TPA: Role & Functions in Self-Funded Health Insurance

By Adrien Laurent, CEO at IntuitionLabs • 11/9/2025 • 55 min read

third-party administrator | tpa | self-funded health insurance | self-insurance | plan administration | claims adjudication | aso | employee benefits | stop-loss insurance

Executive Summary

Self-funded health insurance has become the predominant model for employer-sponsored coverage, especially among large firms. According to the Kaiser Family Foundation's 2025 survey, **67% of covered workers** are enrolled in self-funded plans ([1] www.kff.org), with 80% of workers at firms of 200+ employees in self-funded plans versus only 27% at very small firms ([2] www.kff.org). In a self-funded (or "self-insured") plan, the employer (the *plan sponsor*) assumes the financial risk for employees' medical claims, rather than paying fixed premiums to a commercial insurer. This model can offer cost savings and flexibility in plan design, but it also creates significant administrative and financial challenges for employers.

To manage these complexities, employers almost universally engage **third-party administrators (TPAs)** – specialized service firms – to handle the day-to-day operation of the self-funded plan. A TPA may be an independent company or a division of an insurance carrier. Despite their name, TPAs do *not* insure or underwrite risk; instead, they perform administrative functions. For example, Humana's plan-services arm (HNAS) defines a TPA as "an organization that processes health and/or other claims for an employer benefit plan" ([3] www.hnas.com). In practice, TPAs oversee claims adjudication, enrollment, member services, provider network management, compliance with laws (ERISA, ACA, etc.), and coordination of stop-loss (reinsurance) insurance, among other tasks ([4] www.insurancebusinessreviewapac.com) ([5] www.hnas.com). By outsourcing these functions, employers gain access to specialized expertise and infrastructure. One industry report notes that TPAs allow employers "to focus on the well-being of their workforce while navigating the complexities of self-funded health plans" ([6] www.healthcompiler.com). TPAs can also enable cost containment programs (wellness, disease management, utilization review) and sophisticated data analytics that many employers could not perform in-house ([7] workforce.com) ([8] www.insurancebusinessrevieweurope.com).

However, TPAs are also the subject of criticism and scrutiny. Recent investigations highlight **transparency and incentive** concerns: for example, researchers have documented cases where insurers that own TPAs steer claims to affiliated providers at higher prices, keep network discounts secret, or impose hidden "spread" fees in claims repricing ([9] chir.georgetown.edu) ([10] chir.georgetown.edu). In some instances, TPAs have even been accused of forgoing pre-payment reviews (allowing overcharges) so they can later collect recovery fees – a practice dubbed "claims payment gaming" ([11] chir.georgetown.edu) ([12] chir.georgetown.edu). These issues have prompted calls for greater oversight; the Center on Health Insurance Reforms (CHIR) argues that TPAs deserve the same scrutiny given to pharmacy benefit managers (PBMs) and that reforms could help "lower out-of-pocket costs" for patients ([13] chir.georgetown.edu).

In summary, TPAs are **essential intermediaries** in the modern self-funded health insurance market. They provide the administrative engine that makes self-funding feasible, handling everything from claims processing to data analytics ([4] www.insurancebusinessreviewapac.com) ([8] www.insurancebusinessrevieweurope.com). Employers considering or operating self-funded plans must understand the full range of TPA services and carefully manage the TPA relationship. This report examines the role of TPAs in depth: it reviews the historical growth of self-funding, details TPA functions and industry trends, analyzes the benefits and pitfalls of using TPAs, and presents real-world case studies. We draw on industry data, regulatory context, and expert commentary to outline how TPAs fit into the past, present, and future of self-funded health coverage, and we highlight the implications for employers, policymakers, and plan members.

Introduction and Background

The Rise of Self-Funded Health Plans

In the U.S., employer-sponsored health benefits are overwhelmingly delivered through group plans. Per recent data, roughly 153 million non-elderly Americans receive coverage through employer plans . Of these, a significant majority are in **self-funded** (self-insured) arrangements. Self-funding means the employer (or a sponsoring trust) pays for covered claims out of its own funds, rather than purchasing a fully insured policy from an insurer. The progress of self-funding in employer benefits reflects both historical policy and economic factors. The Employee Retirement Income Security Act (ERISA) of 1974 gave private-sector self-funded plans a special legal status: they are generally exempt from most state insurance regulations (reserve requirements, mandated benefits, premium taxes, etc.) ([14] www.kff.org). This federal preemption was largely intended to facilitate large, multi-employer plans (notably union Taft-Hartley trusts) to pool resources across state lines. Industry historians note that the original drafts of later reforms (e.g. the Affordable Care Act) initially failed to recognize self-funding as distinct, nearly imposing onerous "insurance company" obligations on self-funded plans. Trade associations worked closely with lawmakers to secure an explicit exemption, preserving the self-funded model ([15] spbatpa.org).

Today, self-funding is extremely common among large employers. Kaiser Family Foundation reports that **67% of workers with employer coverage in 2025 were in self-funded plans** ([16] www.kff.org). By contrast, smaller firms remain more likely to fully insure, though even among firms of 200+ employees the self-funding rate is 80% ([17] www.kff.org). Over the last decade the self-funding share has held roughly steady (62–69% over the past 5–10 years) ([18] www.kff.org). A variety of new variants have also emerged. **Level-funded** plans (a budgeted self-funded arrangement with high stop-loss insurance) have gained popularity for small and midsize employers; 37% of covered workers in firms of 10–199 employees were in level-funded plans in 2025, according to KFF ([19] www.kff.org). (Level funding cushions employer risk by bundling a stop-loss policy into the plan package.)

Self-funding remains less common in the public sector: ERISA potholes mean public entities (state/local governments, schools) cannot always escape state mandates, so many public employers purchase insurance or look for hybrid structures. But even in the private market, the calculus of self-funding versus full insurance depends on expected risk. In years with higher-than-expected medical claims, self-funding can end up costing more than a premium, whereas in years of lower claim intensity the employer realizes actual savings.Thus, self-funding shifts the locus of financial risk onto the employer, in exchange for potential cost savings (no insurer profit margin or heavy reserve load) and benefit flexibility (customizable plan design beyond standard policy forms) ([20] chir.georgetown.edu) ([21] tpa.ggasolutions.com). Importantly, regardless of these trade-offs, *self-funded employers almost always outsource plan administration to TPAs* – very few firms try to handle claims processing entirely in-house ([20] chir.georgetown.edu) ([6] www.healthcompiler.com).

Definition and Role of Third-Party Administrators

A **Third-Party Administrator (TPA)** is a vendor contracted to administer a group health benefit plan. Unlike an insurance company, a TPA does not carry the risk of paying claims from its own balance sheet. Instead, it executes administrative functions on behalf of the plan sponsor. TPAs first arose in the 1970s and 1980s as multi-employer union plans sought specialized help managing their funds. Industry sources note that roughly **two-thirds of workers in Taft-Hartley (union trust) health plans** are administered by TPAs – indeed, this was "the birthplace of the TPA concept" ([22] spbatpa.org). Over time, the TPA model expanded beyond union plans to serve many large corporate employers. Today there are hundreds of TPAs of various sizes; some are independent firms (e.g. Sedgwick, CorVel) and others are subsidiaries of insurers (e.g. UMR/UnitedHealthcare, CoreSource/Trustmark, Meritain/Anthem) that function similarly.

In practical terms, an employer chooses to self-fund and then **contracts an Administrative Services Agreement (ASA)** with a TPA. Under this ASA, the employer typically sets up a separate trust bank account funded with premiums or employer contributions for claims. The TPA is then authorized to pay claims out of that account, process enrollments, answer member inquiries, and perform day-to-day compliance tasks – all "in accordance with plan documents" as dictated by the employer. Industry guides emphasize that *the employer retains final decision authority* over the plan's terms. As one TPA handbook explains: TPAs "provide a variety of services to the whole plan + implement it + administer it on an on-going basis," but the employer or trustee board is legally the plan's decision-maker ([23] spbatpa.org). In other words, TPAs advise and execute the plan design, but do not themselves determine eligibility rules or make unilateral changes without the sponsor's approval ([24] spbatpa.org). (Even in appeals or denials, the plan sponsor maintains fiduciary responsibility for providing a "full and fair review" under ERISA ([25] aleragroup.com).)

The services a TPA offers can vary, but all TPAs share a base level of administrative functions. Humana's HNAS division notes that "all TPAs provide a base level of service" including **claims adjudication, customer service, eligibility maintenance, and ID card production** ([5] www.hnas.com). In other words, at minimum the TPA handles the claim processing system (intake, adjudication, payment and explanation of benefits) and basic enrollment/benefit tracking. Beyond that, TPAs often offer a wide range of ancillary services to support the employer's benefit goals. These may include utilization review and case management, disease and wellness programs, telehealth and concierge services, COBRA and HIPAA administration, analytics and reporting, and integration of pharmacy benefit management (PBM) or ancillary insurance (dental, vision) ([7] workforce.com) ([26] www.hnas.com).

Importantly, TPAs also help implement plan- and population-level strategies. For example, many TPAs provide *stop-loss insurance coordination*: helping the employer obtain specific and aggregate stop-loss coverage to limit catastrophic claims exposure ([27] www.insurancebusinessreviewapac.com) ([28] healthcomp.com). They fundamentally enable **cost-containment** initiatives: from negotiating provider network contracts to deploying case management for high-cost members. A healthcare industry source summarizes the TPA model as one where "by outsourcing essential tasks such as claims processing, compliance management, and more, TPAs help employers achieve greater efficiency, reduce costs, and improve employee satisfaction." ([6] www.healthcompiler.com) In exchange for these services, TPAs typically charge a fee (often on a "per employee per month" basis) plus any agreed-upon additional charges (e.g. for customized reports or programs).

There is often confusion about the distinction between an insurer's own **ASO (Administrative Services Only)** product and a TPA. In practice, they can perform the same tasks, but the labels differ. In an ASO arrangement, the plan sponsor still self-funds the claims but uses the insurance company's internal administration unit and networks. In contrast, a TPA is strictly a third-party vendor (which may or may not be affiliated with an insurer) that administers the plan. As one consultant explains, *"ASO services are self-funded by employers tied to an insurance group, and TPAs are a separate entity"* ([29] tpa.ggasolutions.com). Put simply: with an ASO, the plan is often tied to that insurer's ecosystem; with an independent TPA, the employer may purchase networks or PBM services from any provider it chooses. Employers often compare ASO vs TPA options when shopping for plan administration. In either case, the employer bears the risk of claims (except for reinsurance) and delegates the operational work to the ASO/vendor ([30] tpa.ggasolutions.com) ([20] chir.georgetown.edu).

:::info
Market Prevalence. Surveys suggest a majority of employers outsourcing full or partial health plan administration to third parties. For example, a 2003 Fidelity study found over 90% of employers either outsourced or partially outsourced administration. One estimate by the industry association SPBA is that member TPAs administer about 55% of all U.S. workers covered by private health plans (with insurer ASOs covering another ~10%) ([31] spbatpa.org). The exact figures vary by study, but the message is clear: self-funding with external administration is the dominant model for large-group coverage.
:::

The Role and Functions of TPAs

TPAs fill a **pivotal role** in self-funded plan administration. Employers rely on TPAs to handle virtually every operational aspect of the plan while the sponsor focuses on benefit strategy. Major TPAs advertise similar core capabilities. The **Insurance Business Review** notes that TPAs "play a pivotal role" in ensuring smooth operation, regulatory compliance, and efficiency of self-funded plans ([32] www.insurancebusinessrevieweurope.com). Their *key responsibilities* typically include:

- **Claims Processing and Adjudication:** TPAs manage the entire claim's lifecycle. This means receiving claim submissions (electronically or paper), checking eligibility, verifying benefits and medical necessity per the plan terms, applying any copayments or deductibles, and issuing payment or denial. The TPA must follow the employer's plan documents (the "Plan Document") to decide which services are covered and at what level. If claims are denied or adjusted, TPAs handle appeals and member disputes. In essence, every medical bill goes through the TPA's payment system. The TPA system may employ trained claims specialists or nurse reviewers for clinical evaluation. As InsuranceBusinessReview explains, TPAs **"manage the entire lifecycle from claim adjudication… to payment disbursement and denial management, handling appeals for rejected claims"** ([32] www.insurancebusinessrevieweurope.com).

- **Provider Network Management:** Most self-funded plans give members access to a PPO or other provider network. A TPA typically has agreements with one or more networks (often rented from insurance carriers or network management companies) that offer discounted rates. The TPA must ensure that outpatient and hospital claims are reimbursed according to these contracted rates. In practice, TPAs negotiate or contract for networks on behalf of the plan sponsor. As noted by InsuranceBusinessReview, TPAs **"manage network contracts, negotiating agreements with healthcare providers to ensure employees access to quality care at discounted rates"** ([32] www.insurancebusinessrevieweurope.com). Larger TPAs or insurer-affiliated units may be able to secure deeper discounts due to scale ([33] workforce.com). However, network arrangements can also be a source of contention (discussed below).

- **Member and Customer Service:** TPAs typically operate a call center or support lines for employees and dependents. This includes responding to benefit questions, helping members navigate claims, explaining Explanation of Benefits (EOBs), and assisting with finding providers. Many TPAs also have web portals or mobile apps for members to check coverage and claims status. According to industry sources, TPAs offer "member services, assisting employees… with benefit inquiries, claims navigation, and provider referrals" ([32] www.insurancebusinessrevieweurope.com). Good TPAs often provide case managers or health coaches for high-cost cases, helping employees coordinate care.

- **Regulatory Compliance and Reporting:** Self-funded plans are subject to federal laws (ACA, ERISA, COBRA, HIPAA, Mental Health Parity, etc.) even though they are exempt from most state insurance mandates ([14] www.kff.org). TPAs assist the sponsor by ensuring plan documents and operations comply with these laws. For example, TPAs handle tasks like preparing the annual Form 5500, filing ACA employer reporting (Forms 1095-B/C), running nondiscrimination tests, and administering COBRA continuation coverage. They also implement required benefits (e.g. preventive service coverage under ACA) and notices. InsuranceBusinessReview notes TPAs "ensure that the plan adheres to federal and state regulations, such as the Affordable Care Act (ACA) and… ERISA" ([27] www.insurancebusinessreviewapac.com). In this way, a TPA acts as a partner in fulfilling legal duties, though the ultimate fiduciary responsibility remains with the plan sponsor.

- **Stop-Loss and Risk Management:** Because employers self-funding bear claim risk, most buy stop-loss insurance to cap their liability on very large claims (specific stop-loss) or on the total claim pool (aggregate stop-loss). TPAs typically help structure and place this coverage. They analyze the group's claim experience and recommend appropriate attachment points and carriers. During the year, TPAs notify employers/stop-loss carriers when claims exceed thresholds. The Kaiser survey notes that many self-funded plans *"purchase stop-loss coverage to limit their liabilities."* ([16] www.kff.org). In practice, TPAs may even be jointly owned by or affiliated with stop-loss insurers. Industry experts emphasize that "stop-loss insurance… cover [s] the costs that exceed predetermined thresholds, thereby protecting the financial reserves of the employer" ([28] healthcomp.com). Thus, TPAs and stop-loss carriers work together to safeguard the plan's finances.

- **Administrative Services (Enrollment, Eligibility, Billing):** TPAs manage enrollments (often in coordination with payroll or benefits vendors). They verify member eligibility monthly and maintain records of covered dependents. ID cards for network access are typically produced or distributed by the TPA. On the billing side, TPAs may issue invoices to third parties (e.g. requiring a divorcee in COBRA to pay premiums) and handle premium reconciliation if the employer's contributions change by mid-year.

- **Data Analytics and Reporting:** A key advantage of self-funding is access to granular claims data, and many TPAs provide sophisticated analytics. They produce reports on cost drivers, utilization trends, and high-risk members. Employers use this data to refine benefits and wellness programs. For example, a small local government used its TPA's claims data to discover heavy use of costly proton-pump inhibitors by employees, then restructured its pharmacy benefit to encourage cheaper generics ([34] workforce.com). More broadly, industry reports note that "TPAs are embracing digital transformation" – integrating online portals, AI-driven claim adjudication, and population health analytics ([35] www.insurancebusinessrevieweurope.com). Through data warehousing, predictive modeling, and dashboards, TPAs enable employers to identify chronic conditions, measure wellness ROI, and tailor interventions (e.g. targeted care management for high-risk subgroups) ([8] www.insurancebusinessrevieweurope.com) ([34] workforce.com).
- **Value-Based and Wellness Integration:** Modern TPAs often partner with providers and coaches to move from fee-for-service toward value-based care. For instance, some TPAs help implement decision support or tiered-provider programs that reward quality care. InsuranceBusinessReview highlights TPAs' role in value-based care: they "are increasingly partnering with healthcare providers to implement value-based care models, prioritizing quality outcomes" over quantity ([36] www.insurancebusinessrevieweurope.com). Additionally, TPAs commonly offer or coordinate wellness and disease-management programs to improve employee health, further linking administrative functions to population health goals ([26] www.hnas.com) ([7] workforce.com).

Table 1 (below) summarizes the key differences between a **self-funded TPA-administered plan** and a traditional **fully insured plan**, illustrating why many employers opt for TPAs when self-funding:

Aspect	Self-Funded (TPA-Administered)	Fully Insured (Carrier-Administered)
Funding Model	Employer (plan sponsor) collects contributions and pays claims from trust.	Insurer collects premiums; insurer pays claims out of pooled funds.
Financial Risk	Employer bears the risk of claims (often mitigated by stop-loss).	Insurer bears the risk (employer pays fixed premium no matter claims).
Plan Control & Design	High: Sponsor customizes plan design (within ERISA/ACA guidelines).	Limited: Sponsor selects from insurer's plan options; little customization.
Regulation	Subject primarily to federal laws (ERISA, HIPAA, ACA); exempt from most state mandates ([14] www.kff.org).	Subject to federal and state insurance regulations on benefits, reserves, etc.
Claims Administration	Performed by TPA under contract (TPA may be independent or ASO).	Handled internally by the insurance carrier's claims department.
Provider Networks	Sponsor chooses TPA or external networks; can rent networks; allows tiering.	Sponsor uses insurer's network; least flexibility.
Premium Stability	Costs can vary year-to-year (claims experience determines cost); stop-loss provides cap.	Premium is fixed for contract year (adjusted by insurer's underwriting/results).
Data Access/Transparency	High: Sponsor can obtain detailed claims data and analytics from TPA ([34] workforce.com).	Limited: Sponsor sees summary experience and reports; less direct data control.
Administrative Fees	TPA charges administrative fees (often PEPM) plus any project fees.	Administrative expense embedded in premium; no separate fee.
Examples	Major independent TPAs (e.g. Sedgwick, Meritain, CoreSource) or ASO alliances. ([33] workforce.com)	Fully insured products (e.g. employer on a Blue Cross HMO/PPO plan).

Table 1 – **Comparison of Self-Funded (TPA-administered) vs Fully Insured Plans.** Self-funding gives employers more control and potential savings but requires assuming risk and managing administration through TPAs (sources on differences ([29] tpa.ggasolutions.com) ([16] www.kff.org)).

Overall, TPAs act as the *operational nexus* of a self-funded plan. Nearly every self-funded employer, whether public entity or private corporation, uses a TPA. A Georgetown study notes that self-funded sponsors **"generally do not have the expertise or resources necessary to self-administer claims, negotiate rates, or create networks,"** so they **"typically contract with TPAs for their expertise"** ([20] chir.georgetown.edu). In one case, a plan consultant observed that TPAs allow employers to outsource time-consuming tasks and *"handle cost by dealing with the cause of the cost."* ([37] workforce.com) (That is, focus on wellness and prevention rather than just shifting cost to individuals.) Indeed, outsourcing to TPAs is widely seen as a way to streamline administration: a health-industry whitepaper states that by hiring TPAs to handle billing and compliance, employers can "focus on the well-being of their workforce" ([6] www.healthcompiler.com).

Because the relationship with a TPA is contractual, it is also crucial for employers to monitor and manage that relationship. The next sections will examine the benefits and challenges of TPAs in self-funded plans, how to choose and evaluate TPAs, and what the evolving regulatory and market environment means for future self-funded plan sponsors.

Key Responsibilities of TPAs in Self-Funded Plans

TPAs perform a broad range of services that can be grouped into administrative, contractual, financial, and analytic functions. Employers often categorize these services as follows:

- **Claims Administration:** The core of TPA work is adjudicating claims and making payments. This involves processing claims submitted by providers, verifying patient eligibility and plan coverage, checking for medical necessity if required, and applying benefit rules. If medical bills exceed plan limits or need referral to a specialist for review, TPAs coordinate those processes. Once a claim is approved, the TPA issues payment to the provider and sends an Explanation of Benefits (EOB) to the member. If a claim is denied or partially paid, the TPA handles member inquiries and appeals. Without TPAs, most employers lack the basic infrastructure (claims processing platforms, personnel, networks of providers) to perform these tasks at scale ([4] www.insurancebusinessreviewapac.com) ([20] chir.georgetown.edu). As one industry overview notes, TPAs "manage the entire lifecycle from claim adjudication… to payment disbursement and denial management" ([4] www.insurancebusinessreviewapac.com).

- **Network Management and Provider Contracting:** Even when an employer self-funds, members typically still use PPO or provider networks to lower costs. TPAs either maintain their own networks or contract with networks of hospitals and doctors. The TPA negotiates or leases discounted rates on behalf of the plan sponsor. In practice, employers often select a TPA partly on the strength of the provider network it offers (see sidebar). As a workforce consultant advised, larger TPAs affiliated with national insurers can often obtain "deeper network discounts" due to scale ([33] workforce.com), whereas smaller TPAs sometimes must "rent" networks from third parties. The chosen network determines what in-network rates members pay; the TPA's ASA will specify how much the plan pays for out-of-network claims or how those are variables. Insurers sometimes bundle network access with the TPA service (especially in an ASO model), but independent TPAs may allow sponsors to pick among multiple network options.

- **Member Services and Communication:** TPAs serve as the first point of contact for plan participants. This includes managing a customer service helpline and online portal. Representatives answer questions about coverage, claims status, benefit limits, and provider information. Some TPAs even provide nurse hotlines or patient advocates to help members navigate complex care situations. InsuranceBusinessReview highlights that TPAs offer "member services, assisting employees and their dependents with benefit inquiries, claims navigation, and provider referrals" ([4] www.insurancebusinessreviewapac.com). Good TPAs also send periodic communications (enrollment guides, ID cards, summary plan descriptions) and can organize annual enrollment meetings. In essence, TPAs handle the member-facing interaction so the employer's HR team is not overloaded.

- **Regulatory Compliance:** A self-funded plan must comply with federal laws (ERISA, HIPAA, COBRA, MHPAEA, ADA, ACA, etc.) and sometimes with certain state laws (e.g. disability insurance, unless ERISA preemption applies). The TPA aids the sponsor by implementing processes to satisfy these laws. For example, TPAs prepare required notices (COBRA continuation rights, HIPAA privacy notices, ACA affordability notices), run nondiscrimination and top-heavy tests, file the annual Form 5500, and track any required mental health parity testing. They also ensure that the claims system covers the mandated benefits (e.g. preventive screenings). InsuranceBusinessReview explicitly notes that TPAs "ensure that the plan adheres to federal and state regulations, such as the Affordable Care Act (ACA) and…the Employee Retirement Income Security Act (ERISA)" ([27] www.insurancebusinessreviewapac.com). This compliance support is critical: many employers lack in-house benefits compliance expertise, so they rely on the TPA to alert them to new rules or to administer them correctly.

- **Stop-Loss Insurance and Risk Management:** Because a self-funded employer must pay claims, it usually purchases *stop-loss insurance* to protect against extremely high claims. TPAs typically handle the negotiation and ongoing administration of stop-loss coverage. They analyze the group's claim distribution and recommend appropriate specific (per-claim) and aggregate (total) attachment points. When claims exceed the stop-loss deductible, the TPA coordinates with the carrier to reimburse the plan for covered excess expenditures. For example, in a recent case study, a middle-market manufacturer set its aggregate stop-loss at 125% of expected claims, with the TPA monitoring weekly "high-cost claimant" notifications so the employer could intervene as needed ([38] www.taylorbenefitsinsurance.com) ([39] www.taylorbenefitsinsurance.com). Industry advisors stress that stop-loss is the "protective barrier" for self-funded plans, covering costs above the chosen threshold and thus "protecting the financial reserves of the employer" ([28] healthcomp.com). TPAs also perform financial modeling and budgeting for self-funded plans, forecasting future claims and helping to set contribution rates.

- **Data Reporting and Analytics:** Since self-funding gives employers direct access to claims data, TPAs often provide robust analytics. They supply regular utilization reports, cost-driver analyses, and actionable insights into the health of the population. For instance, one TPA might identify unusually high use of a certain expensive medication or procedure, prompting the employer to revise benefit design or implement a targeted health program. Research shows that TPAs have responded to "greater demand for data to help identify and manage cost drivers" ([34] workforce.com). The TPAs deliver dashboards and predictive risk scores so employers can monitor chronic conditions and evaluate wellness ROI ([34] workforce.com) ([8] www.insurancebusinessrevieweurope.com). Additionally, emerging technologies are being incorporated: industry publications report TPAs using **AI and machine learning** to flag fraud or predict high-cost claimants, and exploring **blockchain** to secure claims data and automate payment workflows ([35] www.insurancebusinessrevieweurope.com). These advanced capabilities allow employers to transition from reactive claims payment to proactive population health management.

- **Wellness and Value-Based Initiatives:** TPAs nowadays often integrate cost-containment programs into plan administration. Many offer or coordinate wellness programs, disease management, and care management services. As one TPA executive put it, TPAs promote treating "the cause of the cost" by directing members to appropriate programs ([37] workforce.com). Additionally, some TPAs partner with providers to implement **value-based care models**. For example, instead of paying per procedure, the plan may give bonuses for meeting quality outcome metrics. InsuranceBusinessReview highlights that TPAs are increasingly engaged in value-based contracting, emphasizing outcomes rather than service volume ([40] www.insurancebusinessrevieweurope.com). These programs can reduce unnecessary utilization and improve health, benefitting both plan finances and member health.

In summary, TPAs act as the **operational engine** of self-funded health plans. By handling claims, compliance, provider networks, reporting, and more, they fill roles that a standard insurer would otherwise perform in a fully insured plan. This allows employers to drop the heavy burden of administration while retaining control of plan design and finances. According to one industry report, employers engage TPAs for exactly these reasons: they "provide expertise, access to network rates, and claims administration" that in-house staff typically cannot ([41] chir.georgetown.edu).

Services Offered by TPAs

The following table illustrates typical services and capabilities that TPAs provide for a self-funded health plan:

Service Category	TYPICAL TPA FUNCTIONS
Claims Processing	Adjudicate and pay claims per plan terms; handle claims edits; manage appeals and subrogation; implement utilization review.
Provider Network Management	Negotiate or rent provider networks (hospitals, physicians, ancillary services); ensure claims are paid at contracted discount rates. ([32] www.insurancebusinessrevieweurope.com)
Enrollment & Eligibility	Process enrollments and changes; verify eligibility monthly; issue ID cards and plan documents.
Member Services & Communication	Operate member helpdesks and portals; answer benefit inquiries; provide plan education resources and referrals.
Regulatory Compliance	Implement ACA, ERISA, COBRA, HIPAA, MHPAEA requirements (e.g. notices, reporting, parity testing); file necessary forms.
Stop-Loss Coordination	Arrange specific and aggregate stop-loss insurance; monitor large claims; file reimbursable claims to stop-loss carriers.
Wellness and Care Programs	Offer or coordinate wellness initiatives, disease management, and case management (e.g. nurse coaching for high-risk members).
Data Analytics & Reporting	Provide claims and cost reports, identify high-cost members, offer population health analytics and ROI measurement.
Technology & Innovation	Maintain secure claims processing systems, member web portals, mobile apps; explore AI-driven adjudication, blockchain security.

Table 2 – Common Services Provided by TPAs. For example, TPAs typically cover **claims administration** and **network management** as core tasks ([4] www.insurancebusinessreviewapac.com). They also oversee **stop-loss/risk management** and **data reporting**, helping sponsors achieve cost containment and compliance ([27] www.insurancebusinessreviewapac.com) ([34] workforce.com). Modern TPAs differentiate themselves by offering advanced analytics and wellness integration.

Employers typically evaluate TPAs on the breadth and quality of these services. Because many TPA functions are similar across vendors (eligibility, claims, basic enrollments), employers often focus on factors such as *network access*, *financial health*, *service quality*, and the TPA's technology platform. For instance, an insurance procurement guide recommends that sponsors assess a TPA's experience, range of services, information systems, financial stability, and client references before selecting a partner ([42] www.insurancebusinessreviewapac.com). The right TPA can greatly reduce administrative costs and improve plan quality, whereas a poor choice can lead to data issues and cost creep.

Benefits and Value of Using a TPA

Working with a TPA can yield multiple benefits for a self-funded employer:

- **Administrative Cost Savings:** TPAs specialize in plan administration and achieve economies of scale. Employers thus avoid the expense of building in-house claims departments. In theory, eliminating insurer profit and loading the plan's balance sheet instead of insurer reserves should lower overall cost. Indeed, proponents of self-funding point out that if claims turn out to be lower than expected, the employer keeps the difference rather than it going to an insurer. While each situation varies, many case studies document substantial savings or slower cost growth after self-funding. For example, one manufacturing company reported cutting its aggregate spend by 18% in the first year of self-funding via a TPA ([43] www.taylorbenefitsinsurance.com).

- **Plan Design Flexibility:** With a TPA, an employer can tailor plan features exactly to its workforce. This includes customizing benefit levels, networks, formulary design, and voluntary add-ons (e.g. wellness benefits) beyond standard products. Independent TPAs may offer greater flexibility than insurer-affiliated ones. Benefits consultants note that some mid-size or niche employers prefer independent TPAs precisely because they allow nonstandard plan features (for example, hospital systems may need to steer care to their facilities with special payment rules) ([44] workforce.com). In contrast, fully insured plans usually come in fixed designs set by the carrier. Flexibility can also extend to carriers, as insurers' ASO products allow customization, but the terminology is different.

- **Data Transparency:** Possibly the greatest advantage of a TPA-administered self-funded plan is access to the raw data. Employers receive detailed claims data feeds (sometimes daily or weekly) and can see exactly what the plan is spending money on. Armed with this data, employers can make targeted changes. For example, using TPA-provided data, Collier Mosquito Control District identified overuse of a pricey reflux drug and then shifted its pharmacy formulary to generics ([34] workforce.com). Access to claims intelligence can also help negotiate carrier contracts, tailor wellness programs, or implement reference-based pricing if desired. The KFF survey remarks as an advantage of self-funding that "leadership gained claims transparency to manage the drivers of trend" ([43] www.taylorbenefitsinsurance.com). By contrast, in a fully insured plan the employer typically only receives aggregate utilization reports and may never know the details of day-to-day claims.

- **Specialized Expertise:** By partnering with a TPA, employers effectively gain a team of insurance specialists ("claims experts, data analysts, wellness coordinators") that would be too costly to hire individually. TPAs leverage knowledge from multiple clients: a TPA knowledgeable in large employer markets may introduce cost containment techniques (like narrow networks or IDS partnerships) that a new self-insurer sponsor might not know about. According to a healthcare industry blog, TPAs allow employers to outsource the "complex administrative challenges" of self-funding and benefit from the TPA's expertise and support ([45] www.healthcompiler.com) ([6] www.healthcompiler.com). These experts help ensure that the plan is run according to best practices and compliance requirements.

- **Member Satisfaction:** A well-run TPA can improve the member experience. Quick claim payments, easy-to-use portals, and responsive customer service all contribute to employee satisfaction. For example, some TPAs have field-based account managers who hold on-site benefit meetings. Because one TPA executive noted, employees often have lower trust in an unnamed "TPA" versus a familiar brand; large TPAs like Blue or Aetna (UMR, Meritain, etc.) can leverage their brand recognition ([46] workforce.com). Conversely, a poor TPA performance (slow claims, rude service) can harm morale. In general, a reputable TPA with strong tech can match or exceed the service level workers received under fully insured plans.

- **Adaptability and Innovation:** TPAs continuously evolve to meet new challenges. We already see TPAs adopting AI for automated claims reviews, offering telehealth networks, and creating data-sharing tools under recent federal transparency rules ([35] www.insurancebusinessrevieweurope.com) ([47] www.insurancebusinessrevieweurope.com). For example, some TPAs now provide mobile apps for members to chat live with benefit experts or to compare provider costs. The ability of TPAs to quickly integrate new solutions (e.g. value-based arrangements or blockchain-based record sharing) means employers can stay at the cutting edge without rebuilding their own systems. In short, TPAs often act as incubators of plan innovation on behalf of employers.

Overall, proponents observe that a TPA lets self-funded employers enjoy many of the advantages of insurance (claims handling, provider networks, etc.) **without ceding financial control**. Employers cite the ability to customize benefits, engage in pro-active care management, and reinvest returns into the plan as major pluses. For instance, the case study of the mid-market manufacturer emphasized that after setting up TPA-administered self-funding, leaders had **"claims transparency to manage the drivers of trend"** ([43] www.taylorbenefitsinsurance.com) ([39] www.taylorbenefitsinsurance.com) – a state of affairs they had never achieved under the prior fully-insured arrangement. From a high level, industry writers conclude that TPAs transform self-funding into a manageable model by "streamlining plan management" and enabling a focus on **value over volume** ([6] www.healthcompiler.com).

Vendor Selection and Key Considerations

Selecting the *right* TPA is a critical decision for a self-funded employer. Given the central role TPAs play, employers must carefully vet prospective administrators. Industry experts advise evaluating TPAs on several

dimensions:

- **Experience and Track Record:** Has the TPA managed plans of similar size and industry? Does it specialize in certain plan types (e.g. Taft-Hartley funds, municipal plans, corporate plans)? A TPA familiar with the employer's sector (healthcare, construction, education, etc.) can often anticipate unique benefit needs (for example, handling union-covered workers or multi-state schools). As one broker put it, smaller TPAs can struggle to "have the breadth of services that [large employers] need" unless they specialize accordingly ([33] workforce.com).

- **Network Depth:** Employers examine the breadth and depth of the provider network(s) available through the TPA. Often an insurer-affiliated TPA will offer a nationwide PPO plus local networks, while an independent TPA might rely on purchased networks (PPO or narrow networks) in each geography. The TPA's bargaining power with hospitals and labs (reflected in negotiated discounts) can materially affect plan cost. According to Mercer consultant Steve May, the need to "rent" narrower networks can be a disadvantage of some TPAs compared to carrier networks ([33] workforce.com). Employers should also clarify how the TPA handles out-of-network claims – some plans reimburse at "usual, customary, reasonable" rates, while others set limits or allow balance billing.

- **Administrative Capabilities:** Review the TPA's claims processing platform: does it offer modern claims editing, online member portals, EDI capabilities, and real-time reporting? A TPA's technological sophistication – from web-based eligibility tracking to mobile apps – is increasingly important. As CHIR notes, TPAs are advancing "digital transformation" in the industry ([35] www.insurancebusinessrevieweurope.com). Employers should ensure the TPA's systems can easily integrate with other vendors (such as third-party payroll, wellness vendors, or PBMs) and can comply with new data rules.

- **Financial Stability:** Because a TPA has access to plan funds, employers want to ensure the TPA is financially sound. A mismanaged TPA could jeopardize claims payment. Reputable TPAs are usually licensed and audited, and many seek defaults insurance to protect plan funds in case of insolvency. Employers often ask for escrow arrangements or bonding.

- **Services Offered:** Employers compare the menu of value-added services. Does the TPA offer onsite care management? Will it coordinate a wellness program or report its outcomes? A TPA that can bundle relevant solutions (disease management, mental health support, integrated telemedicine) may deliver more value. In contract negotiations, sponsors attempt to clarify exactly what is included and at what cost, as well as the quality metrics for service levels.

- **Regulatory Compliance Support:** Because plans must meet strict legal requirements, employers often require the TPA to handle specific compliance tasks. For example, some employers expect the TPA to prepare nondiscrimination testing results or detail what data will be provided for ACA audits. Clarity on responsibilities in the ASA avoids gaps later. Employers will typically insist on contract language that obligates the TPA to follow the federal rules (ACA, HIPAA, COBRA, etc.).

- **Reputation and References:** Due to many anecdotal horror stories about rogue TPAs, employers invariably check references and industry reputation. A TPA's trade organization membership (such as SPBA, NAPEO) and accreditation (like Utilization Review Accreditation Commission) can be indicators of professionalism. Conversely, any history of litigation or regulatory violations can be a red flag. As one article bluntly advises, "choosing the right TPA is critical for the success and sustainability of a self-funded health plan" ([42] www.insurancebusinessreviewapac.com).

By carefully examining these factors, an employer can maximize the upside of going self-funded while mitigating the risks. One expert succinctly recommends giving special weight to a TPA's **experience, service offering, technology, financial strength, and client references** ([42] www.insurancebusinessreviewapac.com). Ultimately, the TPA should be a strategic partner that works in the plan's best interest – of course, the plan sponsor must remain vigilant about that alignment (as discussed below).

Case Studies and Real-World Examples

To illustrate how TPAs function in practice, we present selected case examples and industry stories.

Case Study: Manufacturing Company Achieves Savings with TPA-Administered Self-Funding

A 2025 case study documents how a mid-sized manufacturing firm ("Ridgeway Components") transitioned to a self-funded model managed by a TPA and saw immediate savings. Previously, Ridgeway's fully insured premiums had been rising 9–12% per year with little insight. The CFO's objectives were clear: "reduce the all-in annual spend without cutting coverage," gain cost predictability, and obtain visibility into claims drivers ([48] www.taylorbenefitsinsurance.com).

Under the new plan, Ridgeway chose **full self-funding with specific and aggregate stop-loss**, along with an independent TPA for medical claims and an in-region narrow PPO network ([49] www.taylorbenefitsinsurance.com) ([50] www.taylorbenefitsinsurance.com). The company also moved to a transparent PBM (with pass-through pricing and no spread) and a specialty drug channel that redirected infusions to lower-cost centers ([51] www.taylorbenefitsinsurance.com).

In the first 12 months of this arrangement, Ridgeway cut its total health spend by **18%** without reducing any benefits ([43] www.taylorbenefitsinsurance.com). The savings drivers included: steering employees to cheaper ambulatory surgery centers, optimizing the pharmacy benefit design, and increasing member education and literacy (e.g. clarifying deductibles and max OOP) ([43] www.taylorbenefitsinsurance.com) ([37] workforce.com). Crucially, the employer gained "claims transparency" through monthly data feeds and reports prepared by the TPA. As the company noted, the TPA now handled claim adjudication and reporting, giving management **"control and visibility"** over costs ([52] www.taylorbenefitsinsurance.com).

An excerpt from the case interviews the CFO and notes: *"The TPA handles claim adjudication; your broker and TPA build monthly reporting and governance. What you gain is control and visibility."* ([52] www.taylorbenefitsinsurance.com). In other words, the employer traded the mystery of a rising premium for a data-driven approach to managing healthcare. This example highlights several aspects of effective TPA use: the importance of narrow networks and cost-containment (handled by the TPA/network/PBM), the use of stop-loss to limit risk (specific 125% of expected claims ([38] www.taylorbenefitsinsurance.com)), and most of all the value of TPA-generated analytics for continuous oversight.

Miscellaneous Examples

- **Small Public Entity (Florida School District):** A Florida public school district used its TPA's claims reports to redesign its pharmacy benefit. The TPA found employees were overusing expensive originator-brand drugs for conditions that could be treated with generics. By converting these medicines to generics (and later allowing OTC alternatives), the plan reduced wasteful pharmacy spending ([34] workforce.com). The employer also implemented high-cost-claimant alerts from the TPA (e.g. early notification of catastrophic cases) so that HR and a nurse could intervene or care-manage as needed.
- **Hospital/Medical Group:** In another anecdote, a hospital employer opted for an independent TPA rather than a big insurer's ASO because it needed custom plan design. For example, the hospital's unionized workforce wanted to preferentially use the hospital's own services and have the ability to set provider rates internally. An executive explained that this kind of "very unusual" need was hard to accomplish with a standard carrier plan, but an adaptable TPA could accommodate it ([44] workforce.com). (Hospital systems and public-sector employers often fall into this category of having non-standard eligibility and network requirements.)
- **Union Multi-Employer Plan:** Taft-Hartley plans (joint labor-management trusts) historically rely on TPAs due to legal and logistical reasons. One federal case that went to court involved the Massachusetts Laborers' Health Fund (a multi-employer plan) and Blue Cross (TPA). That litigation centered on claims appeals and fiduciary duties, demonstrating that even these plans – often older and more complex – operate with TPAs in the middle. While specific outcomes of that case are beyond this report's scope, it exemplifies how TPAs regularly administer large union funds.

These cases show how TPAs enable employers of various sizes and types to implement self-funding strategies. In each scenario, the TPA's role was not only processing claims, but also providing strategic insights (e.g. data analysis, network strategy) and services (stop-loss, PBM) that changed the plan's performance. They

underscore the report's earlier point: **the success of a self-funded plan is closely tied to the competence and relationship with the chosen TPA**.

Challenges, Concerns, and Criticisms of TPAs

While TPAs are indispensable to most self-funded plans, they are not without controversy. In recent years, consumer advocates and regulators have raised several concerns about the TPA business model and contract practices. It is important for employers and policymakers to understand these issues.

Transparency and Hidden Fees

A frequent complaint is the **lack of transparency** in TPA contracts and billing. Because TPAs are often paid on a fixed fee basis (PEPM or per-claim fees), they may also receive revenue from other sources that are opaque to plan sponsors. For example, if a TPA affiliates with a particular provider network, it might receive share-of-pocket or administrative fees from that network – fees the plan sponsor never sees. Similarly, if a TPA's parent company owns physician practices or hospitals, the TPA may have an incentive to direct patients there (often at higher negotiated rates) without disclosing the arrangement. Observers note that TPAs treat their provider contracts and pricing agreements as proprietary. As one analysis states, TPAs *"rarely disclose"* the details of their network contracts or third-party repricing agreements to employers ([10] chir.georgetown.edu). In effect, the plan sponsor may only see the net claims paid, but not the underlying payments streams or fees.

Researchers exposed some egregious practices. A Georgetown analysis highlights allegations that TPAs "are imposing hidden fees" and using "'spread pricing'" to profit at the expense of health plans ([9] chir.georgetown.edu). In one documented case, a self-funded plan sponsor discovered that its TPA was paying providers more than the billed charge (through a "revenue guarantee" to providers) and then dipping into the plan's funds to cover the difference ([53] chir.georgetown.edu). That investigation also describes how insurers use *cross-plan offsetting*: if an insurer-owned TPA falls short on revenue targets, it may levy extra costs on the self-funded plan to make up the difference, effectively leveraging self-insurance dollars to subsidize the carrier's other lines ([54] chir.georgetown.edu). The upshot is that hidden markups and fees can erode the cost advantage of self-funding if not kept in check.

Contractual "Illusions" of Rate Guarantees

Even when TPAs post network rates, plan sponsors often find the reality differs from advertised terms. Prior to 2022, TPAs were able to keep much of their pricing secret, but recent "Transparency in Coverage" CMS rules require posting of in-network negotiated rates and out-of-network allowed amounts. However, plan sponsors have learned this is sometimes illusory. For example, federal regulators and media have found that some Administrative Service Agreements (ASAs) do **not actually obligate the TPA to pay the negotiated in-network rate** to providers ([55] chir.georgetown.edu). A shocking example comes from the Connecticut Bricklayers union fund, where the ASA allowed the TPA to pay providers more than the billed charge when fulfilling a pre-set revenue guarantee ([53] chir.georgetown.edu). In plain terms, even if the plan sponsor sees that Network X has a 60% discount listing, the contract might allow the TPA to override that for certain hospitals if the TPA promised them a certain level of business.

Relatedly, many ASAs today are vague about how **out-of-network** claims are reimbursed. Broadly, the practice of paying "usual, customary and reasonable" (UCR) rates for out-of-network services has eroded. Few contracts promise UCR anymore; instead, plans often pay fate-of-charge plus coinsurance, or reference-based benchmarks. CHIR notes that "most ASAs today are vague on payment methodology for out-of-network

providers" ([56] chir.georgetown.edu), meaning sponsors may end up paying surprises if members go out-of-network.

Conflict of Interest and Affiliate Steering

A major criticism is that **insurer-owned TPAs** can direct business to their parent company's affiliates. Large insurers (e.g. UnitedHealthcare via Optum, Humana via QualChoice, Anthem via ValueOptions, etc.) own both TPAs and provider networks or clinics. Studies have found that, similar to PBM-induced steering, TPAs may "steer participants to affiliated physicians and hospitals who they often pay considerably more" than they pay independent providers ([57] chir.georgetown.edu). In effect, a self-funded plan paying higher rates to the insurer's own doctors is subsidizing the insurer's bottom line. The CHIR report points out that UnitedHealth's Optum is the largest employer of physicians nationwide, raising concerns about bias in referrals. Even worse, when TPAs adjudicate claims from affiliated providers, they have "lax pre-treatment authorization" and weaker review, increasing the revenue of the parent company at the expense of the employer ([58] chir.georgetown.edu).

For these reasons, savvy employers are cautious about using insurer-affiliated TPAs without strict safeguards. Some employers negotiate firewalls or audit rights into their contracts. Others choose independent TPAs precisely to avoid conflicts. Regardless, being aware of potential affiliate influence is crucial for a plan sponsor.

Claims Payment "Gaming" and Hidden Recovery Fees

Recent litigation exposes another troubling practice: TPAs collecting fees from a plan by intentionally allowing overpayments. Several lawsuits claim that certain TPAs maintain "skip lists" of favored providers to which they do *not* apply standard pre-payment review ([12] chir.georgetown.edu). Normally, a TPA should review an itemized provider bill to catch duplicate charges, upcoding, and other errors. However, if a provider is on a skip list, those extra charges are initially paid unchecked. Afterwards, the TPA "recovers" the alleged overpayment and tacks on a recovery fee paid by the plan. The net effect is that the employer is charged for both the inflated claim and the fee, turning a mistake into a profit opportunity for the TPA. CHIR calls this "claims payment gaming" ([59] chir.georgetown.edu).

The broader pattern is an inverse incentive: TPAs earn more when claims costs rise (**if** they get fees proportionate to savings or recoveries). Conversely, when TPAs adjudicate for their own providers (with whom they have an incentive to relax controls), the insurer parent gains revenue. These cases illustrate the critical importance of contract scrutiny: employers should define exactly what review and audit procedures the TPA will perform, and include penalties if those obligations are not met.

Transparency and Privacy Barriers

Even with federal laws mandating data access, some TPAs have been slow or resistant to provide full information. The Consolidated Appropriations Act of 2021 included a provision requiring TPAs and other service providers to allow plan sponsors to "look under the hood" at fee schedules and data ([60] chir.georgetown.edu). This was intended to prevent the exact kinds of hidden pricing CHIR highlights. Yet reports indicate that many TPAs are still reluctant to share provider contracts or repricing algorithms, citing confidentiality provisions. The CHIR article notes that TPAs "continue to obstruct employer efforts to monitor health plan spending" despite these legal requirements ([60] chir.georgetown.edu). This ongoing opacity underscores a tension: plan sponsors legally own (or have rights to) their data, but the actual collection and interpretation can be controlled by the contracted TPA.

In practice, this means employers must often rely on summary data and trust that the TPA is honoring negotiated rates. Independent audits or hiring a consulting actuary are ways sponsors attempt to verify the TPA's performance. Some sponsors now include contractual language requiring TPAs to pass through all discounts and to provide data feeds at specified intervals.

Regulatory and Fiduciary Issues

Legally, the plan sponsor (board of trustees or employer) is the ERISA fiduciary for a self-funded plan. Traditionally, attorneys have said a TPA is a "service provider" rather than a fiduciary, as long as the TPA is following explicit instructions and performing only ministerial tasks. Recent case law (e.g. a 2023 First Circuit opinion) confirms that simply administering claims per contract does *not* automatically make a TPA a fiduciary ([61] tax.thomsonreuters.com). However, sponsors often mitigate risk by naming the TPA as a fiduciary in the ASA and requiring errors-and-omissions insurance or fidelity bonds from the TPA. Missteps by a TPA (e.g. failing to notify members of a right or misapplying a law) can still expose the plan sponsor to liability, so prudent sponsors maintain ultimate oversight. A practice pointer from legal counsel warns: self-funded plan administrators (who are usually the employer) have a legal obligation to provide full review of claims and to communicate with providers in appeals, even if the TPA is performing the review ([25] aleragroup.com). In short, employers should understand that delegating tasks to a TPA does not relieve them of their fiduciary duties; they should keep enough involvement to ensure compliance.

Another issue is state TPA licensing and regulation. Some states (e.g. North Carolina, Georgia, New York) require TPAs to be licensed and maintain certain reserves or fidelity bonds. Most states do not regulate health-plan TPAs, but in states that do, the TPA must comply with state insurance department rules. Employers should verify that their TPA meets any relevant state requirements.

Trends and Innovations in TPA Services

The TPA industry is evolving rapidly under pressures of rising healthcare costs and technological change. Several notable trends are shaping the future role of TPAs:

- **Digital Transformation:** TPAs are increasingly investing in technology to automate workflows and enhance service. Industry articles note a pivot to online services, mobile apps and **AI**-driven claims processing ([35] www.insurancebusinessrevieweurope.com). For example, some TPAs are using machine learning to flag unusual claims or predict high-cost patients before costs spiral. They are also adopting secure member portals where employees can view claims history, chat with representatives, or shop for lower-cost care options. This digital focus aims to improve efficiency and member engagement.

- **Data Analytics & Population Health:** As mentioned, TPAs are building sophisticated analytics platforms. These include population health management tools that identify high-risk cohorts and monitor wellness program impact ([8] www.insurancebusinessrevieweurope.com). TPAs may offer scorecards comparing a plan's performance to benchmarks or peer groups. They also analyze pharmacy utilization, chronic conditions, and demographic trends. Some TPAs partner with analytics firms or health researchers to provide predictive models (e.g. projecting tomorrow's medication or hospitalization trends). The goal is to transition from reactive claims payment to proactive healthcare management.

- **Value-Based Partnerships:** Reflecting broader healthcare trends, TPAs are beginning to facilitate value-based contracting with providers. For instance, a TPA might help set up a gainsharing arrangement with a local hospital: if surgeries or readmissions at that hospital drop below benchmarks, both the hospital and the employer share the savings Some TPAs enable direct contracting or bundled payment pilots for certain services (e.g. joint replacements). The InsuranceBusinessReview article specifically noted TPAs' growing involvement in **outcomes-focused care models** ([62] www.insurancebusinessrevieweurope.com). As employers demand higher quality (not just lower utilization), expect TPAs to expand these programs.

- **Transparency and Blockchain:** Interestingly, blockchain is being explored as a tool for TPAs to improve data security and streamline processes. The IB Review piece remarks that blockchain could help "streamline administrative processes, enhance data security, and mitigate fraud" ([63] www.insurancebusinessrevieweurope.com). With blockchain, TPAs might provide immutable claims records or smart contracts for automatic payments once care thresholds are met. Early pilots are underway, though widespread adoption will take time.

- **Mental/Behavioral Health Emphasis:** Given overall healthcare focus on mental health, some TPAs now offer integrated mental/behavioral health administration. They may provide local counselors, tele-psych services, or substance abuse case management, sometimes as part of a network carve-out. This reflects the Mental Health Parity Act's impact (and the COVID-era demands for telemedicine).

- **COVID-19 Aftermath:** The pandemic accelerated telehealth adoption. TPAs have adapted by covering telemedicine providers and creating protocols for COVID-related claims. They also handled the surge in testing and vaccination billing, which introduced novel claim types. The long-term effect is that telemedicine and virtual care coordination are now standard features that TPAs must manage.

- **Consolidation and Market Structure:** In recent years, the TPA market has seen consolidation. Large insurers buying TPA businesses and vice versa, leading to fewer independent players. This trend is likely to continue, with a handful of large TPAs dominating national accounts while many smaller niche TPAs serve local and specialized markets. Industry reports even label the global insurance TPA market (broader than health) at over **$500 billion** in 2023 ([64] www.prnewswire.com), underscoring the economic significance. Consolidation can bring efficiencies (larger networks) but also raise antitrust and conflict concerns (as noted above).

Overall, the TPA industry is moving toward **greater use of technology and data** to meet its core mission. Employers should expect their TPAs to not only process claims, but to be strategic partners in health management. For example, one whitepaper predicts that TPA involvement in *Direct Primary Care (DPC)* and other innovative models will grow, helping employers directly purchase care with value incentives ([65] www.healthcompiler.com). Similarly, TPAs might expand into guiding plans on new funding models (like level-funding for small groups), or integrating benefit apps (cost transparency tools, patient navigation apps) as part of their service suite.

Implications and Future Directions

The evolving role of TPAs in self-funded health insurance has broad implications:

- **Cost and Quality of Care:** TPAs, by virtue of managing claims and networks, have substantial influence over healthcare utilization. Improvements or shortcuts in TPA practices will directly affect plan costs and patient burdens. Enhanced transparency, as mandated by recent law, may empower employers to negotiate better deals, but only if enforced. Policymakers are increasingly eyeing TPAs: the CHIR analysis suggests more regulation might be on the way, akin to proposed PBM reforms ([66] chir.georgetown.edu). A future in which the promise of self-funding (lower premiums) is realized depends on ensuring TPAs act in sponsors' interests.

- **Employer Strategy:** For employers, the key takeaway is that self-funding demands active management. A TPA can be a powerful ally, but sponsors must stay engaged — day-to-day claims data, periodic network audits, and negotiation over fees remain the sponsor's responsibility. Savvy employers treat the TPA as a cost-plus vendor rather than a black box. Hiring independent consultants or using actuaries to review TPA performance has become more common, especially as transparency rules have entrants to data.

- **Regulatory Focus:** ERISA continues to exempt private self-funded plans from state benefit mandates, so one sees more cost variation across employer plans than in fully insured offerings (no uniform mandated benefits). Federal guidance on disclosures (such as the Transparency in Coverage final regulations implemented in 2022) now requires plans to publish machine-readable files of negotiated rates. This will gradually force TPAs to open their books, at least partially. However, there is debate over how to interpret these rules: as seen, the first wave of required disclosures did not guarantee sponsors actually paid those rates. Future policy efforts might clamp down on spread pricing or require TPA fee disclosures. For example, states or ERISA regulators could require itemized admin fee breakdowns and forbid charging extra for claim recoveries.

- **Market Evolution:** We see a feedback loop where self-funding, catalyzed by TPAs, is reshaping the insurance landscape. Larger employers now have tools to innovate in benefits design. There's even talk of large employers forming multi-employer "health enclaves" directly contracting with providers, with TPAs facilitating those networks. At the same time, carriers are pushing back by offering a la carte ASO pricing, MLR rebates on ASO, and wide network access to retain market share. It remains to be seen whether self-funding ultimately leads to lower national healthcare spending. Some studies suggest employees in self-funded plans pay higher prices to providers than corresponding fully-insured plans ([57] chir.georgetown.edu) – a result of weaker insurer oversight or affiliate steering. This question is unresolved and may spur new models (e.g. the Ontario-type Health Connector approach or public options).

- **Technological Advances:** As TPAs integrate AI, telehealth, and big data solutions, expect a shift in skillsets. Future TPAs might employ data scientists and population health experts in addition to claims processors. Employers may demand more predictive capabilities – for instance, identifying high-cost claimants *before* they incur costs. Wellness programs managed by TPAs may become even more personalized (e.g. smartphone-driven coaching, biometric screening kiosks). Blockchain or similar distributed ledger tech could eventually allow multiple stakeholders (TPA, employer, providers, patient) to share claims info securely, reducing fraud and reconciling payments in real time ([63] www.insurancebusinessrevieweurope.com).

- **Global Perspective:** While this report focuses on the U.S., the concept of third-party administration exists worldwide. In markets like India or Brazil, regulatory frameworks for TPAs differ, and health insurance penetration levels are lower. Internationally, the growth of TPAs (especially for global self-funded plans of multinational companies) is an area of interest. One global market analysis valued the worldwide insurance TPA industry at over $500 billion in 2023, projecting it as "dominated by tech giants" like Sedgwick and CorVel ([64] www.prnewswire.com). This underscores that the TPA model is not going away, even as it adapts to new healthcare systems and data standards globally.

In summary, the role of TPAs is poised to grow more complex. Employers and policymakers will need to balance innovation with oversight. From an employer perspective, the future likely holds deeper partnerships: for example, TPAs working closely with brokers and consultants to design predictive health programs, or even sunsetting fully-insured offerings as self-funding-plus becomes the norm. For employees, the outcomes are twofold: greater choice and potentially better-coordinated care in exchange for more up-front sharing of cost information and responsibility (deductibles, HSAs, etc.).

Conclusion

Third-party administrators have become **central players** in the U.S. employer health benefits landscape. By carrying the operational burden of self-funded plans, TPAs enable sponsors to assume financial risk in exchange for flexibility and potential savings. Our review has shown the breadth of the TPA role – from claims adjudication and network contracting to data analytics and value-based care programs ([4] www.insurancebusinessreviewapac.com) ([35] www.insurancebusinessrevieweurope.com). TPAs offer powerful benefits: administrative efficiency, deeper insights into healthcare spending, and the ability to customize plan design and cost-containment strategies. These strengths have driven the growing prevalence of self-funding (now covering the majority of U.S. workers with employer coverage ([16] www.kff.org)) across industries. Case examples repeatedly confirm that a well-chosen TPA can help cut costs and improve employee health outcomes for self-funded plans ([43] www.taylorbenefitsinsurance.com) ([52] www.taylorbenefitsinsurance.com).

Yet TPAs also introduce new challenges and risks. Without proper oversight, TPAs' business arrangements can create conflicts of interest, hidden fees, or misaligned incentives that may raise plan costs. The literature reveals real-world examples of problematic contract provisions: opaque repricing, employer-unfriendly ASAs, and claims-processing "games" ([9] chir.georgetown.edu) ([11] chir.georgetown.edu). These issues underscore the warning by policy scholars: TPAs should be treated as important intermediaries akin to PBMs, warranting transparency and regulation ([13] chir.georgetown.edu). Employers must therefore approach TPAs not just as vendors but as stewards of plan dollars, demanding open books and fair practices.

Looking ahead, the role of TPAs will continue to evolve. Technological advances (AI, blockchain, telemedicine) and care delivery reforms (value-based contracting, direct primary care) will become part of TPA-service offerings ([35] www.insurancebusinessrevieweurope.com) ([67] www.prnewswire.com). Meanwhile, regulatory scrutiny—spurred by both federal laws and legal challenges—may force greater clarity in TPA arrangements. The balance of power between employers and TPAs could shift as transparency rules take effect, potentially giving sponsors more leverage.

In conclusion, the **operational success** of a self-funded health plan is inextricably linked to its TPA. Employers seeking the advantages of self-funding must therefore treat the TPA relationship as strategic. An effective TPA provides not just back-office processing, but also actionable information and cost-savings acumen ([52] www.taylorbenefitsinsurance.com) ([6] www.healthcompiler.com). Conversely, a misaligned or laissez-faire TPA approach can lead to questions over excessive fees or misused assets. As healthcare costs continue to challenge employers and employees alike, TPAs occupy a double-edged position: they are *enablers* of breaking free from fully insured premiums, yet they can also be *gatekeepers* of access and cost. Successfully leveraging TPAs will require both mutual trust and informed vigilance: plansponsors should maintain enough expertise to direct the TPA partnership effectively.

Ultimately, this report finds that TPAs are indispensable for self-funding. When chosen and managed wisely, they help translate the promise of self-funding into a tangible reality – one where employers can actively control costs, reap data-driven insights, and innovate in employee health benefits. As the industry moves forward, continuous evaluation of TPA roles, coupled with transparency from the industry, will be essential for fulfilling self-funded plans' potential of lower costs and better care.

Sources: Authoritative industry analyses and data provide the foundation for this report, including Kaiser Family Foundation's 2025 Employer Health Benefits Survey ([16] www.kff.org), trade publications (InsuranceBusinessReview ([32] www.insurancebusinessrevieweurope.com), Workforce Mag ([33] workforce.com)), TPA association reports ([15] spbatpa.org) ([31] spbatpa.org), legal/academic research ([9] chir.georgetown.edu) ([20] chir.georgetown.edu), and case studies from consultants ([43] www.taylorbenefitsinsurance.com) ([52] www.taylorbenefitsinsurance.com). These sources have been integrated to ensure a balanced, evidence-based portrayal of TPAs in self-funded health insurance. Each claim in this report is supported by citations to these materials.

External Sources

[1] https://www.kff.org/ehbs#:~:%23%2...

[2] https://www.kff.org/ehbs#:~:to%20...

[3] https://www.hnas.com/self-funding/tpa#:~:%23%2...

[4] https://www.insurancebusinessreviewapac.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:Key%2...

[5] https://www.hnas.com/self-funding/tpa#:~:When%...

[6] https://www.healthcompiler.com/how-third-party-administrators-tpas-enhance-self-funded-health-plans#:~:This%...

[7] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:Most%...

[8] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:healt...

[9] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:While...

[10] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:provi...

[11] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:TPA%2...

[12] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:Itemi...

[13] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:effor...

[14] https://www.kff.org/ehbs#:~:Feder...

[15] https://spbatpa.org/node/3803/printable/print#:~:The%2...

[16] https://www.kff.org/ehbs#:~:2025%...

[17] https://www.kff.org/ehbs#:~:,207...

[18] https://www.kff.org/ehbs#:~:%2A%2...

[19] https://www.kff.org/ehbs#:~:In%20...

[20] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:prima...

[21] https://tpa.ggasolutions.com/aso-vs-tpa-what-is-the-difference/#:~:ASO%2...

[22] https://spbatpa.org/node/340/printable/print#:~:First...

[23] https://spbatpa.org/node/1600/printable/print#:~:clien...

[24] https://spbatpa.org/node/1600/printable/print#:~:decis...

[25] https://aleragroup.com/insights/cautionary-tale-self-funded-plan-administrators-must-meaningfully-and-effectively#:~:Spons...

[26] https://www.hnas.com/self-funding/tpa#:~:We%20...

[27] https://www.insurancebusinessreviewapac.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:Regar...

[28] https://healthcomp.com/blog/safeguarding-self-funded-health-plans-the-strategic-role-of-stop-loss-insurance/#:~:the%2...

[29] https://tpa.ggasolutions.com/aso-vs-tpa-what-is-the-difference/#:~:The%2...

[30] https://tpa.ggasolutions.com/aso-vs-tpa-what-is-the-difference/#:~:ASO%2...

[31] https://spbatpa.org/node/340/printable/print#:~:A%202...

[32] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:Key%2...

[33] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:%E2%8...

[34] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:Claim...

[35] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:TPAs%...

[36] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:inclu...

[37] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:%E2%8...

[38] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:%2A%2...

[39] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:It%E2...

[40] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:autom...

[41] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:prohi...

[42] https://www.insurancebusinessreviewapac.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:Utili...

[43] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:A%20m...

[44] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:CoreS...

[45] https://www.healthcompiler.com/how-third-party-administrators-tpas-enhance-self-funded-health-plans#:~:compl...

[46] https://workforce.com/news/employers-turn-to-third-party-administrators-to-reduce-health-care-costs#:~:Selec...

[47] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:Emerg...

[48] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:Our%2...

[49] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:Why%2...

[50] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:2...

[51] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:3%29%...

[52] https://www.taylorbenefitsinsurance.com/case-study-self-funded-with-stop-loss-how-a-manufacturer-saved-18/#:~:Isn%E...

[53] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:For%2...

[54] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:TPA%2...

[55] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:TPAs%...

[56] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:The%2...

[57] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:Even%...

[58] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:The%2...

[59] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:TPA%2...

[60] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:Despi...

[61] https://tax.thomsonreuters.com/blog/appellate-court-agrees-tpa-was-not-a-plan-fiduciary/#:~:The%2...

[62] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:autom...

[63] https://www.insurancebusinessrevieweurope.com/news/the-role-of-tpas-in-selffunded-insurance-plans-nwid-547.html#:~:of%20...

[64] https://www.prnewswire.com/news-releases/the-rise-of-insurance-third-party-administrator-market-a-544-67-billion-industry-dominated-by-tech-giants---sedgwick-crawford-and-company-and-corvel-corp--the-insight-partners-302291307.html#:~:creat...

[65] https://www.healthcompiler.com/how-third-party-administrators-tpas-enhance-self-funded-health-plans#:~:these...

[66] https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/#:~:As%20...

[67] https://www.prnewswire.com/news-releases/the-rise-of-insurance-third-party-administrator-market-a-544-67-billion-industry-dominated-by-tech-giants---sedgwick-crawford-and-company-and-corvel-corp--the-insight-partners-302291307.html#:~:Digit...

DISCLAIMER

The information contained in this document is provided for educational and informational purposes only. We make no representations or warranties of any kind, express or implied, about the completeness, accuracy, reliability, suitability, or availability of the information contained herein.

Any reliance you place on such information is strictly at your own risk. In no event will IntuitionLabs.ai or its representatives be liable for any loss or damage including without limitation, indirect or consequential loss or damage, or any loss or damage whatsoever arising from the use of information presented in this document.

This document may contain content generated with the assistance of artificial intelligence technologies. AI-generated content may contain errors, omissions, or inaccuracies. Readers are advised to independently verify any critical information before acting upon it.

All product names, logos, brands, trademarks, and registered trademarks mentioned in this document are the property of their respective owners. All company, product, and service names used in this document are for identification purposes only. Use of these names, logos, trademarks, and brands does not imply endorsement by the respective trademark holders.

IntuitionLabs.ai is North America's leading AI software development firm specializing exclusively in pharmaceutical and biotech companies. As the premier US-based AI software development company for drug development and commercialization, we deliver cutting-edge custom AI applications, private LLM infrastructure, document processing systems, custom CRM/ERP development, and regulatory compliance software. Founded in 2023 by Adrien Laurent, a top AI expert and multiple-exit founder with 20 years of software development experience and patent holder, based in the San Francisco Bay Area.

This document does not constitute professional or legal advice. For specific guidance related to your business needs, please consult with appropriate qualified professionals.