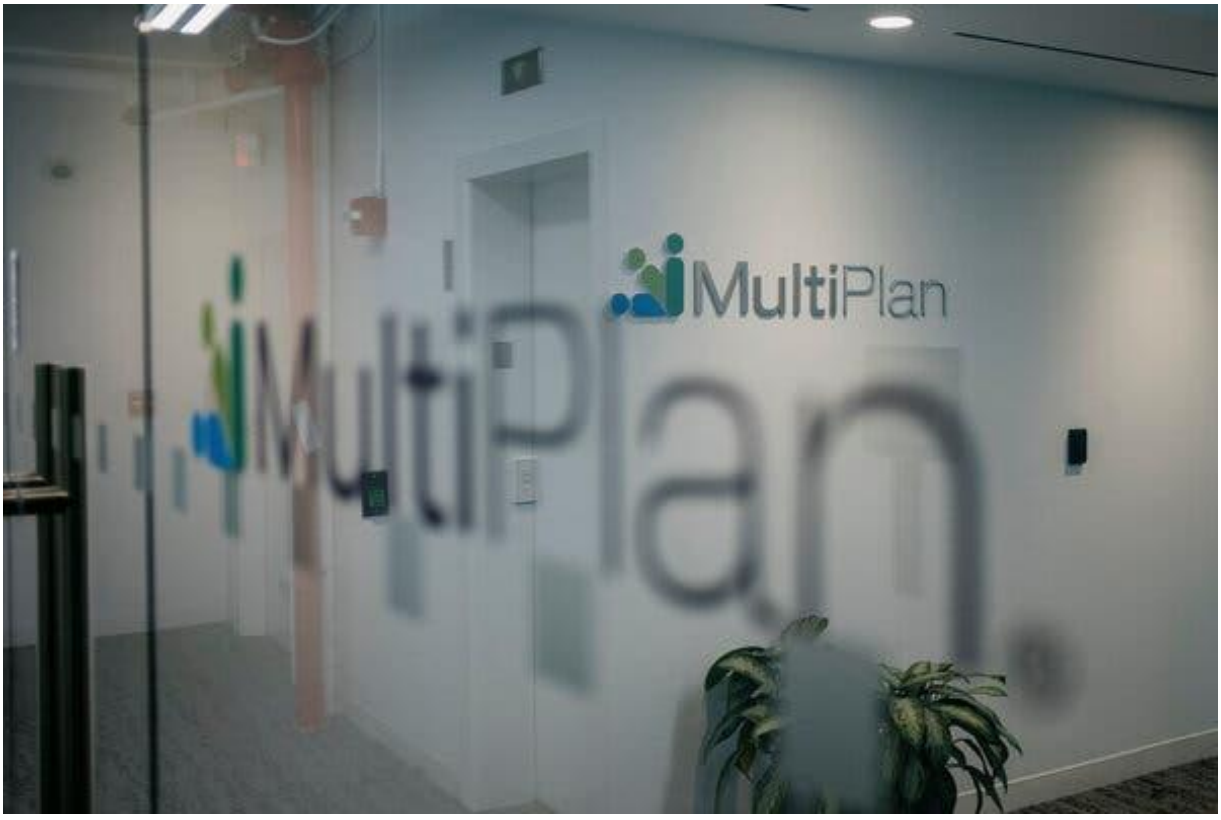
Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill.

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.



MultiPlan has pursued more aggressive "cost-containment" approaches since it was first sold to private equity investors.Credit...José A. Alvarado Jr. for The New York Times

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.

April 7, 2024, 3:00 a.m. ET

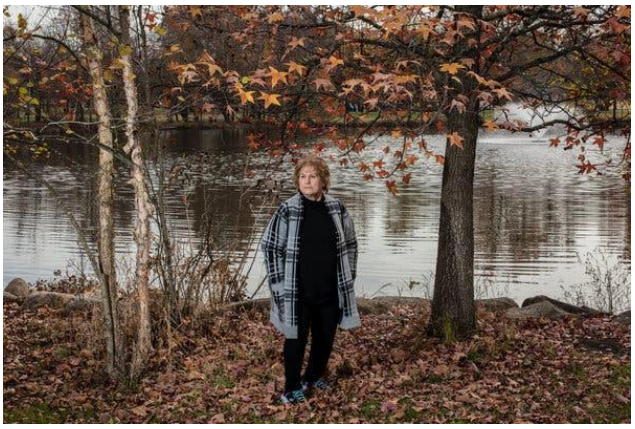
Weeks after undergoing heart surgery, Gail Lawson found herself back in an operating room. Her incision wasn't healing, and an infection was spreading.

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. Credit...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.

Health Insurers' Lucrative, Little-Known Alliance: 5 Takeaways
April 7, 2024

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 employer's 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.

A lower payment means bigger fees for the insurer and MultiPlan, but also a bigger potential bill for the patient. Fee percentages vary based on negotiated contracts.

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.

Health Care in the United States

- **Glasses Improve Income:** A study found that when farsighted workers in Bangladesh were given free reading glasses, they earned 33 percent more than those who had not.
- **Hospital vs. Insurer:** After months of stalled contract negotiations, Mount Sinai Health System, a leading New York City hospital system, and the health insurance giant UnitedHealthcare announced a deal that will keep Mount Sinai’s hospitals and doctors in network.

- **Long-Term Investors:** As health care systems increasingly see a link between stable housing and better health, some are becoming partners and investors in affordable housing projects.
- **A Paralyzing Cyberattack:** Medical care providers, including large hospital networks and small clinics, faced a severe cash squeeze after hackers paralyzed the biggest billing and payment system in the United States. Here's what to know about health care cyberattacks.

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

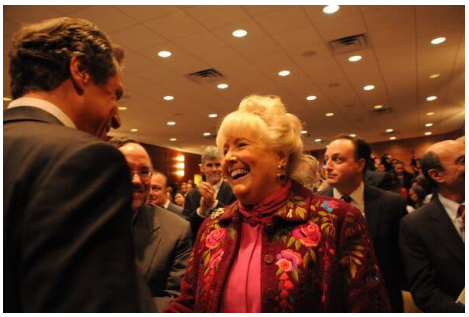
In 2009, a woman from Yonkers, N.Y., became a symbol of patients' outrage and the promise of change.

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. Credit...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. Credit...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."

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.

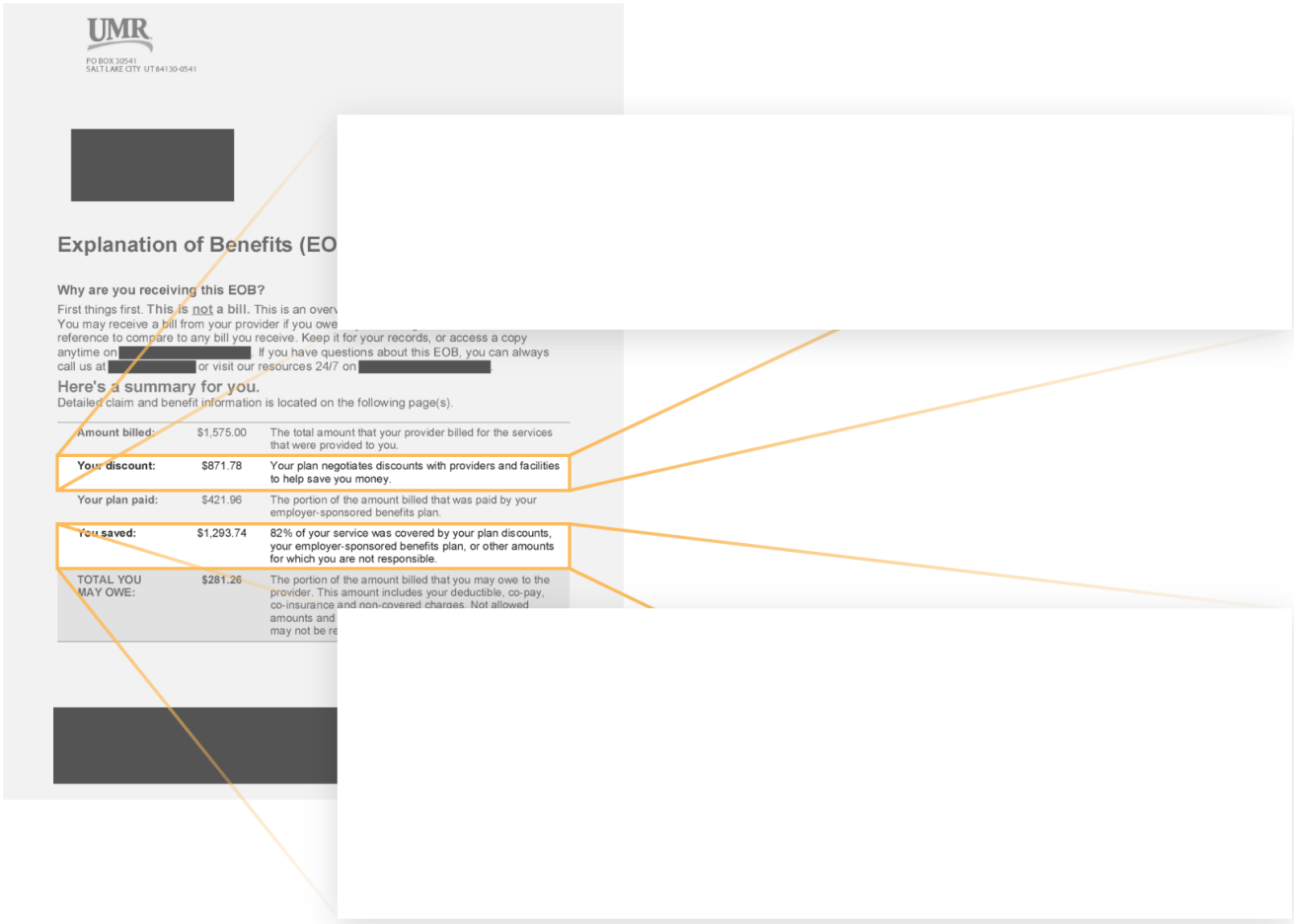
Cari Campbell, who received fertility treatment in Minnesota, was charged thousands of dollars that her insurer had labeled "you saved." In Kansas City, Kan., Paul Haddix paid the amounts labeled "your discount" for his daughter's occupational and speech therapy. In New Jersey, Jonathan Menjivar paid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

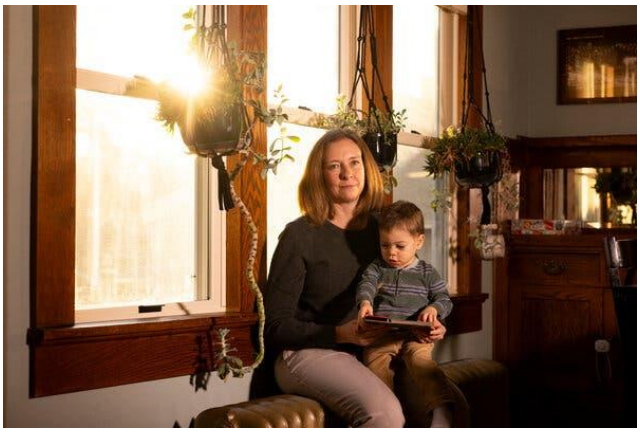
“I expected there would be some payment that wasn’t covered,” she said. “What I didn’t expect was the deceit that caused an even higher payment, an amount I never dreamed.”

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.`

Source: 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.” Credit...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.

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

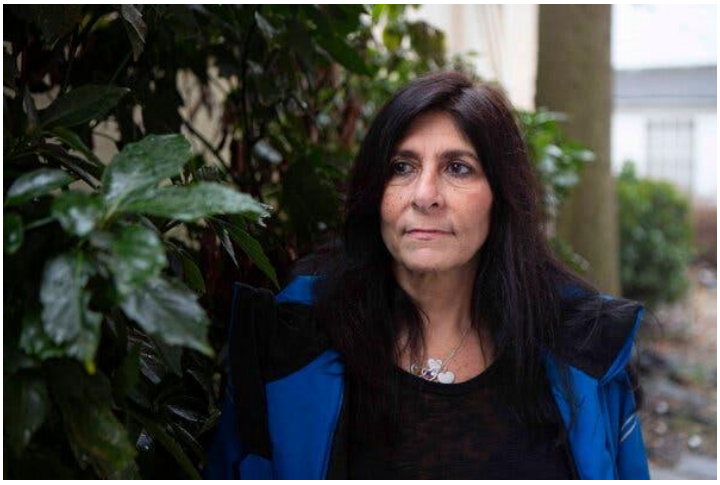
Cost-containment programs can be a "revenue center" for insurers, Mr. Gelfand said, but are "extremely difficult for employers to police."

'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. Credit...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.

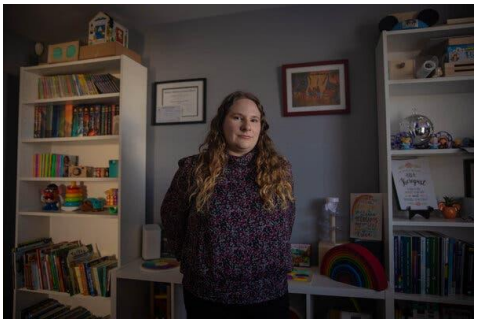
After meeting in 2019 with a MultiPlan executive, a UnitedHealthcare senior vice president wrote in an internal email that other insurers were using MultiPlan's aggressive pricing options more broadly, and that UnitedHealthcare could catch up.

"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 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. Credit...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. More about Chris Hamby

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