MEDICAL CLAIMS SPREAD · THE LARGER, LESS-EXAMINED MIDDLEMAN ECONOMICS

The Larger Spread. Medical claims and the unlitigated frontier.

The fiduciary-breach wave that began with prescription drugs has so far ignored three quarters of the plan. Medical claims, not pharmacy, are where most self-funded dollars flow, and where the most opaque form of spread pricing operates. This paper documents the mechanics, sizes the exposure, maps the live ERISA litigation, and argues that the next wave will be medical, decided on the one thing the pharmacy cases lacked: a concrete, claim-level price analysis.

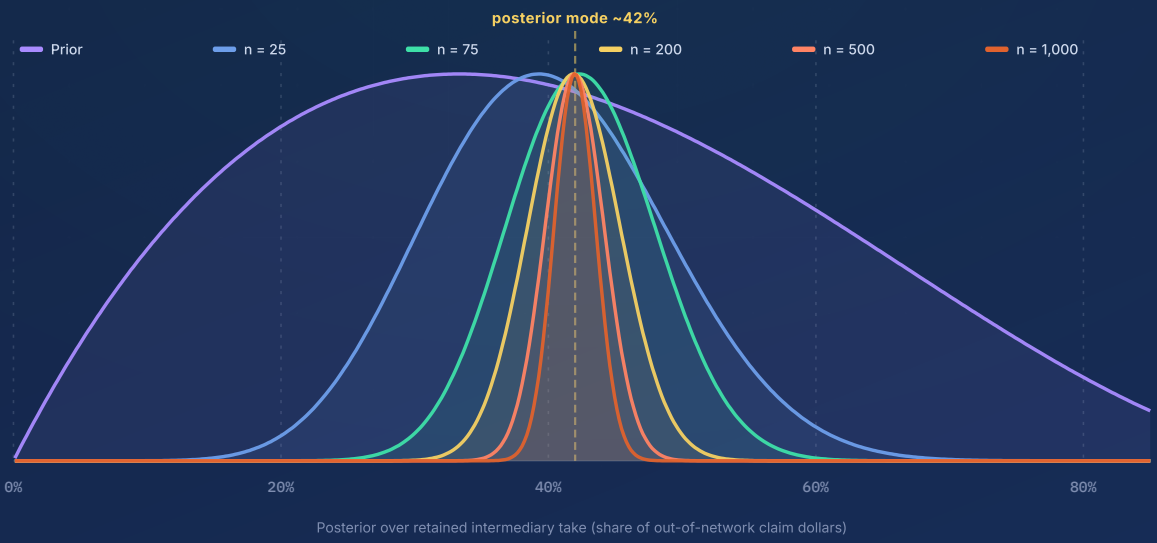
$5.3T
National health spend
18% of GDP, 2024 (CMS)

~75%
Of plan spend is medical
Pharmacy is the litigated 25%

up to 50%
Shared-savings fee
Of the claimed savings (CHIR)

67%
Workers self-funded
80% at large firms, 2025 (KFF)

BAYESIAN CONVERGENCE · THE RETAINED TAKE AS RECONCILED CLAIMS ACCUMULATE



MODELED Beta-Binomial posterior · a diffuse prior tightens to a defensible point estimate as the plan's 835 and 837 files are reconciled, the uncertainty that defeats a pleading collapsing into the figure that standing requires

Jeremiah Shrack · CEO & Chairman, Kincaid Risk Management Co. & SiriusB iQ · June 2026

TRIPLE-CHECK CERTIFIED

ABSTRACT · SUMMARY OF FINDINGS

What this paper establishes.

ABSTRACT

Spread pricing is widely understood as a pharmacy phenomenon. It is not confined to pharmacy. Third-party administrators and their repricing vendors operate an analogous, and materially larger, form of spread on medical claims: they bill the plan an amount that exceeds what the provider is paid, and retain the difference, often as a "shared-savings" fee computed as a percentage of a discount the plan can neither verify nor predict. Because medical claims represent roughly three quarters of self-funded plan spend, the dollars at stake dwarf the pharmacy cases now in court. We document the mechanics, size the exposure against CMS and KFF data, review the standing-driven dismissals in the pharmacy litigation, and conclude that the decisive variable in the coming medical-claims wave is evidentiary: a fiduciary, or a plaintiff, who can produce a claim-level price analysis from the 835 and 837 transaction files.

Five findings

1 **The spread is bigger on the medical side**

Medical claims are roughly 75% of plan spend against pharmacy's 25%. The same extraction mechanism applied to a three-times-larger base is a three-times-larger problem.

2 **The fee can exceed the care**

Shared-savings fees of up to 50% of claimed savings mean the intermediary can retain more than the provider received on the same claim.

3 **Opacity is contractual, not accidental**

Administrative-services agreements grant repricing discretion while confidentiality clauses keep provider contracts and the fee split out of the sponsor's view, even after CAA 2021 granted a data-access right.

4 **The litigation is pharmacy-only, for now**

Lewandowski, Navarro, and Stern all attack PBM economics. The medical-claims analog is unlitigated, and the precedents are being written without it.

5 **Standing turns on evidence the data already contains**

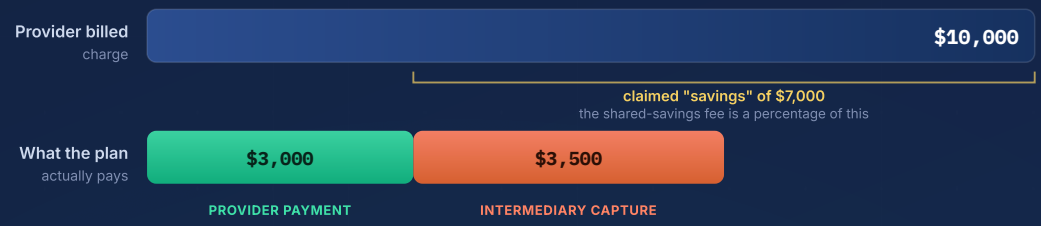
Cases died on speculative-harm grounds. The one that survived pleaded a specific price analysis. The 835 and 837 files make that analysis possible for medical claims.

MECHANICS · HOW MEDICAL SPREAD OPERATES

A markup the plan is contractually blind to.

Spread pricing on medical claims is structurally simple. The intermediary in the payment chain, typically the third-party administrator, bills the self-funded plan a higher amount for a service than it disburses to the provider. The difference, the spread, is retained as revenue and is generally unknown to the employer. The self-funded employer carries the full financial risk of the claim, yet delegates to the administrator the discretion to process and price it. That delegation is precisely where the spread enters.

ANATOMY OF A REPRICED OUT-OF-NETWORK CLAIM



At a 50% shared-savings rate, the intermediary keeps $3,500 on a claim where the provider received $3,000.

The fee exceeds the care. The plan sponsor, by contract, often cannot see the split.

Illustrative out-of-network claim under a common repricing arrangement. Mechanics per Georgetown CHIR / Health Affairs.

The out-of-network repricing model

For non-network claims, administrators commonly route payment through "repricers" rather than a published benchmark. The repricer pressures the provider to accept a steep underpayment, then the administrator and repricer collect a "shared-savings" fee from the employer, reported by Georgetown CHIR and Health Affairs at as high as 50% of the gap between the provider's billed charge and the amount ultimately paid. Plans and members can no longer predict what the plan will pay.

The data that exposes it

Two standardized transaction files settle the question. The **837** is the claim as submitted. The **835** is the remittance, what was actually paid and to whom. Reconciling the two, claim by claim, reveals the spread the contract obscures. CAA 2021 granted plan sponsors a right to this data, yet administrators frequently obstruct, citing confidentiality over provider contracts and repricing algorithms.

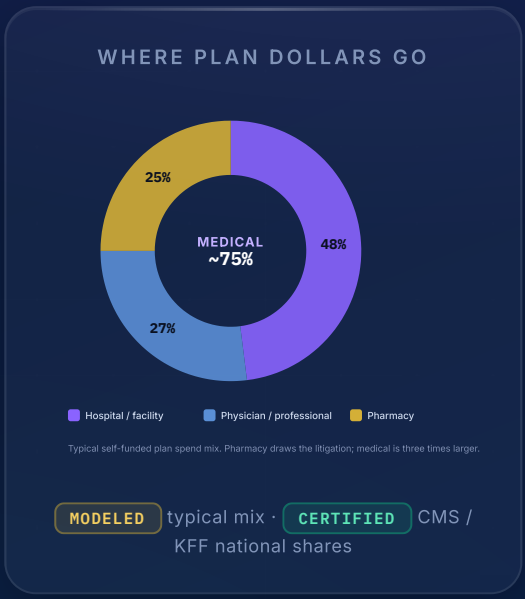
Adjacent tactics compound the spread. Administrators have been alleged to forgo pre-payment review so that overpayments can later be "recovered" for a fee of 25% to 40%, a practice observers call claims-payment gaming. In other arrangements, administrators owned by large insurers guarantee hospitals a minimum annual payment, then draw on employer funds to honor it, at times paying more than the provider billed. In each case the structure rewards the intermediary for higher gross prices, not lower net cost.

MAGNITUDE · WHY MEDICAL SPREAD DWARFS PHARMACY SPREAD

The litigation is chasing the smaller pool.

National health spending reached **$5.3 trillion**, 18% of GDP, in 2024. Hospital care alone was **$1.6 trillion**, nearly a third of the total and up from $609 billion in 2005. Physician and clinical services account for roughly another fifth of spending growth. Retail pharmacy, the sole target of the current fiduciary litigation, is a single-digit share of national spending growth and roughly a quarter of a typical plan's spend.

The arithmetic is unforgiving. Self-funded plans now cover **67%** of all covered workers and 80% at large firms. The average family premium reached **$26,993** in 2025. Apply the same extraction mechanism that the pharmacy cases attack to the medical three-quarters of that spend, and the exposure is several times larger. The spotlight is simply pointed at the wrong end of the plan.

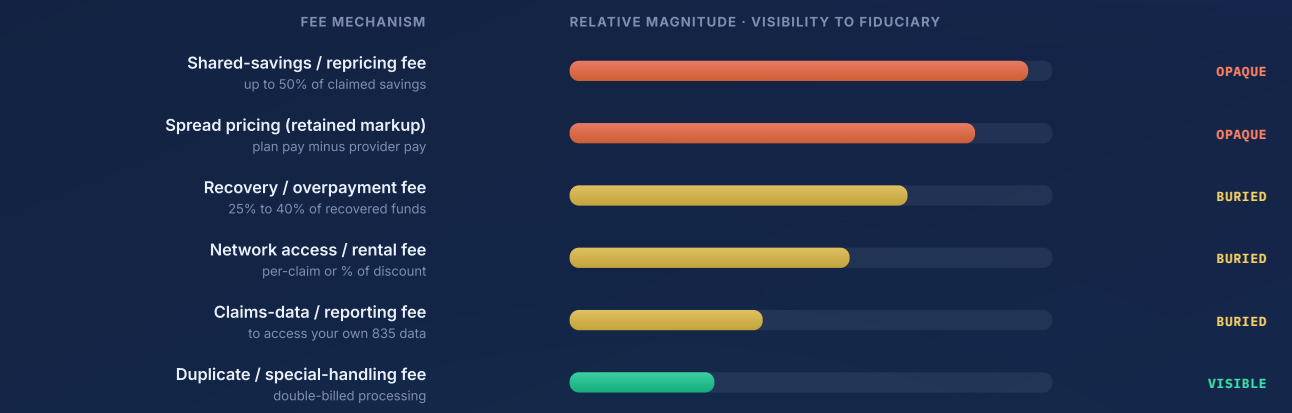


A larger base, a thinner light. Pharmacy spread became visible because drug list and net prices are discretely reported and benchmarkable. Medical pricing is bespoke, facility-specific, and buried in confidential provider contracts, so the same dollar of spread hides far more easily on the medical side.

The fiduciary stakes scale with the base. An imprudent fee arrangement on 25% of spend is a problem. The identical arrangement on 75% of spend, unexamined for years, is the kind of cumulative loss that defines an ERISA breach claim once it can be measured.

It is rarely one fee. It is a stack.

Spread is the headline mechanism, but it travels with companions. Each line below siphons plan assets, and each is calibrated to a different level of visibility to the fiduciary. The most lucrative are, predictably, the least visible.



MODELED relative magnitude and fiduciary visibility · percentages where publicly reported (CHIR, Claim Informatics, Health Affairs)

Opaque by design

Shared-savings fees and retained spread sit inside the claim itself. They are not invoiced as fees, so a plan reviewing its administrative-fee line will never see them. They surface only in a reconciliation of the 835 to the 837, which is exactly the data administrators resist sharing.

Buried, but recoverable

Recovery fees, network-access charges, and data-access fees appear in the contract, but in language dense enough that most sponsors discover them only in a deep audit. They are findable. They are simply not surfaced unless someone goes looking with the right instrument.

Reasonable compensation is a legal test, not a courtesy.

ERISA prohibits a transaction between a plan and a service provider unless no more than reasonable compensation is paid for the services. A plan fiduciary who cannot quantify what its administrator is actually keeping cannot certify that the compensation is reasonable. Opacity is therefore not a commercial inconvenience. It is a structural barrier to discharging the duty itself.

THE DUTY

Prudence & loyalty

Fiduciaries must act for the exclusive benefit of participants and pay only reasonable fees.

CAA 2021

Data-access right

Granted sponsors the right to look under the hood at fee schedules and claims data.

THE GAP

Obstruction

Administrators frequently decline to share provider contracts or repricing logic, citing confidentiality.

THE EXPOSURE

Prohibited transaction

Unreasonable, undisclosed compensation on plan assets is the precise shape of an ERISA claim.

In April 2025 the Supreme Court, in *Cunningham v. Cornell*, eased the pleading standard for prohibited-transaction claims, holding that a plaintiff need not plead the absence of an exemption to survive a motion to dismiss. The practical effect is a lower bar to discovery, and discovery is where spread lives. The doctrine is now aligned with the data. What remains is the instrument to read it.

THE LITIGATION · A WAVE AIMED AT PHARMACY

Three cases, one missing analysis.

The health-plan fiduciary wave is real and accelerating, and every case so far targets the pharmacy benefit. The decisive battleground has not been the merits. It has been Article III standing: whether participants can show a concrete, traceable financial harm rather than a speculative one.

Lewandowski v. Johnson & Johnson

2024 · on appeal

The case that opened the wave. Alleged mismanagement of the prescription drug program. Dismissed on standing in January 2025 and again on the amended complaint in November 2025; the alleged premium and out-of-pocket harms were held too speculative to trace to the fiduciary breach. Plaintiff has appealed.

Navarro v. Wells Fargo

2024 · on appeal

Echoed the J&J theory and alleged more than $25 million in administrative fees to the PBM as excessive. Dismissed on standing in 2025 and 2026 on the same speculative-harm reasoning. Also on appeal.

Stern v. JPMorgan Chase

2025 · proceeding on OOP claims

The exception. The court distinguished Lewandowski and Navarro, holding that the plaintiffs had pleaded a specific price analysis sufficient to establish standing on the out-of-pocket-cost claims. The difference was not the theory. It was the evidence.

The medical-claims analog to all three is unlitigated. The precedents that will govern it are being set right now, in cases about a quarter of the plan, by courts asking a single question the medical data can answer better than the pharmacy data ever could: show me the harm, specifically.

THE METHOD · TURNING CLAIMS DATA INTO STANDING

The 835 and 837 are the witness.

The lesson of the pharmacy wave is evidentiary, not theoretical. The cases that failed asserted harm. The case that advanced measured it. For medical claims, the measurement already exists in the plan's own transaction files; it simply has to be reconciled with discipline.

The forensic reconciliation

Reconcile 837 to 835. Match the billed claim to the remittance, claim by claim, to recover the actual provider payment and isolate the spread the contract conceals. This converts an allegation into an arithmetic.

Benchmark the take. Express the retained amount as a share of provider payment and of claimed savings, then test it against a national benchmark index. A fee that exceeds the care is not an opinion once it is computed.

Establish lineage. Every figure carries a tag: certified to a source document, modeled with stated assumptions, or flagged where the record is withheld. No anchor, no claim. No lineage, no publish.

Quantify the harm. Aggregate the spread to a plan-level loss with a defensible methodology, the concrete and traceable injury that the standing inquiry demands and that speculative pleadings could not supply.

This is the Kincaid iQ Verify discipline applied to the medical side of the plan: a constitutional, evidence-anchored reconciliation built on a national benchmark index, designed so that the output survives a prosecutor's reading and a fiduciary audit alike. The pharmacy plaintiffs lacked the instrument. The medical data rewards the side that brings one.

CONCLUSION · THE NEXT WAVE IS MEDICAL

The spotlight will move. The data is ready.

Spread pricing is not a pharmacy problem that happens to appear elsewhere. It is a middleman problem that is largest where the dollars are largest, and the dollars are largest on the medical side. The current litigation has taught the market exactly what the next wave requires: not a sharper theory, but a concrete, claim-level price analysis. That analysis is latent in every plan's 835 and 837 files. The fiduciaries who run it first will protect their participants and themselves. The intermediaries whose economics cannot survive it will be repriced, in court or in renewal.

There is a person at the end of every spread. The dollar retained between the billed charge and the provider's payment is a dollar that left a working family's premium and never bought a minute of care. Naming it precisely is not an act of accounting. It is the first fiduciary act, and the overdue one.

SELECTED SOURCES

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Jeremiah Shrack, CEO & Chairman, Kincaid Risk Management Co. and SiriusB iQ. Carmel, Indiana. ERISA fiduciary defense for self-funded employer health plans. This working paper is analysis, not legal advice.