UNITED WE FALL? THE CHANGE HEALTHCARE CYBERATTACK AND THE DANGER OF A TOO-BIG-TO-FAIL HEALTH INSURER

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"Disaster to great business enterprises can never have its effects limited to the men at the top. It spreads throughout, and while it is bad for everybody, it is worst for those farthest down."[1]

President Theodore Roosevelt

INTRODUCTION

On February 21, 2024, Change Healthcare (Change)—described as a "billing and payment colossus"—was the target of an incapacitating cyberattack.[2] The hackers were part of a criminal collective known as BlackCat, purportedly based in Russia.[3] The group was able to access a portal not protected by basic multifactor authentication.[4] Change, a subsidiary of UnitedHealth Group (UHG), reportedly handles one-third of all patient records in the United States,[5] or roughly fifteen billion health care financial transactions a year.[6]

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[1]President Theodore Roosevelt, First Annual Message (Dec. 3, 1901), *in* AM. PRESIDENCY PROJECT, https://www.presidency.ucsb.edu/documents/first-annual-message-16.

[2]Reed Abelson & Margot Sanger-Katz, *4 Things You Need to Know About Health Care Cyberattacks*, N.Y. TIMES (Apr. 9, 2024), https://www.nytimes.com/2024/03/29/health/cyber-attack-unitedhealth-hospital-patients.html?searchResultPosition=1.

[3]Jenna McLaughlin, *Change Healthcare's Cyberattack Casts a Light into How Cybercriminal Groups Work*, NPR (Mar. 13, 2024, 5:55 PM), https://www.npr.org/2024/03/13/1238410246/change-healthcares-cyberattack-casts-a-light-into-how-cybercriminal-groups-work.

[4]Daniel Gilbert & Dan Diamond, *UnitedHealth CEO Faces Grilling from Congress Over Change Healthcare Hack*, WASH. POST (May 1, 2024, 6:30 PM), https://www.washingtonpost.com/business/2024/05/01/united-health-hack-ceo-congress-change-healthcare/.

[5]*See id.*

[6]*See* Reed Abelson & Julie Creswell, *Cyberattack Paralyzes the Largest U.S. Health Care Payment System*, N.Y. TIMES (Mar. 7, 2024), https://www.nytimes.com/2024/03/05/health/cyberattack-healthcare-cash.html.

Even weeks after the attack, which prevented health care providers from billing and some health insurance enrollees from filling prescriptions, UHG had provided no timeline as to its resolution,[7] though it reportedly paid a $22 million ransom in cryptocurrency to the hackers on March 1.[8] A "Temporary Funding Assistance Program" announced by UHG to assist cash-strapped providers was described by Richard Pollack, the head of the American Hospital Association, as "not even a band-aid on the payment problems" created by the cyberattack, characterizing its terms as "shockingly onerous."[9]

Ironically, the financial distress for one Oregon medical practice even facilitated state agency approval of its sale to UHG, despite the objection of consumer advocates and a locally elected official:

> Benton County Commissioner Xan Augerot asked the agency to deny [the sale], suggesting UnitedHealth was seeking to take advantage of a situation it had created.
>
> "Is it appropriate to grant emergency access to this acquisition to a predatory, vertically integrated company that has just ensured it will get access to Corvallis Clinic at a fire sale price?" Augerot wrote.[10]

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[7] *Id*.

[8] Andy Greenberg, *Hackers Behind the Change Healthcare Ransomware Attack Just Received a $22 Million Payment*, WIRED (Mar. 4, 2024, 12:41 PM), https://www.wired.com/story/alphv-change-healthcare-ransomware-payment/.

[9] Letter from Richard J. Pollack, President & CEO, Am. Hosp. Ass'n, to Dirk McMahon, President & COO, UnitedHealthGroup (Mar. 4, 2024), https://www.aha.org/system/files/media/file/2024/03/Letter-AHA-Expresses-Concerns-with-UHG-Program-in-Response-to-Cyberattack-on-Change-Healthcare..pdf.

[10] Amelia Templeton, *Update: Oregon Approves Controversial Corvallis Clinic, Optum Merger*, OR PUB. BROADCASTING (Mar. 14, 2024, 6:23 PM), https://www.opb.org/article/2024/03/13/corvallis-clinic-optum-merger-oregon-health-care/. "A longtime affordable health proponent in Benton County said he worries the buyout will shift control of local health care services from owners who live in Corvallis to a faraway private equity giant in the middle of a nationwide grab." Alex Powers & Shayla Escudero, *UnitedHealth Subsidiary Will Buy Out Doctor-Owned Corvallis Clinic*, CORVALLIS GAZ.-TIMES (Mar. 21, 2024), https://gazettetimes.com/news/local/business/health-care/unitedhealth-buys-out-corvallis-clinic-physicians/article_b338490f-a8b5-556b-97a7-8b8b9b94360c.html.

Prior to that acquisition, UHG reportedly was the parent company of "2,642 separate companies that collectively raked in $371.6 billion last year[.]"[11]

Indeed, it was UHG's acquisition of Change that showed not even the federal government could reign in UHG, as its efforts to block that acquisition were rejected by a federal judge.[12] As was true with financial institutions deemed "too-big-to-fail" during the 2007-08 financial crisis, UHG's enormous scale raises moral hazard concerns—the theory that entities "protected from the negative consequences of their risky actions will be tempted to take more risks."[13]

This Article examines the implications of the outsized footprint UHG, a company worth more than the biggest U.S. financial institutions,[14] has upon our health care system. Part I explores the company's dominance in offering private Medicare insurance, which has involved allegations of impropriety in billing and care denials. Part II focuses on the federal judge's shortsighted decision to approve the Change Healthcare acquisition and addresses the repercussions of the Change cyberattack. The Article concludes by asking whether the disaster unleashed by the cyberattack will awaken policymakers to the need to better regulate UHG.

I. GOBBLING A SAFETY NET: UHG AND MEDICARE ADVANTAGE

The Tax Equity and Fiscal Responsibility Act of 1982[15] set privatized Medicare in motion by allowing Medicare to enter contracts with health maintenance organizations to cover beneficiaries.[16] The Balanced Budget Act of 1997 further expanded the privatization of this critical safety net for seniors.[17] It created what were called Medicare + Choice or Part C plans

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[11]Maureen Tkacik, *UnitedHealth Exploits an 'Emergency' It Created*, AM. PROSPECT (Mar. 10, 2024), https://prospect.org/health/2024-03-10-unitedhealth-exploits-emergency-change-ransomware-oregon/#xd_co_f=YzhiNmEwOTEtNTIyZC00NzVkLWE4ZTctYjU0MTY3NGIyMzgz~.

[12]*See* United States v. UnitedHealth Grp., 630 F. Supp. 3d 118, 155 (D.C. 2022).

[13]Steven L. Schwarcz, *Too Big to Fool: Moral Hazard, Bailouts, and Corporate Responsibility,* 102 MINN. L. REV. 761 (2017).

[14]*See* Charlotte Morabito, *How UnitedHealth Group Grew Bigger Than the Nation's Biggest Banks*, CNBC (May 22, 2023, 11:30 AM), https://www.cnbc.com/2023/05/20/how-unitedhealth-group-grew-bigger-than-the-nations-biggest-banks.html. At the time of the article, based upon market valuation, it was reported that "not only is UnitedHealth the biggest health-care conglomerate in the United States based on market cap and revenue, it's even bigger than JPMorgan Chase, the nation's largest bank." *Id*.

[15]Pub. L. No. 97-248, 95 Stat. 975 (1982).

[16]*See id.* at §114.

[17]Pub. L. No. 105-33, 111 Stat. 251 (1997).

offered through private insurers, with the initial objective, as described by the Congressional Budget Office, that payments would be less than fee-for-service (FFS) Medicare.[18]

Insurers benefitted further when the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[19] rebranded Part C as "Medicare Advantage" (MA) programs. This change garnered crucial public support from AARP to "give private health insurance companies a huge new role in Medicare."[20] AARP and the Republican supporters of the legislation overcame the argument by Senator Edward M. Kennedy (D-MA) that "Congress would provide lavish subsidies to private health plans, giving them an unfair advantage in competition with the traditional government-run Medicare program."[21] Additionally, the Bush Administration concealed the actual cost of the new law from lawmakers, ultimately further assisting in the Act's passage.[22]

Four years later, the *New York Times* reported that "UnitedHealth already ha[d] 1.3 million Medicare Advantage customers and [wa]s pushing for many more as it market[ed] those policies in a partnership with AARP."[23]

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[18]*See, e.g.*, Sandi Christensen, Medicare + Choice Provisions in the Balanced Budget Act of 1997*,* CONG. BUDGET OFF. (Nov. 12, 1997), https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/1997_11_12_choice.pdf.

[19]Pub. L. No 108-173, 117 Stat. 2066 (2003).

[20]Robert Pear & Robin Toner, *Medicare Plan Covering Drugs Backed by AARP*, N.Y. TIMES (Nov. 18, 2003), https://www.nytimes.com/2003/11/18/us/medicare-plan-covering-drugs-backed-by-aarp.html.

[21]*Id.*

[22]*See* Amy Goldstein, *Foster: White House Had Role in Withholding Medicare Data*, WASH. POST (Mar. 19, 2004), https://www.washingtonpost.com/archive/politics/2004/03/19/foster-white-house-had-role-in-withholding-medicare-data/af6d062c-4d4b-43f8-902f-72332abf7610/; Robert Pear, *Bush's Aides Put Higher Price Tag on Medicare Law*, N.Y. TIMES (Jan. 30,-2004),-https://www.nytimes.com/2004/01/30/us/bush-s-aides-put-higher-price-tag-on-medicare-law.html.

[23]Milt Freudenheim, *Two Insurers Increase Bet on Medicare,* N.Y. TIMES (Dec. 5, 2007), https://www.nytimes.com/2007/12/05/business/05insurance.html?searchResultPosition=6. The line between consumer advocacy and insurance peddling had been quickly blurred by AARP. *See* Robert Pear, *AARP Says It Will Become Major Medicare Insurer While Remaining a Consumer Lobby,* N.Y. TIMES (Apr. 17, 2007), https://www.nytimes.com/2007/04/17/health/17insure.html?searchResultPosition=3. AARP has not been forthcoming about its revenue from this partnership, and it is not the only arrangement AARP has in the Medicare field that raises conflict-of-interest concerns:

> AARP, the giant organization for older Americans, agreed to promote a burgeoning chain of medical clinics called Oak Street Health, which has opened more than 100 primary care outlets in nearly two dozen states.

By 2012, UHG was the dominant insurer in thirty-eight of the one hundred counties in the U.S. with the highest number of Medicare beneficiaries, while Blue Cross affiliated insurers were a distant second—dominant in only thirteen of the one hundred counties.[24]

Such plans did not save Medicare money, as a 2008 study from the Commonwealth Fund estimated MA plans were 12% more expensive than care paid for directly by the federal government by FFS Medicare with an average extra payment of $986 a year.[25] Though the Commonwealth Fund noted that the expanded "role of private plans in Medicare" was ostensibly intended "to reduce growth in Medicare spending," it found that "[e]xtra payments to MA plans between 2004 and 2008 will total nearly $33 billion."[26]

Yet this was but the tip of the iceberg to come. To quote an opinion from the U.S. Ninth Circuit Court of Appeals: "Unfortunately, human nature being what it is, Medicare Advantage organizations also have some incentive to improperly inflate their enrollees' capitation rates, if these organizations fall prey to greed."[27] In citing a federal report, the court noted that "audits have revealed excess payments for unsupported diagnoses steadily increasing over the last decade, reaching an estimated $16.2 *billion*—nearly ten cents of every dollar paid to Medicare Advantage organizations—in 2016 alone."[28]

You would not have known of this bounty based upon the insurance industry's messaging that year. As the *Washington Post* editorialized: "MEAN OLD Washington is out to get granny again—or at least that's the impression created by ad campaigns on TV and the Internet, in which seniors warn, in heart-rending terms, of impending 'cuts' to the Medicare Advantage

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> The deal gave Oak Street exclusive rights to use the trusted AARP brand in its marketing — for which the company pays AARP an undisclosed fee.

Fred Schulte, *AARP's Billion-Dollar Bounty*, KAISER HEALTH NEWS (June 6, 2022), https://kffhealthnews.org/news/article/aarp-health-marketing-partnerships-medicare-medigap/.

[24]*See* Brian Biles, Giselle Casillas, & Stuart Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?*, COMMONWEALTH FUND (Aug. 25, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/competition-medicare-private-plans-does-it-exist.

[25]Press Release, Commonwealth Fund, Extra Payments to Medicare Advantage Plans to Total $8.5 Billion (Sept. 4, 2008), https://www.commonwealthfund.org/press-release/2008/extra-payments-medicare-advantage-plans-total-85-billion.

[26]*Id.*

[27]United States *ex rel.* Silingo v. WellPoint, Inc., 904 F.3d 667, 672 (2018).

[28]*Id.* at 673 (citation omitted).

program."[29] Yet, as the *Post* noted:

> [the federal government] subsidizes these plans partly based on how many chronic conditions their clientele has; the sicker the population, the bigger the subsidy. This gives insurers an incentive to diagnose more conditions but not necessarily to treat them; in recent years, some companies have deliberately driven up the "risk profile" of their clients, increasing costs to taxpayers with debatable health benefits, if any, for patients.[30]

Few have played the game better than UHG. Among other MA insurers identified in a government report as having overbilled Medicare using "questionable billing practices" in 2017, UHG "stood out from the rest — a company that covered 22% of all beneficiaries enrolled in the health plans at the time, yet received a disproportionately high $3.7 billion, or 40% of the total payments based on these methods."[31]

That year, Benjamin Poehling, a former finance director for UHG, was reported to have asserted that "[f]inance directors like him monitored projects that UnitedHealth had designed to make patients look sicker than they were, by scouring patients' health records electronically and finding ways to goose the diagnosis codes."[32] According to his allegations, "[t]he sicker the patient, the more UnitedHealth was paid by Medicare Advantage — and the bigger the bonuses people earned, including Mr. Poehling."[33]

The U.S. Department of Justice joined Poehling's whistle-blower lawsuit against UHG, alleging $3 billion in improper payments "from 2010 to 2015 alone, according to the complaint."[34]

The case went before Judge Michael Fitzgerald of the U.S. District Court for

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[29]Editorial, *The Annual Medicare Advantage Dance Avoids the Bigger Issues of Entitlements*, WASH. POST (Mar. 20, 2016, 7:04 PM), https://www.washingtonpost.com/opinions/medicare-advantage-dance/2016/03/20/874e00ae-ec7f-11e5-a6f3-21ccdbc5f74e_story.html.

[30]*Id.* (hyperlinks omitted).

[31]Christopher Snowbeck, *Report Says UnitedHealth Group Was Top Recipient of Questionable Medicare Payments*, STAR TRIB. (Oct. 19, 2021, 6:06 PM), https://www.startribune.com/report-says-unitedhealth-group-was-top-recipient-of-questionable-medicare-payments/600108138/?refresh=true.

[32]Mary Williams Walsh, *A Whistle-Blower Tells of Health Insurers Bilking Medicare*, N.Y TIMES (May 15, 2017), https://www.nytimes.com/2017/05/15/business/dealbook/a-whistle-blower-tells-of-health-insurers-bilking-medicare.html?searchResultPosition=1.

[33]*Id.*

[34]Mary Williams Walsh, *UnitedHealth Overbilled Medicare by Billions, U.S. Says in Suit*, N.Y. TIMES (May 19, 2017), https://www.nytimes.com/2017/05/19/business/dealbook/unitedhealth-sued-medicare-overbilling.html.

the Central District of California, where the federal government alleged that UHG had "known that many provider-reported diagnosis codes were not supported by the beneficiaries' medical records."[35] The government alleged that UHG knew its duty was to delete invalid and codes conduct "Chart Reviews that 'looked both ways' to identify both additional codes to submit and codes to delete."[36] Instead, UHG allegedly "conducted 'one-way' Chart Reviews, ignored unsupported codes . . . and retained risk adjustment payments to which they were not entitled."[37] Further, the government alleged UHG knowingly submitted false "annual Risk Adjustment Attestations to the Medicare Program."[38]

UHG responded that the government failed to "specifically allege anywhere that CMS' risk adjustment payments to Defendants would have changed if CMS knew Defendants' ***Attestations*** were false."[39] While the government had described "how the payments would change if Defendants submitted only valid diagnoses and deleted previously submitted invalid diagnoses," it failed to "allege how CMS' conduct would have changed if it knew the Attestations were false."[40]

Because Judge Fitzgerald found that the federal government failed to demonstrate it would have refused to make the risk adjustment payments had it known they were based on false attestations, he ruled that the government failed to meet its burden of pleading that the attestations, false or not, were material to its payment decisions.[41] He granted UHG's motion to dismiss the substantive claims, though granting leave for the federal government to amend its complaint to demonstrate the attestations' materiality within two weeks,[42] which it did not.

UHG had gotten away with retaining payments unsupported by patient diagnoses. Yet, from a patient's perspective, it is arguably worse to deny payments for care than it is to exaggerate one's care needs—which is the latest complaint against UHG.

Among the multitude of UHG subsidiaries is a company called

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[35]United States *ex rel.* Poehling v. UnitedHealth Grp., Inc., No. CV 16–08697–MWF, 2018 WL 1363487, at *3 (C.D. Calif. Feb. 12, 2018).
[36]*Id.*
[37]*Id.* (citation omitted).
[38]*Id.* at *5.
[39]*Id.* at *9.
[40]*Id.*
[41]*Id.* at *10.
[42]*Id.* at *13.

NaviHealth,[43] which supplies a computer algorithm alleged in litigation "to 'systematically deny claims' of Medicare beneficiaries struggling to recover from debilitating illnesses in nursing homes."[44] A class action lawsuit alleged that UHG knew the nH Predict algorithm had an error rate of 90% according to the plaintiffs, but that UHG denied patients' claims anyway knowing that "only a tiny percentage—0.2%—would file appeals to try to overturn the insurer's decision."[45]

An investigation that involved a review of UHG documents found that "frontline clinician reviewers were blocked from approving rehab care for most patients who lived permanently in nursing homes." [46] Instead, care requests were routed to NaviHealth's physician medical reviewers, where they were invariably denied according to sources familiar with that review process.[47] Other insurers use NaviHealth and nH Predict too.[48]

However, another major MA insurer, Cigna, reportedly used its own care-denying algorithm.[49] In 2022, "Cigna doctors refused to pay for 300,000 claims using the PXDX system, spending an average of 1.2 seconds on each case, according to internal spreadsheets that tracked how fast they worked."[50]

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[43]Krista Brown & Sara Sirota, *Building a Giant*, AM. PROSPECT (Dec. 20, 2023), https://prospect.org/health/2023-12-20-building-a-giant-unitedhealth/. "NaviHealth is just one among countless companies UnitedHealth has swallowed up since its inception in the 1970s: health insurers, pharmacy benefit managers, financial services firms, medical data harvesters, physician groups, and more." *Id.*

[44]Casey Ross & Bob Herman, *UnitedHealth Faces Class Action Lawsuit Over Algorithmic Care Denials in Medicare Advantage Plans*, STAT (Nov. 14, 2023), https://www.statnews.com/2023/11/14/unitedhealth-class-action-lawsuit-algorithm-medicare-advantage/.

[45]*Id.*

[46]Bob Herman & Casey Ross, *UnitedHealth Used Secret Rules to Restrict Rehab Care for Seriously Ill Medicare Advantage Patients*, STAT (Dec. 28, 2023), https://www.statnews.com/2023/12/28/medicare-advantage-united-health-navihealth-rehab-care-restrictions/.

[47]*See id.*

[48]Casey Ross & Bob Herman, *Denied by AI: How Medicare Advantage Plans Use Algorithms to Cut Off Care for Seniors in Need*, STAT (Mar. 13, 2023), https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/. The fact that "Medicare Advantage corporations are paid a set fee per patient" creates motivation to deny claims. Fran Quigley, *Seize the Moment: The Opportunity to Realize the Human Right to Healthcare in the United States*, 17 IND. HEALTH L. REV. 53, 60 (2020). However, "savings from wrongfully denied care may be fueling profits, but they are not reducing costs to the taxpayers that fund the programs." *Id.*

[49]Patrick Rucker, Maya Miller, & David Armstrong, *Congressional Committee, Regulators Question Cigna System That Lets Its Doctors Deny Claims Without Reading Patient Files*, PROPUBLICA (May 16, 2023, 5:30 PM), https://www.propublica.org/article/cigna-health-insurance-denials-pxdx-congress-investigation#:~:text=The%20letter%20follows%20an%20investigation,PXDX%20system%2C%20spending%20an%20average.

[50]*Id.*

Representative Cathy McMorris Rodgers (R-WA), chair of the U.S. House Commerce and Labor Committee, "noted that 'policyholders under Cigna's Medicare Advantage plans appeal about one in five denials for requests for medical procedures, known as prior authorizations. Of those denials, about 80% are overturned.'"[51]

Looking at the industry as a whole, a federal report issued in 2022 on Medicare Advantage Organizations (MAOs) reviewed a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by fifteen of the largest insurers "during a 1-week period, June 1-7, 2019."[52] Based on its sample, it concluded that:

> [o]f the 12,273 denials of requests for services (prior authorization denials) issued by the 15 selected MAOs during the first week of June 2019, an estimated 13 percent met Medicare coverage rules. In other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service).[53]

The level of chiseling is remarkable. For example, a "76-year-old had a history of joint pain, post-polio syndrome, ankle and foot surgery, and was at-risk for falls," yet was denied coverage for a $112 walker.[54] We cannot know the number of these denials specific to UHG. However, we can deduce that many involved UHG simply because it is the biggest MA insurer, accounting, according to the Kaiser Family Foundation, "for 29% of all Medicare Advantage enrollment in 2023, or 8.9 million enrollees."[55]

This widespread practice of MA claim denials hurts patients and

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[51] *Id.*

[52] U.S. DEP'T OF HEALTH & HUMAN, OFF. INSPECTOR GEN., OEI-09-18-00260, SOME MEDICARE ADVANTAGE ORGANIZATION DENIALS OF PRIOR AUTHORIZATION REQUESTS RAISE CONCERNS ABOUT BENEFICIARY ACCESS TO MEDICALLY NECESSARY CARE 6 (2022).

[53] *Id.* at 9.

[54][54] *Id.* at 42. Prior authorization processes are a common complaint among providers and patients alike: "'Medicare Advantage makes us jump through so many hoops,' said Dr. Sandeep Singh, chief medical officer of the Good Shepherd Rehabilitation Network in Allentown, Pa. 'It's created such stress in the health care system.'" Paula Span, *When 'Prior Authorization' Becomes a Medical Roadblock,* N.Y. TIMES (May 25, 2024), https://www.nytimes.com/2024/05/25/science/medicare-seniors-authorization.html.

[55] *See* Nancy Ochieng, Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, & Tricia Neuman, *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KAISER FAMILY FOUND. (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

providers alike,[56] as does the practice of shortening the duration of needed care, with a broad consensus among nursing home providers and resident advocates that MA plans are ending nursing home and rehabilitation coverage before beneficiaries "are healthy enough to go home."[57] They are also limiting the care they cover for those in nursing homes: "Dr. George Williams, president of the American Academy of Ophthalmology (AAO), who sees patients in skilled nursing facilities, said it was very disturbing to see the number of critical eye surgeries and medications being delayed or denied by large insurance providers."[58]

By 2022, as a *New York Times* article reported, the U.S. "spen[t] nearly as much on Medicare Advantage's 29 million beneficiaries as on the Army and Navy combined."[59] And what passes for regulation by the U.S. Centers for Medicare and Medicaid Services (CMS) has featured a revolving door. In 2015, the head of CMS, Marilyn Tavenner, left to run the health insurance industry's trade group and was replaced by Andy Slavitt, formerly a top UHG executive.[60]

Tavenner did not wait even four months after departing her regulatory role to take up her advocacy position for insurers: "Asked about her priorities, Ms. Tavenner said she wanted to protect Medicare Advantage, the program under which private insurers manage care for more than 30 percent of the 55 million beneficiaries of Medicare."[61] Clearly Tavenner had regulated favorably. During her CMS tenure, a proposed 2.3% Obama Administration rate reduction for MA under the Affordable Care Act became a

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[56]*See* Gretchen Morgenson, *'Deny, Deny, Deny': By Rejecting Claims, Medicare Advantage Plans Threaten Rural Hospitals and Patients, Say CEOs*, NBC NEWS (Oct. 31, 2023, 6:30 AM), https://www.nbcnews.com/health/rejecting-claims-medicare-advantage-rural-hospitals-rcna121012, (noting "a five-hospital system in Oregon" stated it had ended its contract with UHG for this reason).

[57]Susan Jaffe, *Nursing Home Surprise: Advantage Plans May Shorten Stays to Less Time Than Medicare Covers*, KFF HEALTH NEWS (Oct. 4, 2022) (citing UHG Medicare Advantage examples), https://kffhealthnews.org/news/article/nursing-home-surprise-medicare-advantage-plans-shorten-stays/.

[58]Zahida Siddiqi, *'Astronomical' Medicare Advantage Denials, Pre-Auth Issues Cause Outcry from Nursing Homes*, SKILLED NURSING NEWS (July 5, 2023), https://skillednursingnews.com/2023/07/astronomical-medicare-advantage-denials-pre-auth-issues-cause-outcry-from-nursing-homes/.

[59]Reed Abelson & Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. TIMES (Oct. 8, 2022) (hyperlinks omitted), https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.

[60]*See id.*

[61]Robert Pear, *Head of Obama's Health Care Rollout to Lobby for Insurers*, N.Y. TIMES (July 15, 2015), https://www.nytimes.com/2015/07/16/us/ex-medicare-chief-marilyn-tavenner-top-lobbyist.html.

3.3%increase.[62] It was reported that "Health and Human Services Secretary Kathleen Sebelius also played a role, directing the budget crunchers at CMS to overlook their 'professional judgment'" that was based on actuarial science.[63]

Before coming to CMS, Slavitt had run Quality Software Services Inc. (QSSI), the UHG subsidiary that served as the general contractor for the Affordable Care Act's troubled HealthCare.gov website.[64] QSSI was purchased by another UHG subsidiary, OptumInsight, after a top CMS administrator, Steve Larsen, left to work for OptumInsight.[65] At the time, some members of Congress expressed concern that, by building a website to provide national access to other health insurers, "QSSI might have access to information or would build the technology in a way that would give UnitedHealth's insurance business an advantage."[66] When Slavitt became the acting administrator of CMS upon Tavenner's departure, two Republican senators, Charles Grassley (R-IA) and Orrin Hatch (R-UT), expressed concern:

> "The multiple relationships between Mr. Slavitt and United subsidiaries raise real concerns about how, and to what extent, CMS has prevented conflicts of interest given the fact CMS makes decisions that impact United and its subsidiaries every day. . . .While Mr. Slavitt may have recused himself from such decisions in the past, it may be difficult or impossible for him to do so in his current position at CMS."[67]

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[62]*See* Sarah Kliff, *How Insurers Flipped a Medicare Pay Cut into a Pay Raise*, WASH. POST (Apr. 2, 2013, 10:22 AM), https://www.washingtonpost.com/news/wonk/wp/2013/04/02/how-insurers-flipped-a-medicare-pay-cut-into-a-pay-raise/, (noting that after the news, "Monday afternoon was a really great time to be a health insurance plan.").

[63]Jennifer Haberkorn & Brett Norman, *CMS Reverses Course on Cuts*, POLITICO (Apr. 3, 2013), https://www.politico.com/story/2013/04/insurance-medicare-advantage-cuts-health-care-089569.

[64]*See* Juliet Eilperin, *QSSI to Stay on as HealthCare.gov's General Contractor*, WASH. POST (Jan. 14, 2014, 10:55 AM), https://www.washingtonpost.com/news/post-politics/wp/2014/01/14/qssi-to-stay-on-as-healthcare-govs-general-contractor/.

[65]Jia Lynn Yang, *QSSI, Contractor Chosen to Fix HealthCare.gov, Faced Questions from Lawmakers Last Year,* WASH. POST (Oct. 25, 2013, 8:03 PM), https://www.washingtonpost.com/business/economy/contractor-chosen-to-fix-healthcaregov-faced-questions-from-lawmakers-last-year/2013/10/25/fe27e8ee-3da3-11e3-b6a9-da62c264f40e_story.html.

[66]*Id.*

[67]Peter Sullivan, *GOP Senators Question Industry Ties of Obama Health Official*, THE HILL (Apr. 1, 2015, 4:05 PM), https://thehill.com/policy/healthcare/237649-gop-senators-raise-conflict-of-interest-concerns-about-top-health-official%20/.

Observers could perhaps be forgiven for thinking CMS serves the interests of UHG and other MA insurers. As one scholar wrote: "With the opportunity for great profit, Medicare Advantage plans are potentially motivated to maximize the risk adjustment data score by manipulating the rules and process."[68]

Government service can lead to lucrative returns. NaviHealth was founded by a former CMS administrator, Tom Scully, as it "aligned perfectly with the Medicare Advantage program he had played a pivotal role in creating during the Bush administration."[69] Scully personally invested $6 million and raised another $50 million for the company before selling in 2015 "for $410 million — roughly eight times the investment."[70] By 2020, when it was acquired by UHG, it was worth $2.5 billion.[71]

Under President Trump, CMS heavily promoted MA and reportedly "extolled the virtues of the private plans in emails sent to millions of beneficiaries."[72] Again, the lines had been blurred between regulation and advocacy: "Richard S. Foster, who was for many years the nonpartisan chief actuary of the Medicare program, said the emails sounded 'more like Medicare Advantage plan advertising than objective information from a public agency.'"[73]

Even if CMS was serious about regulation, it is ill-equipped in the matchup with moneyed insurers like UHG. Donald Berwick, a former CMS administrator, has noted that "CMS operates with a very, very thin administrative budget," while "MA plans are very wealthy and can and do pour money into lobbying, advertising, and coding software."[74]

CMS audits may uncover some MA fraud, but one scholar notes that "audits should not be confused with oversight."[75] In her opinion, true oversight "requires continual responsiveness on the part of the private partners as a term of participation. Auditing is a more limited way to identify goal divergence, and because of their random nature, audits are likely to only

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[68]Casie C. Rodenberger, Note, *Pre-Submission Risk Adjustment Audits: Preventing Medicare Advantage Plans from Draining Medicare Funds Dry*, 103 IOWA L. REV. 841, 858 (2018) (footnotes omitted).

[69]Ross & Herman, *supra* note 48.

[70]*Id.*

[71]*Id.*

[72] *See* Robert Pear, *Trump Administration Peppers Inboxes with Plugs for Private Medicare Plans*, N.Y. TIMES (Dec. 1, 2018), https://www.nytimes.com/2018/12/01/us/politics/trump-medicare-advantage-plans.html?searchResultPosition=5.

[73]*Id.*

[74]Cheryl Clark, *Obama CMS Chief: Medicare Advantage Plans Game the System*, MEDPAGE TODAY (Mar. 1, 2024), https://www.medpagetoday.com/special-reports/exclusives/108980.

[75]Hannah Ruth Leibson, *Hidden in Plain Sight: Two Models of Medicare Privatization*, 33 U. FLA. J.L. & PUB. POL'Y 81, 113 (2022) (footnotes omitted).

identify some instances of fraud and abuse."[76]

The amount of spending is stupendous and growing. In March 2024, the annual report to Congress from the Medicare Payment Advisory Commission noted that "Medicare spends an estimated 22[%] more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $83 billion in 2024."[77]

II. NEVER BIG ENOUGH: UHG AND CHANGE HEALTHCARE

UHG has long been voraciously acquisitive.[78] As the *New York Times* reported in 2023:

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[76]*Id.* at 114.

[77]MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 358 (2024), https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

[78]*See, e.g.*, *UnitedHealth to Buy LHC Group for $5.4 billion in Home Healthcare Push*, REUTERS (Mar. 29, 2022, 3:29 PM), https://www.reuters.com/business/healthcare-pharmaceuticals/unitedhealth-buy-lhc-group-about-54-billion-2022-03-29/; Carolyn Y. Johnson, *New Mega-Deal Shows How Health Insurers Are Taking Over Your Access to Medical Care*, WASH. POST (Dec. 6, 2017, 1:39 PM), https://www.washingtonpost.com/news/wonk/wp/2017/12/06/new-mega-deal-shows-how-health-insurers-are-taking-over-your-access-to-medical-care/ ("The nation's largest insurer, UnitedHealth Group, announced Wednesday that it would buy a network of 300 primary care and specialist clinics from dialysis giant DaVita for $4.9 billion, in the latest deal reshaping the business of health insurance.") (hyperlink omitted); Reed Abelson, *UnitedHealth Group to Buy Outpatient Surgery Chain for $2.3 Billion*, N.Y. TIMES (Jan. 9, 2017), https://www.nytimes.com/2017/01/09/business/unitedhealth-surgical-care-affiliates.html?searchResultPosition=10; Reed Abelson, *Health Care Companies in Merger Frenzy*, N.Y. TIMES (Oct. 29, 2015) https://www.nytimes.com/2015/10/30/business/dealbook/health-care-companies-in-merger-frenzy.html ("UnitedHealth, which has created a portfolio of health care businesses, fortified its pharmacy benefit manager, known as OptumRx, by buying Catamaran Corporation a fast-growing competitor, this year."); *UnitedHealth to Buy Sierra Health for $2.6 Billion*, N.Y. TIMES (Mar. 12, 2007, 8:38 AM), https://archive.nytimes.com/dealbook.nytimes.com/2007/03/12/unitedhealth-to-buy-sierra-health-for-26-billion/?searchResultPosition=4; Robert Jablon, *UnitedHealth Group To Acquire PacifiCare*, WASH. POST (July 6, 2005, 8:00 PM), https://www.washingtonpost.com/archive/business/2005/07/07/unitedhealth-group-to-acquire-pacificare/8c698c35-e6fa-468a-b29a-e69d390d2986/ ("PacifiCare Health Systems Inc. said Wednesday it has agreed to be acquired by UnitedHealth Group Inc., one of the nation's largest health insurers, in an $8.1 billion deal."); Bill Brubaker, *UnitedHealth Agrees to Buy MAMSI*, WASH. POST (Oct. 28, 2003, 12 AM), https://www.washingtonpost.com/archive/business/2003/10/28/unitedhealth-agrees-to-buy-mamsi/7808d52d-472d-411b-a73a-10cdccd6aca6/ ("UnitedHealth Group Inc., the largest health insurer in the United States, yesterday announced plans to acquire Mid Atlantic Medical Services Inc., the second-largest health insurer in the Washington area, in a $2.7 billion cash-and-stock deal.").

> UnitedHealth Group is a sprawling example of consolidated services. It owns the major insurer that has nearly 50 million customers in the United States and oversees its ever-expanding subsidiary, Optum, which has bought up networks of doctors and medical sites. Optum can send patients from one of its roughly 70,000 doctors to one of its urgent care or surgery centers.[79]

An *American Prospect* investigation into UHG acquisitions noted that "[i]t's not hyperbole to describe UnitedHealth as the bulk of our country's health care system—and its $85 billion in publicly disclosed acquisition spending played a big part."[80]

As a source of seemingly limitless financing, UHG benefits in its acquisitions from fire sales besides the clinic in Corvallis, Oregon. In March 2024, Steward Health Care announced it would sell its nationwide physician network to UHG subsidiary Optum.[81] Two months later, Steward declared bankruptcy and announced it would also sell its 31 hospitals nationwide.[82]

A recent analysis found that UHG "quietly acquired dozens of outpatient facilities in 2023, with a particular focus on surgery centers," many of which "sit in geographic areas where UnitedHealth is the biggest Medicare Advantage player, based on the latest insurance market share data."[83] This allows UHG to steer customers to itself.[84] And as the nation's largest

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[79]Reed Abelson, *Corporate Giants Buy Up Primary Care Practices at Rapid Pace*, N.Y. TIMES (May 12, 2023) https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html?searchResultPosition=2; *see also* Bob Herman, *The Health Insurer Will See You Now: How UnitedHealth Is Keeping More Profits, as Your Doctor*, STAT (Dec. 5, 2022), https://www.statnews.com/2022/12/05/unitedhealth-keeping-profits-as-your-doctor-insurer/.

[80]Brown & Sirota, *supra* note 43.

[81]*See* Steve LeBlanc, *Steward Health Care Strikes Deal to Sell Its Nationwide Physician Network to Optum*, ASSOCIATED PRESS (Mar. 27, 2024, 5:31 PM), https://apnews.com/article/steward-health-care-massachusetts-optum-unitedhealth-group-89ca86d66e3e4e3ad020d4ee94edac3c.

[82]*See* Dietrich Knauth, *Bankrupt Steward Health puts its hospitals up for sale, discloses $9 bln in debt*, REUTERS (May 7, 2024, 5:14 PM), https://www.reuters.com/business/healthcare-pharmaceuticals/bankrupt-steward-health-puts-its-hospitals-up-sale-discloses-9-bln-debt-2024-05-07/.

[83]Bob Herman, *UnitedHealth Is on a Buying Spree of Outpatient Surgery Centers*, STAT (Mar. 11, 2024), https://www.statnews.com/2024/03/11/unitedhealth-outpatient-surgery-centers-medicare-advantage-ncp-fresenius/.

[84]*See id.* UHG also steers to itself billions of dollars in profit from its insureds' prescription drug purchases through an Optum Rx subsidiary, Emisar, that avoids higher U.S. taxes by being offshored in Ireland. *See* Rebecca Robbins & Reed Abelson, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, N.Y. TIMES (Jan. 23, 2024),

employer of physicians—"One in every 10 doctors in America has been sucked into the Optum system," according to Sen. Elizabeth Warren (D-MA)—UHG can circumvent the intention of the federal medical loss ratio law requiring insurers to spend 85% of premiums on patient care by simply increasing the cost of the care.[85] Christopher Whaley, a health care economist at Brown University, commented, "You can acquire providers and essentially pay yourself. . . . It provides a disincentive to really care that much about prices and spending growth."[86]

Yet, in 2022, the Biden Administration had sought to stop UHG's $13 billion acquisition of Change Healthcare, arguing it "would give UnitedHealth sensitive data that it could wield against its competitors in the insurance business."[87] Where such an acquisition confers an anti-competitive advantage, or monopoly, it could violate the federal antitrust law known as the Clayton Act:

> No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.[88]

The case was assigned to Judge Carl Nichols of the U.S. District Court

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https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html?searchResultPosition=1. Those obtaining health insurance through UHG can be forced to use Optum Rx as a pharmacy benefit manager instead of being able to shop for better prices. *See id.*

[85]Dan Diamond, Christopher Rowland, & Daniel Gilbert, *UnitedHealth Grew Very Big. Now, Some Lawmakers Want to Chop It Down.*, WASH. POST (Apr. 30, 2024, 11:00 AM), https://www.washingtonpost.com/health/2024/04/30/unitedhealth-congress-review-cyberattack/.

[86]*Id.*

[87]David McCabe, *Justice Dept. Sues to Block $13 Billion Deal by UnitedHealth Group*, N.Y. TIMES (Feb. 24, 2022), https://www.nytimes.com/2022/02/24/business/doj-antitrust-lawsuit-unitedhealth.html?searchResultPosition=2.

[88]15 U.S.C. § 18 (2024). "The word 'person' or 'persons' wherever used in this Act shall be deemed to include corporations and associations existing under or authorized by the laws of either the United States, the laws of any of the Territories, the laws of any State, or the laws of any foreign country." 15 U.S.C. § 12 (2024).

for the District of Columbia, a conservative appointee of President Trump,[89] who noted that UHG has two main subsidiaries: UnitedHealthcare (UHC) and Optum, consisting of OptumHealth, OptumRx, and OptumInsight. He acknowledged that the federal government "has made a *prima facie* showing that the proposed merger is likely to substantially lessen competition, having relied on both a presumption of harm and evidence of lost head-to-head competition."[90] And, in fact, "UHG does not dispute the Government's market-share and concentration statistics, nor does it dispute the claim that Change and OptumInsight are head-to-head competitors."[91]

The government argued that by acquiring Change through Optum, UHC "will gain broad access and use rights to the claims data of UHC's rivals. The argument then posits that Optum will have an incentive to share the data—or at least the competitively sensitive insights that can be gleaned from the data—with UHC."[92] Yet the judge found that for this to happen, "United would have to uproot its entire business strategy and corporate culture; intentionally violate or repeal longstanding firewall policies; flout existing contractual commitments; and sacrifice significant financial and reputational interests."[93] This sanguine view ran contrary to his acknowledgement that "the evidence did establish that United has an incentive to arm UHC with valuable insights about its health insurance rivals."[94]

The judge made much of the "culture of trust and integrity" at UHG,[95] apparently not taking judicial notice of the company's various transgressions

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[89]*See* Ellis Kim, *Carl Nichols, Trump's Pick to DC District Court, Wins Senate Approval*, NAT'L L. J. (May 22, 2019, 6:13 PM), https://www.law.com/nationallawjournal/2019/05/22/carl-nichols-trumps-pick-to-dc-district-court-wins-senate-approval/. Nichols clerked for Justice Clarence Thomas. *Id.* He also "broke with at least seven other U.S. trial judges" by "striking down the lead felony charge brought in the government's Jan. 6 investigation" of the U.S. Capitol riot. *See* Spencer S. Hsu, Tom Jackman, & Rachel Weiner, *U.S. Judge Dismisses Lead Federal Charge Against Jan. 6 Capitol Riot Defendant*, WASH. POST (Mar. 8, 2022, 7:58 PM) https://www.washingtonpost.com/dc-md-va/2022/03/08/judge-tosses-jan-6-obstruction-charge/. That decision was reversed on appeal. *See* Ryan J. Reilly, *Appeals Court Upholds 'Obstruction' Charge Used Against Hundreds of Jan. 6 Rioters, For Now*, NBC NEWS (Apr. 7, 2023, 12:41 PM), https://www.nbcnews.com/politics/justice-department/appeals-court-upholds-jan-6-riot-obstruction-charge-rcna78692.

[90]United States v. UnitedHealth Grp., 630 F. Supp. 3d 118, 134 (D.C. 2022).

[91]*Id.* at 134-35.

[92]*Id.* at 140.

[93]*Id.* at 141.

[94]*Id.* at 144.

[95]*Id.* at 145.

described previously in this article or by its subsidiary Optum itself.[96] Despite the government's "evidence that United would have some incentive (and ability) to exploit competitors' competitively sensitive data for its own economic benefit following the acquisition[,]" the judge deemed UHG too benevolent to do so based largely on "convincing testimony from senior executives[.]"[97] He granted judgment to UHG.[98] Interestingly, the Biden Administration dropped its appeal of this ruling.[99]

Judge Nichols' faith in UHG's good intentions not only ignored its prior bad acts, it ignored evidence that its wholly-owned subsidiaries might communicate with one another, a probability that a senior executive telegraphed in a memorandum that seemed to downplay "financial and data firewalls between Optum and UHC[.]"[100] This communication could be difficult to detect. In advising UHG, the consulting company, McKinsey & Co., had "concluded that UnitedHealth could 'utilize transactions intelligence' from Change's claims data to 'optimize benefit design' for UnitedHealthcare, UnitedHealth's insurance subsidiary[.]"[101]

Nor was it simply competition among insurers that could be affected. As the American Medical Association (AMA) warned, UHG, by controlling Change, would be able to know what rates its competitors were paying physicians, giving it a unique advantage in negotiating its own payment rates by potentially using the insights it gathered through snooping to establish a noncompetitive payment ceiling.[102] The AMA noted that there are noncompetitive markets where insurers other than UHG have such leverage that they can set rates for physicians that are lower than they would be if insurer competition existed.[103] In such cases, UHG, through Change, would

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[96]*See, e.g.*, Press Release, Off. of Ohio Att'y Gen. Dave Yost, $15 Million OptumRx Settlement Pushes AG Yost's Total Recoveries from PBMs Past $100 Million (Oct. 25, 2022) https://www.ohioattorneygeneral.gov/Media/News-Releases/October-2022/$15-Million-OptumRx-Settlement-Pushes-AG-Yost's-To ("OptumRx will repay the state $15 million in prescription-drug overcharges assessed to the Ohio Bureau of Workers' Compensation").

[97]UnitedHealth Grp., 630 F. Supp. 3d at 150.

[98]*See id.* at 155.

[99]*See US Drops Appeal of UnitedHealth Acquisition of Change Healthcare*, REUTERS (Mar. 21, 2023, 1:32 PM), https://www.reuters.com/legal/us-drops-appeal-unitedhealth-acquisition-change-healthcare-2023-03-21/.

[100]Cezary Podkul, *What Will UnitedHealth's New Trove of Claims Data Mean for Consumers?*, PROPUBLICA (Nov. 16, 2022, 11:00 AM), https://www.propublica.org/article/united-healthcare-change-acquisition-claims-records.

[101]*Id.*

[102]Letter from James L. Madara, Am. Med. Ass'n, to Richard Powers, Acting Assistant Att'y Gen., U.S. Dep't of Just. (Apr. 6, 2021) (footnote omitted), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-6-Letter-to-DOJ-FINAL.pdf

[103]*See id.*

know what physicians had to settle for and go no higher in its own rates.[104]

This is by no means a far-fetched worry, as UHG has already proven its ability to play hardball with even major hospital systems.[105] As one scholar noted, MA "market power yields the potential for predatory negotiation of hospital contracts for healthcare."[106] Under fee-for-service Medicare, "the government both funds and manages the healthcare of enrollees."[107] However, under MA, the government's role is limited to funding, while the private insurer "manages the healthcare of enrollees under an at-risk model where they can profit by: (1) having superior negotiation positions in contracting with hospitals; (2) reducing the payments to providers of care; and (3) denying care to enrollees."[108]

Obviously the bigger a MA insurer is, perhaps to the point of monopolizing a market as UHG so often does through its exponential growth,[109] the more leverage it has in squeezing providers.[110] One AMA

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[104]*See id.*

[105]*See* Joseph Goldstein, *Hospital vs. Insurer Dispute Could Force Thousands to Switch Doctors*, N.Y. TIMES (Mar. 14, 2024) https://www.nytimes.com/2024/03/14/nyregion/united-healthcare-mount-sinai-insurance.html ("The negotiations have sent many patients scrambli ng to find new doctors. UnitedHealthcare says about 80,000 Mount Sinai patients are affected."). This dispute ended up being settled "just days before Mount Sinai-affiliated doctors were due to be removed from UnitedHealthcare's network." *See* Joseph Goldstein, *Mount Sinai and UnitedHealthcare Reach Insurance Deal*, N.Y. TIMES (Mar. 19, 2024) (hyperlink omitted), https://www.nytimes.com/2024/03/19/nyregion/united-healthcare-mou nt-sinai-hospital-deal.html.

[106]Andrew Keller, *Medicare Advantage: Connecticut Insurance Industry Profits at the Expense of Hospitals*, 26 QUINNIPIAC HEALTH L. J. 95, 107 (2023) (footnote omitted).

[107]*Id.* at 108.

[108]*Id.*

[109]*See* Bob Herman, *The Big Medicare Advantage Players Keep Getting Bigger*, AXIOS (Jan. 19, 2022), https://www.axios.com/2022/01/19/medicare-advantage-2022-enrollment-united health-humana ("UnitedHealth Group had almost 7.9 million MA members as of Jan. 1, the most of any insurer and an 11% increase from the 7.1 million members it had at the same time in 2021, according to federal data."). Lack of competition is a problem with MA plans:

> In 2003, there were an estimated 146 Medicare Advantage plans offered across the country. This number has risen to an estimated 3,843 plans in 2022. With so many approved plans, one might expect that competition should have similarly increased in each region. Instead, between 2009 and 2017, up to seventy percent of Medicare Advantage enrollees were in highly-concentrated markets with only two or three insurers.

Leibson, *supra* note 75.

[110]As one report notes:

> Market power in input markets is known as monopsony power—the ability to reduce and maintain input prices (e.g., prices paid to physicians) below

leader with a six-physician private practice in Kentucky wrote an op-ed in 2023 complaining that "a major insurance company [had] recently put forth a contract renewal proposal based on 80 percent of the Medicare reimbursement rate – with surgical rates below what they paid [his practice] six years ago."[111] The insurer refused to budge from their initial offer. He further noted that "this insurance company now controls 60 percent of the private payer market in our region. Financially, we are not sure we can survive if we sign the contract, but if we cancel, our patients will suffer and financially, we lose either way."[112]

Though Judge Nichols had written of UHG's "strong legal, reputational, and financial incentives" to protect its insurance rivals' Change Healthcare data,[113] that prediction has aged poorly in light of the cyberattack that exposed an untold amount of sensitive information to malicious actors, which may, among other things, have violated the Health Insurance Portability and Accountability Act.[114] In a preliminary estimate, UHG acknowledged that the personal information of one-third of Americans may have been compromised.[115]

It was not until the third week of the "payment paralysis" resulting from the cyberattack that the Biden Administration finally summoned the

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> competitive levels. Monopsony is the mirror image of monopoly. The exercise of monopsony power would also reduce the quantity (or quality) of health care below competitive levels and in turn harm consumers. Research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and employment.

Competition in Health Insurance: A Comprehensive Study of U.S. Markets 6, AM. MED. ASS'N (2023), https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.

[111]Bruce A. Scott, *Inaction on Medicare Payment Reform Jeopardizes Quality Care*, THE HILL (July 6, 2023, 5:30 PM), https://thehill.com/opinion/congress-blog/4084291-inaction-on-medicare-payment-reform-jeopardizes-quality-care/.

[112]*Id.*

[113]UnitedHealth Grp., 630 F. Supp. 3d at 149.

[114]*See* Dan Diamond, *HHS Opens Probe into UnitedHealth's Cybersecurity as Hack Fallout Continues*, WASH. POST (Mar. 13, 2024, 3:15 PM), https://www.washingtonpost.com/health/2024/03/13/patient-data-breach-hhs-probe-unitedhealth-change-healthcare/.

[115]*See* Gilbert & Diamond, *supra* note 4. Four months after the cyberattack, UHG began notifying "affected corporate customers" about what information was compromised but had not yet begun sharing that information with individual UHG enrollees. *See* Brooks Johnson, *UnitedHealth cyberattack compromised credit cards, health history, Social Security numbers*, STAR TRIB. (June 20, 2024, 4:30 PM), https://www.startribune.com/unitedhealth-cyberattack-compromised-credit-cards-health-history-social-security-numbers/600374968/.

CEO of UHG to the White House.[116] That belied the urgency of the crisis for providers like individual doctors:

> The ransomware attack last month on Change Healthcare, a subsidiary of UnitedHealth Group, has turned into a national crisis. For doctors like Christine Meyer of Exton, Pennsylvania, it has become a personal nightmare.
>
> "It's been one of the most stressful things we've gone through as a practice, and that's saying something given that we survived COVID," Meyer told CBS News. ". . .To find ourselves suddenly, you know, looking at our home and its value, and can we afford to put it up to pay our employees, is a terrible feeling."[117]

As the story noted, "On an average weekday prior to the cyberattack, Meyer said her practice would get anywhere from $20,000 to $50,000 in deposits."[118] After the attack, she reported a day where she "received only $77 in deposits. She said it will take months for [her practice] to recover from the impact of the ransomware attack."[119]

Detailing the impact upon rural critical access hospitals in New Hampshire, Senator Maggie Hassan (D-NH) wrote: "Due to the Change Healthcare hack, these hospitals have seen nearly all – 98 percent – of their claims and cash flow disappear in the last few weeks. These hospitals' ability to care for patients in the weeks to come is seriously compromised without urgent financial support."[120]

Far from being responsive to such concerns, reports found that "providers seeking advice or help from a human in customer support at Change Healthcare instead were greeted with a recorded message: 'Due to unforeseen circumstances, we are unable to answer your call at this time.

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[116]Dan Diamond, *White House Summons UnitedHealth CEO as Payment Paralysis Enters 3rd Week*, WASH. POST (Mar. 12, 2024, 6:40 PM), https://www.washingtonpost.com/health/2024/03/12/unitedhealth-change-healthcare-white-house-becerra-hhs/.

[117]Nicole Sganga, *UnitedHealth Cyberattack "One of the Most Stressful Things We've Gone Through," Doctor Says*, CBS NEWS (Mar. 14, 2024, 8:00 PM) (hyperlinks omitted), https://www.cbsnews.com/news/doctor-describes-devastating-effects-unitedhealth-cyberattack-change-healthcare/.

[118]*Id.*

[119]*Id.*

[120]Press Release, Off. of Sen. Maggie Hassan, Senator Hassan Pushes UnitedHealth Group and Optum to Increase Assistance to Rural Hospitals Following Hack (Mar. 13, 2024), https://www.hassan.senate.gov/news/press-releases/senator-hassan-pushes-unitedhealth-group-and-optum-to-increase-assistance-to-rural-hospitals-following-hack.

Please try your call again later. Thank you for calling.' And then the call was disconnected."[121]

Even patients seeking to fill vital prescriptions were affected,[122] and cancer treatment availability imperiled.[123] Yet it appeared UHG was getting special treatment:

> - "Jamie Dimon would already be on Capitol Hill," if this had happened to JPMorgan Chase, said Boe Hartman, co-founder and chief technology officer of Nomi Health, who spent the majority of his career in the banking sector.
> - "That's what stuns me. They've punched a hole in 20% of the U.S. economy . . . and it appears at the moment no one's being held to account," Hartman said.[124]

Doctor Jesse Ehrenfeld, president of the American Medical Association, expressed frustration with the lack of accountability from AHIP, the national trade association for health insurers:

> It is dumbfounding that following weeks of silence and a lack of assistance to struggling practices in the wake of the Change Healthcare cyberattack, AHIP's response is a "business as usual" approach to prior authorization. This approach is

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[121]Reed Abelson & Julie Creswell, *With Cyberattack Fix Weeks Away, Health Providers Slam United*, N.Y. TIMES (Mar. 8, 2024), https://www.nytimes.com/2024/03/08/health/united-healthcare-cyberattack.html.

[122]*See* Daniella Silva & Aria Bendix, *Patients Struggle to Get Lifesaving Medication After Cyberattack on a Major Health Care Company*, NBC NEWS (Mar. 6, 2024, 1:31 PM), https://www.nbcnews.com/health/health-care/cyberattack-change-healthcare-patients-struggle-get-medication-rcna141841; Marlene Cimons, McKenzie Beard, & Teddy Amena bar, *How a Health-Care Cyberattack May Affect Your Prescription Drug Access*, WASH. POST (Mar. 5, 2024, 11:26 AM), https://www.washingtonpost.com/wellness/2024/03/05/change-healthcare-hack-prescriptions-affect/; Reed Abelson, *A Cyberattack on a UnitedHealth Unit Disrupts Prescription Drug Orders*, N.Y. TIMES (Feb. 27, 2024), https://www.nytimes.com/2024/02/26/health/cyberattack-prescriptions-united-healthcare.html.

[123]*See* Sean Lyngaas, *'We're Hemorrhaging money': US Health Clinics Try to Stay Open After Unprecedented Cyberattack*, CNN (Mar. 9, 2024, 1:52 PM) https://www.cnn.com/2024/03/09/tech/medical-supply-chain-cybersecurity/index.html ("Mel Davies, chief financial officer of Oregon Oncology Specialists, told CNN she is worried that the private clinic that treats 16,000 cancer patients annually could be forced to close if she doesn't get financial relief soon.").

[124]Tina Reed, *UnitedHealth Faces Growing Calls for Accountability Over Cyberattack*, AXIOS (Mar. 13, 2024), https://www.axios.com/2024/03/13/change-healthcare-attack-accountability.

> particularly galling since service outages have exacerbated the administrative burdens and care delays already associated with this process. Prioritizing profits over the stability and solvency of our care delivery system starkly contrasts with the Biden Administration's appeal to health plans to "meet the moment."[125]

It was not until over two months after the cyberattack that the head of UHG finally appeared before a congressional hearing.[126]

Far from being held accountable, UHG appeared to be using the cyberattack to its advantage, considering how its temporary funding assistance program for affected providers was described by Richard Pollack of the American Hospital Association:

> Among other things, your form agreement: (1) requires repayment of loans within 5 days of receiving notice; (2) allows your bank, Optum Financial Services, to recoup funds "immediately and without prior notification"; (3) permits Optum to change the agreement simply by providing notice; (4) *requires providers to give UnitedHealth Group and its subsidiaries access to past, current and future claims payment data*; and (5) contains broad waivers of liability and strict limitations on damages.
>
> Taken together, the limited eligibility and these one-sided contractual terms severely undermine the intent of this program.[127]

Effectively this was a contract of adhesion, as many cash-strapped providers would be forced to accept its onerous terms lest they receive no assistance whatsoever. Moreover, the fact that the agreement required giving UHG access to such comprehensive payment data, though Change Healthcare processes claims from other insurers, belied Judge Nichols' finding that competitors' data would be shielded from UHG following its acquisition of Change.

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[125]Press Release, Am. Med. Ass'n, AMA: AHIP Offers Tone-Deaf Response to Cyberattack (Mar. 14, 2024) (hyperlink omitted), https://www.ama-assn.org/press-center/press-releases/ama-ahip-offers-tone-deaf-response-cyberattack.

[126]*See* Reed Abelson & Noah Weiland, *Senators Slam UnitedHealth's C.E.O. Over Cyberattack*, N.Y. TIMES (May 1, 2024), https://www.nytimes.com/2024/05/01/health/united-health-cyberattack-senate.html.

[127]Pollack, *supra* note 9 (emphasis added).

III. CONCLUSION

How big is too big? The Change Healthcare hack revealed that UHG's vulnerabilities could cause the entire U.S. health care system to teeter. As Chris Stanton wrote in *New York Magazine*, "the devastating scope of the attack is a direct product of industry consolidation, particularly at UnitedHealth Group, the owner of Change and the country's largest health care provider."[128] As he wrote,

> Change was important to the daily operations of the U.S. health-care system before UnitedHealth bought it, but the merger turned it into critical infrastructure — providing a target that, if hit correctly, could simultaneously postpone a surgery in Milwaukee, delay a teenager's prescription refill in New York, and choke the revenue stream of an oncology practice in Albuquerque.[129]

Douglas Hoey, the head of the National Community Pharmacists Association, stated that "[o]ne of the biggest lessons learned from this situation is that when we put all of our eggs in one basket, when that basket tips over, all the eggs crack and there's none left. We're scrambled at that point."[130]

Senator Ron Wyden (D-OR), chair of the Senate Finance Committee, declared that "United Health Group botched basic cybersecurity practices by allowing a single hack to create chaos across the nation's health care system and should be held accountable."[131] He stated that "[r]egulators must prevent companies in critical infrastructure sectors like health care from growing so large that they pose a systemic risk, as occurred here."[132]

And yet the likelihood of any real accountability by UHG may be slim.

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[128]Chris Stanton, *Corporate Greed Made the Change Healthcare Cyberattack Worse*, N.Y. MAG. (Mar. 7, 2024), https://nymag.com/intelligencer/article/corporate-greed-made-the-change-healthcare-cyberattack-worse.html.

[129]*Id.*

[130]Michel Martin & Jenna McLaughlin, *The Health Care System Is on the Brink of Disaster Because of a Cyberattack*, NPR (Mar. 6, 2024, 5:14 AM), https://www.npr.org/2024/03/06/1236201898/the-health-care-system-is-on-the-brink-of-disaster-because-of-a-cyberattack.

[131]Press Release, Off. of U.S. Sen. Ron Wyden, Wyden Statement on the United Health Group Hack (Mar. 8, 2024), https://www.wyden.senate.gov/news/press-releases/wyden-statement-on-the-united-health-group-hack.

[132]*Id.* The anti-monopolist suggested "UnitedHealth may have invested in acquiring and integrating Change rather than in data security."

To put a cyberattack ransom of $22 million into context, a former CEO of UHG made $142 million in 2021,[133] and April 2024 reporting revealed that the chairman of UHG and three senior executives netted over $100 million from selling UHG stock in the four months leading up to public notice of a federal antitrust investigation.[134]

Even the penalties for overt wrongdoing are not a proportionate deterrent. In 2023, Washington's insurance commissioner announced he fined UHG $500,000 "for failing to demonstrate how it administers its mental health and substance use disorder benefits in accordance with state and federal laws. Half of the fine—$250,000—is suspended, pending adherence to a compliance plan."[135] Would such a fine even be noticed by UHG?[136]

In 2022, New York's attorney general announced a $13.6 million settlement for consumers denied mental health care coverage under what she described as a "landmark agreement with UnitedHealthcare, the nation's largest health insurer."[137] As more than 20,000 people in New York were affected, one wonders how much solace that settlement provided for the inconvenience, quite possibly life-threatening, of those denied mental health

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[133]*See* Bob Herman, *Seven Health Insurance CEOs Raked in a Record $283 Million Last Year*, STAT (May 12, 2022), https://www.statnews.com/2022/05/12/health-insurance-ceos-raked-in-record-pay-during-covid/.

[134]*See* John Tozzi & Ander Melin, *UnitedHealth Chair, Executives Sold $102 Million in Stock Before US Probe Became Public*, BLOOMBERG NEWS (Apr. 11, 2024), https://www.bnnbloomberg.ca/unitedhealth-chair-executives-sold-102-million-in-stock-before-us-probe-became-public-1.2057830. "Typically a company's general counsel would declare a blackout period barring trading in light of a sensitive investigation, according to John C. Coffee Jr., a corporate governance expert at Columbia Law School. 'Apparently, this did not happen' at UnitedHealth, he said in an email." *Id.*

[135]Press Release, Off. of Wash. Ins. Comm'r. Mike Kreidler, Kreidler Fines UnitedHealthcare $500,000 for Not Demonstrating Compliance with Mental Health Parity Laws (Oct. 18, 2023), https://www.insurance.wa.gov/news/kreidler-fines-unitedhealthcare-500000-not-demonstrating-compliance-mental-health-parity-laws.

[136]To add perspective to a quarter-million-dollar fine, a *New York Times*' investigation reported UHG is part of a scheme with "a little-known data analytics firm called MultiPlan," whereby insurers stick patients with large out-of-pocket bills for care provided outside their networks: "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." Chris Hamby, *Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill.*, N.Y. TIMES (Apr. 9, 2023), https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html.

[137]Press Release, N.Y. Off. of Att'y Gen. Letitia James, Attorney General James Provides $13.6 Million to Consumers Who Were Denied Mental Health Care Coverage (May 20, 2022), https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental.

care or subjected to alleged reimbursement reductions.[138] Juxtapose $13.6 million for over 20,000 people with the fact that UHG's chief legal officer alone made $11.2 million in 2022.[139]

Arguably fines and settlements are simply the cost of doing business for a company that earned over $22 billion in profits in 2023 alone,[140] which is more in a single year's profit than, say, the state of New Hampshire's $15.2 billion budget for two years.[141] In 2018, a company UHG has since acquired agreed to pay $270 million for allegedly having provided inaccurate patient information to allow MA plans to receive inflated payments.[142] In 2009, UHG itself agreed to pay $350 million to settle class-action lawsuits that the AMA and other groups had filed on behalf of providers and patients alleging they were underpaid for out-of-network services.[143]

One article on the damage inflicted by the Change Healthcare cyberattack quoted Katie Raiten, owner of a New Mexico health care clinic: "What's really frustrating about this whole situation is if you look up the subsidiaries of UnitedHealth Group, UnitedHealth Group is kind of like a monstrosity of a company."[144] More vividly, Cornell University Professor Rosemary Batt has said of MA insurers generally that "[t]hese conglomerates are like an octopus with a tentacle in every aspect of the health care

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[138]*See id.*

[139]*See* Brian Baxter, *UnitedHealth Top Lawyer Earned $11 Million as Company Fought DOJ*, BLOOMBERG L. (Apr. 24, 2023, 11:32 AM), https://news.bloomberglaw.com/business-and-practice/unitedhealth-top-lawyer-earned-11-million-as-company-fought-doj.

[140]Bruce Japsen, *UnitedHealth Group Profits Hit $22 Billion In 2023*, FORBES (Jan. 12, 2024, 6:17 AM), https://www.forbes.com/sites/brucejapsen/2024/01/12/unitedhealth-group-profits-hit-23-billion-in-2023/?sh=538b757a67ad. "At UnitedHealthcare, in particular, full-year revenue grew nearly 13% to $281.4 billion as the company grew its customers served in its health plans by more than 1 million people last year to 52.7 million. Meanwhile, Optum full year revenues grew 24% to $226.6 billion year over year." *Id.*

[141]*See* Holly Ramer, *New Hampshire Budget Passes After Rare Bipartisan, Bicameral Cooperation*, ASSOCIATED PRESS (June 8, 2023, 3:27 PM), https://apnews.com/article/new-hampshire-budget-9fa209778b6a44f0b6ba83e9ad2d0978.

[142]*See* Nate Raymond, *DaVita Unit to Pay $270 Million to Resolve Medicare Payments Probe*, REUTERS (Nov. 18, 2018, 2:25 PM), https://www.reuters.com/article/idUSKCN1MB3J1/.

[143]*See* Editorial, *Not So Reasonable and Customary*, N.Y. TIMES (Jan. 16, 2009), https://www.nytimes.com/2009/01/17/opinion/17sat1.html?searchResultPosition=3.

[144]Gabrielle Porter, *Amid Cyber Attacks, Concern Over Health-Care Consolidation*, GOV'T TECH. (Apr. 3, 2024), https://www.govtech.com/security/amid-cyber-attacks-concern-over-health-care-consolidation.

system."[145] And no insurer has more tentacles than UHG.

In 2010, during the economic crisis brought on by the collapse of the home mortgage industry, Federal Reserve Chairman Ben Bernanke spoke "of so-called too-big-to-fail firms. A too-big-to-fail firm is one whose size, complexity, interconnectedness, and critical functions are such that, should the firm go unexpectedly into liquidation, the rest of the financial system and the economy would face severe adverse consequences."[146]

UHG is such a firm when it comes to the functioning of our nation's health care system. While the company's documented transgressions relative to Medicare Advantage should have been enough, the question now is whether the Change Healthcare disaster, occurring while a comprehensive federal antitrust investigation of UHG was already reportedly underway,[147] will awaken federal policymakers to the need to reform, and possibly break up, this too-big-to-fail leviathan.

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[145]Julie Greco, *Report: Medicare Advantage Plans Cost More, Provide Less*, CORNELL CHRON. (Nov. 2, 2023), https://news.cornell.edu/stories/2023/11/report-medicare-advantage-plans-cost-more-provide-less#xd_co_f=YzhiNmEwOTEtNTIyZC00NzVkLWE4ZTctYjU0MTY3NGIyMzgz~.

[146]Ben S. Bernanke, Chairman, Fed. Rsrv., *Causes of the Recent Financial and Economic Crisis*, Testimony Before the Financial Crisis Inquiry Commission (Sept. 2, 2010), https://www.federalreserve.gov/newsevents/testimony/bernanke20100902a.htm.

[147]*See* Anna Wilde Mathews & Dave Michaels, *U.S. Opens UnitedHealth Antitrust Probe*, WALL ST. J. (Feb. 27, 2024, 5:32 PM), https://www.wsj.com/health/healthcare/u-s-launches-antitrust-investigation-of-healthcare-giant-unitedhealth-ff5a00d2.