and in-house counsel on the negotiation and documentation of revolving, bridge and term loan facilities, including acquisition financings, recapitalizations and “going private” transactions. Additionally, she represents residential mortgage servicers and lenders in financing servicing advance receivables and servicing rights. With nearly thirty years of experience advising borrowers across all industries, Kim is adept at quarterbacking a team to handle all aspects of financing transactions, from negotiating term sheets, engagement documents and credit agreements to facilitating due diligence, disclosures and other closing mechanics. With a practical approach and even demeanor, Kim also guides clients through amendments and waivers, debtor-in-possession and exit financings, troubled loans, workouts and restructurings.

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- Selling an ESOP-Owned Company: A List of Business and Legal Issues (June 2026)
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- Hot Compensation Topics (August 2026)
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- Preparing for Proxy Season: Start Now (an Annual Program) (September 2026)
- 2026 Year-End ERISA Compliance Wrap-Up & What to Expect for 2027 (October 2026)
- Carrot and the Stick: Delving Into Various Stick-Related Retention Ideas (October 2026)
- Form 4 Training Course (November 2026)
- Compensation: Year-End Review of 2026 Items (December 2026)

Presentation Overview and Topics

A. Review of health plan sponsor fiduciary responsibilities.

B. The current health plan litigation landscape.

C. Health plan fiduciary governance best practices.

D. Risk mitigation & cost containment strategies.

E. Key takeaways.

Review of ERISA Fiduciary Responsibilities

- ERISA requires plan fiduciaries (i.e., individuals and entities that sponsor/manage employee benefit plans) to:

  1. Act solely in the interest of the plan participants and beneficiaries, with the exclusive purpose of **providing benefits and paying reasonable plan expenses**.

  2. Act with the care, skill, prudence, and diligence that a prudent person familiar with such matters would exercise in similar circumstances. This includes making informed decisions based on relevant facts and circumstances and engaging advisors where expertise is necessary or appropriate.

  3. **Avoid conflicts of interest** and must not engage in transactions that benefit themselves or related parties at the expense of the plan.

  4. **Monitor the performance of service providers** to ensure they are acting in the best interest of the plan.

  5. Follow the plan documents.

- Breaches of fiduciary duty can result in penalties, participant recoveries, and potential personal liability.

Health Plan Litigation Landscape and Other Information

- Plaintiffs' lawyers have increasingly been turning their attention to the $5+ trillion health care market.

1. **High-Cost Pharmacy Claims** - High-profile lawsuits against large employers that challenge the drug pricing models and choice of formularies.
    - *Lewandowski et al. v. Johnson & Johnson et al.; Navarro et al. v. Wells Fargo & Company et al.* – Plaintiffs lacked standing.
    - *Seth Stern et al. v. JPMorgan Chase & Co., et al.* – Court ruled on motion that minimum pleading standard was met to survive motion to dismiss.

Health Plan Litigation Landscape and Other Information

2. **Excessive Fee Cases -** Plaintiffs are applying historic 401(k) "excessive fee" arguments to healthcare plan operations.

- *Owens & Minor, Inc. v. Anthem Health Plans of Virginia, Inc. 2023*- Plan sponsor of self-funded plan sued the TPA alleging gross overpayment certain medical claims and pocketed pharmaceutical rebates that should have been paid to the plan.
- *Aramark Services v. Aetna Life Insurance Co. 2025* - Aramark alleges that Aetna mismanaged claims and diverted plan assets through various undisclosed or improper practices, causing tens of millions of dollars in losses to the plans.
- *Kraft Heinz v. Aetna 2023* – Kraft alleged Aetna breached its fiduciary duties by paying over $1.3 million in improper claims, failing to adequately monitor self-funded claims, delaying and withholding required HIPAA claims data, and using practices like cross-plan offsetting and affiliated repricing fees that improperly shifted costs to Kraft Heinz.
- *Mars, Inc. v. Aetna and Optum 2021* – Mars claimed that Aetna, working with subcontractor Optum, created "dummy codes" to bury administrative fees in claims data. Mars asserted that these hidden fees led to substantial overcharges for its employees' health plans.
- *Illinois recovers $45M settlement from CVS Caremark in May 2025 for alleged failure to pass through rebates.*
- *Connecticut Unions v. Elevance Health 2021* - Unions alleged that TPA restricted access to claims data and deliberately overcharged the unions by not applying contracted discounts.
- *Sweda v. University of Pennsylvania* - Third Circuit held that ERISA plan fiduciaries may breach their duty of prudence by continuing to retain high-cost service providers without adequately monitoring them or considering more cost-effective alternatives.

Health Plan Litigation Landscape and Other Information

3. Other Health Plan Fiduciary Cases -

- *Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan*. – Sixth Circuit reversed district court and ruled that TPA was an ERISA fiduciary to the plan and had profited off its mismanagement of plan assets.
- *Oregon Potato Company v. Marsh McLennan* - ERISA looks to the party's function, not contract terms, to determine whether fiduciary status attached.

4. Voluntary Benefits Under Fire.

5. States Getting into the Act -

- States like Maine and Indiana now require TPAs and PBMs to allow full audits of claims, removing or prohibiting audit restrictions.
- In 2025, 15 State Financial Officers sent joint letter to Fortune 500 companies asking them to, among other things, monitor third party health providers.

Health Plan Governance Framework

- Welfare plan governance historically overlooked.
- In light of increased pricing transparency, data analytics, and AI, this creates fiduciary risk and potential liability.
- Best practices should include:

1. Formally adopt and implement a health and welfare benefits fiduciary committee and charter.
2. With outside assistance, conduct and document a review of current service providers to assess their capabilities, competitiveness, and record.
3. Review plan communications (e.g., SPDs, SMMs, SARs, COBRA notices, ACA notices, etc.) to ensure legal compliance.
4. Regularly engage independent third-party auditors to assess the plan's compliance with service provider contract fees and claims accuracy.
5. Provide yearly education training sessions on current legal landscape to avoid the potential risks of noncompliance by fiduciaries.
6. Ensure that health plan fiduciaries make decisions for the health plan and/or properly delegate those decisions to the appropriate individuals.
7. Monitor the fiduciaries making those decisions and request frequent updates.
8. Maintain detailed records of all decisions made regarding the health plan, the rationale behind these decisions, and the information that was used to make them.

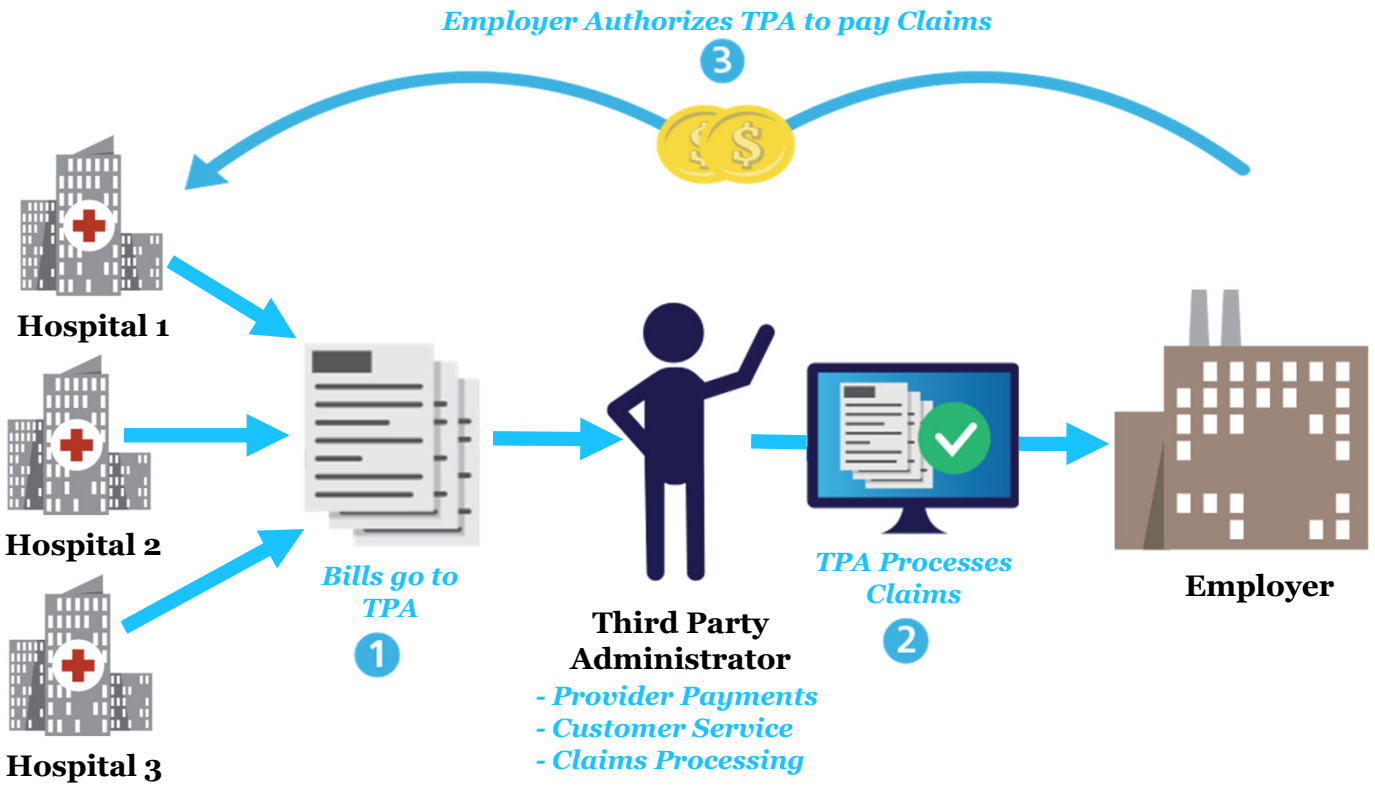
Self-Insured Health Plan Overview

- Health benefit plan costs are usually one of an employer's largest yearly expenses.
  - For most large employers, this is can be in the top five of largest yearly expense items.
  - Health care plan costs increase each year; 2026 was projected at 9% increase over 2025.
- Employers with 50 or more employees are required to provide health insurance plans for their employees.
- Employers with 100 or more employees usually "self-insure" their health plans to save costs, rather than purchasing health insurance.
  - Employers often see 10% to 15% lower annual premiums when moving from a fully insured plan to a self-funded (self-insured) plan, assuming similar coverage and service levels.
  - But must hire an outside "third party administrator" (TPA) to process and pay claims, typically charging administrative fees ranging from about 1% to 5% of total plan assets, depending on the scope of services provided.

Risk Mitigation & Cost Containment Strategies

- Employers with self-insured health plans generally hire an outside "third party administrator" (TPA) to process and pay claims. A TPA usually provides:

1. Plan design assistance.
2. Claims processing – ensuring that payments are made accurately and timely.
3. Plan administration – participant interactions and the day-to-day operations of the plan.
4. Vendor management – act as an intermediary between providers (i.e., doctors, hospitals, etc.) and the plan/sponsoring employer.


Employer Authorizes TPA to pay Claims
3
Hospital 1
Hospital 2
Hospital 3
Bills go to TPA
1
Third Party Administrator
- Provider Payments
- Customer Service
- Claims Processing
TPA Processes Claims
2
Employer

Risk Mitigation & Cost Containment Strategies

- Until recently, employers were generally unable to review the accuracy of TPA claim payments in a comprehensive manner.
  - To audit a TPA, employers generally hired health care consultants to review a very small sample of claims (e.g., 100 claims for $60,000 in audit fees, etc.).
  - Most health care consultants come back with a high degree of accuracy.
- Under the Consolidated Appropriations Act of 2021, beginning in 2022 employers must post or provide:
  - Negotiated rates for in-network provider services and supplies.
  - Allowed (paid) amounts for out-of-network provider services and supplies (including prescription drugs).
  - Prescription drug negotiated rates and historical net cost.
  - TPAs must provide access to claims cost data under "anti-gag" rule.

Claims Auditors/Data Miners

- Claims Auditors/Data Miners now can audit/review 100% of a health plan's claims for accuracy.
  - Auditors require plan documents/SPDs and access to the TPA's claims data/source codes for the plan.
  - Can process 3-6 year's worth of claims data in a few months.
  - May work on a contingency up to a cap amount or guarantee a certain level of results.

- Data Miners **are routinely discovering a TPA overpayment rate of 3% - 6%.**
  - On a $10,000,000 yearly health care spend, this would equal a $300,000 - $600,000 per year overpayment by the plan.
  - On a $100,000,000 yearly health care spend, this would equal a $3 mill to $6 mill per year overpayment by the plan.
  - On a $500,000,000 yearly health care spend, this would equal a $15 mill to $30 mill per year overpayment by the plan.

- Overpayment instances may include:
  - Charging the wrong discount rate on a particular medical service.
  - Charging out-of-network fees on an in-network provider.
  - Charging the same expense twice for a particular medical service.
  - Failing to correctly reconcile plan invoices due to timing issues.
  - Failing to credit the employer subrogation or reimbursement amounts.

- The potential overpayments may exceed the fiduciary liability insurance coverage.

TPA Service Agreements and the CAA

- In recent years, TPAs have included language in the Service Agreements with employers such as the following:

  "Employer or an authorized agent of Employer may,, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will ***be limited to no more than three hundred (300) Claims****. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. ..... The audit period* ***will be limited to the current Agreement year and the immediately preceding Agreement year****."*

- Other restrictions may include:
  - Allowing only "statistically valid random sampling" for audit selection.
  - Providing only "minimally necessary" data to limit the scope of audits.
- In response, the Consolidated Appropriations Act of 2021 (CAA) introduced key provisions that:
  - Eliminated restrictions on data transparency.
  - Specifically require plan fiduciaries to monitor the performance of their service providers.

TPA Service Agreements and the CAA

- In 2025, the DOL, Health and Human Services (HHS), and the Treasury issued clarifications identifying several impermissible provisions in service agreements, including:
  - Limiting access to a statistically significant number of de-identified claims.
  - Restricting data access to specific, narrow purposes (e.g., audits only).
  - Unreasonably limiting claims reviews (e.g., no more than once per year).
  - Restricting the number and types of de-identified claims accessible.
  - Limiting the data elements included in de-identified claims.
  - Requiring access to de-identified data only on the TPA's physical premises.
  - The DOL has noted that this is not an exhaustive list and additional prohibited clauses may be shared in the future.

- TPA service agreements that limit access to claims information or an Employer's ability to review a specified number of claims may violate the CAA because such provisions hinder the Employer's ability to monitor plan service providers.
- Employers must attest each year that the TPA service agreement does not have any "anti-gag" provisions.
- The tension between the Service Agreement and CAA requirements may create constructive conversations between the Employer/Counsel and the TPA.

Recoveries or Credits

- The ERISA Statute of Limitation is generally six years.
- Errors and omissions by the TPA are generally covered by the services agreement between the Employer and the TPA.
  - Usually limited to 2-3 most recent years, unless fraud or willful negligence exists.
- Recovery or credit from the TPA may be considered "plan assets" would be used to reduce the Employer's ongoing medical costs under their Health Plan going forward (which would reduce current contributions from the Employer).
  - This would require an analysis of the plan document and TPA arrangement.

Take Aways

1. Review governance structure.
2. Review TPA Services Agreement.
3. Identify CAA Gag clause concerns.
4. Discuss Gag clause concerns, if any, with TPA and document unresolved concerns in annual attestation clause.
5. Interview and select a qualified and experienced health claims payment auditor.
6. Discuss audit with TPA and then conduct audit of TPA payment claims.

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