

Hidden Incentives Drive IDR Volume And Cost: The Role Of Commercial Insurer “Shared Savings” Programs

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The No Surprises Act has protected patients from surprise medical bills. However, the law’s incentives for insurers acting as third party administrators to push providers out of network and under-reimburse for care drive wasteful spending that harms patients, plans, and providers.



Editor's Note

E This article is the latest in the Health Affairs Forefront series, [Provider Prices in the Commercial Sector](#), featuring analysis and discussion of physician, hospital, and other health care provider prices in the private-sector markets and their contribution to overall spending therein. Additional articles will be published throughout 2025. Readers are encouraged to review the [Call for Submissions](#) for this series. We are grateful to [Arnold Ventures](https://www.arnoldventures.org/) for their support of this work. Health Affairs Forefront alone reviews all submissions then selects, edits, and publishes them only if they meet Forefront’s editorial standards.

The federal [No Surprises Act](https://www.cms.gov/nosurprises) (NSA) was designed to protect patients from unexpected out-of-network medical bills while preserving access to care by maintaining sustainable payment rates for providers. Central to this effort is the independent dispute resolution (IDR) process, where certified third-party arbiters resolve payment disputes between providers and payors, keeping patients out of the middle.

The NSA has effectively protected patients from surprise medical bills; however, [IDR activity](#) has been higher than anticipated. The Centers for Medicare and Medicaid Services (CMS) [Public Use Files](https://www.cms.gov/nosurprises/policies-and-resources/reports) (PUF) data offer insights into IDR trends, including volume and outcomes of disputes, but they do not capture the financial incentives driving IDR usage or the operational realities of the process.

This paper combines 2024 PUF data, national survey findings, and real-world examples to provide missing context and dispel myths. Specifically, we describe how commercial health insurers' "shared savings" arrangements create incentives to displace hospital-based providers from a health plan's network, adding cost to health plans, beneficiaries, and the health care system at large.

2024 PUF Data In Context

Volume

The IDR process is costly. The non-refundable, per-dispute administrative fee is \$115, and the fees for the arbiters, called IDR entities (IDREs), range from \$200 to \$1,173 or more. While the IDRE fee is refundable to the prevailing party, it must be paid upfront. Despite these expenses, the volume of IDR dispute submissions has continued to grow since the program's inception. Our analysis of the PUF data reveals that in just the second half of 2024, there were approximately 26 percent more dispute submissions initiated (853,374) than in all of 2023 (679,156). There have been another [1.4 million](https://www.cms.gov/nosurprises/policies-and-resources/reports) disputes submitted in the first 7 months of 2025. Two main factors contribute to the rising volume of IDR cases: expanded access to IDR and persistent demand.

First, access to IDR has increased with the emergence of companies that assist in IDR submission. Historically, small- to mid-sized medical organizations lacked the ability and resources to navigate the complex bureaucracy and [deadlines](https://www.cms.gov/files/document/independent-dispute-resolution-idr-timeline-claims.pdf) to submit an IDR dispute. Companies have arisen to fill in that gap. For example, one of the largest filers of disputes in 2024 was [HaloMD](https://www.prnewswire.com/news-releases/halomd-expands-executive-team-with-veteran-healthcare-leaders-to-strengthen-fairness-and-accountability-in-idr-302554171.html?utm_source=chatgpt.com), a company that supports a spectrum of practice sizes in preparing and submitting IDR cases. Contrary to the [idea](#) that IDR is driven by private equity-backed organizations, most HaloMD clients, as well as HaloMD itself, are not affiliated with private equity (based on PUF data analysis and direct communication with HaloMD).

Second, the ongoing need for IDR reflects a structural imbalance. As detailed below, insurers have a financial incentive to push hospital-based providers out of network and then pay below-market rates for services, leaving providers seeking fair reimbursement with no choice but to utilize the IDR process. Rather than providers intentionally leaving health plan networks to leverage the IDR process for greater payment, medical groups typically peg their IDR submissions to [previously received](https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf) payment rates, often a past in-network rate from the same payer. For such groups, it would be far better to be in network at a rate even close to the previously contracted rate, avoiding the costs and uncertainties associated with IDR.

Win Rates In IDR

The PUF data reveal that providers win the vast majority (>80 percent) of IDR determinations. The win rate of insurers has been fairly stable, hovering between 14 and 18 percent. Interestingly, approximately 20 percent of 2024 losses in IDR were by default due to failure to submit an offer and/or pay the required fees. However, even when insurers did submit an offer and pay the fees, they still typically lost. Why is this?

Per [CMS](https://www.cms.gov/files/document/federal-idr-supplemental-background-2024-q3-2024-q4.pdf), insurers typically benchmark their offer in IDR to the qualifying payment amount (QPA [methodology](https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/caaqualifying-payment-amount-calculation-methodology.pdf)). While the QPA was intended to be the median in-network rate for a given item or service in a specific region, the veracity of this value as a typical commercial payment rate and its non-transparent calculation methodology have been a focus of [concern](#). In a national [survey](https://www.americansforfairhealthcare.org/files/ugd/11639b_3948738a47e7439c910c4490a8c47778.pdf) of clinicians, more than 90 percent of respondents reported receiving initial payments (which are benchmarked to the QPA) at or below Medicare rates. Contracted commercial rates are typically above [Medicare rates](https://www.urban.org/sites/default/files/publication/104945/commercial-health-insurance-markups-over-medicare-prices-for-physician-services-vary-widely-by-specialty.pdf?utm_source=chatgpt.com).

Additionally, IDREs may be concerned that insurers are manipulating the QPA, including with "ghost rates" (contracted rates that are rarely or never used but included in a QPA calculation). While [courts](https://www.mcdermottplus.com/insights/breaking-down-the-new-no-surprises-act-faqs-post-tma-iii/) have ruled against this practice, [enforcement](https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-71) of the correct calculation methodology has been delayed until 2026 at the earliest. Since insurers calculate their own QPAs, and there have not been frequent audits, the QPA seems to have less weight with IDREs than provider-submitted, market-based data, such as current and historical rates for the same service in that region.

The “Shared Savings” Scheme And Its Role in IDR

Despite insurers consistently losing most IDR determinations, the PUF data, the national survey data and our own collective experiences indicate that they are not changing their strategy. The likely explanation lies in the financial incentives embedded in “shared savings” arrangements used by some insurers acting as third party administrators (TPAs) to self-insured employer-sponsored health plans. These arrangements, which are unrelated to the similarly named Medicare Shared Savings Program, may reward TPAs for pushing providers out of network and then paying below-market rates, even if that approach leads to higher IDR volume, frequent losses in IDR, and greater costs for their health plan clients. Here is how they work:

- When out-of-network care is delivered, the provider bills their standard, non-discounted out-of-network rate (the billed amount).
- The TPA determines the reimbursement rate, often using the QPA to justify a below-market payment (the paid amount).
- The TPA then takes a percentage of the difference between the billed and paid amounts as a “shared savings” fee. This fee is frequently 25-40 percent of the difference, though fees as high as 50 percent have been [reported <https://chirblog.org/third-party-administrators/#:~:text=Instead%20of%20reference%20to%20a,billed%20charge%20and%20ultimate%20payment.>](https://chirblog.org/third-party-administrators/#:~:text=Instead%20of%20reference%20to%20a,billed%20charge%20and%20ultimate%20payment.>). The lower the payment rate, the greater the shared savings fee, which is paid from the employer’s health plan.

Exhibit 1 illustrates the TPA’s incentive for care to be delivered out of network. Here, the in-network, contracted rate for a service is \$1500, but a provider’s non-discounted out-of-network billed amount is \$3,000. If the provider is in-network, the TPA pays the \$1500 using the health plan’s money and receives no extra fee. If the provider is out of network, the TPA agrees to pay just \$1,000 of the \$3000 billed for this service and, under a shared savings arrangement, charges 30 percent of the \$2,000 “savings” (\$600) as a fee. Altogether, this costs the health plan more than its in-network rate (\$1600 versus \$1500) but is a win for the TPA.

Exhibit 1: Illustrative Example of Increased Costs to Self-Insured Employer due to Shared Savings Arrangement with Third Party Administrator

Care Delivered In-Network	Care Delivered Out-of-Network
Contracted Rate: \$1500	Billed Rate: \$3000
Amount Paid: \$1500	Amount Paid: \$1000
Extra Fees: \$0	Shared Savings Fee: \$600*
TOTAL COST TO EMPLOYER: \$1500	TOTAL COST TO EMPLOYER: \$1600

Notes: *Assumes 30% shared savings rate.

Source: Authors’ analysis.

As described in the [New York Times <https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html>](https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html), the shared savings fees paid to insurers acting as TPAs for claims processing can exceed the amount paid for the care itself. In an example [shared with the Senate <https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf>](https://www.help.senate.gov/imo/media/doc/5c4f7817-d6d7-43a9-bfc9-dcc28f188898/Deacon%20Testimony.pdf), claims administration accounted for almost 80 percent of the cost paid by an employer for an episode of care. Because shared savings fees increase as provider payments decrease, insurers are financially motivated to underpay, thereby escalating the need for IDR.

The TPA may then treat the IDR-related fees as a pass-through expense, paid by the employer’s health fund, not the TPA. Any additional reimbursement to the provider resulting from IDR also comes from the employer’s health fund. This structure insulates the TPA from financial risk. Meanwhile, the TPA may collect a per-claim fee from the employer, based on a claim’s eligibility for IDR, regardless of whether a dispute is filed, as illustrated in an email from a TPA that was shared with us by an employer who self-insurers (Exhibit 2).

Exhibit 2: Email Describing TPA's Charges for NSA-eligible Claims Processing and Pass-through of IDR-related Fees

Date: Thursday, August 15, 2024
To:
Cc:
Subject: NSA Claim Fee Change 11/1/24

We wanted to make you aware of a change in the NSA claim fee, the details of which are provided below. You will be receiving a 60-day notice of change regarding fees that Aetna charges to cover the cost of administering the required claims operations brought about by the No Surprises Act.

Background: In December 2020, Congress passed the No Surprises Act (NSA) to protect plan participants from surprise medical bills from out-of-network providers. For certain out-of-network claims, the NSA protects plan participants by limiting cost sharing to the preferred benefit level and prohibits balance billing by out-of-network providers. For NSA-eligible claims, a provider may choose to go to Independent Dispute Resolution (IDR) if the provider does not accept Aetna's payment as payment in full. Upon implementation, Aetna implemented a fee for each NSA-eligible claim.

Notice of Fee Increase: The administrative fee applied to **NSA-eligible claims** is increasing from \$50 to \$90. This fee increase will take effect for claims paid dates on November 1, 2024 and after.

While we have not adjusted the fee since our implementation of the NSA over two years ago, the administrative burdens and CMS-driven changes related to the NSA have had a substantial and material impact. Payers are experiencing sustained, significant volumes and administrative burdens arising from this regulation, notably within the IDR component. In response, Aetna has initiated the formation of new teams and the deployment of a new system. Additionally, substantial manual interventions persist due to the inherent complexity of the NSA framework. As a result, a fee increase is necessary in order to offset the costs associated with the required operational enhancements and infrastructure needed to ensure ongoing compliance.

Please note there are no changes to the existing IDR fee process. **The IDR fees (initial fee and arbitration fee) are separate from our NSA administrative fee. The IDR initial fee and arbitration fee are dictated by CMS. Aetna is invoiced and pays these fees to the Independent Dispute Resolution Entities (IDRE's) for their services. Once a decision is made by the IDRE, Aetna simply passes through these incurred costs to our Plan Sponsors with no mark-ups or adjustments.**

As always please let us know if you have any questions or how we can assist you further.

Source: Email provided to the authors from a health insurer acting as a third-party administrator to an employer-sponsored, self-funded health plan.

The critical caveat is that shared savings fees are dependent on out of network care. As a result, the TPA's financial incentives may be misaligned with those of the employer and its beneficiaries. Exhibit 3 uses real world data from an IDR dispute won by the practice of one of the authors and assumes a 30% shared savings fee. This shows that the employer's health fund paid 264 percent more for out of network care than in network care. Although the employer's health fund paid more, the provider received 35 percent less. In fact, the TPA received more money (\$243.95) for processing the out of network claim than the provider who delivered the care (\$206.59).

Exhibit 3: Real World Example of Employer Costs, Including Shared Savings & IDR Fees

In-Network (Pre-NSA)	Out-of-Network (Post-NSA)
Contracted Rate: \$318.81	Billed Rate: \$948
Amount Paid: \$318.81	Amount Paid: \$134.82
Extra Fees: \$0	Extra fees:
TOTAL COST TO EMPLOYER:	<ul style="list-style-type: none">Shared Savings Fee: \$243.95*IDR Fee = \$115IDRE Fee = \$595
\$318.81	Additional Award Amount (paid to provider): \$71.77
	TOTAL COST TO EMPLOYER: \$1160.54

Notes: *Assumes 30% shared savings rate.

Source: Authors' analysis.

Shared savings programs existed before the NSA, but the law's enactment may have [inadvertently fueled their expansion](#). Now, TPAs can generate new revenue from shared savings and other fees by pushing hospital-based providers out of network. And because patients and employers rarely choose a [health plan <https://www.vox.com/even-better/23905148/health-insurance-obamacare-ppo-epo-premium-deductible-copay-cobra-explainer>](https://www.vox.com/even-better/23905148/health-insurance-obamacare-ppo-epo-premium-deductible-copay-cobra-explainer) based on its network of hospital-based specialties such as anesthesiology, emergency medicine, or radiology, excluding certain providers may have little impact on a plan's marketability.

Costs To The Health Care System

A [study](#) attempted to estimate IDR's costs to the health care system; however that analysis has meaningful limitations. For example, the single largest cost category was payment amounts, defined as the difference between the QPA/initial payment and the prevailing offer in IDR. However, this assumes that the QPA/initial payment is a typical in-network rate, which has been [questioned](#). Perhaps more importantly, the study implied the award amount was an extra cost, though it frequently is pegged to a previously accepted payment amount. As an example, if the initial payment/QPA is \$1,000, and the previous negotiated, in-network rate was \$1,500, then an IDR award of \$500 is not an extra cost to the health care system. While that study likely overestimated the additional costs associated with award payments, it also ignored the costs associated with shared savings fees and may have underappreciated other fees charged by insurers.

Although shared savings arrangements may be presented as a cost savings to employer-sponsored health plans, Exhibit 3 shows the opposite may be true. When viewed at a health care system level, the costs are even greater, with two IDR fees included, one from each party. Patients experience these increased costs as rising premiums and higher cost sharing. Even worse, anecdotal [evidence <https://www.americansforfairhealthcare.org/_files/ugd/11639b_94e949aa17d348a1847644e68961405d.pdf>](#) suggests some insurers may [inappropriately <https://www.cms.gov/files/document/faqs-part-69.pdf>](https://www.cms.gov/files/document/faqs-part-69.pdf) increase patients' cost share amounts after an IDR determination.

While the exact amount of additional spending from IDR is unclear, it is fair to say there is substantial administrative expense. These costs are antithetical to the intent of the NSA, which was thoughtfully designed to encourage providers and insurers to act reasonably and avoid the costs of IDR. However, if insurers acting as TPAs are shielded from those costs, then their incentive to avoid IDR is lost. Paired with shared savings fees, this may explain why some insurers seem to prefer out-of-network care and to be indifferent to losing in IDR.

Opportunities For Improvement

To reduce unnecessary spending and promote better care, there are a variety of actions that policymakers should consider.

Reduce The Need For IDR

Policymakers should address the financial incentives that encourage insurers to direct care out of network. It is inappropriate that shared savings fees are used with NSA-eligible claims, which already have a mechanism for cost management.

By closing loopholes that allow insurers to profit from under-reimbursing out of network care, policymakers can encourage responsible in-network contracting and reasonable initial out of network payment amounts. Such actions could reduce the need for IDR and improve patients' access to in-network care. For example, in a [study](#), IDR-related fees and internal expenses were more than half of the total costs associated with the IDR system. If the IDR award amounts had instead been paid upfront in the form of higher initial payments, presumably far fewer IDR cases would have been filed, dramatically reducing costs.

Increase Auditing And Improve Enforcement

Policymakers should require frequent QPA calculation audits and impose meaningful penalties for those who illegally manipulate values. The QPA was intended to be a typical, specialty-specific, in-network rate. However, enforcement gaps have allowed insurers to manipulate QPA rates without fear of consequence.

There should also be consequences for violating the law's mandates. For example, there should be penalties for failure to pay the full award amount within the law's required timeframe. Further, TPAs that inappropriately increase patient cost sharing after IDR should face penalties.

Improve Transparency

In addition to greater transparency around the QPA and its calculation, Congressional and regulatory policymakers should act to improve understanding of TPA policies, including increased transparency of the fees charged by TPAs, and study the costs to the health care system from activities such as shared savings.

Several members of the [House Committee on Ways and Means](https://waysandmeans.house.gov/wp-content/uploads/2025/09/WM-NSA-Letter-2025-FINAL.pdf), including the committee chair and the Health Subcommittee chair, penned a letter articulating their concerns regarding some of these issues with the NSA.

Conclusion

The 2024 PUF data demonstrate an increasing volume of IDR submissions, which we believe is driven by increased access to IDR paired with ongoing need for IDR. Providers continued to win the vast majority of disputes in 2024, likely reflecting ongoing concerns about the QPA and greater trust in transparent data on actual payment rates.

While the NSA has successfully protected patients from surprise medical bills, incentives for TPAs to push providers out of network and under-reimburse for care are driving wasteful spending that benefits them at the expense of patients, plans, and providers. Addressing this problem will require confronting shared savings arrangements and ensuring strong enforcement of the law's mandates.

By safeguarding patient access to care, realigning financial incentives, and strengthening transparency, policymakers can fulfill the full promise of the No Surprises Act.

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Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill.

A little-known data firm helps health insurers make more when less of an out-of-network claim gets paid. Patients can be on the hook for the difference.

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By Chris Hamby

Chris Hamby reviewed more than 50,000 pages of documents and interviewed more than 100 people for this article. The New York Times also petitioned two federal courts for materials under seal.

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Weeks after undergoing heart surgery, Gail Lawson found herself back in an operating room. Her incision wasn't healing, and an infection was spreading.

At a hospital in Ridgewood, N.J., Dr. Sidney Rabinowitz performed a complex, hourslong procedure to repair tissue and close the wound. While recuperating, Ms. Lawson phoned the doctor's office in a panic. He returned the call himself and squeezed her in for an appointment the next day.

"He was just so good with me, so patient, so kind," she said.

But the doctor was not in her insurance plan's network of providers, leaving his bill open to negotiation by her insurer. Once back on her feet, Ms. Lawson received a letter from the insurer, UnitedHealthcare, advising that Dr. Rabinowitz would be paid \$5,449.27 — a small fraction of what he had billed the insurance company. That left Ms. Lawson with a bill of more than \$100,000.

"I'm thinking to myself, 'But this is why I had insurance,'" said Ms. Lawson, who is fighting UnitedHealthcare over the balance. "They take out, what, \$300 or \$400 a month? Well, why aren't you people paying these bills?"



Gail Lawson faced more than \$100,000 in bills after a complex surgery. Her insurance paid out \$5,449.27. Bryan Anselm for The New York Times

The answer is a little-known data analytics firm called MultiPlan. It works with UnitedHealthcare, Cigna, Aetna and other big insurers to decide how much so-called out-of-network medical providers should be paid. It promises to help contain medical costs using fair and independent analysis.

But a New York Times investigation, based on interviews and confidential documents, shows that MultiPlan and the insurance companies have a large and mostly hidden financial incentive to cut those reimbursements as much as possible, even if it means saddling patients with large bills. The formula for MultiPlan and the insurance companies is simple: The smaller the reimbursement, the larger their fee.

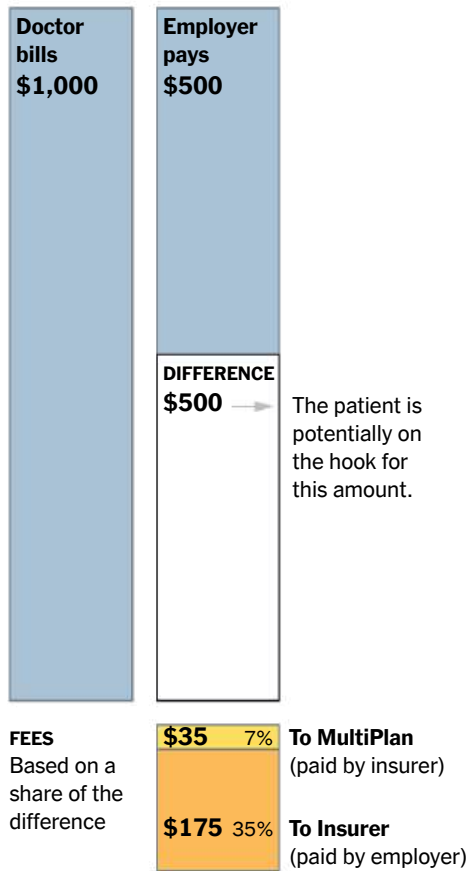
Here's how it works: The most common way Americans get health coverage is through employers that "self-fund," meaning they pay for their workers' medical care with their own money. The employers contract with insurance companies to administer the plans and process claims. Most medical visits are with providers in a plan's network, with rates set in advance.

But when employees see a provider outside the network, as Ms. Lawson did, many insurance companies consult with MultiPlan, which typically recommends that the employer pay less than the provider billed. The difference between the bill and the sum actually paid amounts to a savings for the employer. But, The Times found, it means big money for MultiPlan and the insurer, since both companies often charge the employer a percentage of the savings as a processing fee.

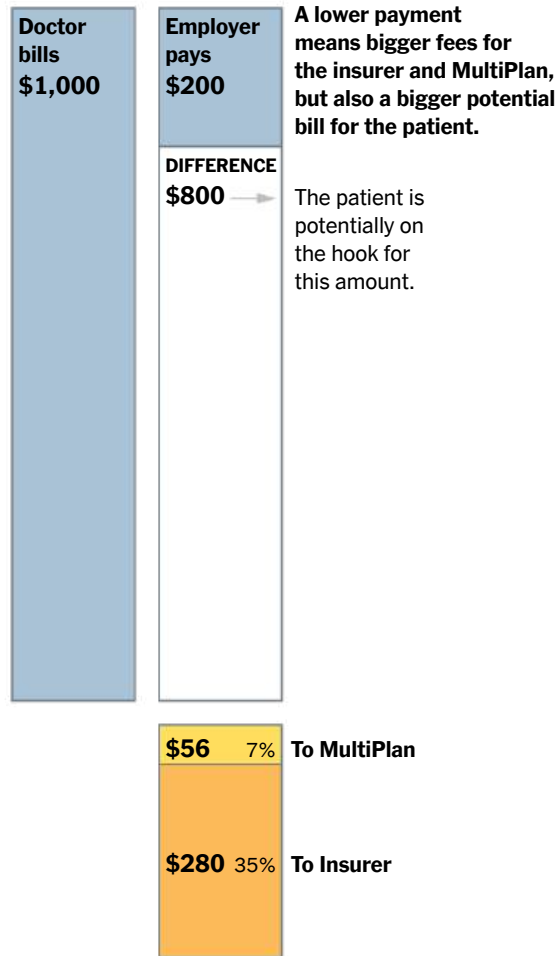
How MultiPlan and Insurers Make Money on Fees

MultiPlan and health insurers typically receive a percentage of the “savings” on each claim, creating an incentive to recommend lower payments.

EXAMPLE 1:
MULTIPLAN ADVISES A 50% PAYMENT



EXAMPLE 2:
MULTIPLAN ADVISES A 20% PAYMENT



Fee percentages vary based on negotiated contracts. • By The New York Times

In recent years, the nation’s largest insurer by revenue, UnitedHealthcare, has reaped an annual windfall of about \$1 billion in fees from out-of-network savings programs, including its work with MultiPlan, according to testimony by two of its executives. Last year alone, MultiPlan told investors, it identified nearly \$23 billion in bills from various insurers that it recommended not be paid.

MultiPlan and the insurers say they are combating rampant overbilling by some doctors and hospitals, a chronic problem that research has linked to rising health care costs and regulators are examining. Yet the little-understood financial incentive for insurers and MultiPlan has left patients across the country with unexpectedly large bills, as they are sometimes asked to pick up what their plans didn't pay, The Times found. In addition, providers have seen their pay slashed, and employers have been hit with high fees, records and interviews show.

In some instances, the fees paid to an insurance company and MultiPlan for processing a claim far exceeded the amount paid to providers who treated the patient. Court records show, for example, that Cigna took in nearly \$4.47 million from employers for processing claims from eight addiction treatment centers in California, while the centers received \$2.56 million. MultiPlan pocketed \$1.22 million.

Confidential Pricing and Fee Data

Itemized payments and fees for thousands of claims were made public in a lawsuit against Cigna after The Times petitioned the court. The insurer and MultiPlan opposed the release, calling the data "highly confidential."

Payment amount

For providing outpatient substance abuse treatment, the facility received **\$134.13**.

Fee for Cigna

For processing the claim, **Cigna received \$658.75**, nearly five times as much as the treatment center.

Fee for MultiPlan

For recommending a payment amount, **MultiPlan received \$167.48**, slightly more than the treatment center.

MultiPlan, which makes nearly all its revenue from such fees, markets its calculations as “defensible, repeatable and completely transparent” and independent of insurance company influence. The firm estimates that its reach extends to more than 100,000 health plans covering more than 60 million people. Patients have encountered its pricing recommendations after a variety of treatments, including spine surgeries, physical therapy appointments and ambulance rides.

The company did not respond to detailed questions from The Times. In a statement, it said it uses “well-recognized and widely accepted solutions” to promote “affordability, efficiency and fairness,” by recommending a “reimbursement that is fair and that providers are willing to accept in lieu of billing plan members for the balance.”

In examining MultiPlan’s dominant role in this secretive world, The Times reviewed more than 50,000 pages of confidential corporate records, legal filings, claims information and other documents. The Times also interviewed more than 100 patients, doctors, billing specialists, advisers to employer health plans and former MultiPlan employees.

The Times found:

- Patients hit with unexpectedly large bills sometimes forgo care or cease long-term treatment, and complain that appeals are fruitless. “They basically took away the mental health care I was getting,” said Olivia Henderson, who stopped her therapy sessions in New York when the cost spiked.
- MultiPlan’s recommended payments not only push back against known overbillers, but can also squeeze smaller practices. Kelsey Toney, who provides behavioral therapy for children with autism from a clinic in rural Virginia, saw her pay cut in half for two patients. “I don’t want to say, ‘I’m sorry I can no longer accept you,’ especially when I’m the only provider within an hour,” she said.
- Insurers pitch MultiPlan to employers as a way to control costs, but the fees can be onerous and unpredictable. New England Motor Freight, a New Jersey trucking company, was charged \$50,650 by UnitedHealthcare for processing a single hospital bill.
- Insurers can influence MultiPlan’s purportedly independent payment recommendations, according to MultiPlan documents made public by a federal judge after a petition from The Times. That generally means paying even less to doctors and making more in fees.
- Former employees at MultiPlan, which has annual revenues of about a billion dollars, described a numbers-driven culture that encouraged locking in unreasonably low payments and tied their bonuses to the reductions. “I knew they were not fair,” said one former

MultiPlan negotiator, Kajuana Young.

- Regulators rarely intervene. The administration of employer-funded health plans is mostly exempt from state regulations. Enforcement primarily falls to an agency within the federal Department of Labor, which says it has one investigator for every 8,800 health plans.

In separate statements, UnitedHealthcare, Cigna and Aetna said MultiPlan helps them control costs for employers. A UnitedHealthcare spokesman said employers negotiate and accept contract terms, including the fee, and described the arrangement as “an industry-standard approach.” A Cigna spokeswoman also said the fee “aligns with industry standards,” adding that “it is fully transparent to our client” and has no influence on payouts to medical providers.

As to the issue of patients being billed for unpaid balances, Aetna said it offered employers “various options and strategies” to minimize the risk of unexpected charges. Cigna said that payment decisions could be appealed, and that it collected no fee if the patient was ultimately billed the balance. UnitedHealthcare blamed “egregious” charges by out-of-network providers and suggested that criticism of its work with MultiPlan had been stoked by a private-equity-backed medical staffing firm that is suing the insurer.

Determining what to pay when a patient goes out of network has long been a contentious issue. While such claims represent a small portion of all medical visits, they can be expensive, little understood by patients and difficult to avoid. Legislation that took effect in 2022 now protects patients from certain kinds of surprise bills but does not cover a vast majority of the claims directed to MultiPlan.

Insurers say that the traditional approach — paying a portion of what providers typically charge — no longer works because of dramatic price hikes. Cigna, in its statement, said some out-of-network providers last year tried to charge “up to 1,904 percent of what they charge Medicare.” Providers, meanwhile, argue that insurers and MultiPlan can’t be trusted to set fair rates.

The situation echoes a past scandal. Fifteen years ago, the New York attorney general broke up a pricing system that his office’s investigation concluded was “rigged.” The central player, UnitedHealth, agreed to pay \$350 million to patients and medical professionals who said they had been shortchanged, and along with other major insurers, it agreed to reforms meant to ensure this wouldn’t happen again.

But the settlement left an opening.

An Industrywide Investigation

In 2009, a woman from Yonkers, N.Y., became a symbol of patients' outrage and the promise of change.

Mary Reinbold Jerome had been diagnosed with ovarian cancer at age 62 and received treatment at Memorial Sloan Kettering. Because the hospital was outside her plan's network, she was billed tens of thousands of dollars.

A tenacious woman who taught English to nonnative speakers at Columbia University, Dr. Jerome lodged a complaint with the state attorney general's office, helping to prompt an industrywide investigation.

She stood beside Andrew M. Cuomo, then the attorney general, as he announced his office's blistering conclusions: A payment system riddled with conflicts of interest had been shortchanging patients, and at its core was a data company called Ingenix. Insurers used the company, a UnitedHealth subsidiary, to unfairly lower their payments and shift costs to patients, the probe found.



Attorney General Andrew M. Cuomo, left, used Mary Reinbold Jerome's experience with health insurance reimbursements to challenge the industry. Office of New York Attorney General Andrew Cuomo

UnitedHealthcare, Cigna, Aetna and other major insurers agreed to replace Ingenix with a nonprofit that would provide independent pricing data. Dr. Jerome was featured on news programs and hailed as an agent of change, while senators held hearings and blasted insurers

for cheating patients.

In 2010, Dr. Jerome died.

“She was thinking beyond her own situation,” her daughter, Eva Jerome, said in an interview. “She was hoping it would have a broader impact.”

But amid the triumph, a key detail in the attorney general’s agreements with insurers largely escaped notice: The companies were required to use the nonprofit database for only five years.

When that term expired in 2014, MultiPlan was well positioned to capitalize.

‘All for Naught’

For decades, the company, founded in 1980, offered a traditional approach to managing out-of-network claims by negotiating rates with doctors. Insurers got discounts and assurances that patients would not have to make up the difference.

But after MultiPlan’s founder sold it to private equity investors in 2006, the company pursued a more aggressive approach. It embraced pricing tools that used algorithms to recommend lower payments, and no longer protected patients from having to pay the difference, documents show.

Meanwhile, private equity ramped up investments in physician groups and hospitals and, in some instances, began billing for extraordinary sums. Once insurers were no longer obligated to use the nonprofit database, FAIR Health, they began looking for ways to combat that billing and other charges they considered egregious. Because FAIR Health’s data was based on what doctors typically charged, insurers contended that overbilling would skew payments too high.

Cigna was particularly concerned with what it considered overbilling and fraud by substance abuse treatment centers. It halted some payments, opened investigations and met with a public relations firm “to precondition public support for any next steps we may need to take,” internal documents show.



Using MultiPlan to help process claims from eight addiction treatment centers in California, Cigna collected nearly \$4.47 million in fees — almost twice what the centers received. Matt Rourke/Associated Press

In a 2015 email, unsealed after The Times’s request and over Cigna’s objection, a Cigna executive reminded colleagues of a key consideration.

“We cannot develop these charges internally (think of when Ingenix was sued for creating out-of-network reimbursements),” wrote Eva Borden, a chief risk officer at Cigna. “We need someone (external to Cigna) to develop acceptable” rates, she wrote.

UnitedHealthcare developed talking points to “position UnitedHealthcare as an advocate that is helping consumers push back on excessively high physician and facility bills,” a 2016 internal memo said.

Both insurers increasingly turned to MultiPlan. Internal documents show that UnitedHealthcare began a campaign to persuade employers to switch from FAIR Health. In a 2019 email, a UnitedHealthcare senior vice president emphasized creating a “sense of urgency” and helping companies still using FAIR Health “understand they don’t want to be on that program anymore.”

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UnitedHealthcare had a big incentive to encourage this change. When it processed claims from employer plans using FAIR Health, the insurer collected no additional fee, according to legal testimony. But when it used MultiPlan, documents show, it typically charged employers 30 to 35 percent of the difference between the billed amount and the portion paid.

MultiPlan, too, charged a percentage of the savings, meaning it could make more by recommending lower payments. (FAIR Health charged a flat fee.)

While UnitedHealthcare was MultiPlan's largest customer, Cigna and Aetna also embraced its tools and fee model, records show. Other insurers that work with MultiPlan include Kaiser Permanente, Humana and some Blue Cross Blue Shield plans.

Employers with self-funded plans administered by insurers include large companies like Coca-Cola and AstraZeneca and smaller organizations like school districts and union locals. (New York Times Company plans also operate this way.)

FAIR Health has expanded the types of data it offers and made it available online. Numerous states use the nonprofit when setting payments for government programs. Big commercial insurers still license its data, but they have largely shifted to other approaches, according to interviews, documents and statements from UnitedHealthcare and Cigna.

"If they're able to go back to their old ways," Eva Jerome said, "then it was all for naught."

'I'm Being Ripped Off'

When claims go through MultiPlan, some patients receive statements highlighting what their insurer calls discounts or savings — even as doctors or hospitals bill them for those amounts.

Cari Campbell, who received fertility treatment in Minnesota, was charged thousands of dollars that her insurer had labeled "you saved." In Kansas City, Kan., Paul Haddix paid the amounts labeled "your discount" for his daughter's occupational and speech therapy. In New Jersey, Jonathan Menjivar paid upfront for therapy appointments and saw his reimbursements plunge.

"I took a closer look at the explanation of benefits," Mr. Menjivar said, "and noticed for the first time this column labeled 'your discount,' which is an interesting way of putting it."

The supposed savings and discounts were the portions MultiPlan had recommended the employers not pay. Patients could still be on the hook.

Fact Check: An Explanation of Benefits

Insurance statements often identify savings or discounts. But sometimes patients can still be billed for that amount, as in this case involving the UnitedHealth subsidiary UMR.

Your discount: \$871.78

Your plan negotiates discounts with providers and facilities to help save you money.

You saved: \$1,293.74

82% of your service was covered by your plan discounts, your employer-sponsored benefits plan, or other amounts for which you are not responsible.

[View the PDF.](#) • [By The New York Times](#)

The burden can fall hardest on people with chronic or complex conditions who see out-of-network specialists. Justin Dynlacht, who has Crohn's disease, paid extra for a plan that covered such visits. After seeing two in-network doctors about persistent abdominal pain, he went to an outside specialist who discovered a hernia containing abdominal tissue.

Aetna sent the specialist's claims to MultiPlan, and Mr. Dynlacht was left with thousands of dollars in bills.

"I'm being ripped off," he said. "It's not right."



Justin Dynlacht paid more for a health plan that would cover out-of-network specialists. He was still hit with unexpectedly large bills after Aetna routed claims to MultiPlan. Amanda Andrade-Rhoades for The New York Times

Staying in-network can be especially difficult for mental health or substance abuse treatment.

A California woman whose teenage son was battling opioid addiction found only one treatment center that would accept him, and it was out of network. “When your kid has hit rock bottom, they’re dying, you get them in wherever you can,” she said, speaking on the condition that she not be named to protect her son’s privacy.


They had the most expensive health plan her employer offered, but her insurer, citing MultiPlan, left the family with tens of thousands of dollars in bills.

“I expected there would be some payment that wasn’t covered,” she said. “What I didn’t expect was the deceit that caused an even higher payment, an amount I never dreamed.”

Fact Check: An Explanation of Benefits

Insurers sometimes suggest that a medical provider agreed to a lower payment, even when it's not so. This patient was billed the amount that Cigna identified as savings.

You saved \$370.62. CIGNA negotiates discounts with health care professionals and facilities to help save you money.

 Full document: Read the PDF.

Some providers said they had begun requiring payment upfront or stopped accepting patients with certain insurance plans because appealing for higher payments can be time-consuming, infuriating and futile. Others have tried to sue insurers or MultiPlan. Dr. Rabinowitz, who repaired Ms. Lawson's incision, hopes to collect the remaining balance from UnitedHealthcare in an ongoing case.



Cari Campbell, with her son, Sam. After receiving fertility treatment, she was charged thousands of dollars that her insurer said she had “saved.” Jenn Ackerman for The New York Times

Surprise bills for some types of care are no longer an issue, insurers said, thanks to the law that went into effect in 2022. Brittany Perritt didn't realize the anesthesiologists at her 3-year-old's brain tumor treatments in 2020 were out-of-network until the claims went to MultiPlan. If that care occurred today, she likely would be spared the calls from debt collectors, because she didn't go out of network by choice.

But MultiPlan assured investors shortly before the law's passage that it was likely to have "limited impact" on the company. In fact, MultiPlan said, 90 percent of its revenue involved out-of-network claims that wouldn't be affected.

'Lining Their Pockets'

Debra Margraf, a trustee for a union health plan covering about 1,500 Phoenix-area electricians, was stunned when she and her colleagues asked Cigna what they had paid for "cost-containment" services.

The answer: The fees had risen from just over \$550,000 in 2016 to \$2.6 million in 2019, according to a lawsuit the trustees filed.

"It's very frustrating to go out and have someone pitch us that they're going to save us money and then end up lining their pockets," Ms. Margraf said.

Cigna did not respond to questions from The Times about specific employer plans.

Other employers have also questioned increased fees and complained about being kept in the dark. A UnitedHealthcare account executive emailed colleagues for help explaining the \$50,650 fee charged to New England Motor Freight. The fee grew out of a \$152,594 bill, of which just \$7,879 was covered.


The trucking company "thinks these are a money tree for us in fees and we are milking them," the account executive wrote.

One UnitedHealthcare executive suggested a partial refund and an annual cap on fees, but a colleague countered, "We have to be concerned about setting precedent."

Inside an Insurer's Debate About Fees

Internal emails show UnitedHealthcare employees grappling with complaints about high fees. When one executive suggested limiting the amount charged New England Motor Freight, a colleague resisted.

As a company we have been unwilling to enter into one-off agreements that cap our revenue, so we have to be very careful.

 Full document: Read the PDF.

The way the fees were calculated was particularly galling: How could MultiPlan and insurers tie their own fees to bills they deemed unreasonable? It made no sense, one consultant for the trucking company wrote, to charge a 35 percent fee “if a hospital were to bill \$20,000 for a flu shot.”

UnitedHealthcare did not respond to questions from The Times about the trucking company. In a statement, the insurer said it also offers fee arrangements not tied to billed amounts.

Cigna’s statement defended its fee, saying that “it enables us to administer the program, negotiate with providers and absorb the long-term risk associated with any challenging negotiation.”

Even verifying the accuracy of fees was difficult when UnitedHealthcare initially refused to provide the trucking company with the full underlying data. Cigna refused a similar request from auditors for Arlington County, Va., which it had charged \$261,000 in one year. “There is no process for verifying the accuracy of any of these amounts,” the auditors wrote.

Large employers also have trouble getting data from insurers, said James Gelfand, head of the ERISA Industry Committee, which represents big companies with employee benefit plans.

Cost-containment programs can be a “revenue center” for insurers, Mr. Gelfand said, but are “extremely difficult for employers to police.”

‘In a Lot of Pain’

Patients have limited recourse. If they want to sue, they usually must first complete an administrative appeals process; even then, they stand to collect relatively modest amounts.

Regulators are unlikely to step in. Self-funded employer plans are largely exempt from state oversight. And federal regulators have limited resources and legal authority to police them.

Even when patients figured out where to direct complaints — the Employee Benefits Security Administration — they described the process as draining and mostly fruitless.



Patti Sietz-Honig, who has chronic back pain, faced tens of thousands of dollars in bills after Aetna began sending her claims to MultiPlan. Erica Lee for The New York Times

Patti Sietz-Honig, a video editor at Fox 5 in New York, filed a complaint in 2022. The cost of seeing a specialist for chronic back pain had spiked, and she faced roughly \$60,000 in bills.

Ms. Sietz-Honig pressed for updates about her complaint and sent articles critical of MultiPlan from Capitol Forum, a site focused on antitrust and regulatory news. Last March, the agency emailed her that her employer and her insurer, Aetna, had agreed to a “temporary exception” and made additional payments.

“Unfortunately,” the agency wrote, the law “does not prohibit the use of third-party vendors” to calculate payments.

Meanwhile, her longtime pain specialist started requiring payment upfront. To save money, Ms. Sietz-Honig spaced out her appointments.

“I’ve been in a lot of pain lately,” she said, “so I’ve been going — and paying.”

‘Not a Real Negotiation’

As MultiPlan became deeply embedded with major insurers, it pitched new tools and techniques that yielded even higher fees, and in some instances told insurers what unnamed competitors were doing, documents and interviews show.

After meeting in 2019 with a MultiPlan executive, a UnitedHealthcare senior vice president wrote in an internal email that other insurers were using MultiPlan’s aggressive pricing options more broadly, and that UnitedHealthcare could catch up.

“Dale did not specifically name competitors but from what he did say we were able to glean who was who,” the executive, Lisa McDonnel, wrote, referring to Dale White, then an executive vice president at MultiPlan. She described how Cigna, Aetna and some Blue Cross Blue Shield plans were apparently using MultiPlan.

In recent years, MultiPlan’s top revenue generator has been an algorithm-based tool called Data iSight that consistently produces the lowest payment recommendations. Some insurers have used it as part of a strategy MultiPlan calls “target pricing” or “meet-or-beat”: Insurers set a maximum price they will pay, and MultiPlan collects a fee only if its recommendation is lower.

In theory, many of MultiPlan’s recommendations are negotiable. But documents and interviews revealed tactics meant to pressure medical practices to accept low payments. Some offers came with all-caps admonitions and deadlines just hours away. Accept and receive prompt payment; refuse and risk an even lower payout. Practices and billing specialists said this often wasn’t an empty threat.

“It’s not a real negotiation,” said Tammie Farkas, who handles billing for her husband’s small New York-area practice focused on repairing blood vessels in the brain.



Kelsey Toney specializes in behavioral therapy for children with autism. Her pay was cut dramatically for patients whose insurance used MultiPlan. Hadley Chittum for The New York Times

Insurers can set negotiation parameters for MultiPlan, including not negotiating at all, records and interviews show. Multiple providers and billing specialists said that in recent years they had increasingly been told their claims weren't eligible for negotiation.

“It wasn't this bad before,” said Tiffany Letosky, who oversees a small practice specializing in surgeries for endometriosis and gynecologic cancers.

Former MultiPlan negotiators said their bonuses had been linked to their success at reducing payments, incentivizing a hard-line approach.

Ms. Young, the former negotiator critical of the process, said she had occasionally called a provider from a cellphone — knowing that her work line was recorded — and advised against accepting her own offer.

Another former negotiator said the pressure to get bigger discounts had made her physically ill. “It was just a game,” she said. “It's sad.”

Jennifer Pittinger, also a former negotiator, said she saw nothing wrong with the hard-driving approach because she believed she was combating overbilling.

“I was a bit of a viper,” she said. “Sometimes I just wanted to go in as hard as I could because my bonus is affected. If I can get a provider to accept 50 percent off, that’s great for me.”

But tools rolled out to combat price-gouging hospitals and private-equity profiteers, The Times found, have also been directed at people like Ms. Toney, the therapist in rural Virginia who treats children with autism.

She charges the rates that Virginia pays for people on Medicaid. But last year, she said, Meritain Health, an Aetna subsidiary, informed her that fair payment for her services was less than half what Medicaid paid, based on calculations by MultiPlan.

Ms. Toney has not billed the parents of her two patients covered by Meritain, but going forward she will not accept patients with similar insurance.

“It puts me in a tough position,” she said. “Do I want to pay myself a salary or be able to help people?”

Julie Tate contributed research. Produced by Guilbert Gates and Rumsey Taylor.

Chris Hamby is an investigative reporter for The Times, based in Washington.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Patients Hit With Big Bills While Insurers Reap Fees

TIMES INSIDER

Taking Account of Rising Health Care Costs

Have your out-of-network insurance bills skyrocketed? Chris Hamby, an investigative reporter for The Times, may have an explanation.

By Josh Ocampo

April 18, 2024

Navigating the health care system in the United States can often feel like being lost in a maze. What kind of doctor should I see? Who takes my insurance? What even is a co-pay, anyway?

For that reason, Chris Hamby, an investigative reporter, has devoted much of his five-year career at The New York Times to guiding readers through such dizzying questions. His latest article, which was published online this month, explored the complex subject of insurance bills.

Last year, Mr. Hamby began investigating MultiPlan, a data firm that works with several major health insurance companies, including UnitedHealthcare, Cigna and Aetna. After a patient sees an out-of-network medical provider, the insurer often uses MultiPlan to recommend how much to reimburse the provider.

Mr. Hamby's investigation revealed that MultiPlan and the insurers are incentivized to reduce payments to providers; in doing so, they score larger fees, which are paid by the patient's employer. Many patients are forced to foot the rest of the bill. (MultiPlan said in a statement to The Times that it uses "well-recognized and widely accepted solutions" to promote "affordability, efficiency and fairness" by recommending a "reimbursement that is fair and that providers are willing to accept in lieu of billing plan members for the balance.")

In an interview, Mr. Hamby shared his experience poring over more than 50,000 pages of documents and interviewing more than 100 people. This conversation has been edited.

Where did your investigation begin?

We were broadly looking at issues in health insurance last year. MultiPlan kept coming up in my conversations with physician groups, doctors and patients. At first, it was unclear what exactly MultiPlan did. There were some lawsuits regarding its work with UnitedHealthcare, but it was difficult to understand the company's role in the industry. We eventually accumulated more information about MultiPlan's relationship with big insurance companies.

What were doctors and other providers saying?

Mostly that they'd seen their reimbursements dramatically cut in recent years and that it was becoming difficult for them to sustain their practices. They said they previously had more success negotiating and obtaining higher payments.

Of your findings, perhaps the most surprising is that MultiPlan receives a cut of the money it saves employers.

Yes, but I wouldn't call it a cut. It's very complicated. MultiPlan charges a fee based on the savings that they obtain for employers. But in some cases, that savings is passed onto a patient as a bill. Both insurers and MultiPlan have financial incentives to keep payments low because they receive more money, in many cases.

But it wasn't always that way, correct?

Right. MultiPlan was founded in 1980, and it was a fairly traditional out-of-network cost containment company. Doctors and hospitals agreed to modest discounts with MultiPlan, and agreed not to try and collect more money from patients. It was a balancing act.

But that balancing act changed over time. MultiPlan's founder sold the company to the Carlyle Group, a big private equity firm, in 2006. It moved away from negotiations and toward automated pricing. They bought one company in 2010, and

another, key company in 2011, and in doing so, acquired these algorithm-driven tools that became the backbone of MultiPlan's business.

You read more than 50,000 pages of documents for your investigation. How does one begin to sift through that much information?

I love a good trove of documents. There wasn't some big leak. It was more about piecing together information from many different sources — legal filings, documents that providers and patients shared with me, their communications with MultiPlan and insurers. We asked federal judges to unseal a few documents that had previously been confidential, including emails between Cigna executives, paperwork describing how some of MultiPlan's tools worked and data on thousands of medical claims.

What was the greatest challenge in your reporting?

Finding patients and providers who were willing to speak on the record about their experiences, because this is a really sensitive subject. A number of providers were concerned that if they spoke on the record, insurance companies would retaliate. For many of the patients I spoke with, it also meant putting their personal medical history out there for the public to read.

What about health care and the pharmaceutical industry drew your interest as a reporter?

For many Americans, health care is an almost universally frustrating or confusing experience. It's one that has direct effects on people's health, their pocketbooks or both. I really like learning about the stuff that impacts people's health. I try to make that information accessible to millions of people who are affected by it but who might not have a lot of time to understand it.

Nobody In The MultiPlan Lawsuit Is The Good Guy

[DAN MCCOY](#)

APR 27, 2026

A note before we start: This piece covers public reporting and active litigation. All allegations are unproven and may ultimately be rejected in court. MultiPlan, Claritev, and the named insurers deny wrongdoing. Nothing here is legal, financial, or medical advice.

https://youtu.be/H3TQUxJt2Xo?si=TWFQK1u5V3j_84tR

Last week, the Texas Medical Association joined a federal antitrust lawsuit against a company most patients have never heard of. The company is called MultiPlan — recently rebranded as Claritev, which is the kind of name you pick when you'd really like people searching for you to land on something new instead of the old headlines.

The story you're going to read this week is that a heroic group of doctors is finally fighting back against the insurance algorithm that allegedly underpaid them by something like \$19B. Doctors versus the machines. Underdogs versus a cartel.

That's a lovely story. It's also missing the part you should actually be furious about.

Whether you're a physician or a patient or — and this is the part nobody's writing about — a self-funded employer, there's a third character in this lawsuit that both sides would prefer you not look at too carefully. That character is sitting in the middle, taking 42 cents on every dollar.

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The setup

To understand what’s happening, you have to go back to a sleepy concept from the 1990s: UCR — usual, customary, and reasonable. UCR was the old way insurance paid out-of-network claims. Look up the median local price. Pay it. Move on.

Then a New York-based data company figured out that if you replaced “median local price” with “whatever our proprietary algorithm spits out,” you could pay much less. And if you charged a percentage of the gap between the original bill and the new payment, you could make a lot of money doing it.

By 2020, MultiPlan was processing more than 370,000 claims per day. Today the lawsuit alleges it touches about 80% of all commercial out-of-network claims in the United States.

This is the pattern that keeps repeating in healthcare: when nobody can agree what something should cost, a middleman sets up shop in the middle of the disagreement and starts charging tolls. Sometimes the toll is bigger than the original bill.

The surface story

In 2024, the American Medical Association sued MultiPlan and its insurance partners — UnitedHealth, Aetna, Cigna, Elevance, and Humana — in federal court. The cases were consolidated into MDL 3121. On April 6, the Texas Medical Association joined.

Their argument is what antitrust lawyers call a “hub-and-spoke conspiracy.” MultiPlan is the hub. The insurers are the spokes. Plaintiffs allege all of the

insurers feed pricing data into the same algorithm, and the algorithm spits out coordinated lowball recommendations that the insurers then accept. The AMA has called MultiPlan an “unlawful cartel.”

The theory got a major boost on March 27 when the U.S. Department of Justice filed a Statement of Interest, supporting key aspects of the plaintiffs’ legal framework. The DOJ said using a pricing algorithm to set benchmark prices can qualify as concerted action under Section 1 of the Sherman Act — the same theory it’s using against RealPage in the rental housing market.

The court has already denied MultiPlan’s motion to dismiss the federal antitrust counts. The first bellwether trial is scheduled for December 7, 2027.

It’s a clean story. The problem is, the moment you look at the actual fee math, the clean story falls apart.

The mechanics

A doctor sends an out-of-network bill for \$1,000. The insurer routes it to MultiPlan. MultiPlan’s algorithm — most often a tool called Data iSight — recommends paying the doctor \$200.

You’d think the math would stop there. It does not.

Of the \$800 difference between the original bill and the new lower payment — what the industry calls “savings” — MultiPlan allegedly takes about 7%. That’s \$56. The insurer charges the employer a fee of around 35% of the savings. That’s \$280. The employer keeps the remaining \$464. The doctor gets the \$200. The patient frequently gets a balance bill for some chunk of the difference, which they did not see coming.

Add it up. Of every \$800 in alleged “savings,” about 42 cents on the dollar gets eaten by middlemen. The thing being sold to the employer as a cost-control program is, by the math in the complaint, primarily a fee-generation program for the people running it.

UnitedHealth alone reportedly pulls in about \$1B a year from these arrangements. MultiPlan's repricing revenue allegedly went from \$23M in 2012 to over \$700M by 2021.

The smaller the doctor's payment, the larger the algorithm's fee, the larger the insurer's fee. Everyone in the middle is paid more when the doctor is paid less. According to the complaint, that's not a bug. That's the design.

What I don't buy about the doctor side

I don't buy the "poor underpaid physicians" framing — and if you're a benefits buyer or a CFO, you shouldn't either.

US doctors are the highest-paid in the world. The 2024 Medscape Compensation Report puts the average American physician at \$374K, specialists at \$404K, and procedural specialists like neurosurgery and orthopedics at \$600K and up. We pay our doctors roughly twice what Canada and the UK pay theirs.

Reasonable people can argue about whether that's deserved or insane. But when you hear "doctors are getting underpaid for out-of-network care," the first reaction shouldn't be sympathy. It should be: compared to what?

Here's where I land. The lawsuit isn't really about whether doctors deserve more money. It's about who captured the savings when an algorithm cut the bill.

The 2026 numbers are in. Small group health insurance premiums are going up about 11%. ACA marketplace premiums are going up around 18%. Some markets are seeing 21%. The Kaiser Family Foundation analysis of small group filings is clear: the main drivers are specialty drugs, hospital prices, administrative cost, and the expiration of enhanced ACA subsidies. Not physician office fees.

The MultiPlan algorithm has been suppressing out-of-network payments for over a decade. It did not prevent a single dollar of those premium increases. It just generated about \$1B a year in fees for UnitedHealth alone.

If the plaintiffs win and the repricing model collapses tomorrow, premiums are not going to spike. The savings the algorithm was generating were mostly being captured as fees by the insurer and the algorithm itself. Removing the suppression also removes the fee.

I'm about 75% confident in that read. The burden of proof is on whoever wants to argue that a system where 42% of "savings" disappears into middleman fees is the thing actually holding premiums down.

What this means if you're writing the check

If you're a self-funded employer or the CFO who signs the ASO agreement, here's the Monday-morning version.

Ask your TPA or carrier exactly how out-of-network claims get repriced. Specifically, ask whether they use **MultiPlan, Claritev, Data iSight, Viant, ProPricer, NCN, or MARS**. Get the answer in writing. If yes, ask what percentage of "savings" your plan is being charged as a fee.

Look at your plan's medical loss ratio for out-of-network claims separately from in-network. If a meaningful percentage of your spend is being routed into algorithm fees rather than care, that may be an ERISA fiduciary issue, not just an accounting one.

Read the percentage-of-savings clause in your administrative services agreement. It's the single most important paragraph nobody on your benefits team is reading. The clause exists because the carriers were betting you'd never look.

This is not a “wait for the lawsuit to settle” situation. The bellwether trial isn’t until December 2027. You have three years of fees to pay between now and then.

The bigger question

The framing of MultiPlan as doctors versus insurers is doing exactly what it’s supposed to do. It’s getting you to pick a team. Both teams would prefer you not notice the third character standing in the middle, calmly collecting a percentage of every dollar that doesn’t get paid.

Healthcare costs in this country aren’t really rising the way the headlines describe. They’re being redistributed. Out of doctors, into algorithms. Out of patients, into fees. Out of employers, into the gap between a bill and a payment that an algorithm decided was the right number.

The December 2027 trial isn’t going to be about whether doctors are overpaid or underpaid. It’s going to be about whether an algorithmic middleman, sitting between a buyer and a seller in a market it doesn’t actually participate in, can keep extracting tolls forever just because nobody can agree on the right price.

That question doesn’t just matter for healthcare. It’s the same question every industry is about to ask about every AI pricing tool that’s been quietly installed over the last five years. Healthcare is just where it’s getting answered first.

Resources & deeper reading

The fee math, fully attributed

Item	Amount	Who keeps it
Original bill	\$1,000	Doctor (billed)
Algorithm-recommended payment	\$200	Doctor (paid)
Difference labeled "savings"	\$800	Split below
MultiPlan / Claritev fee (~7% of savings)	\$56	Algorithm vendor
Insurer fee (~35% of savings)	\$280	Carrier
Net retained by employer plan	\$464	Self-funded employer
Middleman take of "savings"	~42%	MultiPlan + insurer combined

Source: AMA complaint, MDL 3121; New York Times investigation (Abelson & Hamby, April 2024); Capitol Forum reporting on MultiPlan marketing materials.

The Capitol Forum dossier

Capitol Forum reported in 2024 on a set of internal MultiPlan marketing materials shown to providers. The dossier walks through scenarios where MultiPlan's pricing methodology effectively encourages providers to *raise* their initial billed rates — because the algorithm's recommended payment is calculated as a function of the billed amount, and a higher billed amount can produce a higher final payment in some scenarios. MultiPlan has stated publicly that it “does not encourage providers to overcharge” and disputes that interpretation.

Whatever the right reading of the documents, the underlying dynamic the complaint describes is the same: every actor in the middle of the chain has a financial incentive tied to the *gap* between billed and paid amounts. The bigger the gap, the bigger the fee.

→ Capitol Forum: “Provider shows how MultiPlan incentivizes him to raise his billing rate”

Source list

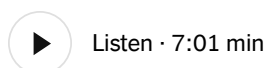
- TMA press release: <https://www.texmed.org/Template.aspx?id=67699>
- AMA on the litigation: <https://www.ama-assn.org/health-care-advocacy/judicial-advocacy/health-insurance-price-fixing-real-and-ama-fighting-it>
- DOJ Statement of Interest coverage: <https://www.jdsupra.com/legalnews/doj-adopts-aggressive-stance-against-4076897/>
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- Court-appointed counsel (Seeger Weiss) case
page: <https://www.seegerweiss.com/antitrust/multiplan-price-fixing-lawsuit/>
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Collusion in Health Care Pricing? Regulators Are Asked to Investigate

A data analytics firm has helped big health insurers cut payments to doctors, raising concerns about possible price fixing.



By Chris Hamby

Chris Hamby has been investigating the lucrative business of out-of-network medical claims.

May 1, 2024

Recent revelations about a data analytics firm's role in determining medical payments have heightened concerns about possible price fixing in health care and led to a call for a federal investigation.

In a letter this week, Senator Amy Klobuchar asked federal regulators to examine whether algorithms used by the firm, MultiPlan, have helped major health insurers conspire to cut payments to doctors and leave patients with large bills. She cited a New York Times investigation last month into MultiPlan's dominance of the lucrative business of pricing out-of-network medical claims.

“Algorithms should be used to make decisions more accurate, appropriate and efficient, not to allow competitors to collude to make health care more costly for patients,” Ms. Klobuchar wrote to the heads of the Justice Department's antitrust division and the Federal Trade Commission.

When patients see a medical provider outside their plan's network, insurers often send their claims to MultiPlan, which uses proprietary algorithms to recommend how much to pay. By driving down payments to providers, MultiPlan and the

insurers can collect higher fees for themselves, The Times reported, but this can lead to higher bills for patients, who may get charged the unpaid balance.

UnitedHealthcare, Cigna, Aetna and other major insurers use MultiPlan's pricing recommendations, and the firm has boasted to investors that it is "deeply embedded" in its clients' claims-processing systems.

In interviews, Ms. Klobuchar, a Democrat from Minnesota, and experts in antitrust law said this arrangement could amount to price fixing: Rather than competing to offer better coverage, insurers could use the low prices recommended by MultiPlan's algorithms, knowing their competitors would likely do the same.

"This should trigger an investigation by the agencies," said Barak Orbach, a law professor at the University of Arizona. "There seems to be a really strong case."

The F.T.C. and Justice Department declined to comment, but both agencies have raised concerns in the past about similar arrangements in other industries.



"Algorithms should be used to make decisions more accurate, appropriate and efficient, not to allow competitors to collude to make health care more costly for patients," Senator Amy Klobuchar wrote in a letter to antitrust regulators. Valerie Plesch for The New York Times

In a statement, MultiPlan did not address the price-fixing allegations, instead emphasizing its commitment “to helping make health care transparent, fair and affordable for all.” In legal filings, the firm has denied allegations of collusion and said that insurers are free to reject its pricing recommendations or negotiate higher payments with providers.

Insurers have said that MultiPlan’s tools help combat outrageous billing by some providers, including consolidated hospital systems and private-equity-backed staffing firms.

Documents reviewed by The Times indicate that MultiPlan has sometimes told insurers how their unnamed competitors were using the firm’s pricing tools. In a 2017 presentation to UnitedHealthcare, MultiPlan shared “Recent Client Strategies to Improve Results,” which included techniques that could reduce payments to providers.

After a 2019 meeting, a UnitedHealthcare senior vice president reported to her colleagues that a MultiPlan executive “did not specifically name competitors but from what he did say we were able to glean who was who.” She then described how Cigna, Aetna and some Blue Cross Blue Shield plans were apparently using the firm’s pricing tools.

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Three hospital systems have sued MultiPlan, accusing it of colluding with major insurers to set unreasonably low payments for medical care, and patients and providers have complained to the F.T.C. about MultiPlan, records obtained through a public records request show.

One provider reported slashed payments from UnitedHealthcare, Cigna and an Aetna subsidiary after the insurers routed claims to MultiPlan's most aggressive pricing tool. Another said the tool "has decimated my life" and caused "the closing of my business," which has "left patients having to travel 2.5 hrs for surgery."

Patients complained to the agency of receiving large bills after insurers used MultiPlan-recommended prices. "This is now affecting my credit score," wrote one patient, describing a bill that had been sent to a debt collector. Another reported being billed thousands of dollars "since they refuse to pay my providers the correct amount."

Pricing algorithms have driven MultiPlan's growth over the past 15 years. The firm previously focused on controlling costs by negotiating with medical providers, but after being sold to private equity investors, it embraced automated, algorithm-based tools, which typically yield lower payment recommendations.

Access to data from hundreds of clients has helped entrench the firm's dominance, executives have told investors. "We build our algorithms on a much larger data lake," one executive said in a 2020 presentation.

The focus on MultiPlan's automated pricing tools highlights growing concern among regulators and some in Congress that algorithms are supercharging price-fixing schemes and driving up costs for consumers.

During the Biden administration, companies' increasing embrace of technological advancements has collided with aggressive enforcement efforts by regulators. The results have been mixed, as the agencies seek to apply laws enacted to combat 19th-century oil and railroad robber barons to 21st-century technology firms.

"Algorithms are the new frontier," the Justice Department wrote in a brief in one case. "And, given the amount of information an algorithm can access and digest, this new frontier poses an even greater anticompetitive threat than the last."

Regulators and some antitrust scholars worry that algorithms can enable sophisticated collusion that is difficult to police. Competitors no longer need to meet in secret to hatch a conspiracy and communicate among themselves to

perpetuate it. They can simply agree to use a common pricing algorithm.

Weighing in on private lawsuits involving apartment rents and hotel room prices, the agencies have argued that such an arrangement is illegal, even if competitors agree with a wink and a nod rather than a formal pact.

But in one case, a judge disagreed in a December ruling, allowing the lawsuit to go forward but requiring renters to offer more explicit evidence that landlords had conspired to raise prices using an algorithm.

Ms. Klobuchar has introduced legislation that would effectively make the agencies' position the default. Courts would presume it illegal for competitors to share nonpublic data with a middleman and use the pricing recommendations that the firm's algorithms produced.

"It is not clear whether current antitrust laws are sufficient to stop this practice," Ms. Klobuchar said in an interview. "It is much better just to clarify this and to close the loophole."

The bill would also require companies to tell consumers if they are buying something that was priced using an algorithm, and it would give regulators greater authority to demand details about how an algorithm works.

Chris Hamby is an investigative reporter for The Times, based in Washington.

A version of this article appears in print on , Section B, Page 4 of the New York edition with the headline: Senator Seeks Inquiry Into Health Care Pricing System

Senators See Possible Conflicts of Interest in Health Care Pricing Tools

A data analytics firm that helps insurers collect big fees while leaving some patients with unpaid bills has been summoned to explain its business model.



Listen · 6:35 min



By Chris Hamby

Chris Hamby has been investigating the lucrative business of out-of-network medical claims.

May 28, 2024

The chairmen of two Senate committees overseeing health policy, concerned about companies “padding their own profits” at the expense of patients, are looking into the practices of a data analytics firm that works with big insurers to cut payments to medical providers.

The firm, MultiPlan, recommends what it says are fair payments for medical care, but the firm and the insurers can collect higher fees when payouts are lower. This business model could “result in an improper conflict of interest,” the chairmen of the two committees, Ron Wyden of Oregon and Bernie Sanders of Vermont, wrote in a letter to the firm’s chief executive that was released on Tuesday.

The senators called on MultiPlan to meet with the committees’ staffs to discuss an investigation last month by The New York Times that found the firm’s pricing tools could leave patients with unexpectedly large bills when they see doctors outside their health plans’ networks.

“Our committees are engaged in ongoing legislative work to put a stop to practices by plan service providers that drive up health care costs for consumers while padding their own profits,” the letter to Travis Dalton, the MultiPlan chief executive, said.

In a statement, MultiPlan said it was working with the Senate committees “to address their questions and explain the cost and complexity patients can face” when choosing high-priced care outside their networks. “We are committed to helping make health care transparent, fair and affordable for all,” the statement said.

The committees’ inquiry reflects growing scrutiny of the New York-based firm, which has largely remained out of the limelight even as it has staked out a dominant position in a lucrative corner of health care.

Another senator, Amy Klobuchar of Minnesota, this month asked federal antitrust regulators to investigate whether insurers and MultiPlan were colluding to fix prices, and multiple health systems have sued the firm, accusing it of similar anticompetitive behavior.

Separately, the Department of Labor said Tuesday that it had “a number of open investigations” into the type of pricing services MultiPlan provides, but declined to name specific companies. The agency, the primary regulator of employer-based health insurance, stressed in a statement that companies were legally obligated to ensure the firms processing medical claims acted in their employees’ best interest.

The letter from Mr. Wyden, a Democrat, and Mr. Sanders, an independent, also steps up attention on employer-based health insurance, which is the most common way Americans get coverage and a major component of MultiPlan’s business.

As health care costs climb, some employers are looking more closely at what they pay insurance companies to administer their plans, but they are often frustrated by contracts that limit access to their own claims data. To address this, a bipartisan group of senators, including Mr. Sanders, introduced legislation in December that would require insurers to turn over this data.

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“Most businesses do their best to manage the ever-increasing cost of their group health plan, but it should be easier,” Senator Mike Braun, an Indiana Republican and cosponsor of the bill, said in a statement.

A majority of employers choose to pay medical claims with their own money and use an insurer to administer their plans. This setup, known as “self-funding,” can be lucrative for insurers like UnitedHealthcare, Cigna and Aetna, as well as specialized firms like MultiPlan.

The insurers pitch MultiPlan’s tools as a way to save employers money when their employees see a medical provider outside the plan’s network. The bills for these out-of-network providers are subject to negotiation, and insurers often send the claims to MultiPlan, which recommends an amount to pay.

Both MultiPlan and insurers typically collect a fee from the employer based on the size of what they call the “savings” — the provider’s list price minus the recommended payment. Lower payouts can mean bigger fees. Meanwhile, patients can be stuck with the unpaid balance, The Times investigation found.

Companies are legally obligated to ensure the insurers act in employees’ best interest, and a closely watched lawsuit filed last year could force them to become more active monitors.

A worker at Johnson & Johnson sued the company, saying it had failed to adequately oversee the administrator of its drug benefits plan. By paying too much — in one instance, \$10,000 for a drug that was available for as little as \$28.40 — the company had allowed the administrator, the Cigna subsidiary Express Scripts, to profit at employees’ expense, the suit claimed.

In a statement, Johnson & Johnson called the claims “meritless” and said, “We are committed to our employees and seek to provide the best coverage.”

A small industry of consultants, lawyers and data analysts has arisen to help companies step up monitoring and negotiate better deals with the insurers administering their plans.

Kraft Heinz last year sued Aetna, claiming the insurer improperly paid claims and kept millions in undisclosed fees. Trustees for a union health plan in Massachusetts sued Blue Cross Blue Shield of Massachusetts in 2021, accusing the insurer of repeatedly overpaying claims and then charging a fee to correct the errors. And in January the Department of Labor sued Blue Cross and Blue Shield of Minnesota, claiming the company forced multiple employers to pay medical providers’ tax bills without disclosing the charges.

(Aetna declined to comment on the case but said it worked with employers “to facilitate access to quality, affordable and convenient health care.” Blue Cross and Blue Shield of Minnesota said the government’s allegations were “without merit” and “based on unsupported interpretations” of the law. A court dismissed the Massachusetts case.)

The success of the employers’ efforts sometimes hinges on an unsettled legal question: Does a company’s duty to act solely in its employees’ best interest extend to insurers and firms like MultiPlan? Courts have reached different conclusions.

MultiPlan has argued that the answer is no, and in March a federal judge in California agreed, dismissing the company from a lawsuit filed by medical providers. The case against the insurer, Cigna, was allowed to go forward.

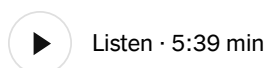
In pitches to investors, MultiPlan has highlighted its murky legal obligations. Because the firm doesn’t provide insurance or pay claims, it noted in a public filing, “we generally are not directly regulated and face significantly lower levels of regulatory complexity.”

Chris Hamby is an investigative reporter for The Times, based in Washington.

A version of this article appears in print on , Section A, Page 15 of the New York edition with the headline: Senators See Possible Conflict of Interest In Company's Health Care Pricing Tools

Congress Asks Regulators About ‘Troubling’ Health Insurance Tactics

Lawmakers are zeroing in on MultiPlan, a firm that has helped insurers cut payments while sometimes leaving patients with large bills.



By Chris Hamby

Chris Hamby has been investigating the lucrative business of out-of-network medical claims.

Aug. 21, 2024

Lawmakers on Tuesday called on health insurance regulators to detail their efforts against “troubling practices” that have raised costs for patients and employers.

In a letter to a top Labor Department official, two congressmen cited a New York Times investigation of MultiPlan, a data firm that works with insurance companies to recommend payments for medical care.

The firm and the insurers can collect higher fees when payments to medical providers are lower, but patients can be stuck with large bills, the investigation found. At the same time, employers can be charged high fees — in some cases paying insurers and MultiPlan more for processing a claim than the doctor gets for treating the patient.

The lawmakers, Representatives Bobby Scott of Virginia and Mark DeSaulnier of California, both Democrats in leadership positions on a House committee overseeing employer-based insurance, highlighted MultiPlan as an example of “opaque fee structures and alleged self-dealing” that drive up health care costs. In their letter, they pressed the department for details on its efforts to enforce rules meant to promote transparency and expose conflicts of interest.

MultiPlan’s business model focuses on the most common way Americans get health coverage: through an employer that “self-funds,” meaning it pays medical claims with its own money and uses an insurance company to process claims. Insurers such as Aetna, Cigna and UnitedHealthcare have pitched MultiPlan’s services as a way to save money when an employee sees a provider out of network.

In many cases, MultiPlan uses an algorithm-based tool to generate a recommended payment. Employers typically pay insurers and MultiPlan a percentage of what they call the “savings” — the difference between the recommendation and the original bill.

While this arrangement is usually disclosed in contracts, the fees have surprised some employers. In one case, UnitedHealthcare used MultiPlan to cut a \$152,594 hospital bill to \$7,879 and then charged the employer a \$50,650 fee for doing so.

In a statement, MultiPlan said: “The New York Times has repeatedly misinformed the public about how MultiPlan works. MultiPlan’s services do not raise patients’ overall health care costs, they lower them — including by minimizing or eliminating balance bills for tens of millions of patients — and to state or imply the contrary is false and misleading.”

In their letter, Mr. Scott and Mr. DeSaulnier noted growing concerns that some firms are profiting at the expense of employers and patients. For example, Kraft Heinz last year sued Aetna, claiming the insurer had paid claims improperly and kept millions in undisclosed fees. Trustees for a union health plan sued Blue Cross Blue Shield of Massachusetts in 2021, accusing it of repeatedly overpaying claims and then charging a fee to correct the errors. (Aetna declined to comment on the case, and the Massachusetts lawsuit was dismissed.)

Companies that operate health plans for their employees are legally required to monitor service providers and ensure their fees are reasonable. But employers sometimes have trouble obtaining and understanding the data showing what they’ve been charged and why.

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In 2020, Congress required service providers to disclose potential financial conflicts of interest, but it is unclear whether the rules apply to companies like MultiPlan.

The lawmakers' letter asked how the Labor Department was enforcing disclosure requirements and whether it would issue rules clarifying them. Mr. Scott and Mr. DeSaulnier have previously pushed the department to more aggressively police health plans, while acknowledging its limited resources. It said it has one investigator for every 8,800 plans.

The department previously told The Times that it had “a number of open investigations” into the type of pricing services MultiPlan provides, but declined to name specific companies. It did not respond to requests for comment about the representatives' letter.

Members of two Senate committees overseeing health policy have also expressed concern that MultiPlan's business model could “result in an improper conflict of interest.” In a May letter, they demanded information from the firm, and a spokesman for the chairman of one of the committees, Senator Ron Wyden, Democrat of Oregon, said last week that he “is committed to identifying and addressing the root cause of these tactics.”

Separately, Senator Amy Klobuchar, Democrat of Minnesota, in April asked the top federal antitrust regulators to investigate whether MultiPlan had colluded with insurers to fix prices.

In addition to the scrutiny from Congress, MultiPlan has faced more than two dozen lawsuits from medical providers accusing it of conspiring with insurers to suppress payments. A federal panel recently consolidated the cases into a single

large proceeding, similar to those against companies accused of driving up rents and fueling the opioid crisis. A judge in California this month dismissed a similar case against MultiPlan filed in state court by a health system.

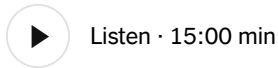
MultiPlan's stock price has been battered, and it disclosed quarterly revenues this month that its chief executive, Travis Dalton, called "disappointing and unacceptable." Mr. Dalton acknowledged during a call with investors that "media scrutiny has been an ongoing challenge," but said that the firm had "established a corporate and government affairs team, inclusive of world-class public relations and lobbying representation."

Chris Hamby is an investigative reporter for The Times, based in Washington.

A version of this article appears in print on , Section B, Page 4 of the New York edition with the headline: Congress Pushes Regulators on Health Insurance Tactics

How Taxpayers Are Helping Health Insurers Make Even Bigger Profits

Local governments often face extra fees when employees get out-of-network medical care, but some don't track the insurance charges or even know about them.



By Chris Hamby

Chris Hamby has been investigating a lucrative and obscure corporate partnership that can increase health care costs for patients and fees for employers.

Oct. 28, 2024

Health insurers have made an enticing pitch to local governments across the country: When your workers see doctors outside your health plan's network, costs can balloon, but we offer a program to protect against outrageous bills.

Cities, counties and school districts have signed up, hoping to control the costs of their medical benefits.

Then come the fees.

In Shelby County, Tenn., the insurer's charges for administering the program climbed last year to \$1.3 million — more than the county budgeted this year for long-term disability insurance for all of its roughly 6,000 employees.

In Hoboken, N.J., the charges sometimes exceeded the amount paid to doctors for providing treatment. And in a stretch of California's Central Valley where two counties share a health plan, the fees unexpectedly quintupled in one year to more

than a quarter-million dollars, contributing to a plan deficit.



MultiPlan, a data analytics firm, helps insurers reduce payments to doctors, then keeps a portion of the savings for itself. José A. Alvarado Jr. for The New York Times

From southern Florida to the Pacific Northwest, local governments have paid similar fees, often with little awareness that their taxpayer dollars have become a lucrative revenue stream for some of the nation's largest insurers, according to a review of documents obtained in two dozen public records requests and interviews with city and county officials and benefits consultants.

“We don’t like it,” said Hollis Magill, a human resources official for the Central Valley counties’ plan, “but there’s not much we can do.”

Behind the fees is a little-known partnership between major insurers — including UnitedHealthcare, Cigna, Aetna and Elevance Health — and a data analytics firm called MultiPlan.

An investigation by The New York Times in April found that together the insurers and MultiPlan cut payments to medical providers, then take a share of the purported savings for themselves, sometimes leaving patients with larger-than-expected bills to make up the difference.

Most contracts between insurers and private employers are confidential, coming to light only when there is litigation. But cities, counties and school districts have to open their books to the public. The Times identified two dozen government entities through publicly available documents, offering a window into a broader trend affecting public-sector employers struggling to provide affordable medical coverage.



In one health plan for public employees in California, Anthem (part of Elevance Health) increased its fees fivefold in just a year. Michael Conroy/Associated Press

The fees, the review found, are a volatile expense for stewards of the public purse that can complicate even the best laid spending plans. “With a set budget, any increase in the cost of health insurance has to be taken from something else,” said Heather Britton, who oversees the health plan covering city and county employees in Denver.

In some instances, the fees are costlier than the medical treatment itself. The records show that Hoboken paid an obstetrician gynecologist \$292.88, less than half the \$629.14 the city paid in fees to the UnitedHealthcare subsidiary UMR to handle the claims. Kitsap County, Wash., paid Aetna roughly \$7,000 for handling a \$16,000 bill that the insurer reduced to \$2,000.

In statements, UnitedHealthcare, Cigna and Aetna defended their cost-containment programs and said they helped protect local governments and their workers from big bills. Elevance declined to comment.


Low Payments, High Fees

Like their private-sector counterparts, many cities and counties have tried to control costs with an arrangement known as self-funding: They pay their workers’ medical bills from their own budgets and hire an insurer to run the plan. When workers see doctors in the plan’s network, most charges have been negotiated in advance; when they go out of network, the bills can vary widely.

In recent years, big insurers have found ways to profit from this arrangement by supplementing their standard charges with add-on fees. UnitedHealthcare acknowledged that it had come to depend on the “significant revenue” generated by fees from its out-of-network program, which totaled \$1.1 billion a year, according to an internal document recently made public by an Oklahoma judge after requests from The Times. And the insurer sketched out plans to goose this income stream, even as it worried about the bad “optics” of the fees.

In a 2018 presentation, UnitedHealthcare noted the substantial fees it collected each year for its out-of-network savings programs.

delivers significant revenue (\$1.1B)

 Full document: Read the PDF

When a patient sees an out-of-network medical provider, the insurer often sends the claim to MultiPlan, a New York-based analytics firm that recommends what it determines is a fair payment. The difference between the original bill and the amount ultimately paid is what the insurer says it saved the employer. The insurer and MultiPlan each collect a percentage of that savings as a fee. Lower payments mean greater savings, which can yield higher fees — a particular sore point for critics of the arrangement.

“This is just direct revenue for the insurance company,” said Ms. Britton of Denver.

Insurers and MultiPlan insist they are beating back rampant overbilling by some doctors and other providers, a well-known problem in health care. In a statement, a MultiPlan spokesperson said the company “plays an important role in our health care system by helping lower out-of-pocket costs, reducing or eliminating balance bills for millions of patients and helping generate millions of dollars in health care cost savings.”

The insurers also say employers knowingly choose the programs and find them valuable. “The fact that we retain over 95 percent of our government clients every year is a testament to the value we deliver,” a Cigna spokesperson said. But interviews with government officials suggest that the value is not always evident.

While a few of the respondents to The Times’s records requests characterized the fees as minor, more expressed frustration at how they were calculated and suspected that insurers were charging too much.

A third of the respondents said they had no documentation of the fees and acknowledged that they didn't know what they were paying. Several declined to be interviewed or answer further questions.



Cigna's fees for administering a plan for Shelby County, Tenn., climbed to more than \$1 million a year. Joe Buglewicz/Bloomberg

Ms. Magill, who is the director of human resources for Fresno County, Calif., and helps manage the county's joint plan with neighboring Tulare County, discovered how the cost-containment program can play out. After learning of the fivefold spike in fees in 2022, she pressed for an explanation from the counties' insurer, Anthem, an Elevance subsidiary.

In part because of an increase in employees seeking substance abuse treatment from out-of-network providers, she was told, the counties had racked up \$1.3 million in out-of-network medical bills.

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Anthem had sent the claims to MultiPlan and ultimately decided that fair payment was \$287,667.30, less than a quarter of the billed amount. The insurer then charged the counties nearly that much in so-called savings fees: \$259,089.74.

“What they’re trying to say is, ‘Look how much it saved you,’ but that’s really not a savings,” Ms. Magill said. She noted that out-of-network providers often set high list prices that they know are rarely paid in full.

Little Choice but to Pay

The cost of providing health coverage for workers continues to accelerate, and such costs represent an even larger share of total compensation for state and local governments, which often pay less but offer richer benefits than the private sector.

When insurers pay medical claims for companies without self-funded plans, they charge premiums that can include a hefty profit. When they administer self-funded plans, the insurers usually receive a lower base payment but often add fees for related services, such as recouping overpaid claims or using a prescription-benefits administrator other than the insurer’s preferred company.

Monitoring these costs — even identifying them in contracts that often exceed 100 pages — can be onerous.


The public records reviewed by The Times came from urban centers with health plans covering more than 10,000 employees and family members, and more rural areas with closer to 1,000 enrollees. Their boards and commissions had reviewed and approved the contracts during public meetings that had agendas crowded with a range of issues, including reappointing notaries, renovating fairgrounds and funding travel for the court clerk.

Some governments chose newer versions of cost-containment programs, which insurers said would save them even more money in part by using algorithms that typically yield even lower payment recommendations.

UMR, for example, has offered one such program that it pitched as its “lead solution,” records from local government meetings show. It was part of the company’s strategy to “force clients to move to more aggressive programs” that usually result in lower payments to providers, and potentially higher fees for employers and larger bills for patients, according to the internal company documents recently made public in Oklahoma.

In a 2020 presentation, UMR outlined plans to push employers to potentially more lucrative cost-savings offerings.

Phase 2: Strategy for 2021 is force clients to move to more aggressive programs

 Full document: [Read the PDF](#)

Insurers told The Times they made a point of offering employers multiple options.

“We offer these products in response to our self-insured customers’ requests to help them manage rising health care costs,” a UnitedHealthcare spokesperson said in a statement.

An Aetna spokesperson said the company offers employers “various options and strategies to help lower costs and minimize balance billing.”

But information from insurers about the fees ranged widely. Some governments received detailed entries for each medical claim, while others got monthly charges that fluctuated wildly with little explanation. Shelby County, for example, had to pay Cigna \$60,000 in fees one month and \$127,000 the next.

In its statement, Cigna said it was proud of its work with Shelby County, adding that “it would be misleading” to focus on the \$1.3 million in fees without mentioning what it considered to be a \$4 million savings in payments to providers.

Still others said they received no fee data at all from their insurers. A spokeswoman for Roanoke County in Virginia said officials didn't know what they had been charged, adding, "We do, however, utilize a professional vendor that vets our fees, and we would be made aware if there were any issues." The vendor, USI Insurance Services, declined to comment.

A spokeswoman for the Sunnyside Unified School District near Tucson, Ariz., said it "has not paid any fees" for its cost-savings program "that we are aware of." After The Times pointed out that the district's insurer, UMR, had projected charging about \$34,000 a year in fees when it pitched the program in 2020, the spokeswoman stopped responding to requests for comment.

A few local officials said their employees rarely saw out-of-network doctors so they had not encountered problems with big fees. "We've not had to ask our employees for a premium increase in years," said Nathan Cahall, acting city manager of Middletown, Ohio.



Middletown, Ohio, was one of a few localities that said they hadn't had to deal with big fees because their employees seldom went out of network. Madeleine Hordinski for The New York Times

More common, however, was a mix of wariness and grudging acceptance: human resources managers doing their best to monitor their insurers, worried that they were missing something. Several pushed their insurers for more information after receiving the records requests and additional inquiries from The Times.

“I don't like it morally, conceptually,” said one benefits manager for a small Midwestern town who feared that speaking publicly would sour the town's relationship with the insurer. She said that a broker hired to help manage the town's plan had told her the cost-containment program was “not something you can opt out of.”

Avoiding the fees is indeed difficult, consultants and lawyers who advise employers said. While some government entities “have no idea what's going on,” said Julie Selesnick, a lawyer, others “are becoming aware of these fees.” But in most cases,

she said, they have little choice but to pay.

UMR advised Columbia Public Schools in Missouri that if the district chose not to use its cost-containment program, the insurer would increase its overall base rate. Internal UnitedHealthcare emails made public in a legal dispute over fees with a private trucking company in New Jersey showed a similar calculation. If the company opted out of the cost-savings programs, an executive wrote, “We would increase their admin fees for the lost fee revenue.”

A Push for Transparency

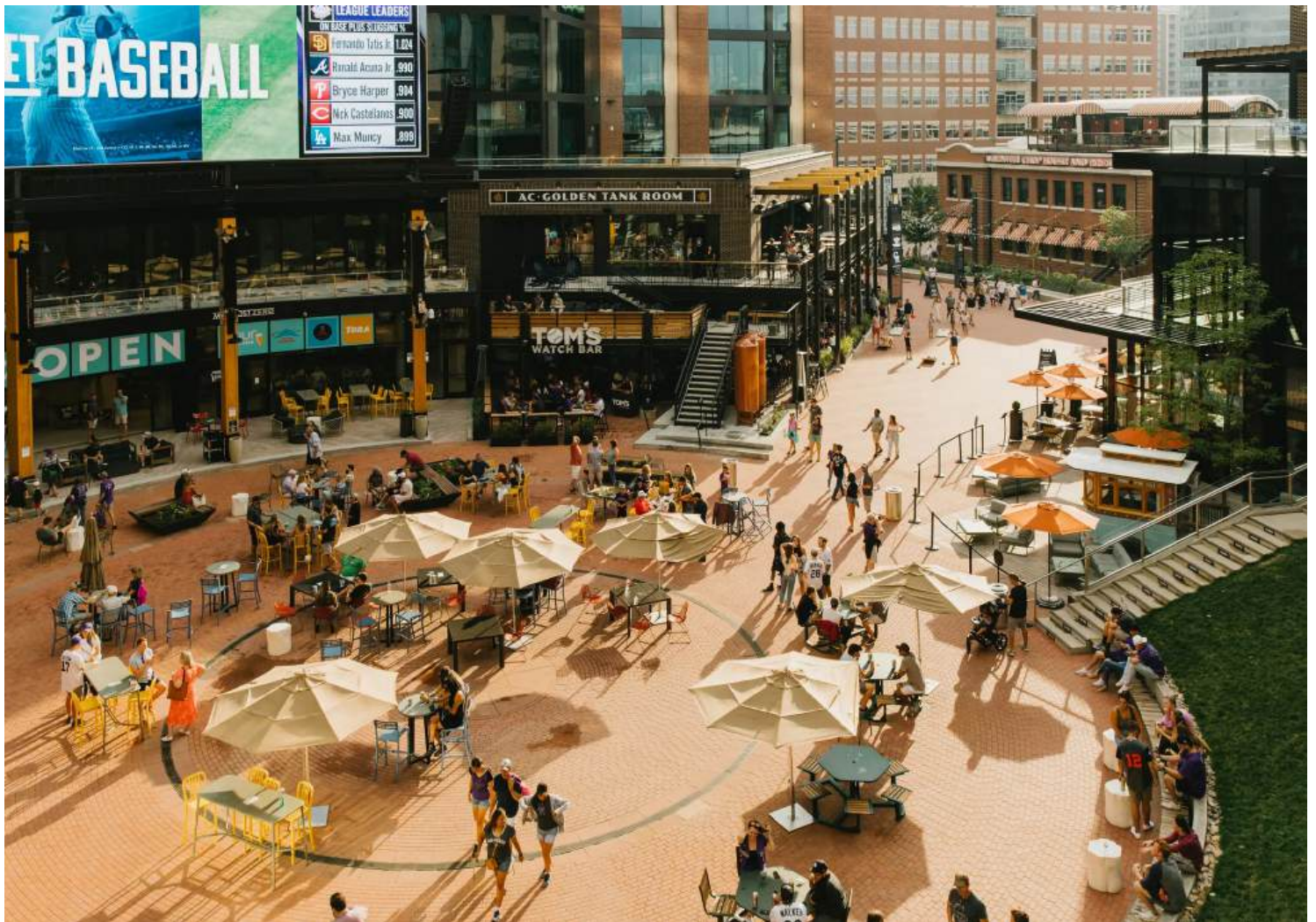
Some local governments have been able to install guardrails. Through a broker, Denver got UnitedHealthcare to limit its fees. Michael Faughnan, a senior vice president for the broker, Lockton, said he began negotiating fee caps for clients a few years ago after identifying large charges buried among their medical claims payments.

Other consultants and data analysts who work with employers also said they had found out-of-network fees interspersed with records of payments to medical providers, obscuring that the money was going to insurers and MultiPlan and not toward employees’ care.

“I’m sure many employers are out there paying this and not even aware that they’re paying it,” Mr. Faughnan said.

The push for more information about the fees reflects growing concerns about insurer transparency. A few employers have sued their insurers, accusing them of improperly paying claims and concealing excessive fees. And in two instances, workers have sued employers, alleging that the companies’ lax oversight allowed their pharmacy benefit managers to fleece the plans.

Legislation enacted in 2020 required that employers have greater access to their workers’ claims data, and a bill introduced last year by a bipartisan group of senators would strengthen those requirements.



Denver got UnitedHealthcare to cap its fees on the health plan covering city and county employees. James Stukenberg for The New York Times

MultiPlan is also under scrutiny. Lawmakers on the House committee overseeing employer-based insurance wrote to the Labor Department to express concern about the firm's practices, and the department has previously said that it had "a number of open investigations" into the type of pricing services MultiPlan provides. Senators have also pressed MultiPlan for information, raising concerns that the firm's business model could present a conflict of interest.

At the same time, Senator Amy Klobuchar has asked top antitrust regulators to investigate whether MultiPlan colluded with insurers to drive down payments to providers and leave patients with big bills. And the American Medical Association and dozens of providers have made similar accusations in lawsuits that were recently consolidated into a single case akin to those brought against companies

accused of improperly hiking rents or peddling dangerous products. The firm is also under financial pressure because of a missed revenue target and a plunging stock price.

The MultiPlan spokesperson said that the lawsuits were “without merit” and that without its services, costs would increase for patients and employers.

Despite all of this, some local government officials said, it is not any easier to negotiate better terms with insurers.

“It just feels like it’s Whac-a-Mole — there’s one more revenue stream that the insurance company wants and they create,” said Ms. Britton, the Denver benefits manager. “And so, OK, what else is out there that we’re missing?”

Julie Tate and Emily Cochrane contributed reporting.

Chris Hamby is an investigative reporter for The Times, based in Washington.



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What if the reason payers are so upset about what's happening under the No Surprises Act isn't simply because of fraud or abuse...but because a very large revenue stream was disrupted?

To be clear: I am not suggesting that providers are faultless in the IDR process. There are legitimate concerns about volume, eligibility disputes, and behavior at the margins. Those issues deserve scrutiny.

But before the NSA, out-of-network (OON) claims for self-funded employers were not just a cost management challenge, they were a massive revenue opportunity for carriers and TPAs.

Historically, carriers and their contracted repricing vendors (including third-party platforms such as [Claritev](#) (formerly Multiplan) typically:

- Repriced OON claims using billed charges as the reference point
- Calculated "savings" as the difference between the provider's submitted charge and the adjusted payment amount
 - Structured shared-savings compensation arrangements frequently ranging from 29%–50% of those calculated reductions
 - Generated additional revenue through OON negotiation, repricing, and recovery services

In the case TML vs. Cigna, the percentage of time the carrier or its vendor was paid more than the provider exceeds 79%. In that case, there was a claim where the plan paid over \$4M for a claims... where the provider kept less than \$900k and Cigna and Multiplan kept over \$3M in "savings fees."

That is not a typo.

In other words, in a substantial portion of OON disputes, the administrative and recovery layers captured more value than the provider ultimately received.

Enter the NSA. Instead of discretionary repricing and negotiated "savings," disputes can now flow into IDR. When an arbitrator awards an amount above the plan's initial payment, those additional dollars go to the provider.

Not to the carrier.

Not to a shared savings vendor.

Not into a recovery services fee.

So.... dollars that previously flowed through carrier-controlled OON recovery structures are now flowing through the statutory IDR process... could this be the cause of their angst?

Maybe this isn't a net new cost to the system.

It is just redistribution of margin.

Again, this does not absolve providers of responsibility.

But, when payment reform disrupts a revenue stream as sweet as the OON recovery services structure, where 29–50% shared savings fees were common and carriers frequently captured more than the provider in OON scenarios, strong reactions should not surprise anyone.

[Preston Alexander](#)[Doug Aldeen](#)[Shawn Gremminger](#)[Randa Deaton](#)[Peter Hayes](#)[Kevin Lyons](#)[Jon Corey](#)[Steve Buffone](#) [J.D., Legal and Business Advisor](#) [Asha George](#)[Julia Posacki](#)[Julie Selesnick](#)[Justin Leader](#)[Dave Chase is Relocalizing Health](#) [Karen Simonton](#)[Karen van Caulil, Ph.D.](#)[Marsha Simon](#) [Drew Morgan](#) [Jonathan Levitt](#)[Christine Castell](#)[Jeffrey Hogan](#)



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Steve Duncan · 3rd+

Senior Vice President Stop Loss Sales at Xchange Benefits, LLC

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Vincent Flores · 2nd
President Co Founder of AVYM Corporation, Vice President Co Founder of YF Corporation

(edited)4d

It is great to finally see some putting the dots together. What most miss about IDR is TPA's argue both sides. Here's simple example: When TPA's withdraw monies from self funded employer health plans its alleged they INCREASE billed charges and insist its fair reasonable/contract/QPA rates. When its time for TPA's to pay from excessive amounts withdrawn they argue fair reasonable/contract rates (QPA) are substantially lower than withdrawn amounts/billed charges, (allegedly keeping spread/difference) which is NOT disclosed or investigated. Could this be why TPA's fail to validate QPA or small initial payment? One can argue this may be another clue revealing the alleged bad actions by TPA's that self funded employer health plans, treating physicians/entities, patients and others do not understand or deny. Most egregious is when TPA's refuse to pay IDR decisions. A question to ask: are self funded employer health plans receiving money back from TPA's that don't pay IDR decisions or are they keeping FULL amounts withdrawn?

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Shawn Gremminger · 2nd
President and CEO at the National Alliance of Healthcare Purchaser Coalitions

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Very interesting perspective. We hate the broken IDR process because we are paying wildly inflated prices to private equity backed physician practices that are intentionally creating surprise medical billing situations. And because there is at least transparency in how often IDR goes against us (80+% of the time) and what the resulting prices are (several/many x the in-network rate) we can see the harm clearly.

The bullshit the carriers / Claritev were pulling was much more opaque and sold to employers as to our benefit (a complete lie) so we (employers, researchers, policymakers) paid less attention to it.

Would he interesting to model the relative impacts of both to see scale of impact on self-funded plans.
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Dave Chase is Relocalizing Health · 2nd

Cracking the health cost code | Author, Relocalizing Health | Creator of community-owned health plans | RosettaFest 2025: Transforming healthcare's waste into community prosperity

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At [The OrthoForum](#), [Patient Rights Advocate](#)'s Cynthia Fisher shared the details of the TML Recovery v Cigna case. She shared an additional tidbit that I'd never heard. [Chris Deacon](#) - can you confirm what I think I heard? Since the case was an inpatient psych case (for addiction), many families do cash pay so PRA called to find the cash pay rate for a similar stay. I think Cynthia said the cash pay rate was under \$90,000.

That would make an already bonkers example even more bonkers. Net net, the employer paid \$4 million for what should have cost under \$90,000 (a 4,300% markup).

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Reply1 reply1 Comment on Dave Chase is Relocalizing Health's comment



Jason Bearup · 2nd

Founder & Lead Advisor, Nexus Benefit Solutions | Building a Home for Sharp Benefits Advisors & Growing Employers

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[Dave Chase is Relocalizing Health](#) just bananasjust bananas

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Craig Herndon · 2nd

Vice President of National TPA Sales | Fiduciary TPA Leader | Helping Employers Build Transparent, Value-Driven Health Plans

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Fraud and gaming in IDR deserve attention. But it's also fair to acknowledge that the NSA changed where certain dollars flow. When a structure that historically generated significant shared-savings fees gets disrupted, reactions are going to be strong.

Whether that is “new cost” or simply margin moving from one pocket to another is a legitimate question. Reform rarely just changes policy. It reshapes incentives.

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jeff leston · 2nd
President and Founder, Castlestone

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we're fighting an 'out of network' claim right now for lab services. Services delivered in network, billed from an out-of-state office. They are trying to tell us that's an out-of-network claim.

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Amy Gasbarro · 2nd
Seasoned Executive Driving Strategic Growth & Innovation | Transforming Vision into Results | Industry Leader in Group Health and Cost Containment | Payment Integrity | Mentor | Board Member

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Very true. This is a major issue that goes well beyond Claritev. Employers are lead to believe they have a 'strong' OON/cost containment strategy in place when in reality, they're often getting hosed. I'm hopeful cases like this will continue to encourage employers to ask more questions and quite simply, do the math.

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Matt Lavin · 2nd
Partner | Gilbert LLP | Healthcare Litigation, Complex Commercial Litigation

(edited)1d

I had some involvement in TML and I've also conducted discovery in other cases into the lobbying (by these same amici) that pushed through the NSA. The payors wrote that bill. It's karma how it's come back to bite them.