Top Medicare Advantage Provider UnitedHealthcare Relies On Small Pool Of MA Beneficiaries For Nearly Half Of Its Revenue, Is Suing Federal Government To Protect Its Profits, And Has Spent Over $22 Million On Lobbying Since Q1 2021

SUMMARY: Medicare Advantage (MA) is a "fast-growing alternative to original Medicare" that covers 32.8 million people—54% of those eligible for Medicare—and has been criticized as a costly "privatized" version of the program that is vulnerable to "billing abuse" by insurers. Notably, the radical Project 2025 recommended making MA the default option for new Medicare enrollees, which would "'supercharge the privatization'" of Medicare.

A 2022 New York Times analysis found that private insurers "exploited" the MA program, with nine out of ten of major insurers accused of fraud or overbilling, and taking billions in overpayments that rival the costs of major federal agencies like the FBI and EPA.

In 2021, former senior Health and Human Services Dept. official Richard Kronick reported that MA plans "cost taxpayers tens of billions of dollars more" than original Medicare, warning federal MA spending could grow by $600 billion by 2031, with two-thirds going straight to insurers' profits. MedPAC, Congress' official Medicare advisory office, said "a major overhaul of MA policies is urgently needed" as it reported that Medicare would spend over $83 billion more on MA enrollees in 2024, totaling $591 billion since 2007. MedPAC also warned MA's growth puts regular Medicare in risk due to remaining enrollees being higher risk.

An August 2021 Kaiser Family Foundation (KFF) report found Medicare Advantage enrollment had doubled over the previous decade, leading to increased payments that could push up premiums for all Medicare beneficiaries and “contribute to the financing challenges facing the Medicare HI Trust Fund.”

The MA insurer market is "highly concentrated" among just seven firms, with 29% of MA enrollees—over 9 million people—covered by UnitedHealthcare, as of 2024.

In late September 2024, UnitedHealth subsidiaries sued the Centers for Medicare & Medicaid Services (CMS), claiming the agency "arbitrar[ily] and capricious[ly]" downgraded its "star rating" following the evaluation of a customer service call. The complaint, filed in the Eastern District of Texas, is "seek[ing] an injunction by the court requiring the CMS to recalculate their star ratings without considering the disputed call."

Star ratings can determine if an insurance plan can "receive bonuses and enroll more members," with poor ratings often leading to "terminated contracts and an inability to market to new customers." In 2024, CMS paid $11.8 billion in Medicare Advantage plan bonuses, higher than "every year between 2015 and 2022," despite the "expiration of pandemic-era policies that temporarily increased star ratings for some plans. UnitedHealthcare received $3.4 billion in bonus payments, 29% of all bonus spending and the most of any Medicare Advantage insurer.

The case is before Judge Jeremy D. Kernodle, a Trump appointee and prominent Federalist Society figure who in 2023 took travel, meals, and lodging from the right-wing Federalist Society and the Scalia Law School, which is also closely linked to right-wing court "architect" Leonard Leo and has been seen as a "an easy pass-through" for donors to influence judges.

Now, a new Accountable.US review has found that UnitedHealthcare—which has spent over $22 million while lobbying on MA issues since 2021—disproportionately relies on a relatively small pool of MA beneficiaries for its total revenues. UnitedHealthcare relied on its MA segment, which made up only 15% of its total enrollment, for 46% of its $281 billion in total revenue in 2023.

- UnitedHealthcare—which covers 29% of MA enrollees—relied on its MA-dominated Medicare & Retirement segment for 46% of its $281 billion in total 2023 revenue, although MA enrollees comprised only 15% of its total enrollment that year. It has also stated that its $31 billion in 2023 revenue growth was "primarily driven" by MA and Medicaid enrollees.

- UnitedHealthcare parent, UnitedHealth Group—which saw $91.5 billion in net income and spent $56.3 billion on shareholder handouts from 2019 through 2023—has complained that MA funding "continues to be pressured" and threatened benefits cuts and cost-cutting.

- UnitedHealth Group—the fourth-largest U.S. company by revenue—has faced widespread criticism of its size, with former Centers for Medicare & Medicaid Services (CMS) Administrator Don Berwick saying it has "'grown too big for this country's good.'"

- UnitedHealthcare has faced a class action lawsuit for illegally using an algorithm to deny ill seniors rehabilitation care, and at least three Justice Department lawsuits for illegally mischarging MA—including one complaint alleging the insurer took part in potentially billions of dollars in MA overcharges.

- UnitedHealth Group has spent $22.3 million while lobbying on Medicare Advantage since Q1 2021. UnitedHealth has also been behind "'astroturf'" MA industry group the Better Medicare Alliance, which itself has spent $4 million on federal lobbying since Q1 2021 and counts a longtime UnitedHealth executive and current Senior Advisor as a board member.

Medicare Advantage (MA) Is A "Fast-Growing Alternative To Original Medicare" That Covers 32.8 Million People—54% Of Those Eligible For Medicare—And Has Been Criticized As A Costly "Privatized" Version Of The Program That Is Vulnerable To "Billing Abuse" By Insurers.

Medicare Advantage (MA) Is A "Fast-Growing Alternative To Original Medicare" Run By Private Health Insurers Which Covers 32.8 Million Americans, Comprising Over 54% Of Those Eligible For Medicare, Up From 45% In 2021 And Up From 19% In 2007.

Medicare Advantage (MA) Is A "Fast-Growing Alternative To Original Medicare" Run By Private Health Insurance Companies. "Medicare Advantage, a fast-growing alternative to original Medicare, is run primarily by major insurance companies." [Kaiser Family Foundation Health News, 11/11/21]

MA Was "Designed By Congress Two Decades Ago To Encourage Health Insurers To Find Innovative Ways To Provide Better Care At Lower Cost." "Medicare Advantage, a private-sector alternative to traditional Medicare, was designed by Congress two decades ago to encourage health insurers to find innovative ways to provide better care at lower cost." [The New York Times, 10/08/22]

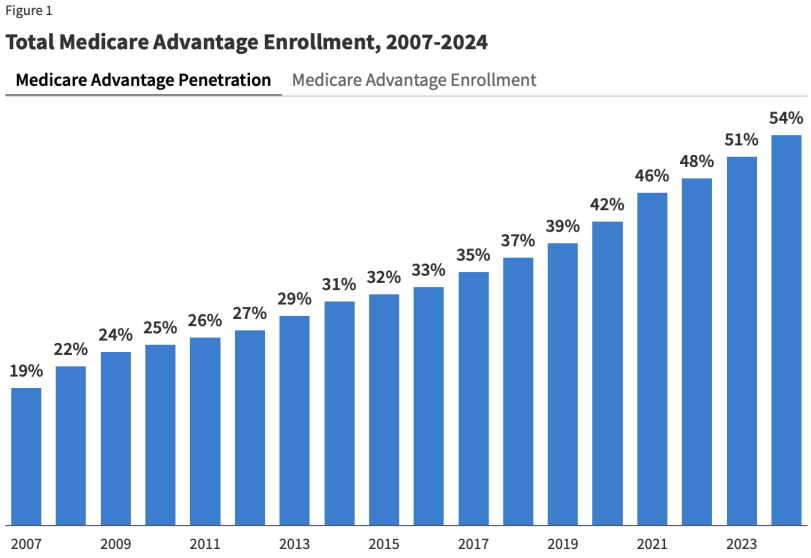
- **MA Was Created Under The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.** "The M+C program in Part C of Medicare was renamed the Medicare Advantage (MA) Program

under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which was enacted in December 2003." [U.S. Centers for Medicare & Medicaid Services, accessed 09/06/24]

In 2024, There Were 32.8 Million People Enrolled In MA Plans, Comprising 54% Of Medicare Eligible Individuals Eligible And $462 Billion (54%) Of Total Federal Medicare Spending. "In 2024, 32.8 million people are enrolled in a Medicare Advantage plan, accounting for more than half, or 54 percent, of the eligible Medicare population, and $462 billion (or 54%) of total federal Medicare spending (net of offsetting receipts, such as premiums)." [Kaiser Family Foundation, 08/08/24]

- **In 2021, MA Plans Enrolled Nearly 27 Million People, About 45% Of Individuals Eligible For Medicare.** "The health plans have enrolled nearly 27 million members, or about 45% of people eligible for Medicare, according to AHIP, an industry trade group formerly known as America's Health Insurance Plans." [Kaiser Family Foundation Health News, 11/11/21]

- **In 2007, MA Plans Enrolled Only 19% Of Individuals Eligible For Medicare:**

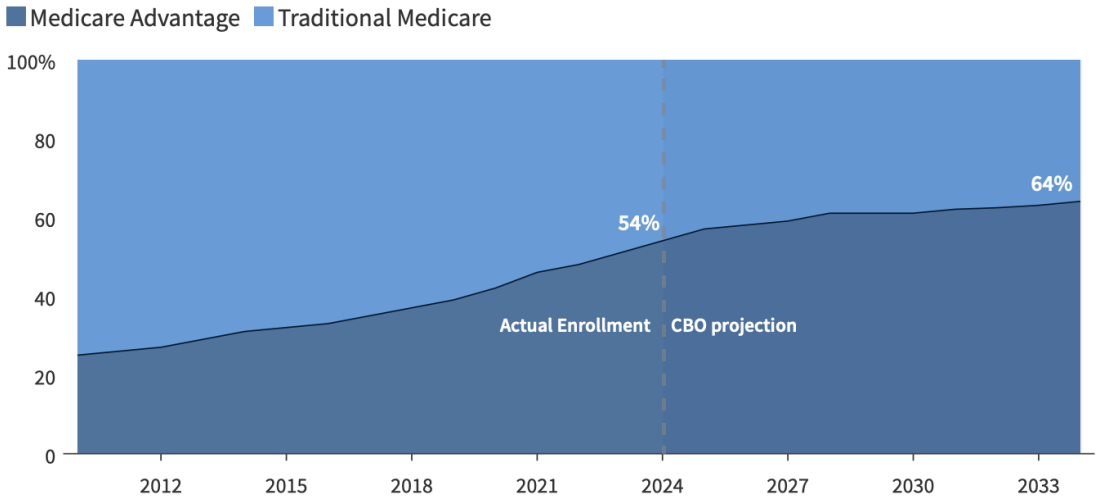


[Kaiser Family Foundation, 08/08/24]

- **The Congressional Budget Office Projects That By 2034, MA Plans Will Cover 64% Of Individuals Eligible For Medicare:**

Figure 2

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. Enrollment numbers from March of the respective year. Projections for 2025 to 2034 are from the June Congressional Budget Office (CBO) Medicare Baseline for 2024. • Get the data • Download PNG

KFF

[Kaiser Family Foundation, 08/08/24]

In 2024, The Average Medicare Beneficiary Had Access To 43 MA Plans, Over "Double The Number Of Plans Offered In 2018." "The average Medicare beneficiary in 2024 has access to 43 Medicare Advantage plans, the same as in 2023, but more than double the number of plans offered in 2018." [Kaiser Family Foundation, 08/08/24]

According To The Kaiser Family Foundation, MA "Enrolls A Disproportionate Share Of People Of Color In Medicare." "Medicare Advantage enrolls a disproportionate share of people of color in Medicare as well as an increasing number of dual eligible beneficiaries." [Kaiser Family Foundation, 08/08/24]

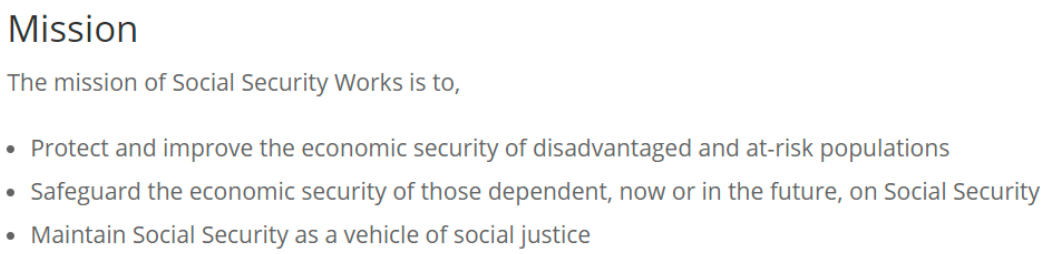
Although The Health Insurance Industry Argues That MA Plans Include Benefits Not Provided By Original Medicare, Critics Have Argued These Plans Cost Taxpayers Too Much And Are Vulnerable To "Billing Abuse" By Insurers.

The Health Insurance Industry Argues That MA Plans Offer Benefits—Including Visions And Dental Care—Not Available Under Original Medicare, But Critics Have Argued That MA Plans Cost Federal Taxpayers Too Much And Are Behind "Billing Abuse" By Some Companies, With The Industry Being A Target Of Multiple Government And Justice Department Lawsuits. "The industry argues that the plans generally offer extra benefits, such as eyeglasses and dental care, not available under original Medicare and that most seniors who join the health plans are happy they did so. [...] Yet critics have argued for years that Medicare Advantage costs taxpayers too much. The industry also has been the target of multiple government investigations and Department of Justice lawsuits that allege widespread billing abuse by some plans." [Kaiser Family Foundation Health News, 11/11/21]

According To Social Security Works, Medicare Is Becoming "A Privatized, Heavily Subsidized Public Health Insurance Program" Through The Growth Of MA Plans, Estimating That Excessive MA Payments Could Reach $100 Billion In 2030.

According To Non-Profit Organization Social Security Works, "Medicare Is Rapidly Becoming A Privatized, Heavily Subsidized Public Health Insurance Program Through The Use Of Private Insurers" In The Medicare Advantage Program. "Medicare is rapidly becoming a privatized, heavily subsidized public health insurance program through the use of private insurers in the Medicare Advantage (MA) program." [Social Security Works, April 2022]

- **Social Security Works Is A Non-Profit Whose Mission Is To "Protect And Improve The Economic Security Of Disadvantaged And At-Risk Populations."**



Mission

The mission of Social Security Works is to,

- Protect and improve the economic security of disadvantaged and at-risk populations
- Safeguard the economic security of those dependent, now or in the future, on Social Security
- Maintain Social Security as a vehicle of social justice

[Social Security Works, accessed 09/23/24]

Excessive Payments To MA Plans Were Over $20 Billion Annually As Of 2022 And Were Expected To Rise To $100 Billion In 2030. "Estimates of excessive payments to MA plans now are in the range of more than $20 B annually, rising to almost $100 B annually in 2030 and costing a total of over $600 B over the next 9 years." [Social Security Works, April 2022]

According To Social Security Works, "People In Traditional Medicare Cost Taxpayers Much Less" Than Those In MA Plans. "People in traditional Medicare cost taxpayers much less. CMS just announced that it will not change its approach to risk scores and therefore expects MA revenue to increase 8.5% in 2023. This increased subsidy will no doubt accelerate the rate of growth of MA even further." [Social Security Works, April 2022]

The MA Insurer Market Is "Highly Concentrated" Among Just Seven Firms, With 47% Of MA Enrollees—Over 15 Million People—Covered By UnitedHealthcare And Humana, As Of 2024.

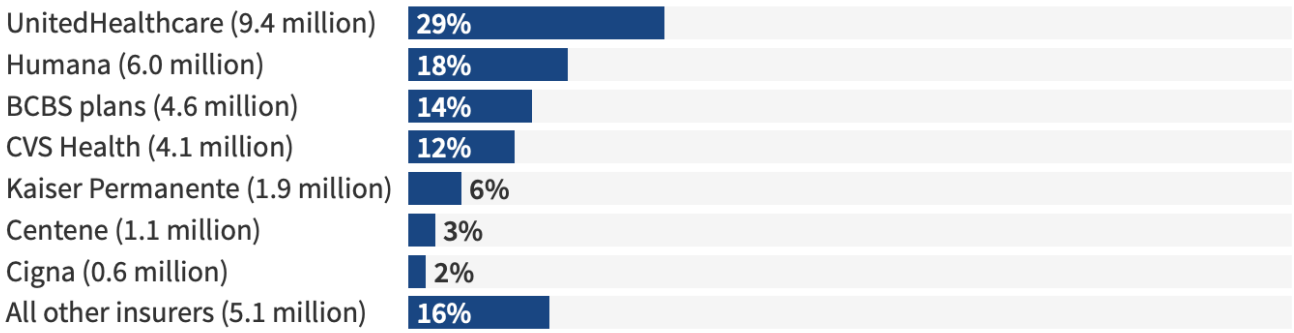
The MA Market Is "Highly Concentrated," Dominated By UnitedHealthcare, Humana, BCBS, CVS Health, Kaiser Permanente, Centene, And Cigna—47% Of MA Enrollees Were Under UnitedHealthcare And Humana Plans, As Of 2024.

In 2024, The Largest MA Insurers, By Enrollment, Were UnitedHealthcare, Humana, BCBS, CVS Health, Kaiser Permanente, Centene, And Cigna:

Figure 8

Medicare Advantage Enrollment by Firm or Affiliate, 2024

Total Medicare Enrollment, 2024: 32.8 million



[Kaiser Family Foundation, 08/08/24]

The MA Market Is "Highly Concentrated Among A Small Number Of Firms, With 47% Of MA Enrollees Covered By UnitedHealthcare And Humana Plans. "Despite most beneficiaries having access to plans operated by several different firms, Medicare Advantage enrollment is highly concentrated among a small number of firms. UnitedHealthcare, alone, accounts for 29% of all Medicare Advantage enrollment in 2024, or 9.4 million enrollees. Together, UnitedHealthcare and Humana (18%) account for nearly half (47%) of all Medicare Advantage enrollees nationwide, the same as in 2023." [Kaiser Family Foundation, 08/08/24]

The Radical Project 2025 Recommended Making MA The Default Option For New Medicare Enrollees, Which Would "'Supercharge The Privatization'" Of Medicare.

The Radical Project 2025—Which Was Linked To At Least 140 Trump Administration Figures, Including Six Cabinet Secretaries—Recommended Rolling Back MA Rules And Making MA The Default Option For New Medicare Enrollees, Which Would "'Supercharge The Privatization'" Of Medicare.

The Radical Project 2025 Proposed Making Medicare Advantage The Default Option For New Medicare Enrollees. "Traditional Medicare as seniors know it could be radically altered depending on this year's election cycle. One proposal in a 'Project 2025' plan developed by allies of former President Donald Trump is to make a private-sector alternative to Medicare the default option when older Americans enroll in the federal health insurance program." [Yahoo! Finance, 07/20/24]

- **Project 2025, Led By The Conservative Heritage Foundation, Is A Radical MAGA Plan To "Roll Back Nothing Less Than 100 Years" Of "Liberal Encroachment" Through The Administrative State—The Plan Proposes To "Defund The Department Of Justice, Dismantle The FBI, Break Up The Department Of Homeland Security And Eliminate The Departments Of Education And Commerce."** "In truth, the program laid out by Dans and his fellow Trumpers, called Project 2025, is far more ambitious than anything Ronald Reagan dreamed up. Dans, from his seat inside The Heritage Foundation, and scores of conservative groups aligned with his program are seeking to roll back nothing less than 100 years of what they see as liberal encroachment on Washington. They want to overturn what began as Woodrow Wilson's creation of a federal administrative elite and later grew into a vast, unaccountable and mostly liberal bureaucracy (as conservatives view it) under Franklin Roosevelt's New Deal and Lyndon Johnson's Great Society, numbering about two and a quarter million

federal workers today. They aim to defund the Department of Justice, dismantle the FBI, break up the Department of Homeland Security and eliminate the Departments of Education and Commerce, to name just a few of their larger targets. [...] And they want to ensure that what remains of this slashed-down bureaucracy is reliably MAGA conservative — not just for the next president but for a long time to come — and that the White House maintains total control of it." [Politico, 09/19/23]

- **At Least 140 Former Trump Administration Figures Worked On Project 2025, Including Six Cabinet Secretaries, Four Ambassador Nominees, And Trump's First Deputy Chief Of Staff.** "Donald Trump has lately made clear he wants little to do with Project 2025, the conservative blueprint for the next Republican president that has attracted considerable blowback in his race for the White House. 'I have no idea who is behind it,' the former president recently claimed on social media. Many people Trump knows quite well are behind it. Six of his former Cabinet secretaries helped write or collaborated on the 900-page playbook for a second Trump term published by the Heritage Foundation. Four individuals Trump nominated as ambassadors were also involved, along with several enforcers of his controversial immigration crackdown. And about 20 pages are credited to his first deputy chief of staff. In fact, at least 140 people who worked in the Trump administration had a hand in Project 2025, a CNN review found, including more than half of the people listed as authors, editors and contributors to 'Mandate for Leadership,' the project's extensive manifesto for overhauling the executive branch." [CNN, 07/11/24]

- **The Heritage Foundation, The Conservative Group Behind Project 2025, Touted That The First Trump Administration Adopted Over Two-Thirds Of The Policy Recommendations In Its 2015 Policy Manifesto, Also Titled "'Mandate For Leadership.'"** "The Heritage Foundation also created a 'Mandate for Leadership' in 2015 ahead of Trump's first term. Two years into his presidency, it touted that Trump had instituted 64% of its policy recommendations, ranging from leaving the Paris Climate Accords, increasing military spending, and increasing off-shore drilling and developing federal lands." [CBS News, 09/10/24]

Project 2025 Also Proposed Rolling Back Regulations On Private-Sector Companies Participating In Medicare Advantage. "The Project 2025 document developed by conservative think tank Heritage Foundation also includes a rollback of regulations governing this private-sector alternative, known as Medicare Advantage (MA). Just over half of Medicare-eligible seniors are already enrolled in MA plans. If ever adopted, these ideas in Project 2025 could limit the choices seniors have for health care services. But insurers may benefit if certain regulations enacted by the Biden administration are undone." [Yahoo! Finance, 07/20/24]

David Lipschutz, Associate Director For The Center For Medicare Advocacy, Said Project 2025 Would "'Supercharge The Privatization'" Of Medicare By Making Medicare Advantage The Default Option For New Enrollees. "One supporter of the current Medicare Advantage regulations, Center for Medicare Advocacy associate director David Lipschutz, said insurers 'would likely embrace an effort to roll back some of the rules that apply to them.' [...] What worries Lipschutz about Project 2025 is it will 'supercharge the privatization' of government-run health coverage by making Medicare Advantage the default option at enrollment." [Yahoo! Finance, 07/20/24]

Project 2025's Chapter On Medicare Was Written By Roger Severino, A Senior Official For Trump's Department Of Health And Human Services.

Project 2025's Chapter On Medicare Reforms Was Written By Roger Severino, A Former Director For The Department Of Health And Human Services' Office Of Civil Rights For Most Of The Trump Administration. "However, the Project 2025 effort is run by close allies of the former president who could have prominent roles in a second Trump administration. Roger Severino, who wrote the section that includes the Medicare reforms, served as the director of the Department of Health and Human Services' Office of Civil Rights from 2017 to 2021 under the Trump administration." [Yahoo! Finance, 07/20/24]

A 2022 New York Times Analysis Found Industry "Exploited" The MA Program, With Nine Out Of Ten Of Major Insurers Accused Of Fraud, Overbilling, And Taking Billions In Overpayments That Rival The Costs Of Major Federal Agencies Like The FBI And EPA.

A 2022 New York Times Analysis On How Insurers Have "Exploited" The MA Program Found That Nine Of The Ten Biggest MA Insurers Faced Fraud Accusations From Whistleblowers And The Federal Government, Or Inspector General Allegations Of Overbilling Medicare.

A 2022 New York Times Analysis Of "Dozens Of Fraud Lawsuits, Inspector General Audits And Investigations By Watchdogs" Found Major Health Insurance Companies "Exploited" The MA Program "To Inflate Their Profits By Billions Of Dollars." "Medicare Advantage, a private-sector alternative to traditional Medicare, was designed by Congress two decades ago to encourage health insurers to find innovative ways to provide better care at lower cost. If trends hold, by next year, more than half of Medicare recipients will be in a private plan. But a New York Times review of dozens of fraud lawsuits, inspector general audits and investigations by watchdogs shows how major health insurers exploited the program to inflate their profits by billions of dollars." [The New York Times, 10/08/22]

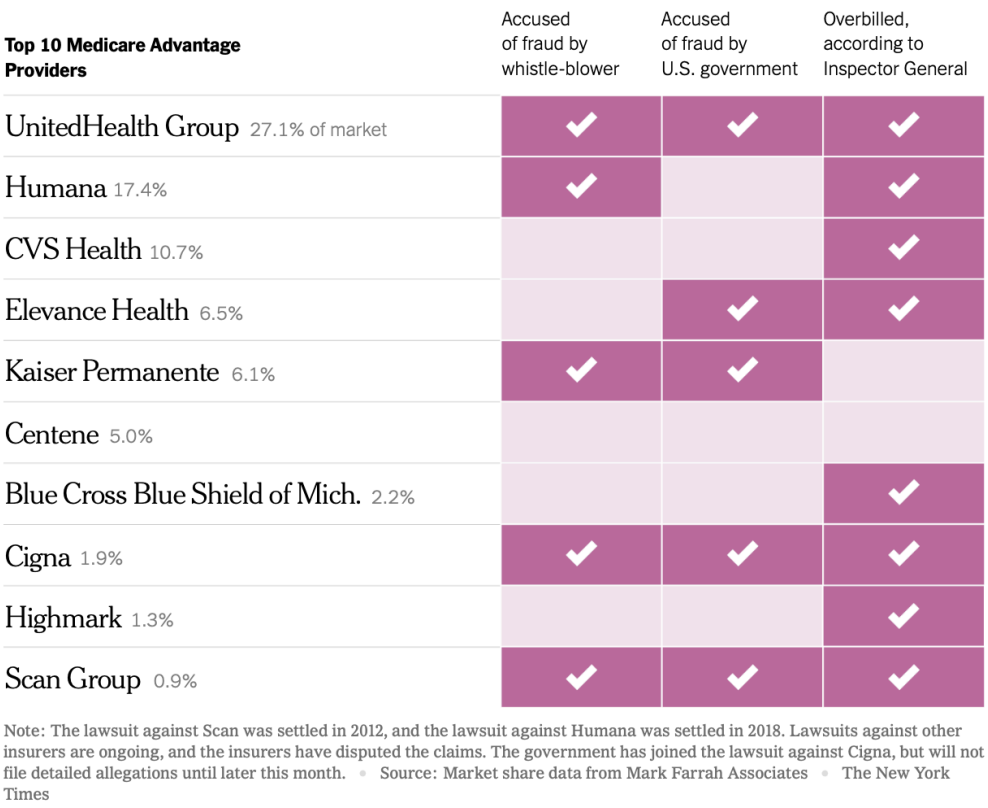
- **HEADLINE: 'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions** [The New York Times, 10/08/22]

The Analysis Found That Eight Of The Ten Biggest MA Insurers, "Representing More Than Two-Thirds Of The Market," Had "Submitted Inflated Bills." "As a result, a program devised to help lower health care spending has instead become substantially more costly than the traditional government program it was meant to improve. Eight of the 10 biggest Medicare Advantage insurers — representing more than two-thirds of the market — have submitted inflated bills, according to the federal audits." [The New York Times, 10/08/22]

The Analysis Found That Four Of The Five Top MA Insurers—UnitedHealth, Humana, Elevance, And Kaiser Permanente—Faced Lawsuits For Overbilling Practices That Had "Crossed The Line Into Fraud." "And four of the five largest players — UnitedHealth, Humana, Elevance and Kaiser — have faced federal lawsuits alleging that efforts to overdiagnose their customers crossed the line into fraud." [The New York Times, 10/08/22]

CVS Health, The Fifth-Biggest MA Insurer, Acknowledged In A 2022 SEC Filing That It Was Being Investigated By The Justice Dept. "The fifth company, CVS Health, which owns Aetna, told investors its practices were being investigated by the Department of Justice." [The New York Times, 10/08/22]

Nine Of The Ten Largest Medicare Advantage Providers Were Either Accused Of Fraud By A Whistleblower Or Government Entity, Or Were Found To Have Overbilled Medicare By An Inspector General:



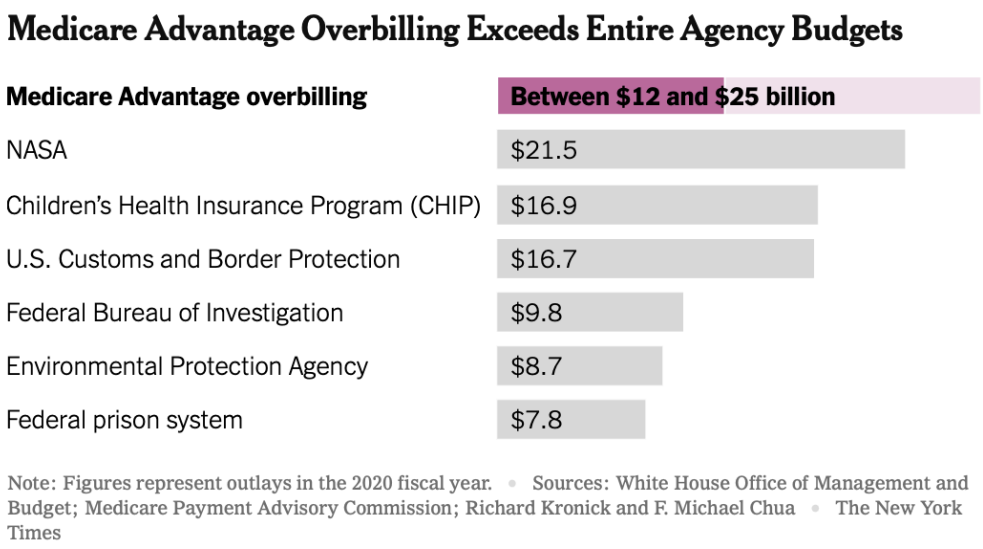
[The New York Times, 10/08/22]

The Analysis Found That The Low-End Estimate Of $12 Billion In MA Overpayments To Insurance Companies Was "Enough To Cover Hearing And Vision Care For Every American Over 65" And Exceeded The 2020 Budgets For Major Federal Agencies Like The FBI, EPA, And Federal Prison System.

Medicare Made An Estimated $12 Billion In MA Overpayments In 2020, "Enough To Cover Hearing And Vision Care For Every American Over 65." "The government now spends nearly as much on Medicare Advantage's 29 million beneficiaries as on the Army and Navy combined. It's enough money that even a small increase in the average patient's bill adds up: The additional diagnoses led to $12 billion in overpayments in 2020, according to an estimate from the group that advises Medicare on payment policies — enough to cover hearing and vision care for every American over 65." [The New York Times, 10/08/22]

- **The Estimate Was Made By The Medicare Payment Advisory Commission (MedPAC), An Independent Congressional Agency To Advise Congress On "Issues Affecting The Medicare Program."** "The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program." [MedPAC, accessed 09/06/24]

The Analysis Found That The Low-End Estimate Of $12 Billion In MA Overbilling Exceeded The Entire 2020 Budgets For The Federal Bureau Of Investigation, The Environmental Protection Agency, And The Federal Prison System:



[The New York Times, 10/08/22]

MA Insurers Have Urged Doctors To "Mine Old Records For More Illnesses" And Reportedly Rewarded Doctors With Bonuses And Champagne Bottles For Padding Profits With Additional Billable Illnesses, As A Growing Number Of Bipartisan Lawmakers Urged "Aggressive Oversight" Of The Industry.

MA Insurers Gave Doctors Champagne Bottles Or Bonuses For Padding Patient Records With Additional Billable Illnesses And Instructed Employees To "Mine Old Medical Records For More Illnesses."

Kaiser Permanente Gave Doctors Champagne Bottles Or Paycheck Bonuses For Adding "Additional Illnesses To The Medical Records Of Patients They Hadn't Seen In Weeks." "The health system Kaiser Permanente called doctors in during lunch and after work and urged them to add additional illnesses to the medical records of patients they hadn't seen in weeks. Doctors who found enough new diagnoses could earn bottles of Champagne, or a bonus in their paycheck." [The New York Times, 10/08/22]

Anthem, Now Known As Elevance Health, "Paid More To Doctors Who Said Their Patients Were Sicker." "Anthem, a large insurer now called Elevance Health, paid more to doctors who said their patients were sicker." [The New York Times, 10/08/22]

Executives From UnitedHealth Group, The "Country's Largest Insurer" As Of 2022, Told Employees To "Mine Old Medical Records For More Illnesses." "And executives at UnitedHealth Group, the country's largest insurer, told their workers to mine old medical records for more illnesses — and when they couldn't find enough, sent them back to try again." [The New York Times, 10/08/22]

A Former Administrator For The Centers For Medicare & Medicaid Services (CMS) Said Of The MA Industry "'We Are Lining The Pockets Of Very Wealthy Corporations That Are Not Improving Patient Care,'" With Bipartisan Lawmakers Urging For "'Aggressive Oversight'" Of The Industry.

Dr. Donald Berwick, A Former CMS (Centers For Medicare & Medicaid Services) Administrator During The Obama Administration, Said, "'Even When They're Playing The Game Legally, We Are Lining The Pockets Of Very Wealthy Corporations That Are Not Improving Patient Care.'" "'Even when they're playing the game legally, we are lining the pockets of very wealthy corporations that are not improving patient care,' said Dr. Donald Berwick, a C.M.S. administrator under the Obama administration, who recently published a series of blog posts on the industry." [The New York Times, 10/08/22]

The Conservative Sen. Chuck Grassley (R-IA) Called For "'Aggressive Oversight'" Of MA Insurers, Citing "'Billions Of Dollars In Improper Payments.'" "'Medicare Advantage is an important option for America's seniors, but as Medicare Advantage adds more patients and spends billions of dollars of taxpayer money, aggressive oversight is needed,' said Senator Charles Grassley of Iowa, who has investigated the industry. The efforts to make patients look sicker and other abuses of the program have 'resulted in billions of dollars in improper payments,' he said." [The New York Times, 10/08/22]

In December 2023, A Bipartisan Group Of Senators Urged CMS To Collect And Publicly Release Data From MA Plans On Beneficiary Out-Of-Pocket Spending Costs And Other Metrics That Would Allow Policymakers And Regulators To Better "Oversee The Program And Legislate Potential Reforms."

December 2023: A Bi-Partisan Group Of Senators Sent A Letter To CMS Urging That Medicare Advantage Plans Should Be Required To Submit Additional Data, With CMS Releasing The Data Publicly. "The Centers for Medicare & Medicaid Services should require Medicare Advantage plans to submit additional data and the agency should publicly release the MA data it already collects, a bipartisan group of senators told the agency last week. The letter requests a staff-level briefing by Dec. 27 on CMS' plan to improve its data collection and reporting practices for MA plans." [American Hospital Center, 12/11/23]

Senators Wrote, "Without Publicly Available Plan-Level Data," "Policymakers And Regulators Are Unable To Adequately Oversee The Program And Legislate Potential Reforms." "'Without publicly available plan-level data on prior authorization requests by type of service, timeliness of determinations and reasons for denials; claims and payment requests denied after a service has been provided; beneficiary out-of-pocket spending; and disenrollment patterns, policymakers and regulators are unable to adequately oversee the program and legislate potential reforms,' wrote Sens. Elizabeth Warren, D-Mass.; Bill Cassidy, R-La.; Catherine Cortez Masto, D-Nev.; and Marsha Blackburn, R-Tenn." [American Hospital Center, 12/11/23]

USC's Schaeffer Center For Health Policy And Economics Estimated That MA Overbilling Could Actually Exceed $75 Billion In 2023, Over Three Times What MedPAC, Congress' Medicare Advisory Agency, Estimated For That Year.

For 2023, USC's Schaeffer Center For Health Policy And Economics Estimated That MA Overbilling Could Exceed $75 Billion, Over Three Times The $23 Billion Estimate Offered By MedPAC, Congress' Medicare Advisory Agency, For That Same Year.

June 2023: The University Of Southern California's Schaeffer Center For Health Policy And Economics Found That Overpayments To MA Plans "Could Exceed $75 Billion In 2023," Which The Center Said Underscored The "Urgent Need For Reform." "Enrollment in the Medicare Advantage program – which allows Medicare beneficiaries to get their health care through plans administered by private insurance companies – has been growing so rapidly that it has recently surpassed enrollment in traditional Medicare. A new analysis by USC researchers warns that overpayments to Medicare Advantage plans now exceed 20% or

$75 billion annually, underscoring the urgent need for reform." [USC Leonard D. Schaeffer Center for Health Policy & Economics, 06/13/23]

- **HEADLINE: Overpayments to Medicare Advantage Plans Could Exceed $75 Billion in 2023, USC Schaeffer Center Research Finds** [USC Leonard D. Schaeffer Center for Health Policy & Economics, 06/13/23]

The Schaeffer Center Study Found That An Estimate From MedPAC—The Independent Agency That Advises Congress On Medicare Issues—Showing $23 Billion In MA Overbilling For 2023 Failed To Factor In "Differences In Spending Between Those Who Enroll In Medicare Advantage And Those Who Remain In Traditional Medicare." "MedPAC estimates that Medicare Advantage plans will be overpaid by $27 billion (6%) in 2023, primarily due to coding differences ($23 billion) and excessive Star Rating (quality) bonuses. However, this estimate does not include the effects of differences in spending between those who enroll in Medicare Advantage and those who remain in traditional Medicare." [USC Leonard D. Schaeffer Center for Health Policy & Economics, 06/13/23]

- **The Medicare Payment Advisory Commission (MedPAC) Is An Independent Congressional Agency To Advise Congress On "Issues Affecting The Medicare Program."** "The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program." [MedPAC, accessed 09/06/24]

In 2021, Former Health And Human Services Dept. Official Richard Kronick Reported That MA Plans "Cost Taxpayers Tens Of Billions Of Dollars More" Than Original Medicare, Warning Federal MA Spending Could Grow By $600 Billion By 2031, With Two-Thirds Going Straight To Insurers' Profits.

A 2021 Study By Former Senior Health And Human Services Department Official Richard Kronick Found MA Plans "Cost Taxpayers Tens Of Billions Of Dollars More" Than Keeping Beneficiaries In Original Medicare, Estimating That Medicare Overpaid MA Plans By Over $106 Billion From 2010 Through 2019.

November 2021: A Study Found That Switching Medicare Beneficiaries To MA Plans "Cost Taxpayers Tens Of Billions Of Dollars More Than Keeping Them In Original Medicare," A Cost That Had "Exploded" Since 2018. "Switching seniors to Medicare Advantage plans has cost taxpayers tens of billions of dollars more than keeping them in original Medicare, a cost that has exploded since 2018 and is likely to rise even higher, new research has found." [Kaiser Family Foundation Health News, 11/11/21]

- **HEADLINE: Researcher: Medicare Advantage Plans Costing Billions More Than They Should** [Kaiser Family Foundation Health News, 11/11/21]

The Study, Done By Former Senior Department Of Health And Human Services Deputy Assistant Secretary Richard Kronick, Found Medicare Overpaid Private MA Plans By Over $106 Billion From 2010 Through 2019 Due To "The Way Private Plans Charge For Sicker Patients." "Richard Kronick, a former federal health policy researcher and a professor at the University of California-San Diego, said his analysis of newly released Medicare Advantage billing data estimates that Medicare overpaid the private health plans by more than $106 billion from 2010 through 2019 because of the way the private plans charge for sicker patients." [Kaiser Family Foundation Health News, 11/11/21]

- **Kronick Was "Deputy Assistant Secretary For Health Policy In The Department Of Health And Human Services During The Obama Administration."** "'They are paying [Medicare Advantage plans]

way more than they should,' said Kronick, who served as deputy assistant secretary for health policy in the Department of Health and Human Services during the Obama administration." [Kaiser Family Foundation Health News, 11/11/21]

Almost $34 Billion Of The Excess Spending Occurred In 2018 And 2019. "Nearly $34 billion of that new spending came during 2018 and 2019, the latest payment period available, according to Kronick. The Centers for Medicare & Medicaid Services made the 2019 billing data public for the first time in late September." [Kaiser Family Foundation Health News, 11/11/21]

Kronick Called MA Costs A "'Systemic Problem,'" With Some Plans Seeing "'Eye-Popping'" Revenue Growth—"Giant Insurer" UnitedHealthcare Saw Excess Payments Of $6 Billion.

Kronick Called The Growth In MA Costs A "'Systemic Problem,'" With Some MA Plans Seeing "'Eye-Popping'" Revenue Gains. "Kronick called the growth in Medicare Advantage costs a 'systemic problem across the industry,' which CMS has failed to rein in. He said some plans saw 'eye-popping' revenue gains, while others had more modest increases." [Kaiser Family Foundation Health News, 11/11/21]

UnitedHealthcare, A "Giant Insurer" Which Had About 6 Million MA Members As Of 2019, Saw Excess Payments Of About $6 Billion, According To Kronick's Analysis. "Giant insurer UnitedHealthcare, which in 2019 had about 6 million Medicare Advantage members, received excess payments of some $6 billion, according to Kronick. The company had no comment." [Kaiser Family Foundation Health News, 11/11/21]

As Opposed To Original Medicare, Where Providers Bill For Each Service, MA Plans Are Paid Using A "Risk Score" That Allows Them To Charge "Thousands Of Dollars More Per Patient," With "Little Monitoring" By The Centers for Medicare & Medicaid Services (CMS).

Under Original Medicare, Providers "Bill For Each Service They Provide," While MA Plans Are Paid Using A "'Risk Score' That Pays Higher Rates For Sicker Patients"—Meaning That MA Plans Can Charge "Thousands Of Dollars More Per Patient" A Year, "With Little Monitoring By CMS." "In original Medicare, medical providers bill for each service they provide. By contrast, Medicare Advantage plans are paid using a coding formula called a 'risk score' that pays higher rates for sicker patients and less for those in good health. That means the more serious medical conditions the plans diagnose the more money they get — sometimes thousands of dollars more per patient over the course of a year with little monitoring by CMS to make sure the higher fees are justified." [Kaiser Family Foundation Health News, 11/11/21]

Although Congress Has Directed CMS To Control MA Costs, Kronick Has Warned That Federal Spending On MA Could Increase By $600 Billion From 2023 To 2031, With As Much As Two-Thirds Going Toward Insurer Profits If CMS Doesn't Better Police Industry Risk Scores.

In 2005, Congress Directed CMS To Control MA Costs By Setting An "Annual Coding Intensity Adjustment" To Keep Insurers' Risk Scores "In Line With Original Medicare," But Since2018, CMS Has Set The Adjustment At The Minimum Amount. "Congress recognized the problem in 2005 and directed CMS to set an annual 'coding intensity adjustment' to reduce Medicare Advantage risk scores and keep them more in line with original Medicare. But since 2018, CMS has set the coding adjustment at 5.9%, the minimum amount required by law." [Kaiser Family Foundation Health News, 11/11/21]

Kronick Warned That If CMS Kept Coding Adjustments At Their Minimum, Federal Spending On MA Would "Increase By $600 Billion From 2023 Through 2031," With "As Much As Two-Thirds Of It [...] Going Toward Profits For Insurance Companies." "Kronick said that if CMS keeps the current coding adjustment in place, spending on Medicare Advantage will increase by $600 billion from 2023 through 2031. While some of that money would provide patients with extra health benefits, Kronick estimates that as much as two-thirds of it could be going toward profits for insurance companies." [Kaiser Family Foundation Health News, 11/11/21]

According To Kronick, MA Coding Schemes Mean Taxpayers "Pay Much More For Similar Patients Who Join [MA] Health Plans Than For Those In Original Medicare." "Legal or not, the rise in Medicare Advantage coding means taxpayers pay much more for similar patients who join the health plans than for those in original Medicare, according to Kronick. He said there is 'little evidence' that higher payments to Medicare Advantage are justified because their enrollees are sicker than the average senior." [Kaiser Family Foundation Health News, 11/11/21]

Kronick Found That In 2019, Risk Scores Were 19% Higher In MA Plans Than In Original Medicare, Having Risen Faster From 2017 To 2019 Than In Previous Years. "Kronick, who has studied the coding issue for years, both inside government and out, said that risk scores in 2019 were 19% higher across Medicare Advantage plans than in original Medicare. The Medicare Advantage scores rose by 4 percentage points between 2017 and 2019, faster than the average in past years, he said." [Kaiser Family Foundation Health News, 11/11/21]

Insurers' "Coding Strategies"—Which Have Allegedly Manipulated Risk Scores To Bill Higher Rates Or Billing For Nonexistent Medical Conditions—Have Been The Subject Of Whistleblower Lawsuits And Government Probes.

MA "Coding Strategies" Have Been Targeted By "Whistleblower Lawsuits And Government Investigations" Alleging MA Plans Have "Illegally Manipulated Risk Scores By Making Patients Appear Sicker Than They Were, Or By Billing For Medical Conditions Patients Did Not Have." "Some of these coding strategies have been the target of whistleblower lawsuits and government investigations that allege health plans illegally manipulated risk scores by making patients appear sicker than they were, or by billing for medical conditions patients did not have." [Kaiser Family Foundation Health News, 11/11/21]

MedPAC, Congress' Official Medicare Advisory Agency, Said "A Major Overhaul Of MA Policies Is Urgently Needed" As It Reported That Medicare Would Spend Over $83 Billion More On MA Enrollees In 2024, Totaling $591 Billion Since 2007.

MedPAC—Congress' Official Advisory Agency On Medicare Issues—Reported That Medicare Would Spend 22%, Or $83 Billion More For MA Enrollees In 2024, Totaling $591 Billion More Than It Spent On Traditional Medicare Enrollees Since 2007.

In Its March 2024 Status Report To Congress, MedPAC Reported That Medicare Spends About 22% More For MA Enrollees Than If Those Same Beneficiaries Were Enrolled In Original, Fee-For-Service (FFS) Medicare, Totaling About $83 Billion For 2024. "Medicare spends an estimated 22 percent 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." [MedPAC, March 2024]

- **The Medicare Payment Advisory Commission (MedPAC) Is An Independent Congressional Agency To Advise Congress On "Issues Affecting The Medicare Program."** "The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program." [MedPAC, accessed 09/06/24]

- **Original Medicare Is Known As "Fee-For-Service" (FFS) Medicare.** "To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional fee-for-service (FFS) Medicare." [MedPAC, March 2024]

MedPAC Acknowledged That Some Of The Increased Payments To MA Were For Supplemental Benefits, But Said It Was "Concerned That The Relatively Higher Payments To MA Plans Are Subsidized By The Taxpayers And Beneficiaries Who Fund The Program." "The Commission acknowledges that a portion of these increased payments to MA plans are used to provide more generous supplemental benefits and better financial protection for MA enrollees. [...] Nevertheless, the Commission is concerned that the relatively higher payments to MA plans are subsidized by the taxpayers and beneficiaries who fund the program." [MedPAC, March 2024]

MedPAC Estimated That Since 2007, Medicare Has Paid $591 Billion More For MA Enrollees Than If They Were FFS Enrollees, With Over Half Of That Spending Occurring From 2020 Through 2024. "Since 2007, we estimate that Medicare has paid $507 billion and will pay $83 billion more for MA enrollees in 2024 than if those beneficiaries had instead been in FFS—a total of $591 billion. Over half (an estimated $338 billion) of the MA payments above FFS spending will have occurred in the last five years—from 2020 through 2024. These higher payments are increasingly driven by coding intensity, which we estimate accounted for the largest share of payments above FFS spending from 2022 through 2024." [MedPAC, March 2024]

MedPAC Noted That Higher MA Spending Raises Part B Premiums For All Medicare Beneficiaries, Estimating $13 Billion In Higher Costs In 2024. "Higher MA spending increases Part B premiums for all beneficiaries (including those in FFS who do not have access to the supplemental benefits offered by MA plans); the Commission estimates that those premiums will be about $13 billion higher in 2024 because of higher MA spending." [MedPAC, March 2024]

MedPAC Stated That "A Major Overhaul Of MA Policies Is Urgently Needed," Citing Overpayments To MA Providers, Disparities Between MA And Original Medicare Beneficiaries, Obstacles To "Meaningful Oversight," And Warning That Medicare Is Not Getting Value For The Money It Spends On MA Coverage.

MedPAC Stated, "A Major Overhaul Of MA Policies Is Urgently Needed," Firstly Because "Beneficiaries Lack Meaningful Quality Information When Choosing Among MA Plans." "A major overhaul of MA policies is urgently needed for several reasons. First, beneficiaries lack meaningful quality information when choosing among MA plans." [MedPAC, March 2024]

- **Secondly, MedPAC Said Reform Is Needed Because "Medicare Is Paying More For MA Than For Comparable Beneficiaries In FFS Medicare."** "Second, Medicare is paying more for MA than for comparable beneficiaries in FFS Medicare." [MedPAC, March 2024]

- **Third, Reform Is Needed Due To "The Disparity Between MA And FFS Payment Disadvantag[ing] Beneficiaries Who—For Medical Reasons Or Personal Preferences—Do Not Want To Enroll In MA Plans."** "Third, the disparity between MA and FFS payment disadvantages beneficiaries who—for medical reasons or personal preferences—do not want to enroll in MA plans that use tools like provider

networks or utilization management policies and instead want to remain in FFS (which includes care provided through alternative payment models)." [MedPAC, March 2024]

- **Fourth, Reform Is Needed Because "The Lack Of Information About The Use And Value Of Many MA Supplemental Benefits Prevents Meaningful Oversight Of The Program."** "Fourth, the lack of information about the use and value of many MA supplemental benefits prevents meaningful oversight of the program such that we cannot ensure that enrollees are getting value from those benefits." [MedPAC, March 2024]

- **Fifth, MedPAC Stated That MA's Growth "Will Increasingly Create Challenges For Benchmark Setting Because Beneficiaries Remaining In FFS May Be Higher Risk."** "Finally, the continued growth in MA will increasingly create challenges for benchmark setting because beneficiaries remaining in FFS may be higher risk (and thus have higher spending) in ways that risk adjustment cannot adequately capture." [MedPAC, March 2024]

MedPAC Said Medicare's "Subsidization Of Supplemental Benefits" Through The MA Program "Should Be Considered With Attention To Their Value," Adding, "Current Policy Does Not Meet That Standard." "Because of Medicare's fiscal situation, the subsidization of supplemental benefits, if desired by policymakers, should be considered with attention to their value. In the Commission's view, current policy does not meet that standard." [MedPAC, March 2024]

An August 2021 Kaiser Family Foundation (KFF) Report Found Medicare Advantage Enrollment Had Doubled Over the Previous Decade, Leading to Increased Payments—With MA Per Enrollee Payments Doubling Traditional Medicare Enrollee Payments—That Could Push Up Premiums For All Medicare Beneficiaries And "Contribute To The Financing Challenges Facing The Medicare HI Trust Fund."

An August 2021 Report from The Kaiser Family Foundation (KFF) Found Medicare Advantage Enrollment Had Doubled Over the Previous Decade, With Spending For MA Growing Faster Than Traditional Medicare.

August 2021: The Kaiser Family Foundation (KFF) Released A Reporting Highlighting Medicare Advantage Enrollees Doubling Over The Last Decade, With Spending For MA Growing Faster Than Traditional Medicare. "The number of people enrolled in Medicare has increased steadily in recent years, and along with it, Medicare spending. In particular, enrollment in Medicare Advantage, the private plan alternative to traditional Medicare, has more than doubled over the last decade. Notably, Medicare spending is higher and growing faster per person for beneficiaries in Medicare Advantage than in traditional Medicare. As enrollment in Medicare Advantage continues to grow, these trends have important implications for total Medicare spending, and costs incurred by beneficiaries." [Kaiser Family Foundation, 08/17/21]

The KFF Report Found That In 2019 Medicare Advantage Per Enrollee Payments Were Twice As Much As Spending For "Comparable Beneficiaries Covered By Traditional Medicare."

KFF's Analysis Found That "Medicare Advantage Payments Per Enrollee In 2019 Were Approximately 103 Percent Of Spending Per Person For Comparable Beneficiaries Covered By Traditional Medicare." "Our analysis finds that Medicare Advantage payments per enrollee in 2019 were approximately 103 percent of spending per person for comparable beneficiaries covered by traditional Medicare, consistent with estimates

based on data submitted by private plans as part of the bidding process and concurrent projections by CMS of future spending in traditional Medicare." [Kaiser Family Foundation, 08/17/21]

KFF Also Noted Increased MA Enrollment Will Raise Payments, Pushing Up Premiums For All Medicare Beneficiaries And "Contribut[ing] To The Financing Challenges Facing The Medicare HI [Hospital Insurance] Trust Fund."

KFF Also Noted That As MA Enrollment Increases, Higher Payments Will Push Up Premiums For All Medicare Beneficiaries And "Contribute To The Financing Challenges Facing The Medicare HI Trust Fund." "Over the next decade, Medicare Advantage enrollment is expected to continue to grow. As more Medicare beneficiaries enroll in private plans, differences in Medicare payments across Medicare Advantage and traditional Medicare will lead to even higher Medicare spending, and more generous benefits for beneficiaries in Medicare Advantage than traditional Medicare. That higher spending increases Part B premiums paid by all Medicare beneficiaries, including those who are not in a Medicare Advantage plan, and contribute to the financing challenges facing the Medicare HI Trust Fund." [Kaiser Family Foundation, 08/17/21]

- **The Medicare Hospital Insurance (HI) Is One Of Two Federally-Run Trust Funds That Pay For Medicare.** "Medicare Trust Funds [...] Medicare is paid for through 2 trust fund accounts held by the U.S. Treasury. These funds can only be used for Medicare. [...] Hospital Insurance (HI) Trust Fund." [Medicare.gov, accessed 10/07/24]

UnitedHealthcare

In Late September 2024, UnitedHealth Subsidiaries Sued The Centers For Medicare & Medicaid Services (CMS) In the Eastern District of Texas After The Agency Downgraded Its "Star Rating"—Which Can Determine If A Company Can Receive Bonuses And Enroll More Members—Following The Evaluation of A Customer Service Call.

In Late September 2024, UnitedHealth Subsidiaries Sued The Centers For Medicare & Medicaid Services (CMS), Alleging The Agency "Arbitrar[ily] And Capricious[ly]" Downgraded Its "Star Rating" Following The Evaluation of A Customer Service Call.

In Late September 2024, UnitedHealth Subsidiaries Sued The Centers For Medicare & Medicaid Services (CMS) After The Agency Downgraded Its "Star Rating." "Affiliates of one of the nation's largest Medicare Advantage plans sued the Biden administration claiming that their quality rating was unreasonably downgraded after one customer service phone call. The complaint filed Monday by subsidiaries of insurance giant UnitedHealth Group Inc. alleges the Centers for Medicare & Medicaid Services downgraded the company's 'Star Ratings' based on an 'arbitrary and capricious assessment of how Plaintiffs' call center handled a single phone call that lasted less than ten minutes.'" [Bloomberg Law, 10/02/24]

In Their Complaint, The Subsidiaries Argue CMS "Arbitrar[ily] And Capricious[ly]" Downgraded The Star Ratings Based On How A "Call Center Handled A Single Phone Call That Lasted Less Than Ten Minutes." "Plaintiffs are health insurance plans that bring this action to challenge an arbitrary and capricious, and otherwise unlawful, evaluation and rating of their performance by the federal agency that regulates them — Defendant Centers for Medicare & Medicaid Services ('CMS'). CMS evaluates the plans at issue through a ranking process it uses to assign Star Ratings that consumers rely upon to choose health insurance during

annual enrollment periods (among other times). One of the measures that CMS uses to conduct such evaluations relates to the performance of a plan's customer service call center. CMS has downgraded Plaintiffs' Star Ratings based on an arbitrary and capricious assessment of how Plaintiffs' call center handled a single phone call that lasted less than ten minutes." [UnitedHealthCare Complaint against CMS, 09/30/24]

- **According To The Complaint, CMS Partially Rates Insurance Plans Based On "Evaluations Relates To The Performance Of A Plan's Customer Service Call Center."** "CMS evaluates the plans at issue through a ranking process it uses to assign Star Ratings that consumers rely upon to choose health insurance during annual enrollment periods (among other times). One of the measures that CMS uses to conduct such evaluations relates to the performance of a plan's customer service call center." [UnitedHealthCare Complaint against CMS, 09/30/24]

The Subsidiaries Alleged A CMS Test Caller Failed To Ask The Required Introductory Question, Denying The Customer Service Representative The Opportunity To Provide A Response. "The plaintiffs claim a CMS test caller had connected to one of UnitedHealth's representatives, yet at no point during the eight-minute phone call 'did the CMS test caller ask the required introductory question.' For this reason, the lawsuit claims, 'the customer service representative did not have the opportunity to provide a response' and the company was unfairly docked on their quality rating score." [Bloomberg Law, 10/02/24]

The Complaint, Filed In The Eastern District Of Texas, Is "Seek[Ing] An Injunction By The Court Requiring The CMS To Recalculate Their Star Ratings Without Considering The Disputed Call."

The Subsidiaries Are "Seek[ing] An Injunction By The Court Requiring The CMSTo Recalculate Their Star Ratings Without Considering The Disputed Call." "The plaintiffs seek an injunction by the court requiring the CMS to recalculate their Star Ratings without considering the disputed call. Alston & Bird LLP represents the insurance companies. The case is UnitedHealthcare Benefits of Texas v. CMS, E.D. Tex., No. 6:24-cv-00357, complaint 9/30/24." [Bloomberg Law, 10/02/24]

- **The Complaint Was Filed On September 30, 2024 In The Eastern District Of Texas.** [UnitedHealthCare Complaint Against CMS, 09/30/24]

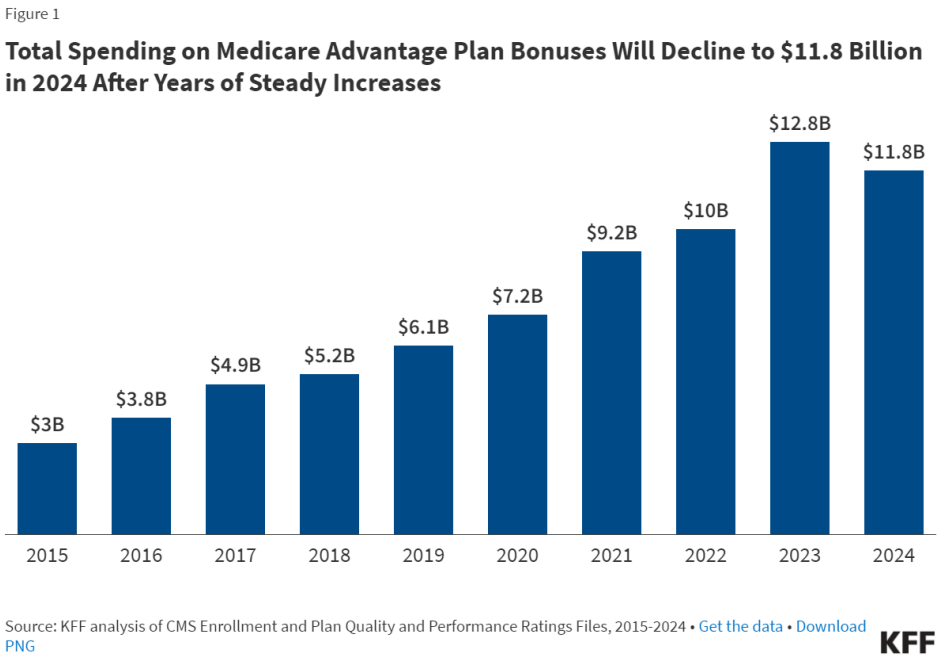
CMS Star Ratings Can Determine If An Insurance Plan Can "Receive Bonuses And Enroll More Members," With Poor Ratings Often Leading To "Terminated Contracts And An Inability To Market To New Customers."

Star Ratings, Ranging From One To Five Stars, Determine If An Insurance Plan Can "Receive Bonuses And Enroll More Members," With Poor Ratings Often Leading To "Terminated Contracts And An Inability To Market To New Customers." "Star ratings, which range from one to five stars, play a crucial role for Medicare Advantage insurers. Higher ratings allow plans to receive bonuses and enroll more members, while poor ratings can lead to terminated contracts and an inability to market to new customers." [Bloomberg Law, 10/02/24]

In 2024, CMS Paid $11.8 Billion In Medicare Advantage Plan Bonuses, Higher Than "Every Year Between 2015 And 2022," Despite The "Expiration Of Pandemic-Era Policies That Temporarily Increased Star Ratings For Some Plans—UnitedHealthcare Received $3.4 Billion In Bonus Payments, 29% Of All Bonus Spending And The Most Of Any Medicare Advantage Insurer.

In September 2024, The Kaiser Family Foundation Reported That The $11.8 Billion In Medicare Advantage Plan Bonuses For 2024 Was Higher Than "Every Year Between 2015 And 2022," Despite The "Expiration Of Pandemic-Era Policies That Temporarily Increased Star Ratings For Some Plans.

September 2024: A Kaiser Family Foundation Report Found The $11.8 Billion In Medicare Advantage Plan Bonuses For 2024 Was Higher Than "Every Year Between 2015 And 2022," Despite The "Expiration Of Pandemic-Era Policies That Temporarily Increased Star Ratings For Some Plans." "After increasing by more than 400% between 2015 and 2023, federal spending on Medicare Advantage bonus payments will decline by $1 billion (8%) to $11.8 billion in 2024, following the expiration of pandemic-era policies that temporarily increased star ratings for some plans. Despite the decline, total spending on Medicare Advantage plan bonuses is higher in 2024 than in every year between 2015 and 2022." [Kaiser Family Foundation, 09/11/24]



[Kaiser Family Foundation, 09/11/24]

In 2024, UnitedHealthcare Received $3.4 Billion In Bonus Payments, 29% Of All Bonus Spending And The Most Of Any Medicare Advantage Insurer.

In 2024, UnitedHealthcare Received $3.4 Billion In Bonus Payments, 29% Of All Bonus Spending And The Most Of Any Medicare Advantage Insurer:

Figure 5

Total Bonus Spending by Firm Tracks Enrollment in 2024

Firm	Enrollment Share	Share of Bonus Spending	Total Bonus Spending	Average Bonus Per Enrollee	Share of Enrollees in Plans with Bonuses
UnitedHealthcare	29%	29%	$3.4B	$365	74%
Humana	18%	21%	$2.5B	$422	88%
BCBS plans	14%	14%	$1.7B	$364	70%
CVS Health	12%	9%	$1.1B	$265	53%
Kaiser Permanente	6%	8%	$976.4M	$516	99%
Centene	3%	0%	$34.8M	$32	8%
All others	17%	18%	$2.1B	$368	72%

[Kaiser Family Foundation, 09/11/24]

The Case Is Before Judge Jeremy D. Kernodle, A Trump Appointee And Prominent Federalist Society Figure Who In 2023 Accepted Travel, Meals, And Lodging From The Right-Wing Federalist Society And Leonard Leo-Linked Scalia Law School, Which Has Been Seen As "An Easy Pass-Through" For Donors To Influence Judges.

The Case Is Before Judge Jeremy D. Kernodle Of The U.S. Eastern District Of Texas, A Trump Appointee And Prominent Federalist Society Figure Who In 2023 Accepted Travel, Meals, And Lodging From The Federalist Society, George Mason University's Scalia Law School, And The George Mason Center For Law And Economics.

The Case Was Before Judge Jeremy D. Kernodle, Of The U.S. District Court For The Eastern District Of Texas:

6:24-cv-00357-JDK UnitedHealthcare Benefits of Texas, Inc. et al
Jeremy D. Kernodle, presiding
Date filed: 09/30/2024
Date of last filing: 10/02/2024

[U.S. Courts, Case Summary, Case No. 6:24-cv-00357-JDK, 09/30/24]

Judge Kernodle Was Nominated By President Trump In 2018. "Jeremy D. Kernodle is a judge on the United States District Court for the Eastern District of Texas. He was nominated by President Trump in 2018." [The Federalist Society, accessed 10/04/24]

Judge Kernodle Has Been President And Vice President Of The Dallas Chapter Of The Federalist Society And Has "Given Numerous Presentations For The Chapter." "You have been President and Vice President of the Dallas Chapter of the Federalist Society and given numerous presentations for the chapter.

You have introduces [sic] speakers for such programs as 'The Legacy of Justice Antonin Scalia' and 'When Can the Executive Decide Not to Enforce the Law.'" [U.S. Senate Committee on the Judiciary, 05/16/18]

Judge Kernodle Has Been Featured In Three Federalist Society Events Since 2019. [The Federalist Society, accessed 10/04/24]

In His 2023 Financial Disclosure, Judge Kernodle Reported Accepting Travel, Meals, And Lodging From The Federalist Society's Houston Lawyers Chapter, The George Mason University Antonin Scalia Law School, And The George Mason Center For Law And Economics:

IV. REIMBURSEMENTS -- *transportation, lodging, food, entertainment.*

(Includes those to spouse and dependent children; see Guide to Judiciary Policy, Volume 2D, Ch. 3, § 330 Gifts and Reimbursements; § 360 Spouses and Dependent Children.)

☐ NONE *(No reportable reimbursements.)*

	SOURCE	DATES	LOCATION	PURPOSE	ITEMS PAID OR PROVIDED
1.	George Mason University Antonin Scalia Law School	May 3 - 6, 2023	Arlington, VA	Educational Seminar	Travel, meals, lodging
2.	George Mason Center for Law and Economics	June 10-17, 2023	Girdwood, AK	Educational Seminar	Travel, meals, lodging
3.	Federalist Society (Houston Lawyers Chapter)	Sept 21-23, 2023	Houston, TX	Panelist	Travel, meals, lodging
4.	Eastern District of Texas Bar Association	Oct 25-27, 2023	Plano, TX	Panelist	Travel, meals, lodging

[Judge Jeremy D. Kernodle Financial Disclosure Report, 2023, 05/15/24]

The Federalist Society, Which Postures As A Politically Neutral "'Debate Society,'" Is Known For Its Role In Cultivating Conservative Judges Under The Leadership Of Co-Chairman And Former Executive Director Leonard Leo, The "Architect" Of The Conservative Federal Judiciary.

The Federalist Society Postures As A "Neutral 'Debate Society'" And Its President And CEO Eugene Meyer Has Claimed The Group "Does Not Take Policy Positions." "'From our very beginning, there has been an aspect of judicial restraint, and there has been an aspect that it's judges' jobs to interpret the Constitution, that whatever it says, that's what they should do — and those two can sometimes be in tension,' said Eugene Meyer, the president and CEO of the Federalist Society, as we spoke in a back hallway of the conference center. [...] At Meyer's urging, the society goes to great lengths to emphasize that it does not take policy positions or weigh in on the merit of individual cases, preferring to present itself as a neutral "debate society" for right-leaning intellectuals." [Politico, 03/17/23]

Federalist Society Membership Has Been "An Informal Required Credential To Obtain A Trump Judicial Appointment." "She is a member of the Federalist Society, as six of the nine justices sitting on the Supreme Court are or were. Being a member of the Federalist Society was an informal required credential to obtain a Trump judicial appointment. [...] A correction was made on June 16, 2023: An earlier version of this article misstated the number of justices who are members of the Federalist Society. Four justices are current members, not six; two are former members." [The New York Times, 06/15/23]

Leonard Leo, Co-Chairman And Former Executive Vice President Of "Right-Wing Powerhouse Group The Federalist Society," "Helped Fuel The Rise Of Five Of The Six Republican Supreme Court Justices" And Has Been Called "The Quiet Architect Of A Pivotal Shift To The Right Throughout The Federal Judiciary." "The 90-year-old was said to have gifted $1.65 billion to a conservative nonprofit fronted by Leonard Leo, the cochairman of the right-wing powerhouse group The Federalist Society. Leo helped fuel the

rise of five of the six Republican Supreme Court justices, as ProPublica noted, and has helped fund fights over abortion rights, voting laws, and other conservative causes." [Insider, 08/26/22]

- **Leonard Leo Has Been "The Quiet Architect Of A Pivotal Shift To The Right Throughout The Federal Judiciary" And The Federalist Society's "Roughly 70,000 Members Represent A Vast Web Of Conservative Legal Power."** "As executive vice president of the Federalist Society, Leo has been the quiet architect of a pivotal shift to the right throughout the federal judiciary. He was still at Cornell Law School in 1989 when he joined the society, a network of fresh legal minds who believed limited government was the best way to protect freedom and personal liberty. Today, under Leo's leadership, the group's roughly 70,000 members represent a vast web of conservative legal power." [Politico Magazine, 2018]

- **Leonard Leo "Wrote" Trump's Supreme Court Short List.** "CHANG: By May 2016, Donald Trump had become the presumptive Republican presidential nominee, but he still needed to win over skeptical conservatives. And so he released a list of people he would nominate to the Supreme Court. How much of a role - a personal, direct role - did Leonard Leo play in creating this list? MARCUS: He wrote it." [NPR, 06/21/22]

- **As Of 2018, Leonard Leo Was Executive Vice President Of The Federalist Society.** "Leonard Leo [...] Executive vice president, Federalist Society [...] © 2018 POLITICO LLC" [Politico Magazine, 2018]

- **In 2020, Leo "Stepped Away From His Day-To-Day Role At The Federalist Society" To Run The Concord Fund, The "Rebranded" Judicial Crisis Network.** "In early 2020, Leo stepped away from his day-to-day role at the Federalist Society, the national conservative lawyers group, to help steer the Concord Fund. Between mid-2019 and mid-2020, the Concord Fund paid $1.6 million to a company affiliated with Leo called BH Group, LLC. Leo and his allies rebranded the Judicial Crisis Network as the Concord Fund, turning it into a social welfare organization that fiscally sponsors other organizations." [The Daily Poster, 06/29/21]

Scalia Law School—Named For The Late Justice Antonin Scalia As Part Of A $30 MIllion Gift Brokered By Right-Wing Court "Architect" Leonard Leo —Has Been Seen As "An Easy Pass-Through" Where Donors Or Corporations Can Influence Supreme Court Justices And Where The Law School's Dean Has Been "On A Texting Basis With Justices Kavanaugh And Thomas."

In 2016, Scalia Law School Dean Henry Butler And Leonard Leo "Struck A $30 Million Deal With Donors" To Rename The School After The Recently-Deceased Justice Antonin Scalia, With $10 Million From The Charles Koch Foundation And The Remainder Suspected To Be From Electronics "Mogul" And Conservative Donor Barre Seid. "The windfall, and the way forward, came quickly. About two weeks after Justice Scalia's death on a Texas hunting trip in February 2016, Mr. Butler and Mr. Leo struck a $30 million deal with donors to rename the school for him. Ten million dollars came from the Charles Koch Foundation; the balance, the school explained, came from an anonymous donor who had approached Mr. Leo. (The benefactor is widely believed to be Barre Seid, an electronics manufacturing mogul and conservative donor who would later make an extraordinary $1.6 billion contribution to a political group controlled by Mr. Leo.)" [The New York Times, 04/30/23]

- **The Donations Would Allow Scalia Law School To Establish Right-Leaning Legal Centers, Including The Center For The Study Of The Administrative State.** "The money would, among other things, allow the law school to support new research centers organized around areas of special concern for the legal right, including a Center for the Study of the Administrative State and a Liberty & Law Center." [The New York Times, 04/30/23]

Leonard Leo, Co-Chairman And Former Executive Vice President Of "Right-Wing Powerhouse Group The Federalist Society," "Helped Fuel The Rise Of Five Of The Six Republican Supreme Court Justices" And Has Been Called "The Quiet Architect Of A Pivotal Shift To The Right Throughout The Federal Judiciary." "The 90-year-old was said to have gifted $1.65 billion to a conservative nonprofit fronted by Leonard Leo, the cochairman of the right-wing powerhouse group The Federalist Society. Leo helped fuel the rise of five of the six Republican Supreme Court justices, as ProPublica noted, and has helped fund fights over abortion rights, voting laws, and other conservative causes." [Insider, 08/26/22]

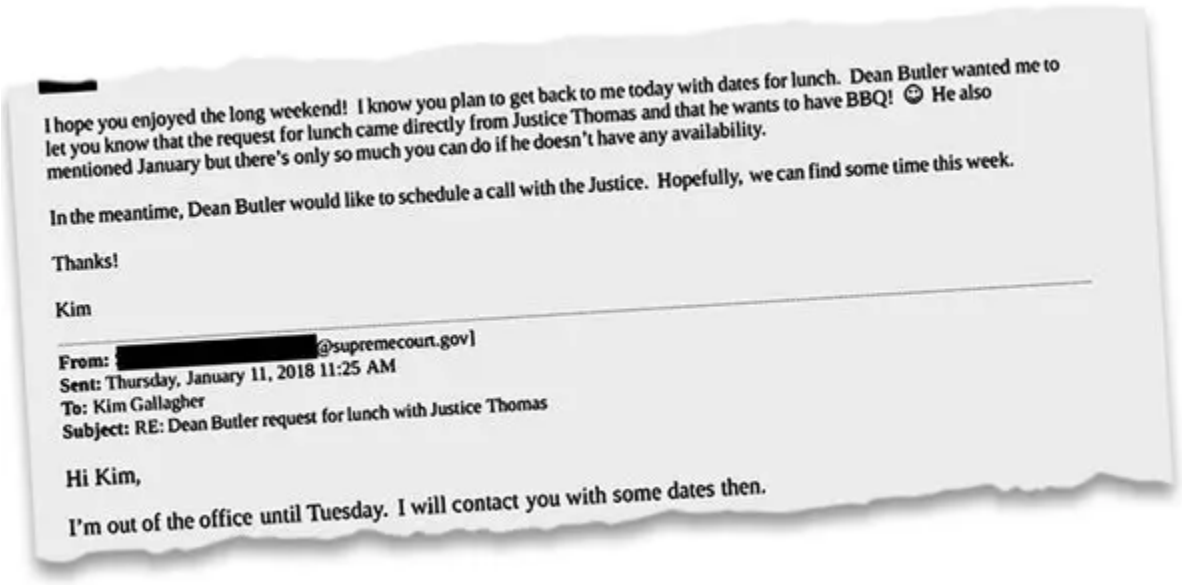
- **Leonard Leo Has Been "The Quiet Architect Of A Pivotal Shift To The Right Throughout The Federal Judiciary" And The Federalist Society's "Roughly 70,000 Members Represent A Vast Web Of Conservative Legal Power."** "As executive vice president of the Federalist Society, Leo has been the quiet architect of a pivotal shift to the right throughout the federal judiciary. He was still at Cornell Law School in 1989 when he joined the society, a network of fresh legal minds who believed limited government was the best way to protect freedom and personal liberty. Today, under Leo's leadership, the group's roughly 70,000 members represent a vast web of conservative legal power." [Politico Magazine, 2018]

George Mason University Has Been Seen As "An Easy Pass-Through In Which A Donor Or Corporation Could Give To The University Before Their Case Appears Before The Supreme Court." "George Mason University law school is an easy pass-through in which a donor or corporation could give to the university before their case appears before the Supreme Court. It could all be above board, but it creates an ethical question." [Raw Story, 04/30/23]

Former Scalia Law School Dean Henry Butler Was "On A Texting Basis With Justices Kavanaugh And Thomas" And Turned His Closeness With The Supreme Court "Into Bragging Rights With Donors." "Right away, the dean at the time, Henry Butler, began sending out save-the-dates for a dedication. At the top of his mind: ensuring that justices would be there. [...] At the law school, Mr. Butler sought to convert his closeness with the justices — he was on a texting basis with Justices Kavanaugh and Thomas — into bragging rights with donors. He also began calling in favors." [The New York Times, 04/30/23]

- **Henry Butler Served As Scalia Law School Dean Until 2020 And Is Now The Henry G. Manne Chair In Law And Economics And Chairman Of The Law & Economics Center At Scalia Law School.** "Henry N. Butler is the Henry G. Manne Chair in Law and Economics and Chairman of the Law & Economics Center at George Mason University's Antonin Scalia Law School. For over 30 years, Butler has developed and led educational programs that teach economics, finance, accounting, statistics, and the scientific method to federal and state judges. He served as dean of the law school from 2015 through 2020 and achieved unparalleled success, including raising record-breaking gifts, establishing a host of new centers, institutes, and clinics, boosting the law school's national and international reputation, and naming the school after the late Justice Antonin Scalia." [George Mason University, accessed 08/03/23]

2018 Emails Show That Justice Thomas Requested To Have A BBQ Lunch With Then-Dean Henry Butler, Who Separately Requested A Phone Call With The Justice:



I hope you enjoyed the long weekend! I know you plan to get back to me today with dates for lunch. Dean Butler wanted me to let you know that the request for lunch came directly from Justice Thomas and that he wants to have BBQ! 😊 He also mentioned January but there's only so much you can do if he doesn't have any availability.

In the meantime, Dean Butler would like to schedule a call with the Justice. Hopefully, we can find some time this week.

Thanks!

Kim

From: [redacted]@supremecourt.gov]
Sent: Thursday, January 11, 2018 11:25 AM
To: Kim Gallagher
Subject: RE: Dean Butler request for lunch with Justice Thomas

Hi Kim,

I'm out of the office until Tuesday. I will contact you with some dates then.

[The New York Times, 04/30/23]

The Scalia Law School's Law & Economics Center, Which Is "Devoted" To The Legal Theory That Courts Must Consider Economic Impacts Of Laws, Has "Offered Training To More Than 5,000 Federal And State Judges." "The law school, established at George Mason only in the late 1970s, had carved out a distinctive place on the right flank of legal academia. Its Law & Economics Center, devoted to one of the pillars of conservative legal thought — the idea that courts must consider the economic impact of the law — had offered training to more than 5,000 federal and state judges." [The New York Times, 04/30/23]

United Healthcare—Which Covers 29% Of MA Enrollees—Heavily Relies On MA Enrollees For Its Hundreds Of Billions Of Dollars In Revenue, Stated $31 Billion In 2023 Revenue Growth Was "Primarily Driven" By MA And Medicaid Enrollees, And Noted That CMS Premiums Accounted For 40% Of Its 2023 Revenue.

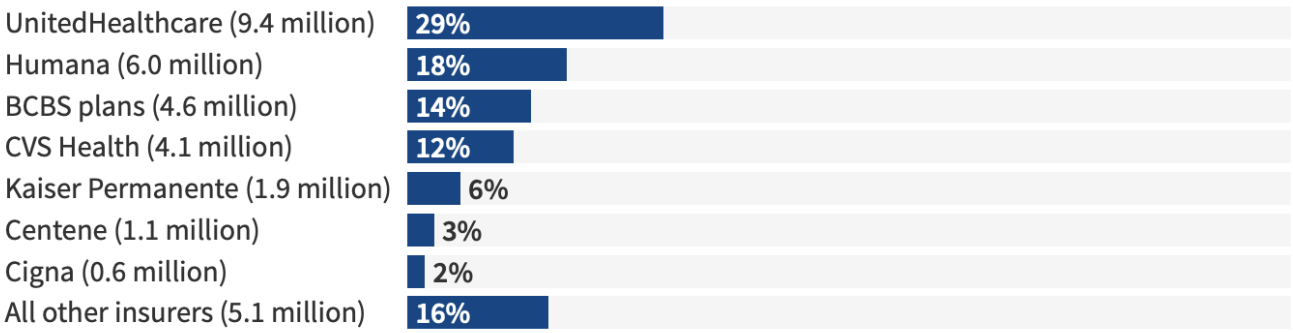
UnitedHealthcare—Which Covers 9.4 Million, Or 29%, Of MA Enrollees—Relied On Its Medicare & Retirement Segment For Over 46% Of Its $281 Billion In 2023 Revenue, Although MA Enrollees Comprised Only 14.6% Of Its Total Enrollment That Year.

As Of 2024, UnitedHealthcare Covers 9.4 Million, Or 29%, Of MA Enrollees:

Figure 8

Medicare Advantage Enrollment by Firm or Affiliate, 2024

Total Medicare Enrollment, 2024: 32.8 million



[Kaiser Family Foundation, 08/08/24]

- **UnitedHealthcare Is UnitedHealth Group's Health Benefit Segment, With Its Medicare & Retirement Segment Serving Medicare Beneficiaries And Retirees.** "Our two distinct, yet complementary businesses — Optum and UnitedHealthcare — are working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences for the individuals and organizations we are privileged to serve. [...] UnitedHealthcare offers a full spectrum of health benefit programs. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

In Its 2023 Fiscal Year, Medicare Advantage Enrollees Comprised Only 14.6% Of UnitedHealth's Total Medical Enrollment While Revenue From Its Medicare And Retirement Segment Comprised 46.2% Of Its $281 Billion In Revenue:

Fiscal Year	MA Enrollment (Thous.)	Total Global Enrollment (Thous.)	Percentage	Revenue, Medicare & Retirement (Mil.)	Total Revenue (Mil.)	Percentage
2023	7,695	52,750	14.6%	$129,862	$281,360	46.2%
2022	7,105	51,695	13.7%	$113,671	$249,741	45.5%
2021	6,490	50,630	12.8%	$100,552	$222,899	45.1%
2020	5,710	48,435	11.8%	$90,764	$200,875	45.2%
2019	5,270	49,150	10.7%	$83,252	$193,842	42.9%
Increase, 2019-2023:	**2,425**	**3,600**	**3.8pp**	**$46,610**	**$87,518**	**3.2pp**

- **UnitedHealth Stated That All 7.7. Million Enrollees In Its Medicare & Retirement Segment Were Served Through Medicare Advantage Products In 2023.** "UnitedHealthcare Medicare & Retirement served 7.7 million people through its Medicare Advantage products as of December 31, 2023." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

In Its 2023 Annual Report, UnitedHealth Stated That Its 2023 Revenues Grew By $31 Billion, Or 13%, "Primarily Driven By Growth In The Number Of People Served Throughout The Year In Medicare Advantage And Medicaid," With Its Medicare & Retirement Segment Seeing Revenue Increase By $16 Billion, Or 14%

In Its 2023 Annual Report, UnitedHealth Stated The $31 Billion Increase In 2023 Revenue Was "Primarily Driven By Growth In The Number Of People Served Throughout The Year In Medicare Advantage And Medicaid," Among Other Factors. "The increases in revenues were primarily driven by growth in the number of people served throughout the year in Medicare Advantage and Medicaid, pricing trends and growth across the Optum businesses. Revenues also increased due to increased investment income, primarily driven by increased interest rates." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

In 2023, United Healthcare's Total Revenue Grew By $31 Billion, Or 13%, While Revenue From Its Medicare & Retirement Segment Increased By $16 Billion, Or 14%:

The following table summarizes UnitedHealthcare revenues by business:

	For the Years Ended December 31,			Change	
(in millions, except percentages)	2023	2022	2021	2023 vs. 2022	
UnitedHealthcare Employer & Individual - Domestic	$ 67,187	$ 63,599	$ 60,023	$ 3,588	6 %
UnitedHealthcare Employer & Individual - Global (a)	9,307	8,668	8,345	639	7
UnitedHealthcare Employer & Individual - Total (a)	76,494	72,267	68,368	4,227	6
UnitedHealthcare Medicare & Retirement	129,862	113,671	100,552	16,191	14
UnitedHealthcare Community & State	75,004	63,803	53,979	11,201	18
Total UnitedHealthcare revenues	$ 281,360	$ 249,741	$ 222,899	$ 31,619	13 %

[UnitedHealthcare Group SEC Form 10-K, 02/28/24]

UnitedHealth's Premium Revenues From The Centers for Medicare & Medicaid Services (CMS) Comprised 40% Of Its Total 2023 Revenue, Up From 38% In 2022 And 36% In 2021.

In Its 2023 Annual Report, UnitedHealth Stated That Premium Revenues From The Centers for Medicare & Medicaid Services (CMS) Were 40%, 38% and 36% Of Its Total Revenues In 2023, 2022, And 2021. "As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 40%, 38% and 36% for the years ended December 31, 2023, 2022 and 2021, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

UnitedHealthcare's Parent, UnitedHealth Group—The Fourth-Largest U.S. Company By Revenue—Has Faced Widespread Bipartisan Criticism For Its Size, With Former CMS Administrator Don Berwick Saying It Has "'Grown Too Big For This Country's Good.'"

UnitedHealth Group, "The Nation's Largest Private Health Insurer" And The Fourth-Largest U.S. Company By Revenue, Has Faced Widespread Criticism For Its Size—A Former Medicare Administrator Said It's "'Grown Too Big For This Country's Good'"; Rep. Buddy Carter (R-GA) Said "'It Needs To Be Busted Up'"; And Top Antitrust Official Jonathan Kanter Criticized Its Playbook.

UnitedHealth Group Is "The Nation's Largest Private Health Insurer And Largest Employer Of Physicians." "In health care, no one is bigger than UnitedHealth Group, the nation's largest private health insurer and largest employer of physicians." [The Washington Post, 04/30/24]

UnitedHealth Group Has About 2,200 Subsidiaries And "Ranks As The Nation's Fourth-Largest Company By Revenue This Year, Just Behind Apple And Ahead Of Tech Giants Alphabet And Microsoft." "Tens of millions of Americans regularly interact with one or several of the company's approximately 2,200 subsidiaries, including middlemen that handle payment processes and pharmaceutical prescriptions, often without realizing it. UnitedHealth ranks as the nation's fourth-largest company by revenue this year, just behind Apple and ahead of tech giants Alphabet and Microsoft. In many parts of the country, a patient could be a UnitedHealth customer from cradle to grave, starting with obstetric care and ending with hospice services." [The Washington Post, 04/30/24]

Don Berwick, The Former Administrator For The Centers For Medicare & Medicaid Services (CMS) During The Obama Administration, Said UnitedHealth Has "'Grown Too Big For This Country's Good,'" Adding, "'Success For UnitedHealth Is Return For Investors.'" "'They've grown too big for this country's good, and for their own good,' said Don Berwick, a Harvard-affiliated physician who oversaw Medicare and Medicaid during the Obama administration. 'Success for UnitedHealth is return for investors.'" [The Washington Post, 04/30/24]

- **Donald Berwick Was Administrator For The Centers For Medicare & Medicaid Services (CMS).** "Lecturer of Health Care Policy, Department of Health Care Policy, Harvard Medical School; President Emeritus and Senior Fellow, Institute for Healthcare Improvement; Former Administrator of the Centers for Medicare & Medicaid Services" [Harvard Medical School, accessed 09/19/24]

Bipartisan Lawmakers Have "Said They're Unhappy About So Much Of America's Health System Running Through A Single Organization." "Lawmakers in both parties said they're unhappy about so much of America's health system running through a single organization, making thousands of hospitals and doctors vulnerable to a single point of failure." [The Washington Post, 04/30/24]

- **Rep. Buddy Carter (R-GA) Said Of UnitedHealth, "'It Needs To Be Busted Up.'"** "'It needs to be busted up,' Rep. Buddy Carter (R-Ga.) said at the congressional hearing on Change Healthcare this month, citing his frustrations as a practicing pharmacist who dealt with UnitedHealth and its subsidiaries." [The Washington Post, 04/30/24]

- **Sen. Elizabeth Warren (D-MA) Called UnitedHealth "'So Damn Big,'" And Added That "'One In Every 10 Doctors In America Has Been Sucked Into The Optum System,'" A UnitedHealth Division Which Employs Over 90,000 Doctors.** "UnitedHealth is 'so damn big,' added Sen. Elizabeth Warren (D-Mass.), singling out the company's $227 billion Optum division, which employs more than 90,000 physicians. 'One in every 10 doctors in America has been sucked into the Optum system." [The Washington Post, 04/30/24]

Jonathan Kanter, "The Justice Department's Top Antitrust Enforcement Official," Has "Criticized The Playbook Followed By UnitedHealth," Without Naming The Company, Stating, "'How About We Bring Values Back To Health Care?'" "Speaking to a conference of emergency physicians in April, Jonathan Kanter, the Justice Department's top antitrust enforcement official, did not mention UnitedHealth by name, according to two physicians and another attendee. But Kanter repeatedly criticized the playbook followed by UnitedHealth, such as how health insurers' strategy to purchase physician practices has allowed them to circumvent federal rules intended to force insurers to spend more money on patient care. 'We talk about value-based health care,' Kanter said, invoking the mantra used by UnitedHealth and other industry players, according to the three attendees. 'How about we bring values back to health care?'" [The Washington Post, 04/30/24]

UnitedHealth—Which Saw Over $91.5 Billion In Net Income And Spent $56.3 Billion On Shareholder Handouts From 2019 Through 2023—Has Complained That MA Funding "Continues To Be Pressured" And Threatened Benefits Cuts And Cost-Cutting.

From 2019 Through 2023, UnitedHealth's Net Income Totaled Over $91.5 Billion As It Spent $56.3 Billion On Shareholder Handouts.

UnitedHealth's Net Income Has Grown By $8.9 Billion From $14.2 Billion In 2019 To $23.1 Billion In 2023—During The Same Period, It Spent A Total Of $56.3 Billion On Shareholder Dividends And Stock Buybacks:

Fiscal Year	Net Earnings (Mil.)	Dividends (Mil.)	Share Repurchases (Mil.)
2023	$23,144	$6,761	$8,000
2022	$20,639	$5,991	$7,000
2021	$17,732	$5,280	$5,000
2020	$15,769	$4,584	$4,250
2019	$14,239	$3,932	$5,500
Increase, 2019-2023:	$8,905	$2,829	$2,500
Total:	**$91,523**	**$26,548**	**$29,750**

In Its 2023 Annual Report, UnitedHealth Warned That MA Funding "Continues To Be Pressured" And Complained About Low MA Rates While Threatening Benefits Cuts And "Cost Management" Measures.

UnitedHealth Warned That "Medicare Advantage Funding Continues To Be Pressured" In Its 2023 Annual Report. "Medicare Advantage funding continues to be pressured, as discussed below in 'Regulatory Trends and Uncertainties' and we have observed increased care patterns as discussed below in 'Medical Cost Trends.' Our 2024 benefit design approach contemplates these trends." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

UnitedHealth Complained About Low MA Rates And Warned That Further Changes To Risk Adjustment Models "Will Continue To Result In Reduced Funding And Potentially Benefits For People." "Regulatory Trends and Uncertainties [...] Medicare Advantage Rates. Medicare Advantage rate notices over the years have at times resulted in industry base rates well below industry forward medical trend. For example, the Final Notice for 2024 rates resulted in an industry base rate decrease, as did the January 2024 Advance Notice for 2025 rates, both of which are well short of what is an increasing industry forward medical cost trend, creating continued pressure in the Medicare Advantage program. Further, substantial revisions to the risk adjustment model, which serves to adjust rates to reflect a patient's health status and care resource needs, will continue to result in reduced funding and potentially benefits for people, especially those with some of the greatest health and social challenges." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

- **UnitedHealth Warned That Due To "Ongoing Medicare Funding Pressures," It Could "Intensify [Its] Medical And Operating Cost Management" And "Adjust Member Benefits."** "As a result of ongoing Medicare funding pressures, there are adjustments we can make to partially offset these rate pressures and reductions for a particular period. For example, we can seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust member benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

- **The Justice Dept. Has Targeted Insurers' MA Risk Adjustment Abuses, With One Expert Calling It "'DOJ's Most Important Healthcare Fraud Priority.'"** "Under the False Claims Act, more than $1.8 billion in settlements and judgments was related to health-related matters in the last fiscal year, about two-thirds of the monetary fraud recoveries by the Department of Justice (DOJ). [...] Health law expert Bill Sarraille said the findings are a warning shot for health plans. 'The press release goes out of its way to signal that Medicare Advantage plans' risk adjustment practices are DOJ's most important healthcare fraud priority,' he told Fierce Healthcare. 'It telegraphs that by making MA risk adjustment the first, and most prominent, specific area it addresses.'" [Fierce Healthcare, 02/23/24]

While Discussing "Risks Related To The Regulation Of [Its] Business," UnitedHealth Disclosed That Changes To MA And Other Programs "May Materially And Adversely Affect" Its Business, Specifically Warning Of CMS Changes To MA Risk Adjustment Payments. "Risks Related to the Regulation of Our Business [...] As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows. We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Some of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, has affected and in future periods may materially and adversely affect our results of operations, financial position and cash flows." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

- **As An Example Of These Risks, UnitedHealth Noted That CMS Could Again "Mak[e] Changes To The Way It Calculates Medicare Advantage Risk Adjustment Payments."** "For example, CMS in the past has reduced or frozen Medicare Advantage benchmarks and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments." [UnitedHealthcare Group SEC Form 10-K, 02/28/24]

UnitedHealth Has Faced A Class Action Lawsuit For Illegally Using An Algorithm To Deny Seniors' Rehabilitation Care, And At Least Three DOJ Lawsuits For Illegally Mischarging MA—Including One Complaint Alleging The Insurer Took Part In Potentially Billions Of Dollars In MA Overcharges.

November 2023: A Class Action Lawsuit—Still Pending As Of September 2024—Accused UnitedHealth And Its Subsidiary NaviHealth Of "Illegally Using An Algorithm To Deny Rehabilitation Care To Seriously Ill Patients," Adding, "'The Elderly Are Prematurely Kicked Out Of Care Facilities Nationwide Or Forced To Deplete Family Savings.'"

November 2023: A Class Action Lawsuit Accused UnitedHealth Group And Its Subsidiary NaviHealth Of "Illegally Using An Algorithm To Deny Rehabilitation Care To Seriously Ill Patients," Despite Both Companies Allegedly Knowing The Algorithm's "High Error Rate." "A class action lawsuit was filed Tuesday against UnitedHealth Group and a subsidiary alleging that they are illegally using an algorithm to deny rehabilitation care to seriously ill patients, even though the companies know the algorithm has a high error rate" [STAT News, 11/14/23]

- **The Lawsuit Accused UnitedHealth And Subsidiary NaviHealth Of "Breach Of Contract, Breach Of Good Faith And Fair Dealing, Unjust Enrichment, And Insurance Law Violations In Multiple States."** "'This demonstrates the blatant inaccuracy of the nH predict AI Model and the lack of human review involved in the claims denial process,' the lawsuit alleges. It accuses UnitedHealth and NaviHealth of breach of contract, breach of good faith and fair dealing, unjust enrichment, and insurance law violations in multiple states." [STAT News, 11/14/23]

- **NaviHealth Is "The Company That Monitors Care And Implements The Algorithm."** "As the class action case has ramped up, a flurry of changes have unfolded at NaviHealth, the company that monitors care and implements the algorithm." [STAT News, 05/22/24]

- **UnitedHealth Has "Scrubbed NaviHealth's Brand Off Its Ledger," Although It Continues To Use Its Algorithm.** "A round of layoffs also swept through the company, and UnitedHealth has scrubbed NaviHealth's brand off its ledger, even as it continues to use its computer model to help decide how much rehab care patients should receive." [STAT News, 05/22/24]

The Lawsuit, Filed On Behalf Of Families Of Deceased UnitedHealthcare MA Enrollees, Followed An Investigation Revealing The Company "Pressured" Employees "To Issue Payment Denials" Based On An Algorithm Designed To Predict The Length Of Patients' Stays In Medical Facilities. "The class action suit, filed on behalf of deceased patients who had a UnitedHealthcare Medicare Advantage plan and their families by the California-based Clarkson Law Firm, follows the publication of a STAT investigation Tuesday. The investigation, cited by the lawsuit, found UnitedHealth pressured medical employees to follow an algorithm, which predicts a patient's length of stay, to issue payment denials to people with Medicare Advantage plans." [STAT News, 11/14/23]

- **Internal Company Documents Showed Managers Urged Employees To Keep Rehabilitation Stays "Within 1% Of The Days Projected By The Algorithm."** "Internal documents revealed that managers within the company set a goal for clinical employees to keep patients rehab stays within 1% of the days projected by the algorithm." [STAT News, 11/14/23]

The Lawsuit Accused UnitedHealth And NaviHealth Of Using The Algorithm To "'Systematically Deny Claims'" To Medicare Beneficiaries Recovering From Illnesses In Rehabilitation Facilities. "The lawsuit,

filed in the U.S. District Court of Minnesota, accuses UnitedHealth and its subsidiary, NaviHealth, of using the computer algorithm to 'systematically deny claims' of Medicare beneficiaries struggling to recover from debilitating illnesses in nursing homes." [STAT News, 11/14/23]

The Lawsuit Said UnitedHealth "'Illegally Denied 'Elderly Patients Care Owed To Them Under Medicare Advantage Plans'" And Used The Algorithm In "Overriding Determinations Made By The Patients' Physicians That The Expenses Were Medically Necessary." "The lawsuit, filed last Tuesday in federal court in Minnesota, claims UnitedHealth illegally denied 'elderly patients care owed to them under Medicare Advantage Plans' by deploying an AI model known by the company to have a 90% error rate, overriding determinations made by the patients' physicians that the expenses were medically necessary." [CBS News, 11/20/23]

The Complaint Alleged That UnitedHealth's "'Fraudulent Scheme Affords Defendants A Clear Financial Windfall In The Form Of Policy Premiums Without Having To Pay For Promised Care.'" "'The fraudulent scheme affords defendants a clear financial windfall in the form of policy premiums without having to pay for promised care,' the complaint alleges." [STAT News, 11/14/23]

The Complaint Alleged, "'The Elderly Are Prematurely Kicked Out Of Care Facilities Nationwide Or Forced To Deplete Family Savings To Continue Receiving Necessary Care, All Because An [Artificial Intelligence] Model 'Disagrees' With Their Real Live Doctors' Recommendations.'" "'The elderly are prematurely kicked out of care facilities nationwide or forced to deplete family savings to continue receiving necessary care, all because an [artificial intelligence] model 'disagrees' with their real live doctors' recommendations.'" [STAT News, 11/14/23]

The Lawsuit Alleged UnitedHealth Knew Of The Algorithm's "Extremely High Error Rate" But Continued To Deny Care As Only "A Tiny Percentage" Of Patients Would File Appeals—In Defending Its Actions, UnitedHealth Argued Plaintiffs "'Failed To Exhaust'" Medicare's Administrative Appeal Process And Should be Suing The Federal Government Instead.

The Lawsuit Alleged That UnitedHealth Was Aware Of The Algorithm's "Extremely High Error Rate"—With As Much As 90% Of Its Payment Denials Reversed Through Appeals—But Continued To Deny Care Because It Knew Only "A Tiny Percentage" Of Patients Would File Appeals. The lawsuit alleges that UnitedHealth knew the algorithm had an extremely high error rate and that it denied patients' claims knowing that only a tiny percentage — 0.2% — would file appeals to try to overturn the insurer's decision. The complaint alleges the algorithm, dubbed nH Predict, has a 90% error rate, basing that calculation on the percentage of payment denials reversed through internal appeals processes or administrative law judge rulings." [STAT News, 11/14/23]

May 2024: UnitedHealth Argued That It Should Be Released From The Class Action Lawsuit, Claiming That Its Plaintiffs "'Failed To Exhaust'" Medicare's Administrative Appeal Process. "UnitedHealth Group should be released from a lawsuit that alleges its algorithm-based technology prematurely cut off care to its Medicare Advantage members, the company said in court filings this week, because patients and their families did not finish Medicare's appeals process. 'Plaintiffs have failed to exhaust the exclusive administrative appeal process set by the Medicare Act,' UnitedHealth's lawyers argued." [STAT News, 05/22/24]

- **UnitedHealth Also Argued That "'Plaintiffs Have Sued The Wrong Defendants,'" Claiming They Should Have Sued The Federal Government.** "'Plaintiffs have failed to exhaust the exclusive administrative appeal process set by the Medicare Act,' UnitedHealth's lawyers argued. Even if those requirements were met, they added, the grievances of patients and families are with the federal government, not UnitedHealth and its subsidiary NaviHealth. 'The plaintiffs have sued the wrong defendants,' the filing states." [STAT News, 05/22/24]

The Appeals Process For Medicare Is "Backlogged And Complicated," Often Resulting In Patients Draining Their Finances Or Even Dying Before An Appeal Decision Is Made. "Medicare's appeals process is backlogged and complicated. Completing it can take years in some instances, potentially draining the finances of Medicare beneficiaries and their families who decide to pay for care on their own while they wait for a resolution. For patients who do appeal, the frailest ones may die before they ever get a decision." [STAT News, 05/22/24]

The Case Was Still Pending As Of September 17, 2024:

[O'Neill Institute, accessed 09/17/24]

May 2017: "For The Second Time In Two Weeks," The U.S. Justice Dept. Alleged UnitedHealth "Mischarged" MA And The Medicare Prescription Drug Program Based On "'Untruthful And Inaccurate Information'" About Its Enrollees' Health.

May 2017: "For The Second Time In Two Weeks," The U.S. Justice Department Filed A Complaint Against UnitedHealth Alleging It "Mischarged the Medicare Advantage and Prescription Drug Programs," Having Knowingly Taken Payments "Based On Untruthful And Inaccurate Information" About Patients. "For the second time in two weeks, the United States has filed a complaint against UnitedHealth Group Inc. (UHG) that alleges UHG knowingly obtained inflated risk adjustment payments based on untruthful and inaccurate information about the health status of beneficiaries enrolled in UHG's Medicare Advantage Plans throughout the United States, the Justice Department announced today." [U.S. Department of Justice, 05/16/17]

- **Justice Department Press Release HEADLINE: United States Intervenes in Second False Claims Act Lawsuit Alleging that UnitedHealth Group Inc. Mischarged the Medicare Advantage and Prescription Drug Programs** [U.S. Department of Justice, 05/16/17]

The Justice Dept. Alleged UnitedHealth "Knowingly Disregarded Information About Beneficiaries' Medical Conditions." "The complaint filed today by the United States alleges that UHG knowingly disregarded information about beneficiaries' medical conditions, which increased the risk adjustment payments UHG received from Medicare. In particular, the lawsuit contends that, for many years, UHG conducted a national Chart Review Program designed to identify additional diagnoses not reported by treating physicians that would increase UHG's risk adjustment payments. However, UHG allegedly ignored information from these chart reviews showing that hundreds of thousands of diagnoses provided by treating physicians and submitted by it to Medicare were invalid and did not support the Medicare payments it had previously requested and obtained. By ignoring this information, UHG avoided repaying Medicare monies to which it was not entitled." [U.S. Department of Justice, 05/16/17]

Acting U.S. Attorney James P. Kennedy Jr. Said, UnitedHealth "'Received Substantial Overpayments Based Upon Untruthful And Inaccurate Information About The Health Status Of Those Enrolled In Its Plans'" And "'Such Fraudulent Spending Of Taxpayer's Dollars Will Not Be Tolerated.'" "'As the nation's largest Medicare Advantage Organization, UHG received substantial overpayments based upon untruthful and inaccurate information about the health status of those enrolled in its plans,' said Acting U.S. Attorney James P.

Kennedy Jr. for the Western District of New York. 'Such fraudulent spending of taxpayer's dollars will not be tolerated.'" [U.S. Department of Justice, 05/16/17]

February 2017: The Justice Dept. Joined A Lawsuit Against UnitedHealth Alleging A "Scheme" That Allowed "'Hundreds Of Millions — And Likely Billions — Of Dollars" In Overcharges Made To Medicare Advantage, With An Executive Saying "'Let's Turn On The Gas!'" When Urging Extra MA Revenue.

February 2017: The Justice Dept. Joined A Lawsuit Against UnitedHealth Alleging "A Scheme That Allowed Its Subsidiaries And Other Insurers To Improperly Overcharge Medicare By 'Hundreds Of Millions — And Likely Billions — Of Dollars'" Through Medicare Advantage. "UnitedHealth Group, one of the nation's largest health insurers, is accused in a scheme that allowed its subsidiaries and other insurers to improperly overcharge Medicare by 'hundreds of millions — and likely billions — of dollars,' according to a lawsuit made public on Thursday at the Justice Department's request. The accusations center on Medicare Advantage, a program through which people 65 or older agree to join private health maintenance organizations, or H.M.O.s, whose costs the government reimburses." [The New York Times, 02/16/17]

- **The Justice Department Joined The Lawsuit's Claims About "Erroneous Coding And Inflated Billing," But Not Other Claims.** "The Justice Department's court notice that it was joining the case involving UnitedHeath was filed by Chad Readler, a lawyer who joined the agency's civil division as part of the Trump administration. It is intervening in the whistle-blower's claims about erroneous coding and inflated billing but is not taking part in other claims." [The New York Times, 02/16/17]

Although UnitedHealth And Other Insurance Companies Supported The Creation Of Medicare Advantage By Claiming They Could Help Contain Medicare Costs Through Managed Care, Their Practices "May Have Improperly Added Excess Costs In The Billions Of Dollars Over More Than A Decade." "The program was created in 2003 after UnitedHealth and other insurers said that managed care could help contain the overall cost of Medicare, which has strained the federal budget by rising faster than the rate of inflation. Instead of slowing Medicare costs, UnitedHealth may have improperly added excess costs in the billions of dollars over more than a decade, according to the lawsuit, which was unsealed in Federal District Court in Los Angeles." [The New York Times, 02/16/17]

In Emails Included In The Original Whistleblower Lawsuit, UnitedHealth Executives Were Seen Saying "'Let's Turn On The Gas!'" And Asking To "'Add Another $100m To Our 2008 Revenue From Where We Are'" Through Raising Medicare Advantage Risk Adjustment Scores. "Mr. Poehling said that he and other employees were given 'risk adjustment' targets and their performance was evaluated based on how well they achieved them. In a 2008 performance review, for example, he was judged on whether he had increased risk scores by 3 percent. [...] Attached to his complaint was an email message from his division's chief financial officer, Jerry Knutson, urging staff members 'to really go after the potential risk scoring that you have consistently indicated is out there.' 'Let's turn on the gas!' Mr. Knutson wrote. 'What can we do to make sure we are being reimbursed fairly for the members and risk we take on more than what we are currently doing. 'When we meet next on our steering committee, I'd like to see what it would take to add another $1OOM to our 2008 revenue from where we are. What would be doable? What resources would you need? What technology would you need?'" [The New York Times, 02/16/17]

UnitedHealth Group Has Spent Over $22.3 Million While Lobbying On Medicare Advantage Since Q1 2021 And It Has Been Behind "'Astroturf'" MA Industry Group, The Better Medicare Alliance, That Has Also Spent $4 Million On Federal Lobbying Since Q1 2021 And Counts A Longtime UnitedHealth Executive As A Board Member.

UnitedHealth Group Has Spent Over $22.3 Million While Lobbying On Medicare Advantage Since Q1 2021.

Registrant	Report Type	Filing Year	Amount Reported	Relevant Lobbying Issue(s)
UnitedHealth Group, Inc.	2nd Quarter - Report	2024	$1,260,000	Medicare Advantage
UnitedHealth Group, Inc.	1st Quarter - Report	2024	$2,510,000	Medicare Advantage
UnitedHealth Group, Inc.	4th Quarter - Report	2023	$1,650,000	Medicare Advantage
UnitedHealth Group, Inc.	3rd Quarter - Amendment	2023	$1,640,000	Medicare Advantage
UnitedHealth Group, Inc.	2nd Quarter - Report	2023	$2,210,000	Medicare Advantage
UnitedHealth Group, Inc.	1st Quarter - Amendment	2023	$3,240,000	Medicare Advantage
UnitedHealth Group, Inc.	4th Quarter - Report	2022	$1,580,000	Medicare Advantage
UnitedHealth Group, Inc.	3rd Quarter - Report	2022	$1,270,000	Medicare Advantage
UnitedHealth Group, Inc.	2nd Quarter - Report	2022	$1,330,000	Medicare Advantage
UnitedHealth Group, Inc.	1st Quarter - Report	2022	$1,520,000	Medicare Advantage
UnitedHealth Group, Inc.	4th Quarter - Report	2021	$1,640,000	Medicare Advantage
UnitedHealth Group, Inc.	3rd Quarter - Report	2021	$910,000	Medicare Advantage
UnitedHealth Group, Inc.	2nd Quarter - Report	2021	$700,000	Medicare Advantage
UnitedHealth Group, Inc.	1st Quarter - Report	2021	$900,000	Medicare Advantage Program Including Medicare Advantage Billing
		Total:	**$22,360,000.00**	

As Of April 2024, UnitedHealth Had Spent About $49 Million On Lobbying Over The Prior Decade, Recruiting Influential Former Lawmakers Such As Senate Majority Leader Trent Lott (R-MS), Former

House Majority Leader Richard Gephardt (D-MO), And Nine Others. "UnitedHealth has worked to head off criticism on Capitol Hill. The company has spent at least $49 million on lobbying efforts during the past decade, employing more than 130 lobbyists — including former Senate majority leader Trent Lott (R-Miss.), former House majority leader Richard A. Gephardt (D-Mo.) and nine other former lawmakers — to defend its interests in Washington, according to congressional records and a database maintained by OpenSecrets, a nonpartisan organization tracking money in politics." [The Washington Post, 04/30/24]

UnitedHealth Group's Senior Advisor And Former Executive Vice President Of Medical Affairs Richard Migliori Is On The Board Of Directors For Better Medicare Alliance, A UnitedHealth-Funded "'Astroturf'" Group Focused On Medicare Advantage That Has Spent Over $4 Million On Federal Lobbying Since Q1 2021.

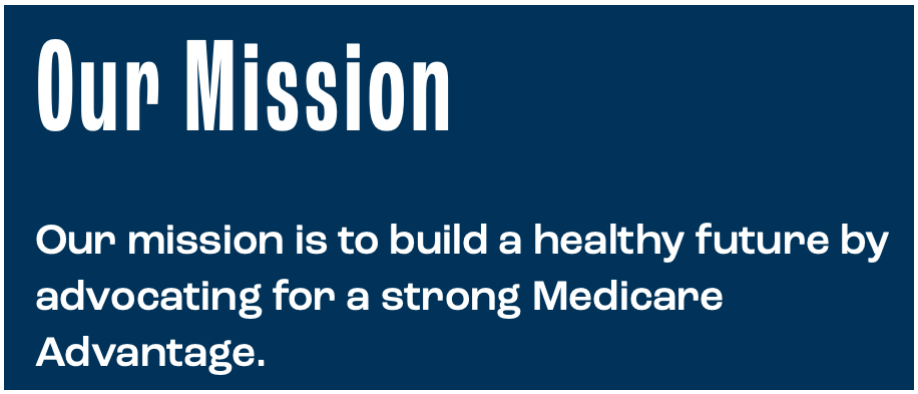
Dr. Richard Migliori, A Senior Advisor For UnitedHealth Group Who Was Previously The Company's Executive Vice President Of Medical Affairs And EVP For Health Services, Is One Of Nine Board Members For The Better Medicare Alliance (BMA). "Dr. Richard Migliori serves as Senior Advisor at UnitedHealth Group, working to help accelerate growth priorities and advance client partnerships. He previously served as Chief Medical Officer for UnitedHealth Group, retiring from the role in December 2021. In 2013, Dr. Migliori was appointed executive vice president of medical affairs at UnitedHealth Group, working with businesses across the enterprise to help improve health care quality, access, and affordability. [...] Previously, as executive vice president for Health Services, Dr. Migliori was responsible for the ongoing development, design and adaptation of market-leading clinical innovations aimed at ensuring clinical excellence, improving clinical and economic outcomes, and delivering robust business performance on behalf of UnitedHealth Group's largest public and private sector clients." [Better Medicare Alliance, accessed 09/19/24]

Richard J. Migliori, MD

Executive Vice President, Senior Advisor, Ret. Chief Medical Officer, UnitedHealth Group

[Better Medicare Alliance, accessed 09/19/24]

BMA's Mission Is To Advocate "For A Strong Medicare Advantage":



[Better Medicare Alliance, accessed 09/19/24]

2018: The Associated Press Reported That BMA "Is Bankrolled By Major Health Insurance Companies That Are Trying To Cash In On Private Coverage Offered Through The Federal Health Insurance Program." "A group gaining influence in Washington as a champion for Medicare beneficiaries is bankrolled by major health insurance companies that are trying to cash in on private coverage offered through the federal health insurance program." [Associated Press, 12/21/18]

BMA's "Multimillion-Dollar Budget" Was Supplied By UnitedHealthcare, Aetna, And Humana, And Not The Network Of "'BMA Seniors'" Claimed By The Group. "The Better Medicare Alliance claims a far-flung network of seniors, with a Facebook community of more than 380,000 and 110,000 signed up to receive email alerts. Its website displays profiles of 'BMA Seniors' who describe private Medicare plans in glowing terms. The Associated Press found that one of the featured seniors, David Kievit, died in March at age 91. The multimillion-dollar budget for the alliance isn't supplied by seniors, but by UnitedHealthcare, Aetna and Humana, according to the group's president and its federal tax returns." [Associated Press, 12/21/18]

Then-BMA President And CEO Allyson Schwartz Admitted That BMA's Funding Came From UnitedHealthcare, Aetna, And Humana. "President and CEO Allyson Schwartz enjoys credibility among Democrats, having helped pass the Affordable Care Act as a Democratic congresswoman from Pennsylvania. [...] The alliance has received $19.9 million in donations over the last three years, accounting for 99.9 percent of its total revenue during that period, according to the organization's tax returns for 2015 through 2017. Schwartz said when asked that the money came from UnitedHealthcare, Aetna and Humana." [Associated Press, 12/21/18]

David Lipschutz, A Senior Policy Attorney For The Center For Medicare Advocacy, Called BMA An "'Astroturf Group'" And Said "'They Really Represent The Interests Of The Insurance Industry.'" "David Lipschutz, a senior policy attorney for the Center for Medicare Advocacy, a nonprofit legal organization that represents Medicare beneficiaries, called the Better Medicare Alliance an 'Astroturf group.' The term refers to an organization that casts itself as a grassroots movement to mask their corporate interests. 'They represent themselves as representing Medicare beneficiaries, but they really represent the interests of the insurance industry,' Lipschutz said." [Associated Press, 12/21/18]

BMA Has Spent $4.09 Million On Federal Lobbying Since Q1 2021 Through Q2 2024:

Registrant	Report Type	Year	Amount
Better Medicare Alliance, Inc.	2nd Quarter - Report	2024	$470,000
Better Medicare Alliance, Inc.	1st Quarter - Amendment	2024	$600,000
Better Medicare Alliance, Inc.	4th Quarter - Report	2023	$300,000
Better Medicare Alliance, Inc.	3rd Quarter - Report	2023	$290,000

Better Medicare Alliance, Inc.	2nd Quarter - Report	2023	$390,000
Better Medicare Alliance, Inc.	1st Quarter - Report	2023	$570,000
Better Medicare Alliance, Inc.	4th Quarter - Report	2022	$330,000
Better Medicare Alliance, Inc.	3rd Quarter - Report	2022	$290,000
Better Medicare Alliance, Inc.	2nd Quarter - Report	2022	$260,000
Better Medicare Alliance, Inc.	1st Quarter - Report	2022	$200,000
Better Medicare Alliance, Inc.	4th Quarter - Report (No Activity)	2021	$70,000
Better Medicare Alliance, Inc.	3rd Quarter - Report (No Activity)	2021	$120,000
Better Medicare Alliance, Inc.	2nd Quarter - Report (No Activity)	2021	$100,000
Better Medicare Alliance, Inc.	1st Quarter - Report (No Activity)	2021	$100,000
		Total:	**$4,090,000.00**