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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.

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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.

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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.

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delivers significant revenue ($1.1B)
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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.

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.

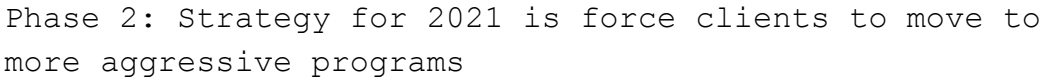
Monitoring these costs — even identifying them in contracts that often exceed 100 pages — can be onerous.

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.



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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. More about Chris Hamby