Senators See Possible Conflict of Interest In Company’s Health Care Pricing Tools

**By Cris Hamby**

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](https://static01.nyt.com/newsgraphics/documenttools/38600d8e40ceb1da/2978fd6e-full.pdf) that was released on Tuesday.

The senators called on MultiPlan to meet with the committees’ staffs to discuss an [investigation](https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html) 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](https://www.nytimes.com/2024/05/01/us/multiplan-health-insurance-price-fixing.html) 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](https://www.congress.gov/bill/118th-congress/senate-bill/3548/text#id41df72f25c354f9cbba20e4060fcc44c).

“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](https://www.statnews.com/pharmalot/2024/02/05/johnson-johnson-pbm-consultant-employer-erisa-drug-prices-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.”