REGULATORS WARN HEALTH PLAN SPONSORS:

Be Aggressive about Provider Payment Error Remediation !

New state and federal health plan price transparency initiatives are focusing attention on a largely unknown, often misunderstood and very underutilized asset preservation / cost management service.

by Richard L. Nicholas, Founder of the **TPA NETWORK** *Research Consortium*

Healthcare represents one of the largest *unaudited* operating expenses for most organizations, a problem regulators want to solve. A new Trump Administration initiative to leverage the *Transparency in Coverage* rules that make negotiated provider rate data available to plan sponsors and participants ... plus measures taken by state regulators toward "*radical price transparency in healthcare*" ... may just do that. Both want plan sponsors to use this newly available price data to analyze their plan's payments and to conduct periodic plan audits, to ensure that they do not overpay providers at the expense of shareholders and plan participants ... "important responsibilities" ascribed to them solely by virtue of their status as a fiduciary.

The Challenge

Claim processing system edits, augmented by healthcare *payment integrity* services and tools, help payer efforts to ensure that claim payments are accurate, proper and fraud-free by focusing on

- incorrect, inaccurate and outdated medical records,
- provider and billing system generated errors,
- incorrect eligibility information,
- misrepresentations by patients and providers,
- coding-related errors and schemes (e.g., upcoding, unbundling),
- erroneous application of plan deductibles, co-pays and coinsurance,
- incorrect discounting by provider networks,
- regulatory and medical guideline changes that result in time-related errors, and
- claim intake and claims adjudication decisions.

They also employ post-payment measures to find errors not able to be detected pre-payment, including:

- *Clinical audit* of complex, high-dollar claims re: medical necessity, care appropriateness, etc.
- *Compliance reviews* to ensure adherence to contractual agreements, payment policies, etc.,
- *Coordination-of-benefits reviews* to resolve issues related to participants' primary coverage,
- *Subrogation reviews* to identify at-fault-parties (re: accidents, negligence claims, etc.), and
- *Fraud, waste and abuse* reviews to identify and defeat illegal, for-profit claim schemes.

Although worthwhile, it must be noted that these targeted payer recovery methods differ greatly from those to remediate *incorrectly priced* provider payments ... the specific issue at hand. Indeed, the measures identified above do not specifically focus on *price-related* errors, of which there are two types:

- *overpayments* (that increase costs for plan sponsors, plan participants and shareholders), and
- *underpayments* (that result in plan participants shouldering costs that are rightly those of the plan).

Moreover, payers and networks ***actually create problems*** that cause avoidable payment errors, including:

- the unintended consequences of *claim auto-adjudication,* which allows up to 70% of claims to bypass standard claim edits and analyses,
- the direct conflict that payors create with the plan's legitimate duty to remediate errors when they *withhold the claims data* needed to identify pricing issues,
- *limitations made by provider networks* to restrict a payer's ability to make valid claim edits, corrections and modifications prior to payment, and
- payer and network imposed restrictions on how payment-error correction can be pursued.

Worse yet, intrinsic payer/provider network conflicts add complexity to pricing error remediation:

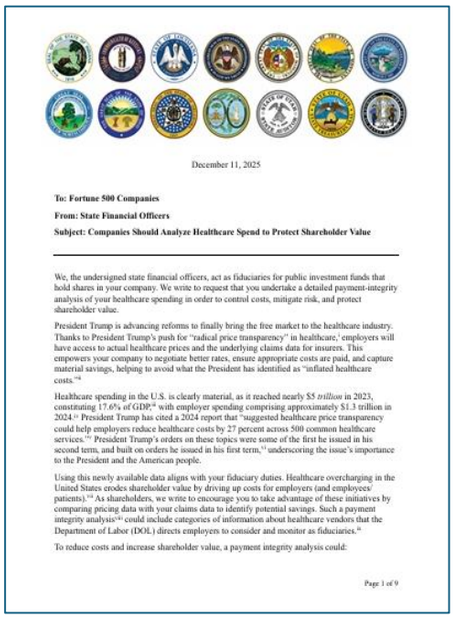
- *Payers* face challenges because some pricing-error remediation efforts may upset providers, (with whom they strive to contract and keep happy) or support the wrong perception that remediation is evidence of an "incorrectly processed" claim and a poor reflection re: payer competence.
- *Provider Networks* also avoid pursuing payment-error correction actions against the providers they work hard to recruit and retain by establishing unreasonable coding standards and payment guidelines for payers. Conflicted, they cannot act in the *plan participant's exclusive best interest*.

The Solution

According to *The Case for Pursuing Overpayment Recovery and Underpayment Remediation: A Guide for Plan Sponsors and Trustees of ERISA-Regulated Health & Welfare Plans*, a new report from the *Research Consortium**

> *"Failure to remediate payment errors allows improper, often systemic payments to go unaddressed. This amounts to a failure of a fiduciary to fulfill his or her ERISA duty to prudently manage and protect plan assets and be loyal to plan participants. Ignoring this reality creates an unnecessary regulatory compliance risk".*

It appears that federal and state regulators agree … including the *National Association of State Auditors, Comptrollers & Treasurers* and the *State Financial Officers Foundation*. In a recent, rare letter entitled *Companies Should Analyze Healthcare Spend to Protect Shareholder Value* they strongly urge plan sponsors to *conduct a detailed payment-integrity analysis* of their health plan claims and to *perform periodic provider payment audits* and *monitor provider fees* to *control costs, mitigate risk and protect shareholder value*.



December 11, 2025

To: Fortune 500 Companies

From: State Financial Officers

Subject: Companies Should Analyze Healthcare Spend to Protect Shareholder Value

We, the undersigned state financial officers, act as fiduciaries for public investment funds that hold shares in your company. We write to request that you undertake a detailed payment-integrity analysis of your healthcare spending in order to control costs, mitigate risk, and protect shareholder value.

President Trump is advancing reforms to finally bring the free market to the healthcare industry. Thanks to President Trump's push for "radical price transparency" in healthcare,[1] employers will have access to actual healthcare prices and the underlying claims data for insurers. This empowers your company to negotiate better rates, ensure appropriate costs are paid, and capture material savings, helping to avoid what the President has identified as "inflated healthcare costs."[2]

Healthcare spending in the U.S. is clearly material, as it reached nearly $5 *trillion* in 2023, constituting 17.6% of GDP,[4] with employer spending comprising approximately $1.3 trillion in 2024.[5] President Trump has cited a 2024 report that "suggested healthcare price transparency could help employers reduce healthcare costs by 27 percent across 500 common healthcare services."[6] President Trump's orders on these topics were some of the first he issued in his second term, and built on orders he issued in his first term,[11] underscoring the issue's importance to the President and the American people.

Using this newly available data aligns with your fiduciary duties. Healthcare overcharging in the United States erodes shareholder value by driving up costs for employers (and employees/patients).[12] As shareholders, we write to encourage you to take advantage of these initiatives by comparing pricing data with your claims data to identify potential savings. Such a payment integrity analysis[13] could include categories of information about healthcare vendors that the Department of Labor (DOL) directs employers to consider and monitor as fiduciaries.[14]

To reduce costs and increase shareholder value, a payment integrity analysis could:

Page 1 of 9

They note that performance can be evaluated based on an analysis of actual *(837/835) charge/payment claim data* and recommend that all claims be reviewed vs. a payer-limited sampling of claims.

Moreover, these financial officers maintain that TPA, PBM, payer and network self-analyzing audits are insufficient as they are conflicted entities that are unlikely to expose practices that may reduce their revenue. As such, they recommend that *pricing-related error audits be conducted by only independent, unconflicted non-payer entities.*

If TPAs, PBMs, payers and provider networks are conflicted and not independent, the question arises as to whether or not plans should involve them in their error correction efforts. Because paid claims fall outside of the claims lifecycle, remediating pricing errors does not require payer involvement as these errors are not claim processing related. Moreover, many experts/sponsors assert that *ERISA supremacy* trumps both state and contract law, thereby requiring them to pursue error remediation without limitation. Right or wrong, these overseers maintain that Involving conflicted entities can only serve to undermine their efforts.

Call to Action

Pricing error payment remediation requires a niche-specific infrastructure and skilled experts capable of carrying out the complex analysis required to identify, validate and pursue error remediation. In recent years, a small number of *independent* specialty vendors have emerged that have developed the resources needed to effectively remediate these errors — post-payment — sans provider abrasion — on a contingent, no-risk fee basis — with no need to involve the TPA/PBM/payer/network — signing on as an ERISA fiduciary.

To provide context as to the magnitude of price-related payment errors, these audits can recover up to 5% of medical and pharmacy provider payments … hardly an inconsequential amount, especially over time. In that these funds should have never been spent, this could in fact be characterized as "asset protection". Therefore, given that the opportunity to conduct such an audit exists, *Can a health plan be fully compliant if it leaves millions of dollars in overpayments unaddressed?* Many regulators would clearly say "No".

* The **TPA Network** *Research Consortium* report (available *here*) details why health plan overseers must address price-related provider payment errors. It provides guidance about choosing a service vendor and also includes the results of a recent survey it conducted of these service vendors, some of which are profiled.

The **TPA Network** *Research Consortium* is a private, non-profit, industry-wide healthcare research initiative that helps providers evaluate and assess new medical technologies and healthcare innovations; plan participants obtain leading-edge health care; scientists advance medical research; and payers reduce risk.

Richard Nicholas is a 48-year veteran of the healthcare industry. He served in C-suite positions with national TPAs and payers, testified in Congress on ERISA regulatory matters, authored one of the first books on corporate healthcare cost management and many scholarly papers, studies and reports on healthcare topics.

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