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Health Plan Sponsors Must Inspect 3rd-Party Admin Payments

By **Shira McKinlay and Kim Wilcoxon** (November 5, 2026)



Shira McKinlay



Kim Wilcoxon

A newly filed class action against Cigna Health and Life Insurance Company puts a spotlight on a common but often overlooked feature of administrative-services-only, or ASO, agreements: shared savings fees that pay the third-party administrator, or TPA, a percentage of the amount it saves the plan on out-of-network claims.

The complaint, Kreutzmann v. Cigna Health and Life Insurance Co., filed in the U.S. District Court for the Southern District of California on Oct. 12, targets only a TPA, not an employer. But the theory it advances, together with recent appellate decisions involving similar TPA fee programs, should prompt plan fiduciaries of self-funded group health plans to take a close look at how their TPAs are paid.

What's Alleged in Kreutzmann?

Under many ASO agreements, the TPA processes claims, makes coverage determinations and negotiates out-of-network providers' fees, while the employer funds the claims. The Kreutzmann complaint alleges that, under its standard ASO agreements, Cigna earns a cost containment fee of up to 29% of the difference between a provider's billed charge and the lower amount Cigna negotiates.

The problem, according to the plaintiff, is ground ambulance services. The No Surprises Act protects plan participants from balance billing for out-of-network emergency services, out-of-network nonemergency services performed at in-network facilities and out-of-network air ambulance services. It does not extend that protection to ground ambulance services, so any amount the plan does not pay a ground ambulance provider can be billed directly to the participant. The complaint alleges that every dollar of savings Cigna generates on a ground ambulance claim therefore becomes both a dollar of balance billing for the employee and a larger fee for Cigna.

The named plaintiff's experience illustrates the conflict. The plaintiff alleges that a ground ambulance provider billed $3,644.91 for a roughly two-minute transport between facilities. Cigna allegedly paid $386.77 on behalf of the plan.

After sending the participant an explanation of benefits stating he owed $0 and had saved 100%, Cigna reported to the employer that it had reduced the bill by $3,258.14 through negotiation. Cigna allegedly charged the employer its shared savings fee of 29% of that amount — nearly $1,000 — while the ambulance provider billed the participant for the full $3,258.14 balance.

The complaint asserts that Cigna, as the plan's claims administrator, breached its Employee Retirement Income Security Act duties of loyalty and prudence and engaged in prohibited self-dealing by paying itself these fees from plan bank accounts.

The complaint also alleges that Cigna's ASO agreements informed employers that its discounts "avoid[] balance billing and substantially reduce[] the patient's out-of-pocket costs," a statement the plaintiff says is untrue for ground ambulance claims. It should be noted that these are allegations only. Cigna has not yet responded, and no court has ruled on the complaint.

Background

Whether a TPA is held to ERISA's fiduciary standards depends on what it actually does under the plan and the ASO agreement, not on its title.

ERISA recognizes two types of fiduciaries: named fiduciaries, which are generally identified in the plan document, and functional fiduciaries, whose status turns on the functions they perform. A party becomes a functional fiduciary if it exercises any discretionary authority or control over the management or administration of the plan, or any authority or control over the management or disposition of plan assets.

Fiduciary status is also not all-or-nothing. A TPA can be a fiduciary for some purposes and not others, so fiduciary status depends on whether the TPA was acting as a fiduciary when it took the specific action being challenged.

In practice, several features of a TPA arrangement may involve actions that would result in functional fiduciary status. A TPA that makes final benefit determinations, interprets plan terms or decides claim appeals is generally exercising discretion.

By contrast, a TPA that only processes claims or calculates benefits within a framework set by others is performing ministerial functions that, under U.S. Department of Labor guidance, do not make it a fiduciary.

Two circuit decisions, both involving TPAs that were paid a percentage of the savings or recoveries they generated for the plan, illustrate how these factors play out in the shared savings context and set the stage for Kreutzmann.

In Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts, the U.S. Court of Appeals for the First Circuit **held** in 2023 that the fund had not plausibly alleged the TPA was a fiduciary with respect to claim overpayments and recovery fees.

The plaintiff fund alleged that the TPA overpaid providers, collected a 20% recovery fee on overpayments caused by its own errors, and charged a 19% coding adviser program fee on savings from post-payment audits of out-of-network claims.

The TPA's role, however, was limited. It was required to apply already negotiated rates, while the fund itself determined eligibility, adjudicated claims, gave final approval before payment, and decided appeals.

The contract also allowed the recovery fee only for overpayments caused by third parties. Because the contract fixed the TPA's rates and fees and the fund controlled claim approval, the court concluded that the TPA lacked the discretion or control needed for fiduciary status, leaving the fund with, at most, contract claims.

In Tiara Yachts Inc. v. Blue Cross Blue Shield of Michigan, the U.S. Court of Appeals for the Sixth Circuit **held** last year that the employer had plausibly alleged the TPA was a fiduciary with respect to claim overpayments and its shared savings compensation.

The employer alleged that the TPA systematically overpaid providers and then profited through a shared savings program that paid the TPA 30% of the overpayments recovered or prevented. Unlike in Massachusetts Laborers', the TPA's role was broad and showed discretionary authority. The Tiara Yachts TPA interpreted the plan, decided whether to grant or deny claims and paid providers out of plan assets.

Although the 30% rate was fixed, the court concluded that because the TPA controlled the pool of claims to which the percentage applied, it exercised discretion over its own pay. The court also rejected the argument that the TPA was insulated from ERISA because its duties arose under a contract.

Kreutzmann appears to fall on the Tiara Yachts side of the line. The complaint describes Cigna as the plan's claims administrator, which is vested with discretionary authority over claims and "decides the precise dollar amounts" plans pay ambulance providers, suggesting that Cigna effectively decides its own fee. In other words, the same discretion that makes a TPA a claims fiduciary allegedly allows it to influence its own shared savings compensation.

Why This Matters for Plan Sponsors

Kreutzmann does not name the employer or the group health plan as a defendant, but plan sponsors should not dismiss this complaint as someone else's problem. When a plan administrator appoints a TPA to serve as claims fiduciary, ERISA generally requires the appointing fiduciary to prudently select and periodically monitor that appointee. The plan administrator is also typically the fiduciary that agreed to the ASO fee structure and approved payment of those fees.

If allegations like those in Kreutzmann succeed in court, participants' counsel could then start asking questions about who agreed to pay the TPA this way, and who was watching.

A plan administrator that signed an ASO agreement with a shared savings fee, that did not investigate or approve how the fee was calculated or which claims it applied to, and that did not review and address the TPA's savings reporting could face a claim that it failed to monitor its delegated claims fiduciary and failed to ensure plan expenses were reasonable.

The Kreutzmann complaint itself highlights the facts on which such a claim would rely. The fee was disclosed in the ASO agreement, the conflict was foreseeable given that ground ambulance providers can balance the bill, and alternative fee structures — flat or hourly fees — were available.

Shared savings programs also affect plan costs directly. In the Kreutzmann example, the employer allegedly paid the TPA more than twice what the plan paid the ambulance provider. And as the Massachusetts Laborers' fund learned when its auditor identified 5,574 problem claims and more than $1.4 million in overpayments, plan sponsors often discover these issues only when they go looking.

Takeaways

Find out what shared savings programs apply to your plan.

Ask your TPA for a list of every shared savings, recovery and payment integrity program in which your plan participates, along with the fee percentage for each program and the amount to which that percentage is applied.

Do not assume you already know. Some programs are added by amendment or automatic enrollment. In Tiara Yachts, for example, the TPA enrolled all of its self-funded customers in its program. For programs that negotiate or reprice out-of-network claims, ask whether the provider accepts the negotiated amount as payment in full or remains free to balance bill participants for the difference.

Request and address plan-specific reporting.

Ask for periodic reports, broken out by program and claim type, showing billed charges, amounts paid, savings claimed and fees charged to your plan. Ask whether and how the TPA tracks which participants were balance billed after a negotiated or repriced claim. Once you receive the reporting, review it and determine whether it is prudent to continue with the current shared savings programs.

Understand your TPA's role.

Review whether your TPA makes final claim determinations, decides appeals, and controls the account from which claims are paid. The more control the TPA has, the more likely it is acting as a fiduciary and the more important your monitoring role becomes. Keep in mind that a TPA that is not named as a fiduciary in the plan document or ASO agreement may still be a functional fiduciary based on its actions.

Revisit the fee structure.

Consider whether a percentage-of-savings fee makes sense for every claim type, particularly where participants can be balance billed. At the request for proposal or renewal stage, discuss alternatives such as flat or per-claim fees, fee caps, carveouts for ground ambulance and other services not protected by the No Surprises Act's balance-billing ban, and express prohibitions on fees for correcting the TPA's own errors. Be prepared for the TPA to impose higher administrative fees in return for changes to any shared savings fees.

Revisit out-of-network provider payment determinations.

Consider whether the TPA's process for calculating the amount to be paid to an out-of-network provider accurately reflects the plan sponsor's intent regarding how participants should share in the cost of out-of-network care in various situations. Consider whether an objective standard, such as a percentage of Medicare, should be used instead of repricing tools with respect to some or all services.

Use your audit rights, and document your process.

Exercise your contractual audit rights periodically, and keep a record of the questions you asked, the information you received and the decisions you made. As the Massachusetts Laborers' fund's audit shows, problems often surface only when someone looks. A documented, prudent monitoring process is one of a plan fiduciary's strongest defenses if a TPA's compensation is later challenged.

Clearly communicate the TPA's process and authority.

Ensure that the summary plan description provides enough information to enable a reader to make an informed decision regarding whether to obtain care from an out-of-network provider, including the method used by the TPA to calculate out-of-network provider payments, the TPA's authority to negotiate with out-of-network providers and the circumstances under which a participant may be balance billed.

Watch Kreutzmann.

The complaint was filed only recently, and its allegations have not been tested. Even so, the outcome could shape how courts view contingent TPA compensation and, by extension, what plan sponsors are expected to know and ask about it.

Shira McKinlay is counsel at Thompson Hine LLP. She previously served as special counsel in the health and welfare branch of the Office of Chief Counsel at the Internal Revenue Service.

Kim Wilcoxon is a partner at the firm.

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