United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

May 22, 2024

Travis Dalton
President and Chief Executive Officer
MultiPlan
115 Fifth Avenue
New York, NY 10003

Mr. Dalton,

As you are aware, a recent *New York Times* investigation exposed the practice of self-insured employer-sponsored group health plans routing negotiations for out-of-network payments through your company and its Data iSight product. While this practice is advertised as a way to constrain health care costs, recent reporting reveals that this practice often dramatically reduces plan payments for out-of-network services and leaves patients with sky-high medical bills that they are on the hook for paying.

The U.S. Senate Finance Committee and HELP Committee together have broad jurisdiction over U.S. health policy, including employer-sponsored group health plans and the Employee Retirement Income Security Act (ERISA). 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. We are concerned that your company's Data iSight product improperly drives up patient health care costs and, further, that the financial incentives built into the fee for the use of the Data iSight product result in an improper conflict of interest between determining a plan's liability for out-of-network claims and the plan's duty to provide promised benefits pursuant to ERISA.

When a patient sees an out-of-network provider, the fees paid to that provider by the group health plan are up for negotiation. According to recent reporting, your company's business model is to work as a go-between, negotiating what rates are paid to providers as promised under the group health plan and taking as a fee a specified percentage of any savings to the health insurer. In the early 2000s, it appears your company negotiated with health care providers to reach these rates, but now through the Data iSight product, appears to use an opaque process to set recommended payments for out-of-network services. Because your company is paid more when it reaches lower payment amounts, the payments to health care providers are often far lower than the billed amount, with some describing these amounts as "crazy low." When the plan is only willing to pay this low amount, patients are on the hook for the remaining bill, which in extreme cases can total hundreds of thousands of dollars.

We are interested in better understanding these practices and the role they play in the U.S. health insurance market. To that end, we request you brief the Finance Committee and HELP

Committee staff on the allegations contained in the April 7th *New York Times* investigation no later than June 5, 2024. We request that the briefing also include a description of whether your company disclaims ERISA fiduciary status as part of its service contracts for the use of its Data iSight product, whether your company believes that any ERISA prohibited transaction class exemption applies to fees it receives with respect to its Data iSight product, and whether your company has ever applied for and been granted a prohibited transaction exemption from the Department of Labor with respect to fees it receives with respect to its Data iSight product.

Sincerely,

Ron Wyden
United States Senator

Bernard Sanders
United States Senator