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ERISA Fiduciary Governance: Selecting and Monitoring Service Providers

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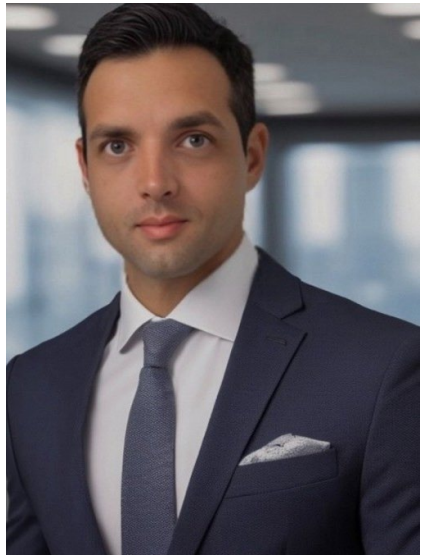

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Please note that the following is intended to be used for general guidance purposes only — it is not intended to constitute tax or legal advice. Any question of application of the law should be addressed to legal or tax counsel. The information is current as of July 16, 2025.

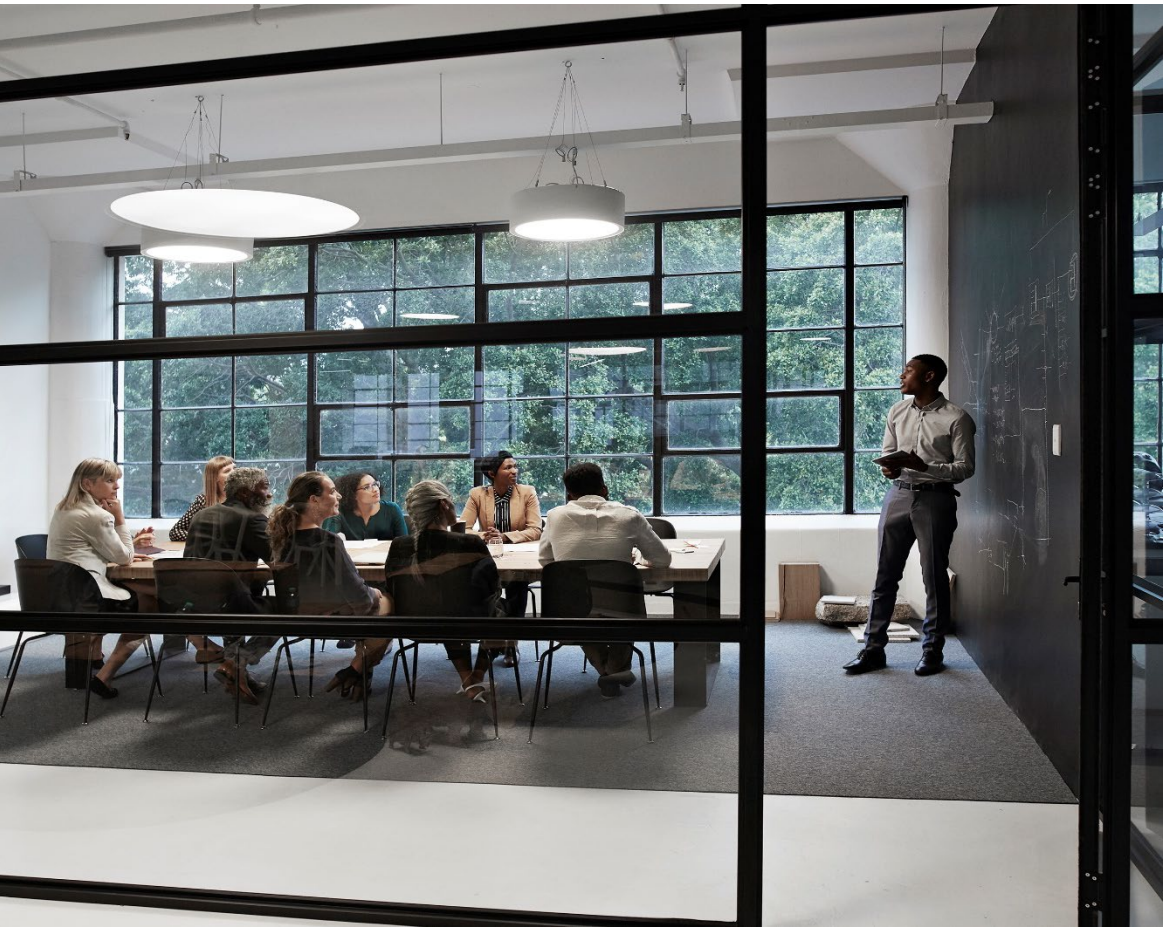
Agenda

- Delegating Plan Duties to a Service Provider
- Defining Role to Outsource
- Selecting a TPA or ASO Provider or Carrier
- Contracting Considerations
- Monitoring Performance
- Recent Litigation
- Final Takeaways and Resources

Delegating Fiduciary Duties to a Service Provider

Delegating Plan Duties to a Service Provider

Who is responsible for selecting group health plan service providers?

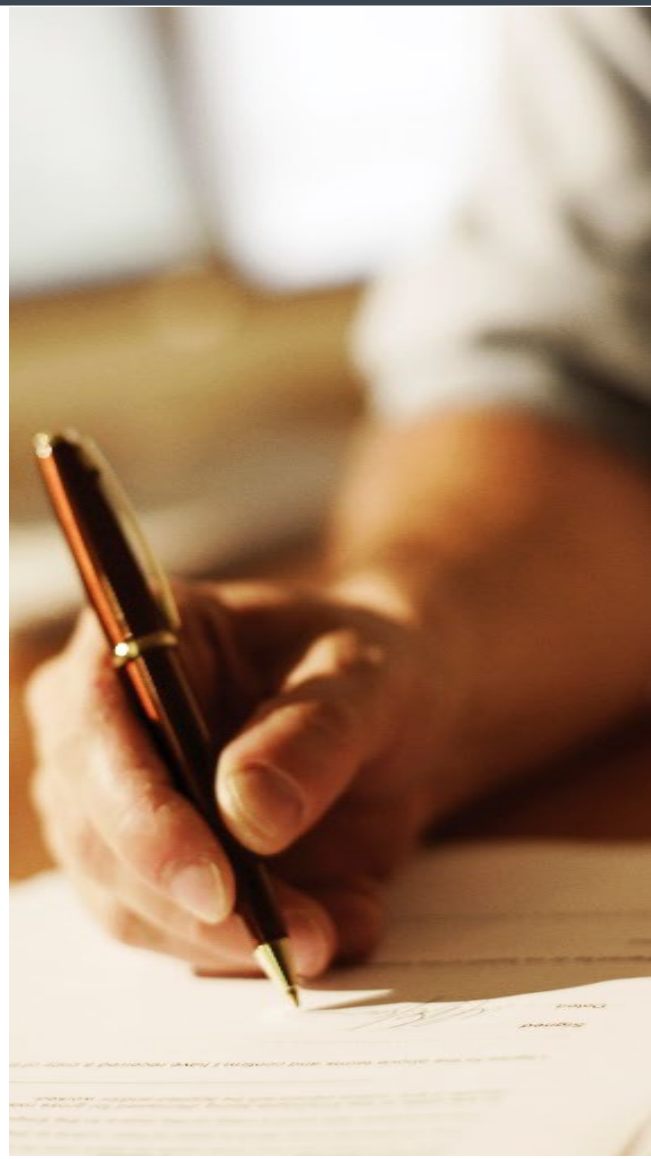


- Generally, the ERISA plan administrator, who is responsible for the plan's overall compliance and operations, is the named fiduciary responsible for prudently selecting plan service providers (including the medical plan carrier or TPA) and maintaining the plan's claim procedures.
- The plan administrator should be specified in the ERISA plan document. The plan sponsor/employer (e.g., Board of Directors) is the default plan administrator.

Delegating Plan Duties to a Service Provider

How does the plan administrator delegate duties to a service provider?

- The plan administrator may delegate duties, including fiduciary duties, to a third-party service provider, in accordance with the plan document.
    - Fiduciary duties are those that involve the exercise of discretionary authority or control over the plan or plan assets.
- If fiduciary duties are delegated, the party accepting the delegation becomes a fiduciary accountable for delegated tasks.
    - *Example:* A self-insured plan administrator contractually delegates fiduciary authority to a TPA to review and decide plan claims and appeals, making the TPA a fiduciary to the extent of such adjudication authority.
- The plan administrator:
    - Must act prudently in selecting the third party and cannot contract away its own fiduciary status by the delegation.
    - Remains responsible for monitoring the third party and assessing whether they are properly performing the delegated duties.




Defining Role to Outsource

Defining Role to Outsource

What are a group health plan's obligations with respect to plan claims?

- The employer as plan administrator is responsible for maintaining reasonable claim procedures so participants can receive promised benefits.
- Most employers will typically hire a carrier or TPA to process claims but should understand the general claim requirements to prudently select a service provider who can comply with the claim standards.
    - This is particularly important for fiduciaries of self-funded plans, who may retain some fiduciary role with respect to claims adjudication.
- Employers should have a basic familiarity with:
    - The timeframes to decide claims
    - The contents of benefit denial notices, and
    - The standards for appeals of benefit denials
    - External review and No Surprises Act requirements

Defining Role to Outsource

What are the required timeframes for plans to decide claims?

- The timeframes (outer limits) within which group health plans must decide filed claims or appeals vary based on the claim type:
  - Urgent (participant's health would be threatened if normal pre-service claim timeframe applied)
    - ASAP, but not later than 72 hours for both claims and appeals
  - Pre-service (approval required before medical care – e.g., preauthorization)
    - Reasonable time not to exceed 15 days for claims and 30 days for appeals
  - Post-service (all other claims, including claims after medical care is provided; most group health plan claims are post-service)
    - Reasonable time not to exceed 30 days for claims and 60 days for appeals
  - 15-day extensions may be available for pre- and post-service claims.
  - Specific timeframes apply when the plan requests more information from the claimant.

Defining Role to Outsource

What must be included in a notice of a claim denial?

- If a plan denies a claim, it must send the claimant a denial notice *written in language the average participant can understand* that includes:
  - Specific reasons for the denial (e.g., not medically necessary or covered by plan);
  - A reference to the specific plan provisions relied upon for the denial;
  - If applicable, an explanation of any additional material needed to perfect the claim;
  - A description of the plan's review procedures (e.g., how to initiate an appeal);
  - If applicable, a description of rules, guidelines, or protocols relied upon in denying the claim;
  - If denied based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical denial judgment, applying plan terms to the claimant's circumstances;
  - A description of the claimant's right to go to court to recover benefits due under the plan.

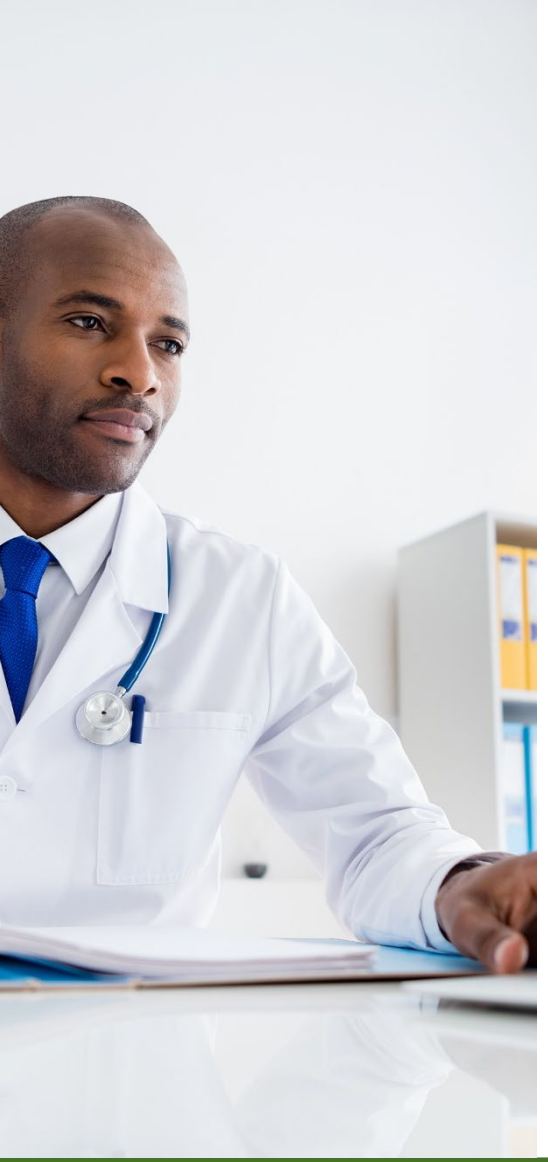
- The notice of a claim denial on appeal must include the same information above and a few additional items.

Defining Role to Outsource

What are the standards for appeals of benefit denials?

- The plan's claims procedure must provide for a full and fair review of a benefit claim. The minimum standards for appeals are:
  - Plans must give claimants at least 180 days to file an appeal;
  - Appeals must be reviewed by someone new. The reviewer cannot be the same person who made the initial decision or that person's subordinate, and the reviewer must give no consideration to the initial decision.
  - The reviewer must consult with a qualified health professional (and others as needed) when the denial is based on a determination of whether a particular treatment, drug or other item is experimental, investigational, or not "medically necessary";
  - Plans can require no more than two levels of review; and
  - Mandatory binding arbitration of claims is generally prohibited. However, non-binding arbitration is permitted if done within the required timelines.

Defining Role to Outsource



How did the ACA and No Surprises Act affect claim review requirements?

- The ACA amended ERISA by enhancing internal claims and appeals requirements and making external review procedures applicable to non-grandfathered group health plans and coverage.
    - External review is designed to ensure claimants denied coverage based on a medical judgment can have an independent reviewer (i.e., not someone employed or contracted by the health plan) evaluate the benefit denial.
- Self-funded plans generally must comply with DOL external review procedures and may choose to refer requests to an accredited Independent Review Organization (IRO).
    - The employer is responsible for contracting and coordinating with the IRO, although TPAs may assist with the process.
- Fully insured plans generally must comply with their state's external review process, if the state meets standards set by HHS. The carrier is responsible for arranging the external review process.
- No Surprises Act (NSA) surprise billing claims are eligible for external review.
    - Grandfathered plans are subject to external review for NSA surprise billing claims.

Defining Role to Outsource

Should a self-insured plan sponsor handle second-level claim appeals?

- Self-insured plan sponsors typically delegate most of the plan's claim and internal appeal obligations to a TPA or administrative services only (ASO) provider.
- However, some self-insured plan sponsors may choose to retain a level of control and direct fiduciary responsibility over the claims process, particularly regarding final appeals of denied claims. (With fully insured plans, all claim and internal appeal decisions are made by the insurer.)
- In deciding whether to play a more hands-on role in the appeals process, a sponsor as plan fiduciary should consider if they have a prudent process is in place to review claim appeals, which requires:
  - Strict compliance with all applicable regulatory requirements, including timeframes and notices;
  - Interpretation and consistent application of plan terms (no ad-hoc exceptions);
  - A full and fair review of the denied claim (and not just rubber-stamping the TPA's prior decision);
  - Gathering and analysis of medical information and records;
  - Consultation with healthcare professionals, if the sponsor lacks medical expertise to effectively evaluate the appealed claim;
  - Careful documentation of the decision-making process and factors leading to the final determination.
- Employers assuming a role in determining appeals should consider whether establishing an appeals committee may help to facilitate a consistent and prudent decision-making process.
- Please see our *Compliance Corner* article: A Self-Insured Employer's Role in Health Plan Appeals

Selecting a TPA, ASO Provider or Carrier

Selecting a TPA, ASO Provider or Carrier

How does an employer prudently select a service provider?

- ERISA does not mandate any one selection process. An employer has flexibility to determine the approach suitable for its benefit plans, size, needs and circumstances.
- However, since selecting a TPA or carrier is a fiduciary function, an employer must be able to show they engaged in a prudent decision-making process.
- Generally, the process should involve collecting and carefully evaluating sufficient information regarding the qualifications of potential service providers, and reasonableness of their fees, deliberating and reaching a measured decision as to the most suitable candidate, and documenting the process.
- For some employers, an RFP may be the most effective way to demonstrate due diligence and may streamline the information gathering and evaluation process.
  - The employer can generally control the RFP process to solicit responses to address its specific plans, special needs and expectations.
  - RFPs can be conducted to select a carrier for a fully insured plan, or a TPA or ASO provider for a self-insured plan.

Selecting a TPA, ASO Provider or Carrier

What is the difference between a TPA and an ASO provider?

- Both TPAs and ASO providers offer a wide range of administrative, claims processing and management, and other services for self-insured plans.
- TPAs can be large or small entities (operating regionally or nationally) but are generally viewed as being independent of insurance companies.
    - Pros: Some sponsors prefer an independent TPA, who may be able to customize services and work with different provider networks.
    - Cons: Extra coordination is typically required to process claims with carrier networks, which may result in communication gaps and delays.
- ASO providers offer similar services to TPAs but through an administrative services only contract with an insurance company that has no insurance element.
    - Pros: More streamlined coordination of services since the various parties (claims review, contracted provider networks) are under one umbrella.
    - Cons: Potentially less flexibility, benefit customization, and transparency when ASO is under exclusive control of one insurer.
- Self-insured plan sponsors may want to consider both options as they evaluate the service provider best suited for their plans, administrative needs and participant population, among other considerations.

Selecting a TPA, ASO Provider or Carrier

What type of information is typically gathered and evaluated?

- The employer should compare service providers based on the same criteria, which may include information about:
  - **The firm itself:** Its financial condition; any recent litigation or enforcement action taken against the firm; its performance records and experience with group health plans of similar size and complexity; whether it uses subcontractors;
  - **Workforce capabilities:** Whether the service provider can meet the plan's overall needs in terms of employee staffing and experience
  - **Quality of care (for healthcare services):** The scope of healthcare services, the experience and qualifications of medical providers and their ratings and accreditations, patient access to providers, patient confidentiality protections, procedures to timely resolve patient questions and complaints and enrollee satisfaction statistics.
  - **Current licensing status** (of insurers, TPAs, healthcare service providers).
  - **Accountability, access and responsiveness:** Statistics regarding the service provider's claim and appeal processing, quality control measures; litigation over the past few years; timeframes for responses to the employer's questions or problems.

Selecting a TPA, ASO Provider or Carrier

What type of information is typically gathered and evaluated?

- The employer should compare service providers based on the same criteria, which may include information about:
  - **Technology resources:** Ability to address new technological requirements or accommodate a customized plan, compatibility with employer and carrier systems, cybersecurity practices (e.g., security standards, audit results and insurance coverage). See the: DOL Tips for Hiring a Service Provider with Strong Cybersecurity Practices
  - **Compliance:** Support from internal/external employee benefits counsel to ensure compliance with applicable laws, inc. DOL claim regulations and HIPAA privacy and security rules; ability to provide legally compliant documents and notices; compliance with/ ability to support plan's compliance with transparency obligations (e.g., MHPAEA NQTL comparative analysis, RxDC reporting, MRF postings, internet self-service tool)
  - **Range of services:** (Beyond claim adjudication), such as administration of COBRA and other continuation coverage, creditable coverage determinations and notices, HRA integration, wellness programs, reporting services, nondiscrimination testing, stop-loss coordination
  - **Specialized services:** Experience or expertise servicing a specific industry (e.g., construction, hospitality, medical providers), geographic area, or plan design (e.g. referenced based pricing)

Selecting a TPA, ASO Provider or Carrier

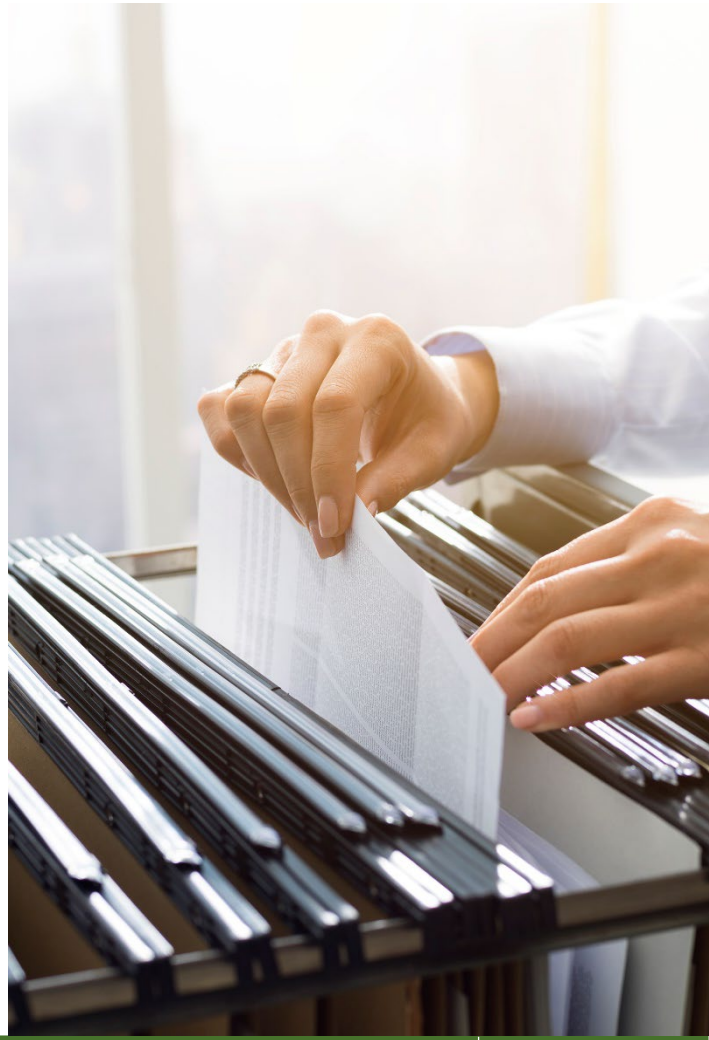
What about fees? How should an employer assess a service provider's compensation?

- When evaluating service provider compensation, the employer as plan fiduciary is not required to select the lowest bidder but must ensure that the compensation is reasonable for the services provided.
- Therefore, the employer must understand the estimated fees and expenses, whether assessed individually for services or as part of a "bundled" arrangement.
- Before entering a contract for group health plan brokerage or consulting services, the employer should ensure they receive a §408(b)(2) compensation disclosure, which includes the service provider's direct and indirect compensation (commission, revenue sharing) for plan services.
- The employer should carefully review and evaluate the compensation information, ask questions as necessary, compare/ benchmark the fees against other service providers' fees for similar services and identify any potential conflicts of interest. The process should be documented.
- The fees and expenses should be monitored throughout the relationship to determine whether they are still reasonable.

Selecting a TPA, ASO Provider or Carrier

How should the service provider selection process be documented?

- When selecting a service provider, the employer is performing a fiduciary duty and held to a high "prudent expert" standard, so it's important to carefully document the decision-making process.
- Although no specific form of documentation is required, maintaining accurate and well-drafted meeting minutes is often the best way for plan fiduciaries (whether a committee or several individuals) to show they exercised due diligence.
    - The goal of meeting minutes is to provide a concise summary of key discussions, deliberations and outcomes, written in a neutral tone.
- The minutes should be accompanied by supporting documents (e.g., RFP responses, benchmarking reports) that help provide context and justification for decisions made.
- Absent such documentation, it will be very difficult for plan fiduciaries to show they engaged in a prudent decision-making process, particularly many months or even years later, when an inquiry, audit or litigation may arise.
- Meeting minutes or documentation, along with other supporting documents, should generally be retained for eight years in a safe place and in a manner that allows for ready review or examination.



Contracting Considerations

Contracting Considerations

How should an employer approach the contracting process?

- The employer should recognize the importance of documenting the agreed upon services arrangement in a binding legal document that clearly identifies each party and details their respective obligations.
- The agreement should be reviewed by legal counsel experienced in employee benefits law before execution by the parties and performance under the agreement begins.
- If an RFP or similar selection process was used, the draft agreement should be carefully compared to the information provided by the service provider during that process.
- Since the services described in the agreement will involve interpreting or applying plan language, the agreement should coordinate with the official plan documentation (e.g., written plan document, summary plan description, stand-alone procedures).
    - For example, the agreement should specify that parties will follow the claims and appeals language described in the plan documentation because fiduciaries have a duty to follow the plan language.
- Where the TPA agreement does not assign responsibility for a particular service and a gap arises, the employer as plan administrator will remain ultimately responsible for performing the service.

Contracting Considerations

What are some key provisions to review in the contract?

- Key provisions to be review include:
  - **Services and deadlines:** A clear and full description of the claim adjudication and other services to be provided (including any limitations or restrictions on those services) and the deadline for completion
  - **Fiduciary status and standard of care:** Since deciding claims and appeals is a fiduciary duty, the carriers, TPAs or ASO provider should acknowledge their fiduciary status in the agreement and agree to adhere to ERISA's fiduciary standard of care.
  - **Subcontractors:** Whether the TPA will use subcontractors to perform the covered services and will notify the employer and guarantee their performance
    - The employer's fiduciary obligation to monitor a service provider extends to its subcontractors.
  - **Compensation, fees and expenses:** All direct (e.g., PEPM) and indirect (e.g., commission) compensation, fees and expenses (e.g., postage costs) payable to the service provider, and circumstances allowing for midyear adjustments (e.g., decrease in enrollment), should be specified.

Contracting Considerations

What are some key provisions to review in the contract?

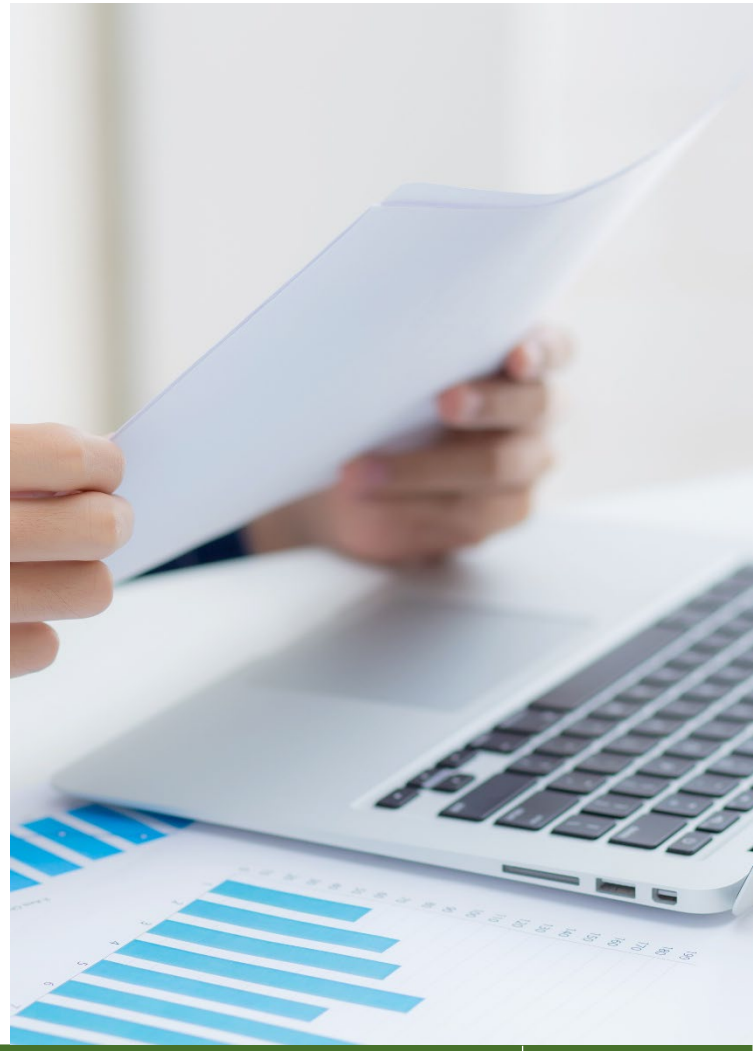
- Key provisions to be review include:
  - **Confidentiality and data security:** The agreement should include protections for each party's confidential and priority information as well as the personally identifiable information and protected health information of employees.
  - **Access to claims data:** As required by the CAA 2021, the employer should ensure all impermissible gag clauses are removed from contracts, so they can access the plan's de-identified claims information for cost containment and analysis purposes.
  - **Indemnification and limitation of liability:** Indemnification is designed to ensure a party is protected from losses due to another party's conduct. A limitation of liability clause aims to limit the party's own liability in entering the contract to manage financial risk. It's advisable for an employer to engage their legal counsel to negotiate these important provisions.
  - **Audit rights:** The agreement should reserve the employer's right to audit the service provide for adherence to the contract term and quality of services.
    - This is important to ensure the employer can fulfill its fiduciary obligation to monitor the service provider.

Monitoring Performance

Monitoring Performance

How can the employer monitor the service provider's performance?

- The employer's fiduciary obligations do not end with the service provider selection and contract execution because the employer has an ongoing duty to monitor the service provider's performance.
- The resulting contract should require periodic reporting from the service provider and the right to audit their performance.
- The employer should also consider establishing a formal process to review the service provider's performance at regular intervals.
    - The review should consider if the service providers are satisfying their contractual obligations and any service performance standards, including by:
        - Reading any reports they provide
        - Asking about policies and practices (e.g., a TPA's claims processes, use of AI)
        - Verifying the actual service fees charged
        - Following up on participant complaints
        - Holding meetings to discuss plan operations



Monitoring Performance

How can the employer monitor the service provider's performance?

- Employers may also consider:
  - Periodic evaluations of claims determinations for accuracy, timeliness, and substantiation;
  - Conducting an audit of the claim administrator (e.g., TPA or ASO).
- Claim reviews and audits are typically conducted by third-party professionals hired by the employer.
- Audit types vary widely and include:
  - Due diligence audits involving a random or targeted sampling of claims over a recent period;
  - Appeal audits of a random selection of internal appeal and external review documents;
  - Implementation audits before a change in service provider or plan design;
  - Customer service audits to evaluate calls to assigned customer service team.
- Each employer should determine the appropriate type, form and level of monitoring for their particular plan, size, funding type and circumstances.

Recent Litigation

ERISA Benefit Claim Litigation Update

Recent ERISA Group Health Plan Denial of Benefits Lawsuits;

Litigation is Ongoing

J.H. et al v. United Behavioral Health et al, U.S. District Court of Utah

- Parents sue United Behavioral Health (UBH), the claim administrator of their ERISA group health plan, for an abuse of discretion in denying their teenage daughter's residential treatment benefits. The court's June 16, 2025, decision largely focused on the inadequacy of UBH's denial letters, which failed to meet ERISA requirements and provide the required information for the parents to perfect their claim. The case was remanded to the insurer to reconsider the claims in accordance with the opinion.
- Deficient denial letters are commonly cited by courts in ERISA benefit denial litigation.
- Please see our July 15, 2025, article in *Compliance Corner*.

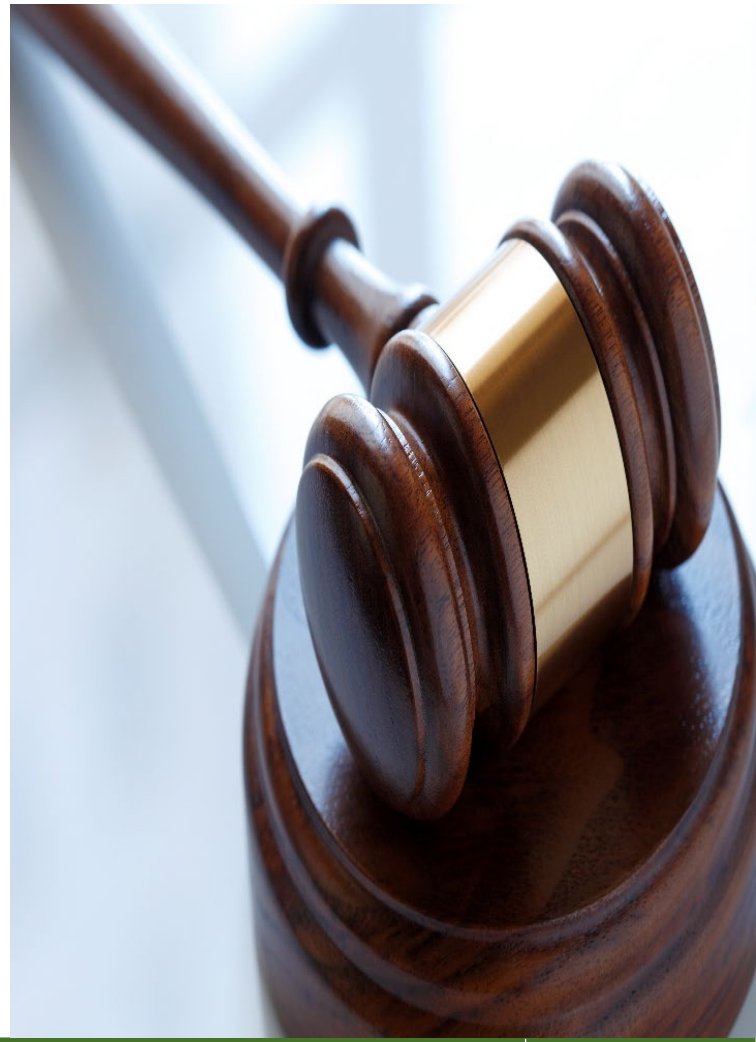
Kisting-Leung et al, v. Cigna Corporation et al, California Eastern District Court

- Class participants argued that the insurer's use of an automated AI-based algorithm in deciding claims was an ERISA fiduciary breach, as it contradicted the group health plan terms, which required a review of medical necessity claims by a medical director. The court denied the defendants' motion to dismiss with respect to certain claims, allowing the case to proceed forward to trial.
- The court's decision was one of the first rulings in a series of new cases involving health insurers' use of AI-based tools to decide health plan preauthorization requests, as well as benefit claims or appeals.
- Please see our April 22, 2025, article in *Compliance Corner*.

Fiduciary Breach Litigation

What is the fiduciary breach litigation about?

- In several high-profile class action lawsuits, participants have claimed plan fiduciaries failed to:
  - Prudently select their service provider (PBM);
  - Negotiate competitive pricing;
  - And monitor the service provider's compensation.
- Participants generally argue the alleged fiduciary breaches by plan fiduciaries cause them to overpay for premiums and OOP costs.
- Thus far, participants have not succeeded in showing they have suffered a personal and concrete injury, as required to establish "standing" to proceed with a case.
- But the lawsuits are expected to continue and present numerous legal risk and potential liabilities for group health plan sponsors.
  - Sponsors can protect themselves and the plan by engaging in a prudent, well-documented process when selecting and monitoring service providers.



Fiduciary Breach Litigation Update

Recent Group Health Plan Participant Class Action Lawsuits;

More Likely to Follow

Lewandowski v. Johnson and Johnson, et al, U.S. District Court of New Jersey

- Class action lawsuit filed in February 2024, alleging J&J breached ERISA fiduciary duties by mismanaging their prescription drug plan and overpaying PBM for drugs, which harmed participants by increasing their premiums and cost-sharing.
- Court dismissed claims in January 2025 for lack of standing; plaintiff didn't show concrete injury and reached OOP max (and thus would have paid same amount regardless of alleged breach). See our January 28, 2025, article.
- New plaintiff (who had not reached OOP max) added and amended complaint filed March 2025.
- Awaiting court to rule on J&J's motion to dismiss amended complaint…

Navarro et al, v. Wells Fargo et al, U.S. District Court of Minnesota

- Class action litigation filed in July 2024 alleging breach of ERISA fiduciary duties like J&J case and that fiduciaries engaged in prohibited transactions by causing the plan to pay excessive PBM fees.
- Court dismissed claims in March 2025, finding participants did not suffer a concrete injury clearly traceable to the defendant's conduct; the allegations of harm were speculative; see our April 9, 2025, article.
- But plaintiff filed amended complaint on May 8, 2025; Wells Fargo motioned to dismiss it on June 12, 2025.

Seth Stern et al, v. JPMorgan Chase & Co. et al, New York Southern District Court

- Class action lawsuit filed in March 2025, alleging JPMorgan Chase mismanaged prescription drug plan, overpaid for generic drugs. failed to prudently select a PBM and evaluate potential conflicts of interest. Complaint points out that Caremark, the plan's PBM vendor is vertically integrated with CVS Specialty, its mail order pharmacy.
- Defendant JPMorgan Chase filed a motion to dismiss on June 3, 2025.

Final Takeaways and Resources

Final Takeaways

What are the final takeaways for employers?

- An employer as plan administrator can delegate fiduciary obligations in accordance with the ERISA plan document.
- When selecting a service provider, such as a carrier or TPA, an employer should:
  - Define the role to be outsourced.
  - Engage in a prudent process to select the service provider.
  - Evaluate the service provider's compensation for reasonableness.
  - Consider engaging legal counsel to review the service provider's contract.
  - Monitor the service provider's performance on an ongoing basis.
  - Document the process.
  - Stay aware of related litigation and regulatory guidance.

NFP Resources

Publication

For further information on the topics discussed during the presentation, please ask your broker or consultant for a copy of the NFP publication **ERISA Fiduciary Governance: A Guide for Employers**.

Publication includes:

- Detailed description of employer steps
- Overview and Checklist
- Sample documents
  - Board resolution/charter
  - Summary of Committee Duties and Responsibilities
  - Committee Appointment Letter and Notice of Acknowledgment
  - Meeting Minutes

Fiduciary Governance Overview and Checklist

Action Item	Comments & Status
For selected PSPs, request broad audit rights and regular reporting from the PSP in the services agreement to ensure the PSP is meeting their contractual obligations and any performance standards.	
Establish a formal PSP review process and follow that review process at regular intervals.	
Establish regular request for proposal (RFP) process every 3-5 years (or sooner if PSP issues arise).	
Request and carefully review a PSP's cybersecurity practices as part of the evaluation process.	
For broker and consultant PSPs, review ERISA 408(b)(2) compensation disclosure to determine if PSP fees are accurate and reasonable.	
Selecting and Monitoring Carriers and Third-Party Administrators (TPAs) as PSPs	
Review administrative services agreement and evaluate fees and terms; ask questions if appropriate.	
Evaluate and understand which services the carrier/TPA provides.	
Ask whether the carrier/TPA follows Consolidated Appropriations Act (CAA) 2021 requirements, including the requirement to: - File RxDC reports. - Post machine-readable files (MRFs). - Provide an internet-based price comparison tool. - Remove all gag clauses from any service agreements. - Submit the annual gag clause attestation.	
Ask whether the carrier/TPA reports and pays related Patient-Centered Outcomes Research Institute (PCORI) fees.	
Ask whether the carrier/TPA prepares and provides a non-quantitative treatment limitation (NQTL) analysis as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). If yes, named fiduciaries should review the analysis, understand its conclusions, and obtain assurances from the carrier/TPA that any NQTLs are justified and/or removed and that the analysis otherwise complies	

NFP Resources

Please Join Us for Our Upcoming Fiduciary-Focused Webinar!

- **Fiduciary-Focused Get Wise Wednesdays Webinar Series – Save the Date**
  - September 17, 2025, 3:00 p.m. ET. More information will be distributed closer to the date.

- **View the rest of the webinar series:**
  - Part 1: Let's Focus on ERISA Fiduciary Obligations and Governance
  - Part 2: Let's Talk Transparency Obligations

- **Additional Communications**
  - We will continue to communicate any updates on fiduciary governance and transparency obligations through our biweekly newsletter, *Compliance Corner*, our webinars, and our various publications.


Questions?
Thank you for joining us!