American Society of Anesthesiologists™

1061 American Lane | Schaumburg, IL 60173-4973 | (847) 825-5586
905 16th Street N.W., Suite 400 | Washington, D.C. 20006 | (202) 289-2222

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Richard Powers, Esq.
Acting Assistant Attorney General
Antitrust Division U.S. Department of Justice
Robert F. Kennedy Department of Justice Building
950 Pennsylvania Avenue, N.W.
Washington, DC 20530-0001

Dear Acting Assistant Attorney General Powers:

On behalf of our over 54,600 members, the American Society of Anesthesiologists ("ASA") writes to express its concerns with the conduct of UnitedHealth Group ("UHG") that is terminating participating provider agreements with anesthesia practices across the country at a high rate with exclusionary intent and consequences.

We respectfully request that the Antitrust Division of the Department of Justice ("the Division" or "DOJ") conduct a thorough investigation of this conduct because UHG's actions have harmed competition for anesthesia services by forcing otherwise willing anesthesia practices to be out of network for patients. UHG is vertically integrated and has the ability and incentive to leverage its UnitedHealthcare ("UHC") subsidiary's status as a health insurer, including to favor UHG's healthcare provider subsidiary Optum and its employed anesthesiologists unfairly. UHG's conduct results in higher out-of-pocket costs for patients due to UHC's higher cost sharing requirements for patients who are treated by out-of-network anesthesiologists and reduced numbers of in-network anesthesiologists for patients to access. UHC also operates as a third-party administrator ("TPA") for employer sponsored health plans. Through the guise of a "Shared Savings" program, UHG has a perverse incentive to reduce the number of in-network anesthesiologists to increase UHG's profits, while *increasing* the fees and overall costs passed on to employers. Additionally, anesthesiologists have been harmed by being foreclosed from access to UHG's members, particularly in areas around the country where UHG's members represent a substantial share of commercially insured patients, which anesthesiologists need to access to remain economically viable. In many instances, the agreements anesthesiologists have had with UHC have been in place for several years and have been mutually beneficial such that their sudden termination makes no economic sense, especially with anesthesia payment rate inflators often lagging UHG's premium cost increase trends. UHG's conduct can only be explained by a desire to inflict anticompetitive harm.

Background on Anesthesiologists

Anesthesiologists are physicians who specialize in anesthesia care, pain management, and critical care medicine. Anesthesiologists evaluate, monitor, and supervise patient care before, during, and after

surgery, delivering anesthesia, leading the anesthesia care team, and ensuring optimal patient safety.[1] Anesthesiologists treat patients in a variety of facilities, including hospitals, ambulatory surgery centers ("ASCs"), and physician offices. It is common for hospitals and ASCs to contract with anesthesiology practices to provide their services at their facilities, including sometimes on an exclusive basis. Anesthesiologists work in a variety of settings ranging from solo practices to regional and even national anesthesiology practices.

Background on UHG

UHG generated more than $242 billion in revenue in 2019.[2] Its subsidiary, UHC, is the largest commercial health insurance company in the United States. With more than 70 million members, and commercial, Medicare and Medicaid insurance plans, UHC has the largest or second largest market share in 20 states.[3] Its network includes 1.4 million physicians and other health care professionals, and more than 6,500 hospitals.[4]

In addition to owning UHC, UHG also owns Optum, which includes over 50,000 physicians, including anesthesiologists, and 1,400 clinics, and through its Surgical Care Affiliates ("SCA") subsidiary also owns over 250 surgery centers at which anesthesiologists practice.[5] This means that UHG is not only an insurer for patients that anesthesiologists treat, but also a source of referrals via the physician practices and surgery centers it owns and a direct competitor to the independent anesthesiologists who comprise ASA's membership. ASA understands that Optum and SCA have financial incentives from UHC for Optum's employed physicians and SCA's surgery centers to steer patients only to in-network anesthesiologists.

Background on Anesthesiologist and Health Insurer Contracting

Anesthesiologists typically contract with health insurers to be participating providers so as to access the most patients as "in-network" providers, from whom patients will receive the broadest coverage and experience the lowest out-of-pocket expense when receiving care. Anesthesiologists typically bill patients for their professional services separately from the facility at which they treat their patients.

The amounts anesthesiologists are reimbursed for their services by health insurers and patients depends on whether their patients have health insurance, which can be commercial, or government sponsored

[1] An anesthesia care team may include nurse anesthetists, anesthesiologist assistants, and anesthesiology resident physicians in addition to physician anesthesiologists.

[2] UnitedHealth Group, Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 (Form 10-K), Mar. 1, 2021 (available at: https://www.sec.gov/ix?doc=/Archives/edgar/data/731766/000073176621000013/unh-20201231.htm).

[3] American Medical Association, Competition in Health Insurance: A comprehensive study of U.S. markets, 2020 update, Table 1. Market concentration (HHI and largest insurers' market shares as of Jan. 1, 2019 Combined HMO+PPO+POS+EXCH (total) product markets. https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf.

[4] UnitedHealth Group, Annual Report (Form 10-K) (Mar. 1, 2021).

[5] UnitedHealth Q4 2020 Earnings Call Transcript, Jan. 20, 2021 ("Transcript"). *See also* https://scasurgery.com/about-us/.

(e.g., Medicare or Medicaid), and the amount of cost sharing the patient is obligated to pay under his or her insurance plan (e.g., deductible, co-insurance, co-pay). The amount of payment anesthesiologists receive from commercial health insurance plans may be the product of negotiations between the anesthesiologist's practice and the commercial health insurance plan or may simply be dictated by the commercial health insurance plan if it has market power. Either way, agreed upon payment rates typically result in significant discounts compared to the anesthesiologist's reasonable and customary charges. Payment received from government sponsored health insurance plans on the other hand is typically set by the responsible agency and is not subject to negotiation (e.g., the Centers for Medicare and Medicaid Services for Medicare patients and analogous state agencies for Medicaid patients).

An anesthesiology patient treated by an "out-of-network" anesthesiologist (i.e., one not under contract with the patient's insurer) typically bears a higher portion of the anesthesiologist's fees, and sometimes must pay the entire amount charged, depending on whether the patient's plan is state regulated, or employer sponsored and how much or how little coverage the patient's plan provides when being treated by "out-of-network" physicians. This can lead to so-called "surprise bills," because patients often do not choose which anesthesiologist he or she sees even if they choose their hospital, ASC, or surgeon and, thus, patients likely do not know whether the anesthesiologist is an in or out-of-network provider for his or her insurance plan prior to receiving care.

Terminations of Participating Provider Contracts Are Harming Competition

Recently, UHC has begun terminating participating provider agreements with ASA member anesthesia practices across the country, despite the fact that some such agreements have lasted several years. These terminations do not make economic sense, absent a desire to harm competition.

As a TPA for large employer sponsored insurance plans, UHC also has a responsibility to the employers it serves to negotiate networks that are cost effective and meet employees' preferences for a broad choice of providers. A so-called "Shared Savings" program operated by UHC is directly at odds with this responsibility and may create an incentive to narrow networks in a way that increases costs for employers and patients and reduces payment for ASA members but increases profits for UHC. ASA understands that under this "Shared Savings" arrangement, whenever a plan enrollee obtains out-of-network care, UHC negotiates or reprices the payment amount to the provider to a much lower amount than the provider's reasonable and customary charges. UHC then charges the employer a percentage of the difference between the amount charged by the provider and the final amount paid. According to a recent lawsuit, the fee charged by UHC to the employer is often *greater* than the amount paid to the provider that performed the medical procedure.[6] The total amount paid by the employer and the patient may also be considerably more than they would have paid had UHC entered into or maintained a network arrangement with the provider instead.[7]

[6] Complaint, 34-39, (ECF No. 1), *US. Anesthesia Partners, Inc. v. UnitedHealth Group, Inc. and United Healthcare Servs., Inc.*, No. 1:21-cv-02380 (D. Colo.).
[7] *Id*.

The fact that UHG is vertically integrated and a direct competitor to ASA member anesthesia practices may also explain UHG's conduct. This is because UHG has the ability and the incentive to leverage UHC's position as a health insurer to terminate participating provider agreements with ASA member anesthesia practices and steer members only to in-network anesthesiologists, including Optum's own employed anesthesiologists. To the extent ASA member anesthesia practices can continue serving UHC's members at hospitals, ASCs, and physician offices, which ASA understands have financial incentives from UHC to refer only to in-network anesthesiologists, they can only do so on an out-of-network basis. Doing so burdens patients with higher out-of-pocket costs despite the fact that they are seeing the same anesthesiologists they used to see on an in-network basis.

This conduct also undercuts the ability of ASA member anesthesia practices to compete. This is because the payments ASA member anesthesia practices receive from patients with commercial health insurance is typically higher than that received from government sponsored health insurance, which frequently does not cover the costs of treating those patients. Thus, UHC's share of commercially covered lives in any particular geography understates UHC's market power. In areas of the country where UHC has a substantial share of commercially insured patients, losing access to UHC members can threaten the financial viability of ASA member anesthesia practices. If left unchecked, UHG's conduct has the potential to make ASA's member anesthesia practices not financially viable and permanently reduce the alternatives for anesthesiology services in favor of UHG's own employed anesthesiologists.

While vertical integration can be procompetitive, that is not the case with UHG and its termination of participating provider agreements with ASA member anesthesia practices.[8] The participating provider agreements UHC has terminated were negotiated at arms' length and mutually beneficial. Moreover, any cost savings from these terminations should be passed along to subscribers in the form of lower premiums or better benefits to be truly procompetitive. Neither is likely here, particularly in those areas where UHC is a dominant insurer and lacks competitive pressure to do so. Indeed, it has been well-reported that the COVID-19 pandemic has dramatically lowered utilization of medical services,

[8] Indeed, UHG's CEO Andrew Witty described the company's vertical integration into healthcare providers as "[t]hat's where some of the magic really sits here, in terms of being able to *leverage* many different aspects.") (emphasis added). Anna Wild Matthews and Matt Grossman, *UnitedHealth's Profit Declines as Patients Seek Deferred Care*, Wall Street J., July 15, 2021 (available at https://www.wsj.com/articles/unitedhealths-profit-declines-as-patients-seek-deferred-care-11626347506).

including surgeries and other procedures requiring anesthesia services.[9] Nonetheless, UHG reported extraordinary profits during 2020.[10]

UHC's contract terminations also have the effect of reducing the value of the impacted anesthesiology practices, which may make them more willing to be acquired. Indeed, UHG has announced plans "to grow [its] employed and affiliated physicians by at least 10,000" and that "[t]his work of building local physician-led systems of care continues to be central to our mission and is accelerating with notable progress in the Northeast, Pacific Northwest, and Southern California ..."[11] If such plans come to fruition, they will only increase UHG's ability and incentive to foreclose competition for anesthesia services by terminating even more participating provider agreements with the third party anesthesia practices that comprise ASA's membership.

Even in areas of the country where Optum does not employ anesthesiologists, UHC's contract terminations still harm competition. The participating provider agreements that UHC has terminated benefitted both UHC and its members and ASA member anesthesia practices. The agreements provided UHC and its members with assured access to high quality anesthesiologists at discounted in-network rates, while providing the practices with access to UHC members. But, after termination, UHC members will have fewer in-network anesthesiologists they can access. And, given the outsized importance of commercial payments compare to payments received from government insured patients, anesthesiology practices can ill afford to lose access to UHC's members and maintain their financial viability.

Conclusion

High quality, affordable anesthesia services are crucial for patient care. UHG's terminations of participating provider agreements with ASA member anesthesia practices are harming competition by forcing otherwise willing anesthesia practices to be out-of-network for patients. This results in higher out-of-pocket costs and reduced numbers of in-network anesthesiologists for patients, especially where UHG can do so to favor its employed anesthesiologists. UHG's conduct is also foreclosing anesthesiologists from access to UHC's members and harming their financial viability, particularly in

[9] See e.g., Elizabeth Jacobs, Olubenga Ogedegbe & Stephen Fihn, *Elective Care and Health Services Research in the COVID-19 Era*, JAMA Network Open, Nov. 5, 2020 (available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772529) (describing 25% reduction in outpatient services, reductions of 90% or more in screenings for breast, colon, and cervical cancers because of COVID-19 induced delays in seeking care); Amit Jain, Punya Jain & Shruti Aggarwal, *SARS-CoV-2 Impact on Elective Orthopaedic Surgery*, The Journal of Bone & Joint Surgery, July 1, 2020 (available at: https://journals.lww.com/jbjsjournal/Fulltext/2020/07010/SARS_CoV_2_Impact_on_Elective_Orthopaedic_Surgery_.10.aspx) (predicting backlog of over 1 million surgical cases at 2 years after the end of elective surgery deferment as a result of COVID-19).

[10] Anna Wilde Mathews & Dave Sebastian, *UnitedHealth's Profits Surge Amid Health-Care Cancellations*, Wall Street J., July 16, 2020 (available at: https://www.wsj.com/articles/unitedhealth-groups-second-quarter-profit-rose-11594809964?mod=searchresults_pos3&page=1).

[11] Transcript.

areas around the country where UHC has a dominant share of commercially insured patients. For these reasons, ASA urges the Division to thoroughly investigate UHG's conduct.

We would be pleased to discuss our concerns with you in more detail at your convenience. Please contact me at president@asahq.org.

Sincerely,

Beverly K Philip MD

Beverly K. Philip, MD, FACA, FASA
ASA President

CC:

Kathleen S. O'Neill, Esq.
Senior Director of Investigations and Litigation
Antitrust Division U. S. Department of Justice
Robert F. Kennedy Department of Justice Building
950 Pennsylvania Avenue NW,
Washington, DC 20530

Eric D. Welsh, Esq.
Chief
Healthcare and Consumer Products Section
Antitrust Division U. S. Department of Justice
Liberty Square Building
450 Fifth Street, NW
Suite 4100
Washington, DC 20530-0001