UNITEDHEALTH GROUP®

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The Honorable Katie Porter
U.S. House of Representatives
1117 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Porter:

Thank you for your May 27 letter.

On behalf of the more than 20,000 UnitedHealth Group employees who live and work in California, including nearly 2,000 of your constituents who work across 16 offices in your district, we share your concern about ensuring access to critically important health care services as our nation battles the COVID-19 pandemic. We know that these are extraordinarily challenging times for health care providers, our health care system and all Americans. We recognize that thousands of doctors and nurses in California and across the nation are providing essential health care on the front lines of the pandemic. We especially appreciate the vital role of clinicians given that nearly 100,000 of our UnitedHealth Group colleagues across the country – including nearly 1,400 in California – are also on the front lines, treating patients, running COVID-19 testing facilities and caring for the most vulnerable in our communities. We would welcome you, at the appropriate time, to visit one of the more than 80 COVID-19 testing facilities we've opened in California, in partnership with Governor Newsom, to show you first-hand how we are caring for California families during this unprecedented health crisis.

Since the COVID-19 outbreak began in this country, UnitedHealth Group has been focused on serving and supporting our members, employees, communities and care providers in our network. We have taken a number of steps to ensure our members can access the care they need and to help alleviate the pressures facing care providers. Among the actions our company has taken in recent weeks, we:

- Waived all member cost-sharing for COVID-19 diagnosis and treatment;
- Provided unlimited in-network telehealth visits for our members at no out-of-pocket cost;
- Provided early refills, prolonged authorizations and increased home-delivery options of medication to ensure no shortages;
- Extended hours at our behavioral health pharmacies to ensure medication adherence for those with mental health and substance use disorders;
- Waived prior authorization requirements for COVID-19 treatment;
- Provided $1.5 billion in direct customer and consumer support through premium credits, cost-sharing waivers and other efforts;
- Allowed grace periods for employers and individuals to pay premiums;
- Expanded assistance for socially isolated members, coordinating access to medications, supplies, food, care and support programs;
- Deployed triage tools including a symptom checker to provide the most up-to-date information about prevention, coverage, care and support needed to rapidly assess symptoms, schedule telehealth visits, talk with a nurse, refill or schedule home delivery for prescriptions and access emotional support 24 hours a day;

- Opened free access to our mental health mobile app and 24/7 emotional support phone lines to help all Americans cope with the mental health impacts of the pandemic;
- Accelerated nearly $2 billion of payments to care providers to provide needed liquidity for the health system;
- Assisted in processing and distributing CARES Act funding to care providers, at the request of the U.S. Department of Health & Human Services (HHS), as well as confirmed that no UnitedHealth Group entities will request or accept any CARES funding and that all fees paid to UnitedHealth Group for the administration of the Provider Payment Program are being donated;
- Launched HHS's Uninsured Initiative to ensure that providers who provided COVID-19 testing or treatment for individuals without insurance are reimbursed for their services;
- Pioneered non-invasive, self-administered COVID-19 testing protocols that streamline testing, reduce PPE usage, increase safety of health care workers and enable the use of alternative testing swabs and viral transport media to broaden access to COVID-19 testing;
- Donated $5 million to accelerate and expand Mayo Clinic's groundbreaking investigational study of convalescent plasma treatments for COVID-19 patients nationwide;
- Deployed 3,000 newly invented lightweight ventilators in collaboration with Boston Scientific, Medtronic and the University of Minnesota;
- Provided more than $80 million in support to those most vulnerable to COVID-19 such as health care workers, people living in hot spots, seniors and individuals experiencing homelessness and food insecurity, including a $1 million donation to the COVID-19 LA County Response Fund to provide urgent assistance to the homeless in LA County; and
- Donated over 575,000 meals to date prepared by our food service partners who were not preparing meals for our employees while they are working from home to ensure that seniors, first responders, children and others in local communities have access to fresh-cooked meals.

This is just a sampling of our efforts to support members, providers and all Americans as our nation continues battling COVID-19. A more comprehensive summary is available on our website.

Affordable Health Care Requires Fair and Competitive Agreements with Hospitals and Doctors

The people we are privileged to serve expect and deserve to have access to health care that is both high quality and affordable. That is why **we have developed a strong national network – the largest in the country – with over 1.3 million physicians and health care professionals and over 6,500 hospitals and other care facilities nationally, including more than 101,000 physicians and health care professionals and over 450 hospitals in California alone**. Our agreements with these care providers give us deep experience and data, which enable us, on behalf of the members, employers, governments and other organizations we serve, to identify fair market value for health care services in virtually every market nationwide.

Given that health care costs continue to be a top concern for consumers and employers, our members and customers expect us to make health care more affordable. We take this responsibility seriously, and ongoing management of our network of care providers is critical to our ability to meet this commitment to our members and customers. It starts with maintaining fair and competitive agreements with the hospitals and doctors in our network. We work to contain rapidly rising health care costs and mitigate the impact they have on the customers, States and members we serve by negotiating with care providers on their behalf to keep reimbursement rates fair, affordable and market competitive. When negotiating with providers, we focus on the dual priorities of ensuring that our members have access to quality health care and that we are supporting our customers' objectives to maintain affordable, sustainable health care coverage.

Networks of care providers are by nature dynamic, with providers joining and leaving the network throughout the year as some contracts end and other contracts are established. For example, we added more than 100,000 physicians to our network in the last year, with nearly 19,000 of those physicians added in 2020. Contract terminations can be initiated by UnitedHealthcare or by care providers. From January through May 2020, our contracts with 1.5% of the physicians in our network terminated, and the majority of these terminations were either initiated by the physicians themselves or were the result of administrative issues such as the provider losing admitting privileges at an in-network hospital. In most

cases, as with other contract negotiations between private parties, a notice of termination does not result in an actual contract termination. On average, we negotiate approximately 2,000 provider contracts per year, and the vast majority go unnoticed by our members and the general public as they are resolved prior to a contract's expiration date. Because the majority of our negotiations result in renewed contracts, our network has been growing over the past year as we establish new relationships with physicians and hospitals while retaining most of the providers that already participate in our network. When comparing the number of physicians who left the network with the number who joined, our network grew by nearly 5,400 physicians from January through May of 2019 and by more than 8,000 physicians during that same timeframe this year.

We understand that our members have personal relationships with their doctors and that network changes can be difficult. Our priority is to ensure our members have access to the quality care they need and that they are protected from the predatory billing practices of some providers who choose to balance bill or overcharge their patients for care.

Minimizing Disruption in Access to Care During COVID-19 Pandemic

Typically the timing of a contract termination notice being issued by a provider or insurer is dictated by the terms of the contract. For example, it's common for contracts to stipulate that termination notices must be sent at least 90 days prior to the contract renewal date, with that renewal date reflecting the date when the contract was originally established. As the severity of the COVID-19 pandemic became evident earlier this year, we began working affirmatively with care providers in our network to extend the renewal dates for their contracts whenever possible to enable them to focus their full attention on caring for patients and to minimize the risk of disruption in access to care for our members. For example, one of those agreements was with a group of hospital-based physicians that staffs emergency rooms at five hospitals in North Carolina. While it is difficult to address some of the allegations set forth in your letter without clear information about the providers in question, based on the information attached to your letter, we believe this was one of the physician groups referenced in your letter. What you may not know is that we offered to extend this group's contract on March 19, 2020. On April 2, 2020, we mutually agreed to extend the contract through September 1, 2020.

With millions of Americans and employers facing new financial challenges stemming from the COVID-19 pandemic, our responsibility to ensure that our members have access to health care that is both high quality and affordable is more important than ever. Suggestions that we maintain our contractual relationships with all in-network providers during the pandemic, including those whose charges are disproportionately higher than their peers, would adversely impact consumers in California and elsewhere given the financial strain that so many of our members and customers are facing. This also isn't a practical solution since, as noted earlier, providers are free to, and regularly do, terminate contracts themselves.

As more hospitals and physician practices are able to resume elective care and surgeries, and as health care utilization rates begin to normalize, we expect that our contract negotiations with the care providers in our network will also normalize. As always, we will approach those conversations with the goal of keeping providers in our network at rates that reflect fair market prices and promote an affordable, predictable experience for our members. Consistent with past practices, we fully expect that most of those conversations will result in renewed contracts given that most physicians, health care professionals and hospitals we work with are contracted at market rates that are fair to providers, consumers and health plan sponsors.

Some Providers Are Disproportionately Driving Up the Cost of Care for Families

A small number of providers are driving up the cost of care for the people and customers we are privileged to serve in California and across the nation. This is particularly evident with physician staffing companies, some of which expect to be paid three, four or even five times the median rate that their peers in their market accept for providing the same services to patients. Ultimately the people harmed by these egregious billing practices are consumers, small businesses, large employers, labor unions and governments.

While we appreciate the concerns you raised, it is important to correct the record with respect to some of the statements in your letter, which reflect information that is not comprehensive or fully accurate.

Throughout our negotiations with providers, particularly those whose charges are disproportionately higher than their peers, we focus on ensuring that our members have access to care that is not only high quality but also affordable. Egregiously high charges are unfair to consumers, employers and labor unions that offer health insurance to their employees or members when patients could receive the same services at more reasonable rates from a different doctor or at a different hospital down the road.

For example, some of the documents attached to your letter appear to be from an anesthesia group in North Carolina. You should be aware that **this group was being reimbursed at more than double the median rate of other anesthesia providers in North Carolina and more than 700% of Medicare rates**. While it is difficult to respond fully to the statements made in your letter without the underlying facts, you should know that in our negotiations with this group, we proposed to reimburse its physicians at rates similar to what we pay other anesthesia providers throughout North Carolina. Those negotiations began in September 2019 when we issued a termination notice along with a proposal for the purposes of beginning the negotiations process. Despite repeated outreach to the group throughout the fall and winter months, it never responded with a counter-proposal, making it impossible to meaningfully negotiate. As a result, the contract terminated on March 1.

To help illustrate the impact of this anesthesia group's egregiously high rates on patients in North Carolina and employers doing business in the State, consider the following examples:

- At a North Carolina hospital staffed by this group, 60 minutes of anesthesia services for a knee arthroscopy surgery would cost nearly $1,320. Had this hospital staffed its facility with anesthesiologists reimbursed at the local market median rate, it would have cost $650 for the identical procedure.
- With cost-sharing that is common in employer-sponsored health insurance plans, this group's egregiously high charges would cost a consumer $264 in out-of-pocket costs compared to $130 had this group been willing to charge rates similar to what other North Carolina anesthesiologists charge for the very same procedure.
- If we reimbursed this anesthesia group at the median rate of anesthesiologists in our North Carolina network, health care costs would have been reduced by $5.7 million, which translates into significant cost-savings for self-funded employers and lower premiums and out-of-pocket costs for consumers in North Carolina.

When this group requested that we bring its physicians back into the network later in March, we quickly indicated a willingness to continue the negotiations process and to work swiftly to reach agreement on market-competitive rates that would bring them back into our network. Unfortunately, the group did not provide a counterproposal until May. We are actively evaluating that proposal.

We work hard to avoid ending contractual relationships with providers, and a decision to terminate a contract is one we do not take lightly. In the case of the anesthesia group referenced in your letter, we had been in protracted discussions for six months prior to the contract's termination date in an effort to reach agreement on rates that would fairly compensate its physicians without driving up health care costs for employers and consumers in North Carolina.

We are also mindful of and follow State laws related to network adequacy and actively monitor our networks to ensure they provide adequate access to services for our members. Given that the two physician groups referenced in your letter practice in North Carolina, it's important to note that the 1.4 million North Carolina residents we are privileged to serve through our health plans will continue to have ample access to in-network care from the 136 hospitals and more than 41,000 primary care physicians, specialists and other health care professionals that participate in our network, including more than 40 anesthesiology groups providing care in facilities statewide. The same is true for the 3 million Californians we are privileged to serve through our health plans. We are in compliance with California's network adequacy law. As noted earlier, our members have access to in-network care from more than 450 hospitals and more than 101,000 primary care physicians, specialists and other health care professionals in our network in California.

When Providers Receive Market-Competitive Rates, Consumers, Labor Unions, Employers and Taxpayers Benefit

Finally, I want to address two other allegations in your letter. First, you suggest that we have "taken actions which threaten the wellbeing of our patients, physicians, and other health care providers" and are increasing the likelihood that our members will receive a surprise bill. On the contrary, the status of our contract with any provider group does not adversely impact our members' access to care. As noted earlier, not only do we have the largest network of any health insurer in the country, but in the case of the North Carolina anesthesia group you included in your letter, we are reimbursing its physicians at market-competitive rates despite the fact that they no longer participate in our network. Put simply, even without a new contract, **these doctors are still able to provide care to patients, and to be reimbursed for that care, regardless of their network status**. Whether this group chooses to accept a fair reimbursement rate comparable to the one their peers in the State are receiving is up to them. It is also up to them if they choose to accept payment from us and then also send a bill to their patients to collect the balance of their billed charges, which are often more than 700% of Medicare rates.

We share the concern about medical providers who send surprise medical bills to consumers. These harmful practices adversely impact consumers, employers and payers. As you know from your personal experience, surprise billing frequently occurs when patients receive care from an out-of-network provider at an in-network hospital, or when they receive emergency services at an out-of-network emergency department and subsequently receive an unexpectedly high bill for services. As the Congressional Budget Office found, eliminating surprise billing will reduce consumers' out-of-pocket costs and premiums, lower health care costs for employers, States and taxpayers, and facilitate movement toward a consumer-centric health care system that organizes care around patients' needs.[1] That is why we have been working with a broad group of stakeholders including consumer groups, labor unions, employers and health plans, to pass comprehensive surprise billing reforms that, among other things, establish a consumer cap and local, market-based benchmark payment rates for providers applicable to States without any protections, and to non-protected consumers in States with some protections. By relying on local market benchmark rates and capping consumer out-of-pocket costs across fully insured and self-insured health plans, health care will be more affordable, health spending can be lowered, providers can receive reasonable payment rates, and consumers can have a better experience with the health care system. We look forward to working with you to pass this much-needed reform.

Second, your assertion that our decision to remove providers from our network is designed to increase our profits is factually incorrect. In reality, reasonable and market-based rates protect consumers from the egregious prices that some providers charge, and the savings are returned to employers, labor unions, consumers and taxpayers in the form of lower health care costs. To illustrate how this works, consider a few critical facts:

- The vast majority of our commercial health insurance members – 70% – are enrolled in self-funded plans, meaning their employers assume the risk and pay the cost of their employees' medical bills themselves rather than relying on UnitedHealthcare to take on that risk and pay those claims. As a result, any savings from negotiating more competitive rates with providers goes directly to our self-funded customers, which they can in turn use to hold premiums steady for employees or to lower them in some cases. Employers can also use any savings to enhance other benefits, increase salaries or otherwise help to grow their organization.
- As noted above in the example of the North Carolina anesthesia group, for health plans that require members to pay co-insurance for certain services, negotiating lower rates with providers means that patients pay lower out-of-pocket costs when they receive care from that provider.
- Finally, under the Affordable Care Act's Medical Loss Ratio (MLR) requirement, any savings generated from negotiating lower rates from care providers that do not directly benefit our employer customers are spent on providing health care benefits for our members or are returned to ratepayers in the form of lower health care premiums.

[1] https://www.cbo.gov/publication/55457

Put simply, consumers, employers, labor unions, taxpayers and providers are all well-served when providers are reimbursed at fair and reasonable market-based rates.

To close, we'd like to reiterate that we understand the unprecedented nature of the COVID-19 pandemic, which is why, as described above, we took affirmative steps to protect consumers from unplanned costs associated with the pandemic by: waiving all member cost-sharing for COVID-19 testing and treatment; providing unlimited in-network telehealth visits for our members at no out-of-pocket cost; providing early refills, prolonged authorizations and increased home-delivery options of medication to ensure no shortages; providing $1.5 billion in direct customer and consumer support through premium credits, cost-sharing waivers and other efforts; offering a special enrollment period for employees seeking coverage; and allowing grace periods for employers and individuals to pay premiums. We have also taken proactive steps to ease the unique challenges facing our provider partners, including accelerating nearly $2 billion of payments to care providers to provide needed liquidity for the health system, waiving prior authorization requirements and extending provider contracts during the pandemic, where possible.

Thank you again for your letter and the opportunity to share our efforts to provide high-quality, affordable health care at this difficult time. Again, I would welcome the opportunity to host you at a facility in California to show you first-hand how UnitedHealth Group is responding to these unprecedented challenges facing the world. I hope you, your family and your staff stay safe and healthy in the months ahead.

Sincerely,

Rob Falkenberg, CEO of UnitedHealthcare in California