IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

ELECTRICAL MEDICAL TRUST, et al.,	§	
	§	
Plaintiffs,	§	CIVIL ACTION NO.: 4:23-CV-04398
vs.	§	
	§	**ORAL ARGUMENT REQUESTED**
U.S. ANESTHESIA PARTNERS, INC., et al.,	§	
	§	
Defendants.	§	

DEFENDANT U.S. ANESTHESIA PARTNERS, INC.'S
MOTION TO DISMISS THE COMPLAINT

Plaintiffs' lawsuit threatens the ability of a leading physician-owned anesthesiology practice to continue to provide high quality service to Texas hospitals and other healthcare facilities. Many hospitals in Houston and Dallas – particularly those in underserved communities – have determined that clinicians affiliated with U.S. Anesthesia Partners, Inc. ("USAP") will provide the best care for their patients. By partnering with USAP, hospital systems secure 24/7 coverage for all procedures across multiple sites, whether their patients have commercial or government sponsored insurance (such as Medicare or Medicaid), or no ability to pay. And competition for these hospital partnerships is fierce. Plaintiffs' lawsuit would interfere with local hospitals' decisions about how best to provide quality care to their patients, and would remake antitrust law in several respects. For the following reasons, all of Plaintiffs' claims should be dismissed.

Plaintiffs Lack Standing To Sue As Indirect Purchasers. Plaintiffs have not sufficiently alleged that they satisfy the "bright-line rule" set forth in *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977), and its progeny: only "*direct* purchasers" may seek damages under the federal antitrust laws. *Apple Inc. v. Pepper*, 139 S. Ct. 1514, 1520 (2019). The Complaint artfully avoids alleging that Plaintiffs *directly* paid USAP for "hospital-only anesthesia services." For good reason: the

Complaint makes plain that the direct purchasers are the commercial insurers USAP negotiates with – not Plaintiffs and other downstream customers of those insurers. The Court should dismiss the Complaint on that ground alone. *See infra* Part I.

The Complaint Does Not Plausibly Allege A Relevant Product Market. Plaintiffs assert that there is a well-defined antitrust market for "commercially insured hospital-only anesthesia services," arbitrarily excluding reasonably interchangeable substitutes – most obviously, anesthesiology performed in ambulatory surgical centers. Plaintiffs do not plead enough facts to make their alleged market plausible in light of either "the rule of reasonable interchangeability" or "cross-elasticity of demand," leaving it insufficient "as a matter of law." *Apani Sw., Inc. v. Coca-Cola Enters., Inc.*, 300 F.3d 620, 628 (5th Cir. 2002). *See infra* Part II.

The Complaint Does Not Plausibly Allege That USAP Has Monopoly Power. Plaintiffs nowhere allege that USAP has charged or has the power to charge supracompetitive rates – *i.e.*, monopoly power – in any alleged market. Indeed, the Complaint takes no steps to analyze competitive market pricing at all. Instead, Plaintiffs' own allegations prove that USAP *cannot* charge rates higher than those set by competitive market negotiation *before USAP even entered the market*. Were there any doubt, recent legislation subjecting out-of-network anesthesiologists' rates to mandatory arbitration now effectively prevents any provider from charging supracompetitive rates. The absence of any plausible factual basis for a claim of monopoly power is fatal to Plaintiffs' claims under Section 2 of the Sherman Act. *See infra* Part III.A.

The Complaint Does Not Plausibly Allege Exclusionary Conduct. Plaintiffs also do not allege exclusionary conduct. Acquisitions like those challenged often increase competition and therefore do not presumptively harm "the competitive *process* and thereby harm consumers." *Rambus, Inc. v. FTC*, 522 F.3d 456, 463 (D.C. Cir. 2008). Plaintiffs' only attempt to plead facts

showing these acquisitions did harm consumers fails because (again) the rates they challenge were set by USAP's nonmonopolist predecessor, not USAP. *See infra* Part III.B.

Plaintiffs' Section 2 Conspiracy Claim Fails. The Court should dismiss Plaintiffs' Section 2 conspiracy claim because, for the reasons Welsh Carson explains in its motion, USAP and Welsh Carson are legally incapable of conspiring under *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 770-71 (1984). *See infra* Part III.C.

Plaintiffs' Section 7 Claim Fails. Plaintiffs do not state a claim under Section 7 of the Clayton Act because they fail to allege a probability that anticompetitive effects would flow from the challenged acquisitions, neither when they were consummated nor with the present benefit of hindsight. *See infra* Part IV.

Plaintiffs' Section 1 "Price-Fixing" Claim Fails. The Complaint also attacks USAP's agreement to handle administrative-billing and payor-relations functions on behalf of three small anesthesiology practices by contorting these separate administrative services agreements into a Section 1 "price-fixing" claim. But the Complaint does not allege an agreement among competitors to fix prices. Rather, it alleges that USAP's administrative services clients assigned it their right to payment from insurers in exchange for compensation at rates other than USAP's. Even as alleged, that is not "price fixing," so the claim should be dismissed. *See infra* Part V.

BACKGROUND

USAP is an organization owned by anesthesiologists who treat patients throughout Texas. *See* Compl. ¶¶ 1-2. USAP did not exist until 2012, when it acquired a preexisting, standalone practice called Greater Houston Anesthesiology, or GHA. *See id.* ¶¶ 2, 56. Apart from providing anesthesiology services, USAP also performs certain administrative services for non-USAP physicians. *See*, *e.g.*, *id.* ¶ 112.

I. Anesthesia Providers Work Both In And Out Of Hospitals And Negotiate Rates Directly With Insurance Companies

"Anesthesiologists administer medications to prevent patients from feeling pain during medical procedures or surgery." *Id.* ¶ 25. Physician anesthesiologists and certified registered nurse anesthetists, or CRNAs, are qualified to practice anesthesiology. *See id.* ¶ 97. These providers can provide anesthesia services in several healthcare facility settings throughout Texas, including hospitals (on an inpatient or outpatient basis), "outpatient surgery centers, ambulatory surgical centers, [and] doctors' offices." *Id.* ¶¶ 25, 27. Yet Plaintiffs' claims are limited to "hospital-only anesthesia services reimbursed by commercial payors." *Id.* ¶ 25.

To guarantee the availability of "hospital-only anesthesia services," hospitals often choose to partner exclusively with anesthesia groups like USAP. *See id.* ¶ 39. Hospitals derive many benefits from these contractual agreements. They "give[ ] the hospital a central hub for scheduling dozens of procedures per day"; "allow[ ] the hospital to implement accountability-of-care quality measures with the practice"; and ensure sufficient staffing for procedures "on a 24/7 basis." *Id.* ¶ 28.

The rates at which anesthesia groups are paid differ depending on who pays them. Government insurers pay at rates set by government fee schedules. *See id.* ¶ 31. Commercial payors pay rates that are set by contracts negotiated between insurers (who offer to include the groups in their provider "networks") and the groups (who, in exchange, offer often-substantial discounts). *Id.* ¶¶ 31, 34, 57; *see also id.* ¶ 94 ("[H]ealthcare providers negotiate reimbursement rates with insurers that must offer plans and maintain networks that cover members [in] multiple cities."). If the providers and insurers do not form such an agreement, the anesthesia group is considered "out of network." *See id.* ¶ 67. Out-of-network providers used to be able to bill at higher rates they set, but the law has recently changed such that this is no longer the case. Under

recent state and federal legislation (the latter known generally as the No Surprises Act), out-of-network providers (like anesthesiologists) must obtain payment through costly and uncertain arbitration. *See generally* No Surprises Act, Pub. L. No. 116-260, div. BB, tit. I, 134 Stat. 1182, 2757-890 (2020); 2019 Tex. Gen. Laws ch. 1342 (S.B. No. 1264).

Plaintiffs are self-funded employee benefit plans that do not themselves negotiate reimbursement rates with providers like USAP. *See* Compl. ¶¶ 14-15. Instead, Plaintiffs each contract with an insurer (in the case of Plaintiff Plumbers Local Union No. 68 Welfare Fund, United Healthcare) that "provides access to its network and negotiates rates with providers." *Id.* ¶ 15; *see also id.* ¶ 33 ("[C]ommercial insurers such as Blue Cross and United Healthcare build provider networks, and self-funded insurers sometimes contract with insurers for access to those networks."). While Plaintiffs allege that they "reimburse[] healthcare providers," *id.* ¶¶ 14-15, their claims are limited to USAP's conduct purportedly harming the alleged market for "hospital-only anesthesia services" that are "reimbursed *by commercial payors*," *id.* ¶ 25 (emphasis added).

II. USAP Inherited Reimbursement Rates That Had Been Negotiated Between Commercial Insurers And GHA

Plaintiffs focus much of their attention on the rates at which USAP's anesthesiologists are compensated. *See*, *e.g.*, *id.* ¶ 8. Many of these rates trace to long-term agreements that GHA had negotiated with commercial payors before USAP existed. When USAP acquired GHA (in 2012), GHA's 220 physicians and 180 CRNAs, *see id.* ¶ 4, were "well-positioned" with four prominent Houston hospitals, *see id.* ¶ 53. But Plaintiffs do not allege that GHA had monopoly power.

In acquiring GHA, USAP inherited GHA's contracts with commercial payors – contracts that established, for example, GHA's in-network status and reimbursement rates. *See id.* ¶¶ 31, 95 (explaining that contracts between providers and commercial payors establish rates and network status); *see also id.* ¶ 53 (alleging one consultant's analysis of GHA's then-existing reimbursement

rates with commercial payors). GHA's pre-acquisition negotiations with commercial insurers "achieved very good levels of reimbursement from commercial payers." *Id.* ¶ 53. Plaintiffs do not allege that these rates were supracompetitive or that GHA had monopoly power when it negotiated these rates.

GHA's legacy contracts generally established that if GHA acquired another practice, the insurer would compensate the newly acquired physicians for their services at GHA's pre-existing, contractually agreed upon rates. *See id.* ¶ 53 ("Savvy Sherpa advised that [after acquiring GHA] USAP would be able to spread [GHA's] higher reimbursement rates to other practices it acquired."). Where necessary, USAP later modified these legacy contracts "to clarify" that GHA's legacy rates "would apply after an acquisition." *Id.* ¶ 68. Plaintiffs do not allege that these provisions (so-called "tuck-in clause[s]," *id.*) were unusual in the industry.

III. USAP Expanded Its Provision Of High-Quality Anesthesia Services Within And Outside Of Houston

After acquiring GHA, USAP sought to grow its business and to improve the quality of anesthesia services offered across the State of Texas. The Complaint alleges that USAP made 15 acquisitions over the course of the following seven years, starting with Lake Travis Anesthesiology in 2013, *see id.* ¶ 60, and ending with Guardian Anesthesia Services in 2020, *see id.* ¶ 82.

Even though GHA's contracts with many commercial insurers authorized USAP to bill the newly acquired practitioners at GHA's negotiated rates, *see id.* ¶ 53, the insurers did not always honor those prior agreements. For example, after USAP acquired Pinnacle – an anesthesia practice in Dallas – one insurer refused to honor the agreed-upon GHA rates, and instead opted to treat the former Pinnacle (now USAP) anesthesia providers "as out of network." *Id.* ¶ 67. It took nearly two years of arbitration to resolve that dispute. *See id.*

IV. USAP Inherited And Executed Administrative Services Agreements In Connection With Certain Acquisitions

Plaintiffs also challenge certain administrative services agreements that USAP either inherited or executed between 2012 and 2014 that are separate from its provision of anesthesia services.[1] USAP inherited two administrative services agreements from practices it had acquired – in 2012, USAP assumed GHA's contract with The Methodist Hospital Physicians Organization, *see id.* ¶ 114; and in 2014, USAP assumed Pinnacle's contract with the Baylor University Medical Center. *See id.* ¶ 117. USAP itself entered into the third challenged agreement with the Baylor College of Medicine in 2014. *See id.* ¶ 121. Notably, that latest agreement was terminated in 2020. *See id.* Plaintiffs nowhere allege that any of these agreements were materially significant.

Plaintiffs allege that under these agreements, USAP agreed to perform back-office functions such as payor relations and billing on behalf of a group of physicians. *See id.* ¶¶ 112, 116. USAP "bill[s] and receive[s] payments" for the anesthesia services performed by client provider groups using USAP's own "name and tax identification number." *E.g.*, *id.* ¶ 116. USAP keeps a portion of the collected payment as compensation for the administrative services it has performed. *See id.* ¶ 117.

LEGAL STANDARD

"Federal Rule of Civil Procedure 12(b)(6) requires that a plaintiff plead facts sufficient to state a plausible cause of action." *Collins v. Midland Mortg.*, 2022 WL 16556810, at *1 (S.D. Tex. Oct. 31, 2022) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "In deciding a Rule 12(b)(6) motion to dismiss for failure to state a claim, the court 'accepts all well-pleaded facts as true, viewing them in the light most favorable to the [nonmovant].'" *Id.* (alteration in original)

[1] Plaintiffs also allege that USAP attempted to enter into a fourth administrative services agreement with physicians at the University of Texas in 2014 and again in 2020, but an agreement was never reached. *See id.* ¶ 123.

(quoting *In re Katrina Canal Breaches Litig.*, 495 F.3d 191, 205 (5th Cir. 2007)). "Even so, 'a plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do.'" *Id.* (alteration in original) (quoting *Twombly*, 550 U.S. at 555). Although USAP disputes many of the facts alleged in Plaintiffs' Complaint, the factual allegations described below are from the Complaint and are taken as true for this motion. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

ARGUMENT

I. PLAINTIFFS LACK STANDING TO SUE AS INDIRECT PURCHASERS

Plaintiffs "have not shown they were direct purchasers," as they must to state a claim. *Hughes v. Tobacco Inst., Inc.*, 278 F.3d 417, 423 (5th Cir. 2001) (affirming dismissal). Under the federal antitrust laws, "*indirect* purchasers who are two or more steps removed from [an alleged antitrust] violator in a distribution chain may not sue" for damages. *Apple*, 139 S. Ct. at 1520 (citing *Ill. Brick Co.*, 431 U.S. at 736). Under this "bright-line rule," *Apple*, 139 S. Ct. at 1520, "customers of parties more directly injured by an alleged antitrust violation do not have standing to assert their own claims for damages." *Sharif Pharmacy, Inc. v. Prime Therapeutics, LLC*, 950 F.3d 911, 915 (7th Cir. 2020).

"In healthcare-services cases, the possible candidates for the mantle of 'direct purchaser' could be the patient, the patient's employer (if the patient is insured under an employer-sponsored health plan), or the insurer itself – or possibly more than one of these candidates if more than one *directly paid the healthcare provider*." *In re NorthShore Univ. HealthSystem Antitrust Litig.*, 2018 WL 2383098, at *6 (N.D. Ill. Mar. 31, 2018) (emphasis added). Courts thus must attend carefully to "the mechanics of the transaction" – even on a motion to dismiss. *E.g.*, *Warren Gen. Hosp. v. Amgen Inc.*, 643 F.3d 77, 88 (3d Cir. 2011) (affirming dismissal because the plaintiff had

purchased from an intermediary, not the alleged antitrust violator); *Sharif Pharmacy*, 950 F.3d at 915 (affirming dismissal of complaint by customers of a pharmacy that was itself the direct victim of an alleged antitrust violation); *In re Xyrem (Sodium Oxybate) Antitrust Litig.*, 555 F. Supp. 3d 829, 881 (N.D. Cal. 2021) (similar result where self-funded payers had purchased the relevant product from an intermediary, not the alleged violator).

Plaintiffs' allegations fail to "show[ ] they were direct purchasers" from USAP. *Hughes* 278 F.3d at 423. The Complaint explains that "[c]ommercial insurers negotiate with providers to set reimbursement rates," Compl. ¶ 31, and that "self-funded insurers sometimes contract with" these commercial insurers "for access to" their provider "networks," *id.* ¶ 33. Pursuant to those contracts, a self-funded payer generally agrees to "fund[ ] a bank account from which *the insurer*" – and not the plan – "pays the claims as they are submitted by the providers." *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 188 (D.D.C. 2017) (emphasis added), *aff'd*, 855 F.3d 345 (D.C. Cir. 2017). A self-funded payer thus does not have antitrust standing to sue a healthcare provider it does not pay directly: in that circumstance, "the *direct* victim of antitrust harm is [the insurer], not" the self-funded payer. *NorthShore*, 2018 WL 2383098, at *8.

Plaintiffs do not sufficiently allege that they paid USAP *directly*, such that they (rather than their insurer counterparties) are "the *direct* victim[s]" of USAP's alleged antitrust violations. *Id.* Plaintiffs come no closer than conclusory statements highlighting this point by negative implication: each of them allegedly "directly reimburses healthcare providers who treat its members," but neither alleges that it *directly* "paid USAP for hospital anesthesia services provided to its plan participants." Compl. ¶¶ 14-15; *cf. In re Surescripts Antitrust Litig.*, 2020 WL 4905692, at *4 (N.D. Ill. Aug. 19, 2020) (dismissing complaint and explaining: "If the plaintiffs paid Surescripts directly for e-prescription routing services, they need only say so to render the *Illinois*

Brick doctrine irrelevant. They have instead engaged in what looks like artful pleading intended (albeit unsuccessfully) to disguise their failure to allege that they are direct purchasers from Surescripts."). Compounding this failure, although each Plaintiff alludes to a commercial insurer,[2] neither alleges the terms of any "contract" it has "with [an] insurer[.]". Compl. ¶ 33; *cf. Warren Gen. Hosp.*, 643 F.3d at 88 (affirming dismissal because the relevant contracts showed that the plaintiff was not a direct purchaser).

The Complaint's class-action allegations drive home Plaintiffs' indifference to the "bright-line [direct-purchaser] rule," *Apple*, 139 S. Ct. at 1520, because they seek to represent anyone who "paid for hospital-only anesthesia services provided in Texas by USAP or its coconspirators." Compl. ¶ 128. If anything, the Complaint undermines Plaintiffs' claim to be direct purchasers. The nub of their theory is the claim that USAP has too much leverage in negotiating reimbursement rates *with insurers*,[3] who in turn contract with self-funded payers. By their own account, then, Plaintiffs are "customers of parties more directly injured by an alleged antitrust violation": the insurers. *Sharif Pharmacy,* 950 F.3d at 915; *see also NorthShore*, 2018 WL 2383098, at *8 ("All in all, the [self-funded payers'] contract simply does not [set up the insurer] as some mere conduit of payment, as if it were some PayPal-like clearinghouse. The only other relevant consideration in the *Illinois Brick* analysis here is which entity negotiated and maintained the contract with the healthcare provider. That is [the insurer].").

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[2] *See* Compl. ¶ 14 (Aetna); *see id.* ¶ 15 (United Healthcare).

[3] *See id.* ¶¶ 7-8, (quoting insurer executive as complaining about USAP's "leverage at the negotiating table"); *id.* ¶¶ 41-42 (contending that USAP has "enjoy[ed] a multiplier effect in negotiations with insurers"); *id.* ¶ 95 (asserting that "USAP" had "successfully negotiated rate increases with Blue Cross in" particular areas); *id.* ¶¶ 108, 119, 122 (challenged conduct increased USAP's "negotiating leverage with insurers"); *id.* ¶¶ 149, 162, 170, 187 (similar express or implicitly incorporated allegations supporting Sherman Act claims); ¶ 155 (same for Clayton Act claim).

Because Plaintiffs have failed to plausibly allege that they are direct purchasers of USAP's anesthesia services, the Court should dismiss the Complaint in its entirety.

II. THE COMPLAINT FAILS TO PLAUSIBLY ALLEGE A RELEVANT PRODUCT MARKET

To state an antitrust claim, Plaintiffs must plausibly plead a relevant product market. *See Apani*, 300 F.3d at 628 (relevant market must be defined for Sherman Act and Clayton Act claims); *Shah v. VHS San Antonio Partners, L.L.C.*, 985 F.3d 450, 453-54 (5th Cir. 2021) (relevant market necessary for both Sherman Act Sections 1 and 2). The Court may determine whether Plaintiffs have sufficiently alleged such a market "as a matter of law." *Apani*, 300 F.3d at 628. If Plaintiffs either have "[1] fail[ed] to define [their] proposed relevant market with reference to the rule of reasonable interchangeability and cross-elasticity of demand, or [2] allege[d] a proposed relevant market that clearly does not encompass all interchangeable substitute products even when all factual inferences are granted in [their] favor, the relevant market is legally insufficient, and a motion to dismiss may be granted." *Id.*

Plaintiffs' proposed product market – "hospital-only anesthesia services reimbursed by commercial payors," Compl. ¶ 25 – requires dismissal on each of the grounds referenced in *Apani*. While the Complaint provides a laundry list of reasons why "hospital-only anesthesia services" are supposedly distinct, they all reduce to the irrelevant tautology that "hospital-only anesthesia services" must be provided in hospitals. *See*, *e.g.*, Compl. ¶ 27 ("Patients requiring hospital admission to receive treatment necessarily must receive anesthesia services in a hospital."); *id.* ("[P]atients whose outpatient procedures or surgeries must occur in a hospital . . . must receive anesthesia services in a hospital"). Conspicuously absent are any supporting allegations regarding reasonable interchangeability (what can be substituted for the relevant service) or cross-elasticity of demand (where consumers will go if prices rise). That alone compels dismissal. *See*, *e.g.*, *NSS*

Labs, Inc. v. Symantec Corp., 2019 WL 3804679, at *9 (N.D. Cal. Aug. 13, 2019) (dismissing antitrust claims for improper market definition where plaintiff "fail[ed] to identify the economic substitutes for the product markets" and did not "plead any facts regarding the cross-elasticity of demand"); *Jacobs v. Tempur-Pedic Int'l, Inc.*, 626 F.3d 1327, 1338 (11th Cir. 2010) (affirming dismissal under *Twombly* where complaint "provide[d] no factual allegations of the cross-elasticity of demand or other indications of price sensitivity").

Plaintiffs' "hospital-only" market definition also "clearly does not encompass all interchangeable substitute products" (here, services). *Apani*, 300 F.3d at 628. Licensed anesthesiologists work in both hospital and non-hospital facilities, and Plaintiffs do not allege that the facility changes the "anesthesia services" themselves in a way that bears on competition. The tautological observation that "[p]atients requiring hospital admission . . . must receive anesthesia services in a hospital," Compl. ¶ 27, is a distraction: absent allegations that that setting-based distinction is also a boundary of competition among "anesthesia services" providers, that distinction makes no market-definition difference. Plaintiffs have not alleged that, so their alleged market does *not* "encompass[ ] the group or groups of sellers or producers who have actual or potential ability to deprive each other of significant levels of business." *Hicks v. PGA Tour, Inc.*, 897 F.3d 1109, 1120-21 (9th Cir. 2018) (citation omitted).

The Fifth Circuit has routinely rejected artificial market definitions similar to Plaintiffs' litigation-driven definition here. For instance, in *Shah*, the plaintiff attempted to define a market for "pediatric anesthesia services" provided at a handful of facilities within an eight-county radius. *See Shah*, 985 F.3d at 454. The Fifth Circuit found the plaintiff's proposed market "insufficient as a matter of law" because it failed to "encompass all interchangeable substitute products." *Id.* at 455. The same is true here. By limiting the market to "hospital-only" anesthesia services,

Plaintiffs have artificially excluded the large population of "non-hospital" anesthesiologists capable of providing the same anesthesiology services, scrubbing the proposed market of "reasonably interchangeable substitutes" and thereby rendering it "unduly narrow and legally insufficient." *New Orleans Ass'n of Cemetery Tour Guides & Cos. v. New Orleans Archdiocesan Cemeteries*, 56 F.4th 1026, 1038 (5th Cir. 2023) (affirming dismissal of antitrust complaint on that ground).

Plaintiffs' other justifications for their obviously crabbed market definition are all unavailing. Most notably, Plaintiffs contend that "[s]ome private insurers formally require . . . billing practices" that distinguish "hospital-only" from non-hospital anesthesia services. Compl. ¶ 26. To begin with, the fact that different insurers employ different billing practices on this point undercuts Plaintiffs' argument that this distinction has widespread commercial significance. But moreover, the Complaint does not allege, and cannot allege, that insurers prevent hospitals from contracting with fully credentialed anesthesiologists merely because those anesthesiologists do not currently practice at a hospital. If, contrary to Plaintiffs' theory, insurers are the relevant consumers in this market and have the power to dictate who provides what service to patients, then plainly the power lies with insurers and Plaintiffs' allegations of monopolization by USAP are entirely misdirected.

Plaintiffs' proposed market definition for "hospital-only anesthesia services reimbursed by commercial payors" is "plainly designed to bolster" its claims "by artificially exaggerating [USAP's] market power." *It's My Party, Inc. v. Live Nation, Inc.*, 811 F.3d 676, 681 (4th Cir. 2016). Dismissal is therefore required.

III. THE COMPLAINT FAILS TO STATE A CLAIM UNDER SECTION 2 OF THE SHERMAN ACT

Counts I, III, and IV of Plaintiffs' Complaint assert violations of Section 2 of the Sherman

Act. "A violation of section 2 of the Sherman Act is made out when it is shown that the asserted violator 1) possesses monopoly power in the relevant market and 2) acquired or maintained that power willfully, as distinguished from the power having arisen and continued by growth produced by the development of a superior product, business acumen, or historic accident." *Stearns Airport Equip. Co. v. FMC Corp.,* 170 F.3d 518, 522 (5th Cir. 1999) (citing *United States v. Grinnell Corp.*, 384 U.S. 563 (1966)).

A. The Complaint Fails To Plausibly Allege That USAP Has Monopoly Power

The Complaint fails to allege that USAP has monopoly power, a *sine qua non* of any Section 2 monopolization claim. *See Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 481 (1992); *Abraham & Veneklasen Joint Venture v. Am. Quarter Horse Ass'n*, 776 F.3d 321, 334 (5th Cir. 2015). Monopoly power is the power to raise price *above a competitive level,* to restrict output (to the same effect), or to reduce quality below a competitive level. *See*, *e.g.*, *Taylor v. Christus St. Joseph Health Sys.*, 216 F. App'x 410, 412 (5th Cir. 2007); *see also Sheridan v. Marathon Petroleum Co. LLC*, 530 F.3d 590, 594 (7th Cir. 2008) ("Monopoly power we know is a seller's ability to charge a price above the competitive level") (Posner, J.) (emphasis omitted). The Complaint fails to plausibly allege that USAP has any such power, in light of both the pricing history they allege and the regulatory context described below. Counts I, III, and IV should therefore be dismissed.

1. Plaintiffs' Pricing Allegations Confirm That USAP Lacks Monopoly Power

Plaintiffs base their claim of monopoly power on allegations that USAP has increased the prices for anesthesia services throughout Texas. But that claim fails because the Complaint lacks any allegation that USAP raised prices "above the competitive level," *Abraham*, 776 F.3d at 335, after it supposedly attained a monopoly through its acquisition of various anesthesia practices in

Texas. Indeed, the pricing history recounted in the Complaint alleges the opposite of what Plaintiffs must plead and prove. The allegations establish that, at all relevant times, USAP has functioned in a highly competitive marketplace that sets prices based on individualized negotiations. Plaintiffs do not allege that USAP has extracted a monopoly price from any purchaser. On the contrary, it has struggled to maintain the contractually agreed prices that a predecessor, *non-monopolist* provider negotiated prior to its acquisition by USAP.

Plaintiffs' only pricing allegations pertain to "Tuck-In Acquisitions" by which USAP acquired a number of smaller anesthesiology practices in Houston and Dallas following its anchor purchase of Greater Houston Anesthesiology in December 2012. *See*, *e.g.*, Compl. ¶¶ 60-82 (describing USAP's subsequent acquisitions). Rather than alleging that USAP followed these acquisitions by raising prices to supracompetitive levels, the Complaint alleges that USAP "tucked in" these acquired practices to the *preexisting* rates that GHA itself had negotiated with the commercial insurers. *See id.* ¶ 57 ("After each acquisition, USAP would raise the new practitioners' reimbursement rates *to those of Greater Houston Anesthesiology*.") (emphasis added)). And at the time of its December 2012 acquisition, GHA had less than a 15% share of even Plaintiffs' gerrymandered market for "commercially insured hospital-only anesthesia services" in Texas. *See id.* ¶ 85. In other words, Plaintiffs' only alleged fact regarding monopoly power is that, after acquiring small anesthesiology practices, USAP raised the rates of *some* (but not all) practices to the prevailing market rate for their services, as it was contractually permitted to do under agreements negotiated at arms-length with sophisticated commercial payors by USAP's concededly non-monopolist predecessor, GHA.

Aside from these self-defeating pricing allegations, Plaintiffs make no serious effort to allege monopoly power. They never allege that USAP has held output below the competitive level

(or, indeed, that output has decreased at all). And although they recite isolated episodes of individual physicians' alleged malpractice, *see* Compl. ¶¶ 102-05, Plaintiffs do not allege that USAP anesthesiologists offer lower-quality patient care than they would have offered but for USAP's challenged acquisitions and agreements. Indeed, no such allegation could be plausible, given Plaintiffs' own allegations that hospitals have continued to contract with USAP. Because a firm that cannot charge more than a competitive price, restrict output to the same effect, or reduce quality below competitive levels is no monopolist at all, the Court should dismiss Plaintiffs' Section 2 claims.[4]

2. The Regulatory Structure Of The No Surprises Act Forecloses Any Claim That USAP Has Monopoly Power

Plaintiffs' allegation of USAP's monopoly power is implausible for a second reason: patient and insurer protections in the federal No Surprises Act and related Texas legislation foreclose any exercise of monopoly power by USAP. As the Supreme Court has explained, "[o]ne factor of particular importance" in assessing a Section 2 Sherman Act claim "is the existence of a regulatory structure designed to deter and remedy anticompetitive harm." *Verizon Commc'ns Inc. v. L. Offs. of Curtis V. Trinko, LLP*, 540 U.S. 398, 412 (2004) (affirming dismissal of Section 2 claim). "Where such a structure exists, the additional benefit to competition provided by antitrust enforcement will tend to be small, and it will be less plausible that the antitrust laws contemplate such additional scrutiny." *Id.* Here, the "regulatory structure" created by the No Surprises Act (and its Texas equivalent) contradicts Plaintiffs' claim that USAP possesses monopoly power because it precludes USAP from exercising any pricing leverage over the patients and insurers that

[4] Plaintiffs' allegations of indirect evidence of monopoly power, in the form of USAP's purportedly dominant share of the market for "hospital-only anesthesia services reimbursed by commercial payors," Compl. ¶ 25, are likewise insufficient due to the gerrymandered nature of that market. *See* Part II, *supra*.

the Act protects. The Court may take judicial notice of these statutes, which form the regulatory background against which USAP's purported exercise of power takes place. *See*, *e.g.*, *In re Waller Creed, Ltd.*, 867 F.2d 228, 238 n.14 (5th Cir. 1989).

In the market for healthcare services, insurers generally respond to price demands from USAP and other provider groups by taking those provider groups "out of network." *See*, *e.g.*, Compl. ¶ 67 (explaining how, following USAP's acquisition of Pinnacle, one insurer responded to USAP's "inflated reimbursement rates" by "treat[ing] the new USAP providers as out of network"). When an insured patient receives care from an out-of-network provider, "the individual's plan or issuer may decline to pay for the service or may pay an amount that is lower than the provider's billed charges." Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872, 36874 (July 13, 2021). "Prior to the No Surprises Act, the [out-of-network] provider could generally balance bill the individual for the difference between the provider's billed charges and the sum of the amount paid by the plan or issuer and the cost sharing paid by the individual, unless otherwise prohibited by state law." *Id.*

Congress enacted the No Surprises Act in December 2020 to change that state of play. *See Tex. Med. Ass'n v. United States Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528, 533 (E.D. Tex. 2022), *appeal dismissed*, 2022 WL 15174345 (5th Cir. Oct. 24, 2022). On June 14, 2019, Texas enacted S.B. 1264, a state law imposing similar requirements. *See Tex. Med. Res., LLP v. Molina Healthcare of Tex., Inc.*, 659 S.W.3d 424, 427-29 (Tex. 2023) (explaining the relevant provisions of S.B. 1264).[5] The Act protects both patients and insurers by preventing out-of-network providers from exercising pricing leverage by balance billing patients in the manner

[5] To the extent USAP had the ability to exercise monopoly power prior to the passage of S.B. 1264, the Sherman Act's four-year statute of limitations precludes liability for any conduct committed prior to that date. *See* 15 U.S.C. § 15b.

described above. With respect to patients, "the Act limits the amount an insured patient will pay for emergency services . . . and for certain non-emergency services furnished by an out-of-network provider." *Tex. Med. Ass'n*, 587 F. Supp. 3d. at 533; *see* 42 U.S.C. §§ 300gg-111; 300gg-131. With respect to insurers, "the Act requires insurers to reimburse out-of-network providers at . . . either the amount agreed to by the insurer and the out-of-network provider or an amount determined through an independent dispute resolution ('IDR') process." *Tex. Med. Ass'n*, 587 F. Supp. 3d at 533-34. That IDR process consists of "a 'baseball-style' arbitration" in which the "provider and insurer each submits a proposed payment amount and explanation to the arbitrator," who in turn "must select one of the two proposed payment amounts." *Id.* at 534; *see* 42 U.S.C. § 300gg-111(a)-(c).

The No Surprises Act perfectly exemplifies the Supreme Court's description of a "regulatory structure designed to deter and remedy anticompetitive harm" that minimizes any "additional benefit to competition provided by antitrust enforcement[.]" *Trinko*, 540 U.S. at 412. The Act's prohibition on balance billing prevents USAP from exercising any pricing leverage that could result in anticompetitive harm to consumers. And the requirement of mandatory arbitration for disputes between providers and insurers over out-of-network rates only further constrains such leverage. What is more, that requirement places insurers in a superior bargaining position by amplifying the power of their networks regardless of the market share that any particular provider group acquires. Plaintiffs offer no explanation of how USAP could exercise monopoly power – "the ability to charge a price above the competitive level," *Abraham*, 776 F.3d at 335 – in the teeth of these statutory protections for patients and insurers. At a minimum, against the regulatory backdrop of the No Surprises Act, Plaintiffs' allegation of USAP's monopoly power is simply not "plausible." *Twombly*, 550 U.S. at 570.

B. The Complaint Fails To Plausibly Allege Exclusionary Conduct

Plaintiffs' Section 2 claims fail for the additional reason that the Complaint contains no cognizable allegations of exclusionary conduct. As the Supreme Court has made clear, "the possession of monopoly power will not be found unlawful unless it is accompanied by an element of anticompetitive conduct." *Trinko*, 540 U.S. at 407.

Plaintiffs' sole allegation of exclusionary conduct is that USAP obtained a monopoly by acquiring several anesthesia practices throughout Texas, consolidated these providers under the USAP umbrella, and thereby increased its market share. *See* Compl. ¶¶ 146-52 (referencing only USAP's acquisitions). Acquisition-based allegations similar to these do not amount to a plausible claim of actionable exclusionary conduct under Section 2. Indeed, as the Fifth Circuit has expressly recognized, "acquiring a monopoly is not in and of itself illegal." *Abraham*, 776 F.3d at 334. Instead, "[t]he illegal abuse of power occurs when the monopolist exercises its power to control prices or exclude competitors from the relevant market for its products." *Id.* Only in rare circumstances not alleged here have acquisitions of competitors been held to be exclusionary under Section 2. *E.g.*, *United States v. Am. Tobacco Co.*, 221 U.S. 106, 183 (1911) (Section 2 violation where defendant spent "millions upon millions of dollars in buying out plants, not for the purpose of utilizing them, but in order to close them up and render them useless for the purposes of trade"). Plaintiffs' theory, which would find exclusionary conduct based on a pattern of acquisitions alone, violates these principles and threatens to collapse the "monopoly power" and "exclusionary conduct" elements of a section 2 claim by allowing the means of obtaining the monopoly to satisfy both elements in a single stroke.

Contrary to that theory, multiple courts have recognized that acquisitions, including acquisitions of competitors, support no presumption of anticompetitive effect because such acquisitions often increase competition and benefit consumers. *See Eastman v. Quest Diagnostics*

Inc., 2016 WL 1640465, at *9 (N.D. Cal. Apr. 26, 2016) ("plaintiffs cannot rely on the fact of the acquisitions alone"), *aff'd*, 724 F. App'x 556 (9th Cir. 2018); *Dresses for Less, Inc. v. CIT Grp./Com. Servs., Inc.*, 2002 WL 31164482, at *12 (S.D.N.Y. Sept. 30, 2002) ("[T]he mere fact that a merger eliminates competition between the firms concerned has never been a sufficient basis for illegality.") (quoting IV Phillip E. Areeda et al., *Antitrust Law* ¶ 901a (1998)). This is particularly true when an established firm acquires a fledgling competitor: there are obvious opportunities for benefits not only to the acquiring company, but also to consumers. *See Dresses for Less*, 2002 WL 31164482, at *12 ("horizontal mergers are much more likely to be procompetitive than anticompetitive"); Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 901a (2023) (competitors may merge "to achieve synergies in the production or distribution of complementary goods, to put inefficiently run assets into the hands of superior management").

Moreover, actionable exclusionary conduct must have an "anticompetitive effect," that is, "it must harm the competitive process and thereby harm consumers." *Rambus*, 522 F.3d at 463; *see also United States v. Microsoft Corp.*, 253 F.3d 34, 58, 79 (D.C. Cir. 2001) (preventing distribution of rival browsers on third-party PCs prevented competition on the merits in the PC operating system market). Plaintiffs' Complaint contains no plausible allegation that USAP's acquisitions caused harm to competition in any measurable way. As explained above, the Complaint nowhere alleges that USAP's rates themselves have increased above a competitive level as a consequence of its acquisitions. And its core allegation – that the newly acquired practices were "tucked in" at USAP's existing rates, *see*, *e.g.*, Compl. ¶ 57 – merely reflects the extension of market rates negotiated at arms-length by a non-monopolist. *See* Part III.A, *supra*.

The Complaint states, in conclusory fashion, that USAP's acquisitions have increased prices for anesthesia services. But given the concrete facts alleged in the Complaint regarding

USAP's pricing practices (as discussed above), Plaintiffs' claims of *market-wide* harm are purely speculative. *See Twombly*, 550 U.S. at 555 (conclusions must be disregarded); *Roy B. Taylor Sales, Inc. v. Hollymatic Corp.*, 28 F.3d 1379, 1385 (5th Cir. 1994) ("Speculation about anticompetitive effects is not enough."). Plaintiffs' allegations do not establish USAP's "exercise[ ] [of] its power to control prices or exclude competitors from the relevant market for its products." *Abraham*, 776 F.3d at 334. Plaintiffs therefore have not alleged the "element of anticompetitive conduct" that a Section 2 monopolization claim requires, *Trinko*, 540 U.S. at 407, and the Section 2 claims should also be dismissed on this independent ground.

C. Plaintiffs' Section 2 Conspiracy Claim Independently Requires Dismissal

USAP hereby incorporates by reference Section II.A.1 of Welsh Carson's motion to dismiss. *See* WC Mot. Section II.A.1. As explained therein, Plaintiffs have failed to state a Section 2 conspiracy claim because Welsh Carson and USAP were not separate economic actors in this context and were thus incapable of conspiring as a matter of law under *Copperweld*, 467 U.S. at 770-71. *See*, *e.g.*, *Surgical Care Ctr. of Hammond, L.C. v. Hosp. Serv. Dist. No. 1 of Tangipahoa Parish*, 309 F.3d 836, 840-41 (5th Cir. 2002) (affirming dismissal of Section 2 conspiracy claim because "as a matter of law, [the two corporate entities concerned] . . . are incapable of conspiring with one another to violate the antitrust laws.").

Plaintiffs' own allegations make this point abundantly clear from the face of the Complaint. Plaintiffs expressly allege that "Welsh Carson has . . . control[led] USAP since its founding through the present." Compl. ¶ 20. *See also id.* ¶ 23 ("Welsh Carson has also controlled USAP by supervising its day-to-day operations, including corporate finances, securing financing from lenders or Welsh Carson funds, identifying targets, conducting due diligence on potential acquisitions, negotiating acquisitions, negotiating prices with insurers, and determining USAP's overall strategy."). Because Plaintiffs expressly allege that Welsh Carson and USAP are not

"independent sources of economic power previously pursuing separate interests," *Copperweld*, 467 U.S. at 771, Count III of Plaintiffs' Complaint must be dismissed.

IV. THE COMPLAINT FAILS TO STATE A CLAIM UNDER SECTION 7 OF THE CLAYTON ACT

Plaintiffs' "unlawful acquisition" claim under Section 7 of the Clayton Act (Count II) also fails. "To state a claim under Section 7, a complaint must define the relevant market and demonstrate the probability of anticompetitive results flowing from the challenged merger or acquisition." *David B. Turner Builders LLC v. Weyerhaeuser Co.*, 603 F. Supp. 3d 459, 466 (S.D. Miss. 2022) (citing *Domed Stadium Hotel, Inc. v. Holiday Inns, Inc.*, 732 F.2d 480, 491-92 (5th Cir. 1984)), *aff'd*, 2023 WL 2401587 (5th Cir. Mar. 8, 2023). Plaintiffs' market definition is deficient for the reasons stated above.

The Section 7 claim should also be dismissed because the acquisitions described in the Complaint are not alone sufficient to state a claim, given the absence of any factual allegations establishing competitive harm "flowing from" these acquisitions. *Turner Builders*, 603 F. Supp. at 466 (dismissing section 7 claim where complaint did "not provide any facts to plausibly suggest the probability of anticompetitive results" from the acquisitions in question). Unlike a typical Section 7 case, where courts have to speculate about potential harm to consumers from a challenged acquisition, here there is no need to speculate. These acquisitions have already taken place (some more than a decade ago), yet Plaintiffs do not (because they cannot) allege that consumers have sustained any cognizable harm as a result of USAP's expanded ability to provide critical care in hospitals throughout Texas. That is, as explained *supra,* the acquisitions have *not* led to prices above competitive levels.

V. THE COMPLAINT FAILS TO STATE A PRICE-FIXING CLAIM UNDER SECTION 1 OF THE SHERMAN ACT

Plaintiffs' price-fixing claim (Count V) fails because the Complaint does not allege the

most basic ingredient of such a claim: an agreement among competitors to fix prices. To establish a violation of Section 1 of the Sherman Act, "a plaintiff must show that the defendant (1) engaged in a conspiracy (2) that restrained trade (3) in a particular market." *BRFHH Shreveport, LLC v. Willis-Knighton Med. Ctr.*, 49 F.4th 520, 525 (5th Cir. 2022) (cleaned up) (quoting *MM Steel, L.P. v. JSW Steel (USA) Inc.*, 806 F.3d 835, 843 (5th Cir. 2015)). For purposes of the first element, "[t]he crucial question is whether the challenged anticompetitive conduct stems from independent decision or *from an agreement*, tacit or express." *Id.* at 526 (quoting *Twombly*, 550 at 553 (emphasis in original)). At the pleading stage, it is the plaintiff's burden to make "allegations plausibly suggesting (not merely consistent with) agreement." *Id.* at 528 (quoting *Twombly*, 550 U.S. at 557).

Count V of Plaintiffs' Complaint claims a violation of Section 1 based on USAP's "[h]orizontal [a]greements [with other anesthesiology practices] to [f]ix [p]rices." Compl. ¶¶ 176-184. Plaintiffs' allegations in support of this claim describe three contracts – two that USAP inherited (GHA's contract with TMHPO, and Pinnacle's contract with Dallas Anesthesiology Associates) and one that USAP entered directly (with Baylor College of Medicine).[6] Through these contracts, the smaller anesthesiology practices (TMHPO, Dallas Anesthesiology Associates, and Baylor College of Medicine) contracted with USAP or its predecessors (GHA and Pinnacle) to obtain certain back-office, administrative services that the larger practices could more efficiently provide. Among other things, USAP and its predecessors agreed to bill and collect from payors on the smaller practices' behalf.[7] The smaller practices "assigned [to] USAP [or its predecessors]

[6] The Complaint also describes one theoretical agreement that USAP "attempted to negotiate" with a group affiliated with the University of Texas. *Id.* ¶ 123. Needless to say, USAP cannot incur antitrust liability for a business proposal that never ultimately materialized.

[7] Apart from payor relations and billing, the Complaint also alleges that Dallas Anesthesiology Associates, for example, paid Pinnacle to maintain a customer-service phone

authority to bill and receive reimbursements for hospital-only anesthesia services provided by their physicians." *Id.* ¶ 109. USAP would then "collect . . . reimbursements for those services using [USAP's] name and tax identification number," and then remit payment to the smaller group, keeping the difference as payment for the administrative services it provided. *Id.* ¶¶ 116, 117.

The Complaint does not (because it cannot) allege that these agreements dictated the price at which USAP would obtain reimbursement from payors. The relevant contract terms dictated that USAP (or its predecessors) would "bill[ ] and collect[ ] . . . reimbursements for [the smaller groups'] services," and that the smaller groups would "assign[ ] [their] rights and interest in receiving payment" to USAP (or its predecessors) in exchange for a payout. *Id.* ¶ 116. But the contracts were agnostic about the rates that USAP (or its predecessors) ultimately charged to insurers. Submitting claims and bearing the attendant risks of non-payment, became USAP's (or its predecessors') prerogative and responsibility. *See*, *e.g.*, *id.*¶ ¶ 112 ("*Greater Houston Anesthesiology* used its billing authority to charge payors higher reimbursement rates for Methodist's services.") (emphasis added); *id.* ¶ 116 ("Under that agreement, *Pinnacle set the rates* it charged payors for anesthesia services provided by Dallas Anesthesiology Associates.") (emphasis added). Because the contracts at issue did not set the price of either party's anesthesia services, they did not constitute an "agreement" to "fix prices."

Indeed, Plaintiffs concede that the contracts at issue recognized a difference between the two parties' reimbursement rates and compensated the smaller practices at their preexisting rates. *See*, *e.g.*, *id.* ¶ 117 (explaining that USAP "compensates Dallas Anesthesiology Associates based on that group's lower rate"). Thus, far from alleging an agreement between competitors to charge the same rates for their services, Plaintiffs' allegations expressly confirm that USAP and the other

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number that Pinnacle's back-office staff would answer on behalf of Dallas Anesthesiology Associates. *See id.* ¶ 118.

anesthesiology practices at issue continued to offer their services at different prices.

Because Plaintiffs have not alleged an agreement to fix prices, they have failed to "nudge[ ] [their price fixing claim] across the line from conceivable to plausible," *Twombly*, 550 U.S. at 570, and Count V must be dismissed. *See*, *e.g.*, *BRFHH*, 49 F.4th at 525 (dismissing Section 1 claim because plaintiff failed to plausibly allege an "agreement" to fix prices for healthcare services).

CONCLUSION

The Court should dismiss Plaintiffs' Complaint in its entirety.

Dated: February 20, 2024

Respectfully submitted,

/s/ *Mark C. Hansen*

David J. Beck (TX Bar No. 00000070)
(Federal I.D. No. 16605)
Garrett S. Brawley (TX Bar No. 24095812)
(Federal I.D. No. 3311277)
BECK REDDEN LLP
1221 McKinney Street, Suite 4500
Houston, TX 77010
Tel: (713) 951-3700
Fax: (713) 951-3720

Mark C. Hansen* (D.C. Bar No. 425930)
Attorney-in-Charge
Geoffrey M. Klineberg* (D.C. Bar No. 444503)
David L. Schwarz* (D.C. Bar No. 471910)
Kevin J. Miller* (D.C. Bar No. 478154)
Collin R. White* (D.C. Bar No. 1031005)
Dennis D. Howe* (D.C. Bar No. 90011114)
KELLOGG, HANSEN, TODD,
FIGEL & FREDERICK, P.L.L.C.
1615 M Street N.W., Suite 400
Washington, D.C. 20036
Tel: (202) 326-7900
Fax: (202) 326-7999

*Admitted *Pro Hac Vice*

Counsel for Defendant U.S. Anesthesia Partners, Inc.

CERTIFICATE OF CONFERENCE

On February 13, 2024, counsel for the U.S. Anesthesia Partners, Inc. conferred with Plaintiffs' counsel by phone and by email regarding this motion. Plaintiffs are opposed to the relief requested herein.

/s/ *Mark C. Hansen*
Mark C. Hansen

CERTIFICATE OF SERVICE

I hereby certify that on February 20, 2024, I filed the foregoing document with the Court and served it on opposing counsel through the Court's CM/ECF system. All counsel of record are registered ECF users.

/s/ *Mark C. Hansen*
Mark C. Hansen