What’s in the Fine Print?

Uncovering hidden costs in your TPA and carrier contract

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HTA HEALTH TRANSFORMATION ALLIANCE

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INTRODUCTIONS & DISCUSSION

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INCENTIVES

Your second-largest expense runs on one contract, and Carrier interests don’t align with yours

Your dollars subsidize their book	Carriers need your plan to pay hospitals generously, so they can pay those same hospitals less on the Medicare Advantage and fully insured business where they carry the risk.
The loopholes are real	Recent lawsuits show that, without safeguards, major gaps in these agreements have been exploited.
Flat fees, rising everything else	Basic admin fees haven’t gone up in over a decade. Increases have been constant in other categories that are poorly reported.

WHERE TO FOCUS

Five categories that matter

1

Data

Everything else depends on seeing it.

Start here

2

Fee transparency

Know every dollar; cap what varies.

3

Audit Rights

Check the work and get the money back.

4

Carve-out rights

Freedom to buy better without a penalty.

5

Steerage rights

Send members to higher-value care.

FEE TRANSPARENCY · WHAT TO REQUEST

The “dark money” categories are fees you rarely see

Common areas where employers pay a lot, often without knowing it — each should be requested.

1 Shared savings on out-of-network claims

A percentage of the “savings” off billed charges, often with no cap.

2 Operating fees mixed into claims

Payment-integrity and coordination-of-benefits fees taken from claim dollars.

3 Unclaimed medical drug rebates

Rebates on drugs billed under the medical benefit that never reach the plan.

4 Unreported provider incentive payments

Bonuses paid with plan dollars, with no report of who earned what.

5 Independent Dispute Resolution (IDR) losses

Surprise-billing arbitration awards the plan pays, rarely reported.

6 BlueCard fees

BCBS plans only. Access and out-of-area fees billed on top of the admin fee.

TAKE-HOME

The fine-print checklist

Data

- [ ] Plan controls claims data
- [ ] Claim-line feeds, no fee
- [ ] No gag clauses

Fees

- [ ] Every fee on one exhibit
- [ ] A cap on every variable fee
- [ ] Lesser of contract or billed

Carve-outs

- [ ] Right to carve out or add on
- [ ] Fees drop when services leave
- [ ] Direct contracts allowed

Audit

- [ ] Your auditor, your sample
- [ ] No fee on your findings
- [ ] Unrestricted fiduciary review okay

Steerage

- [ ] Navigators at point of care
- [ ] Anti-steering terms disclosed
- [ ] Right to exclude providers

Control and exit

- [ ] Plan document governs
- [ ] No changes without consent
- [ ] 90-day exit, no penalty

TAKE-HOME · BEFORE YOUR RENEWAL

Questions to ask your carrier

1	DATA	Will you please help us set up a monthly comprehensive claims data feed to our designated server?
2	FEES	Please share how much we spent last quarter on shared savings and payment integrity fees
3	TRANSPARENCY	Please provide a report on last quarter's medical drug rebates and provider value payments
4	PRICING	Which of our claims in the last year exceeded billed charges? Provide number and amounts
5	CARVE-OUTS	We need the option to carve out specialty drugs; is this permitted or must we go to RFP to do this?
6	AUDIT	Will you resist our performance of a targeted claims audit with a standard sample?
7	STEERAGE	What is the process to implement a two-tier in-network benefit to incentivize high value utilization?

CATEGORY 1 OF 5 · DATA

You can’t manage what you can’t see

⚠ The default

- Data treated as the carrier’s property
- Summary reports, not claim-line detail
- NDAs and fees before vendors get feeds
- Denials and adjustments left out
- Data held hostage at termination

✓ The fix

- Claims data owned by the plan
- Claim-line feeds, denials included
- Sent to vendors you choose, at no fee
- No gag clauses; yearly attestation
- All data handed over when you leave

Start here: request a monthly claim report to a server you control. Either your servers or you can outsource, so long as you can withdraw your paid claims data whenever desired. Your next gag-clause attestation is due December 31, 2026.

CATEGORY 2 OF 5 · FEE TRANSPARENCY

The base fee isn’t the whole fee

⚠ The default

- A flat admin fee in the headline
- Percent-of-savings fees with no cap
- Up to a third of recoveries kept as fees
- Bonuses and fees buried in claim costs
- Fee changes “deemed” accepted

✓ The fix

- Every dollar of pay on one fee exhibit
- Anything else refunded, with interest
- A cap on every variable fee
- Fees billed separately, never in claims
- Changes only with written consent

Start here: ask for total compensation earned from your plan last year — every source, not just the admin fee.

CATEGORY 3 OF 5 · CARVE-OUT RIGHTS

Keep the freedom to buy better

⚠ The default

- Only the carrier deals with providers
- Direct contracts restricted or penalized
- Carving out a service raises your fees
- New programs added without asking
- Exit fees and long notice periods

✓ The fix

- Right to insource, carve out or add on
- Direct contracts paid as you set them
- Fees go down when services leave
- Your plan document governs
- 90-day exit, no penalty, partial allowed

Start here: find every clause that makes a carve-out cost you — then price what a better vendor would save.

CARVE-OUT RIGHTS · PLAN CONTROL

Who really runs your plan?

What the fine print says	What it should say
Fee and program changes take effect unless you object	Changes require your written consent
Carrier medical policies and provider contracts override your plan document	Your plan document governs every conflict
The carrier has the final say on what the plan means	You stay the named fiduciary; they decide initial claims and appeals only
Only the carrier may negotiate with, audit, or contact providers	You can direct contract, carve out, and add your own vendors

Start here: find which document wins when your plan and the carrier's policies conflict.

CATEGORY 4 OF 5 · AUDIT RIGHTS

The right to audit, on paper only

⚠ The default

- Once a year, a few hundred claims at most
- Random sample only, no extrapolation
- Carrier approves the auditor; NDAs first
- No recovering directly from providers
- Repaid as offsets against future claims
- Up to a third kept as a recovery fee

✓ The fix

- Unlimited claim reviews, pre- or post-pay
- Your sampling method, your auditor
- Errors fixed on every matching claim
- No fee on overpayments you find
- Recoveries paid in cash within 60 days
- Audit rights for 36 months after you leave

Start here: read your audit clause for sample limits, auditor approval, recovery fees, and how long rights last after you leave.

CATEGORY 5 OF 5 · STEERAGE RIGHTS

Point members to better care

⚠ The default

- Carrier decides how providers appear
- Anti-steering terms hidden in contracts
- Navigators locked out at point of care
- No real-time eligibility for vendors
- No way to exclude poor-value providers

✓ The fix

- Add navigation and prior-auth vendors
- Real-time eligibility and cost-share feeds
- Disclosure of anti-steering and MFN terms
- Benefit design that rewards better sites
- Right to exclude providers from the plan

Start here: ask which of your top 20 providers' contracts limit steering, tiering or exclusion.

RENEWAL NEGOTIATION

Hold firm on six terms. Trade on the rest.

Hold firm

1. Claims data shareable by the plan — no gag clauses
2. Every dollar of compensation on one fee exhibit
3. Benefits are capped at billed charges
4. Carve out services without penalty
5. Audits you control, with no fee on what you find
6. Freedom to steer members, and your plan document governs

Room to trade

- Performance-guarantee levels
- Audit timing and notice
- Report formats and cadence
- Term length for fee guarantees
- Implementation credits

Review at every renewal, not only at RFP time. A term that slips through once becomes next year’s baseline.