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Five Contract Negotiation "Asks" for Your Upcoming TPA Contract

Negotiating that contract with your third-party administrator (TPA) can be tricky. Self-insured employers typically hire a third-party administrator (TPA) to process claims. While outsourcing your claims to a TPA is advisable, employers must provide a strong level of oversight as the financial risk of your plan is owned by your company and not the TPA. Below are a few suggestions on to help safeguard your organization and enable you to properly oversee your self-funded plan unencumbered by tricky legal jargon and restrictions.

1. Be clear about who owns the CLAIM DATA

First and foremost, you must establish that the healthcare claims data belongs to YOU! As a self-insured plan, you are the fiduciary for your health plan, and ultimately responsible for compliance with all applicable rules and regulations. You will want to make sure your contract with the TPA is specific that you own the data. TPA's should not try to commingle your healthcare data with their "business practices" or "confidential information" to give them ownership rights. These are after all, your critical financial records.

2. Protect your AUDIT RIGHTS

Your audit rights are critical. Audits not only ensure compliance with applicable rules and plan regulations, but also ensure that the TPA is acting as an effective steward with your money. After all, you are essentially handing over your healthcare checkbook to the TPA, and asking them to be the ultimate decision maker around what healthcare expenses you will pay and not pay, what price is considered a "reasonable" one, and exactly how your employees and their families medical expenses are going to be reimbursed. The TPA should not insert language in the audit clause that enables them to "veto" the use of your chosen audit firm or audit requests.

Other restrictions that need to be stricken from the agreement include:

- Requirement that the audit MUST be a statistical sample, and if errors were found, cannot be extrapolated across the population to reclaim dollars. What's the point in performing an audit if you can't make it actionable?
- Limitations on time frame (i.e. "audit must be completed within 5 days or less");
- Constraints regarding how many claims can be retrieved (i.e. "can't request more than 250 claims"). If you're finding lots of errors, it stands to reason that you'll want to pull additional claims;
- Clauses forbidding you from hiring an audit firm on a "contingent fee" basis. This is very disingenuous as all TPA's use contingent fee auditors to ensure compliance within their fully insured plans via claim audits, subrogation, and negotiation of "out-of-network" claims;
- Provision forbidding the use of software to audit the TPA's claim records (Yes, we have really seen this clause in a contract!).

3. Go for FULL FEE DISCLOSURE!

We strongly endorse the need for full disclosure of fees. Many Benefits leaders mistakenly believe that the "per head" charge quoted in the contract represents the primary compensation that the TPA is receiving for their services. We have identified at least 10 other revenue streams that your TPA may profit from directly, or indirectly through one of their affiliates / subsidiaries. These include:

- Fees related to a "percentage of savings" versus the in-network medical provider's non-discounted list price. These savings can be illusory, as there is limited oversight as to whether the list price on the provider's chargemaster has any meaningful correlation with competitive market costs;
- Negotiation of out-of-network claims. These fees can be substantial, as reducing the billed claim costs with a nominal value of $20,000 to $8,000 (which often happens just by asking) can net the TPA a $3,000 commission on a single claim;
- Claim audits by the TPA's captive audit firms;
- Subrogation audits, where they retain upwards of 25% of the "savings";
- Health & wellness programs delivered by independent vendors or even affiliated companies, where there are fees being earned and retained, unbeknownst to you. You as the company are often footing the bill, or worse yet, the monies may be deducted directly from plan assets;
- Revenue for selling your data to outside parties without your knowledge or explicit permission;
- Rebates on pharmaceuticals that are acquired through both medical billings and pharmacy claims;
- Care coordination fees;
- Network access fees; and,
- Inter-Plan fees for accessing out-of-area providers.

We strongly recommend an itemized listing of all compensation streams and the fees associated with each, delivered on a monthly basis. Additionally, if you're one of those companies who doesn't pay your broker / consultant directly, we recommend that you reconsider. While there may be budgetary advantages for you to operate in this manner, we believe it represents a potential conflict of interest. Remember, the broker / consultant should be working for you and not your TPA.

4. Clarify who's on point for measuring and enforcing PERFORMANCE GUARANTEES

Let's talk performance guarantees. They sound like an awesome idea, right? But question number one is, who is defining what is "effective performance"? Just as importantly, which party is measuring these results to verify performance? If the TPA is filling out their own report card, don't be surprised if they rarely or never fall short of the target. Any performance guarantee that you embed within the contract needs to be clearly enforceable by you and have significant "financial teeth". That is, enough financial teeth to make sure that the TPA will dedicate the needed resources to achieve or surpass the guaranteed performance or have significant negative financial consequences if they miss the mark.

5. Make your TPA treat your company's money like it's THEIR MONEY!

At the end of the day, you as a client want the TPA to treat your money as if it's their own. In order to create this level of financial alignment, the TPA needs clear guidelines as to responsiveness to client requests. Here's a few items we like to see addressed in the contract:

- Claims data is your financial data and needs to be delivered commensurate with the funding cycle for the health plan (i.e. daily / weekly);
- For exceptions surfaced to the TPA, client is promised a specific resolution within 7 days if 10 claims or less (or 14 days for up to 50 claims);
- Medical records to support the expense must be requested within 1 week of client request, and delivered to the client's audit resource within 7 days of receipt by the TPA;
- Client reserves the right to dispute and deduct claims paid in error by the TPA from their daily / weekly claim billings, or in the event of a questionable payment issued on client's behalf, to withhold payment until "adequate supporting documentation" is produced to support the billed charges; and,
- If the client is not happy with their pace of progress in retrieving payment support, or if the billing error becomes uncollectible, the client can deduct the monies in question from the next billing.

There you go! Five recommendations for you and hopefully just in time for your contract renewal. Good luck in negotiating a fair agreement with your TPA, and please give ***fin*Health** a call when you're ready to verify that your TPA's internal controls are properly safeguarding these critical health plan assets for your company and your employees!