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Five Things to Watch for in DOJ's Carolinas HealthCare System Case

A partner at Perkins Coie LLP discusses the Justice Department's antitrust lawsuit against the Carolinas HealthCare System in federal court in North Carolina. The author summarizes the case and discusses five key issues to watch for as the case proceeds.

By Jon B. Jacobs

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Earlier in 2017, Judge Robert J. Conrad, of the U.S. District Court for the Western District of North Carolina, denied a motion to dismiss the antitrust case brought against the Carolinas HealthCare System (CHS) by the Department of Justice (DOJ) and the Attorney General of North Carolina. The CHS case is the first antitrust challenge of "anti-steering" contract clauses in the health-care industry. Hospital systems use these provisions in their contracts with commercial health insurance companies to prevent insurers from steering their members to less expensive hospitals. The CHS case is a reminder that hospital systems with a large share in their local inpatient hospital market should be cautious about insisting on such provisions, particularly with a number of insurers that collectively represent a substantial percentage of the commercially insured residents in that market.

This article summarizes the facts of the CHS case and lists five things to watch for as the case proceeds. (Supporting materials not otherwise cited can be found on the court docket for the case, *United States et al. v. The Charlotte-Mecklenburg Hospital Authority d/b/a/ Carolinas Healthcare System*, No. 16-cv-311 (W.D. NC), as well as on the Antitrust Case Filings page of DOJ's website).

Factual Background

The DOJ's Complaint alleges that CHS is the dominant hospital system in Charlotte, N.C., with a share of approximately 50 percent in the inpatient hospital market in the Charlotte area. Its flagship hospital is the Carolinas Medical Center, located in downtown Charlotte. CHS's size, market share, and comprehensive range of services gives it leverage over health insurers, and, according to the DOJ, has enabled it to charge higher prices for its services.

The DOJ also alleges that CHS's market power has allowed it to impose anti-steering provisions in its contracts with at least four health insurers that, together, comprise 85 percent of the commercially insured residents of the Charlotte area: Aetna; Blue Cross Blue Shield; Cigna; and United. These provisions are worded differently in different contracts. In one, an insurer has committed not to "directly or indirectly" steer business away from CHS. Blue Cross Blue Shield of North Carolina is allowed to steer its members elsewhere, but only so long as such steering does not exceed a specified annual net revenue loss to CHS.

The DOJ alleges that these restrictions have prevented insurers from offering health plans designed to lower prices and improve quality, such as those using tiered networks (where patients are incentivized through lower out-of-pocket costs to use lower-cost hospitals), or narrow networks (where higher-cost hospitals are excluded entirely from an insurer's provider network). It also claims that CHS has enjoyed the benefit of patient steering to its facilities but forbids insurers from allowing its competitors to enjoy those same benefits.

In its Answer, CHS stated that the anti-steering provisions are guarantees against health insurers "changing the fundamental economic terms of these agreements after the fact." CHS argues that its current rates are based on the premise that insurers will not affirmatively reduce referred volume by steering their members elsewhere after reimbursement rates, which account for volume expectations, are agreed upon. It alleges that enjoining these provisions "would reduce, rather than enhance, [CHS's] ability to discount its pricing."

Therefore, the two sides disagree fundamentally on how the anti-steering provisions affect CHS's prices. According to the DOJ, they increase CHS's prices. According to CHS, they decrease its prices.

Five Things to Watch

1. Will the case settle?

Most civil antitrust cases settle before trial, so it would not be surprising if this one does as well. The recently announced CHS/UNC Health Care transaction might increase the chances of this happening. On Aug. 31, CHS and UNC Health Care, a state-owned health-care system based in Chapel Hill, announced their intent to combine their organizations into a single joint operating company. ("Carolinas HealthCare System Joining with UNC to Form Hospital Giant," Charlotte Observer, Aug. 31, 2017). Initial news reports of that transaction noted that CHS was proposing to grow even bigger at a time when its "dominance of the local health care market is under close federal scrutiny." (Id.) Settling with the DOJ may be viewed as beneficial to the chances of obtaining regulatory clearance for the merger. And CHS may find that the DOJ is receptive to resolving the case. The views of Makan Delrahim, the new Assistant Attorney General in charge of the Antitrust Division, about antitrust enforcement in the health-care industry are not well known. But like most AAGs in Republican administrations, he may not view civil non-merger cases like CHS as a top enforcement priority.

On the other hand, there are reasons the case may not settle. CHS's merger with UNC Health will almost certainly be handled by the Federal Trade Commission, not the DOJ. So any horse trading of one matter for another—i.e, we'll let you merge if you agree to certain conditions, including settling the anti-steering case—is unlikely. The two matters will also probably focus on different markets. In CHS, the DOJ has alleged a relevant market of the sale of general acute care inpatient hospital services to insurers in the Charlotte Combined Statistical Area. The merger is unlikely to raise significant competitive concerns in that market because all of UNC Health Care's hospitals are located outside of Charlotte. As a result, there may not be any basis for requiring CHS to permit steering in its local market as a condition for permitting the merger to proceed.

2. How will the Court assess the anti-competitive effects in the relevant market?

If the case does not settle, how will Judge Conrad determine whether the anti-steering provisions have caused anticompetitive effects—and in particular, higher prices—in the relevant market? In its Complaint, the DOJ alleged that CHS's senior leaders had identified the steering of patients away from the hospital system as one the biggest risks to its revenue streams. If CHS faces greater competition with other Charlotte-area hospitals for primary and secondary inpatient services they all offer, it may be difficult for CHS to increase its rates even more. The DOJ may credibly argue that the anti-steering provisions have reduced competition and increased rates—at least for less sophisticated inpatient services.

But what about CHS's rates for the higher-level services it offers that other Charlotte-area hospitals do not? What would likely happen to those rates if CHS began losing patient volume to other hospitals for primary and secondary services? In the past, CHS has used its status as the only Charlotte hospital to offer certain services as a justification for its higher rates. In 2015, contract renewal negotiations between CHS and United Healthcare became contentious, the contract expired, and CHS briefly went out of United's provider network. United claimed that CHS's rates were 15 percent to 25 percent higher than all of the other health systems in North Carolina. A senior CHS executive responded by pointing to the unique services offered by CHS: "We have a level 1 trauma center. We have Levine Children's Hospital, Levine Cancer Institute. We do organ transplants. We do bone marrow transplants. We do research and clinical education." ("Why United Healthcare And Carolinas HealthCare System Couldn't Reach A Deal," WFAE 90.7, March 5, 2015). If CHS has been cross subsidizing its trauma and other higher-level services with higher rates on more basic services, enjoining its

anti-steering provisions may lead to an increase in rates for those more specialized services. And to the extent CHS competes with UNC Health Care on those higher-level services, the proposed affiliation between the two will make it easier for CHS to do just that.

This raises several questions:

• If Judge Conrad finds that the likely effect of the challenged restrictions has been higher rates on some hospital services and lower rates on others, how will he weigh those two effects?

• Should he even consider the possibility of higher rates on tertiary and quaternary care services? They are within the relevant product market (the sale of general acute care inpatient hospital services), but CHS does not compete with anyone to provide those services in the relevant geographic market (the Charlotte Combined Statistical Area).

• And will the FTC have approved the CHS/UNC Health Care merger by the time the record closes in the DOJ's case?

3. Will the U.S. Supreme Court's upcoming opinion in American Express affect this case?

The DOJ previously challenged anti-steering restrictions in the credit card industry. In 2010, it filed a lawsuit against American Express, MasterCard, and Visa for prohibiting retailers accepting their respective cards from steering consumers to competing cards that are less expensive for the merchant. After Visa and MasterCard settled, the DOJ tried the case against American Express in 2014 and won. On appeal, the U.S. Court of Appeals for the Second Circuit reversed because it believed the district court had defined the relevant market too narrowly. (*United States et al. v. American Express Co.*, 838 F.3d 179 (2d Cir. 2016)). On Oct. 16, the Supreme Court agreed to hear the case.

The Supreme Court's opinion will be issued by June 2018, at least four months before any trial begins in CHS. Because American Express is another anti-steering case, its opinion could affect CHS in a number of ways. Most likely, however, the Supreme Court will focus on the contested market definition issues. In its opinion, the Second Circuit noted that the credit card market is "two sided," with the upstream market (between card networks and merchants) being highly dependent on the downstream market (between merchants and cardholders). It observed that "cardholders benefit from holding a card only if that card is accepted by a wide range of merchants, and merchants benefit from accepting a card only if a sufficient number of cardholders use it." (*American Express Co.*, 838 F.3d at 185-86). The DOJ had defined a relevant product market limited to the upstream network services market, and the district court had accepted that market as valid. In reversing, the Second Circuit held that the market should have been defined more broadly to account for effects in the downstream market as well.

If the Supreme Court agrees with that approach, it could have an effect on CHS for a couple of reasons. First, like credit card markets, hospital markets are two sided. Consumers benefit from signing up with a health plan if the hospitals they value are included in the plan's provider network, and a hospital benefits from contracting with a health plan if that plan has a substantial number of members and can bring patient volume to the hospital. Second, just like in American Express, the DOJ in CHS limited its relevant product market to the upstream market—in CHS, the market for the sale of general acute care inpatient hospital services to insurers. It did not allege a broader market that also included the sale of health insurance plans to employers and consumers.

Even if Judge Conrad is forced to assess competitive effects in a broader market, that may not undermine the DOJ's case. Although it limited its focus to the upstream market when it was defining the relevant product market in one part of the Complaint, it seemingly hedged its bets by also alleging anticompetitive effects in the downstream market in another part of the Complaint. For example, it alleged that absent the steering restrictions, insurers would offer more innovative products to their members, such as plans with tiered or narrow networks. And it argued that those kinds of plans would increase competition in the downstream market for the sale of health plans to consumers, which would lead to lower prices and improved quality. If the DOJ can prove those allegations, it may avoid any problems raised by the Supreme Court's upcoming opinion in American Express.

4. How will the court weigh any procompetitive justifications?

In its Answer, CHS stated that the procompetitive effects of the challenged provisions outweigh any potential anticompetitive effects. The DOJ has claimed that the restraints do not have any procompetitive justifications. So this will be another hotly disputed issue.

Because CHS has yet to specify in detail all of its defenses, it is unclear what it will use to justify the steering restraints. In antitrust cases involving vertical restraints, defendants often argue that their practices are justified by a concern about free riding. Here, CHS might argue that its trauma center, Children's Hospital, and other unique services bring prestige and more members to health plans that contract with CHS. If those health plans were able to take those members and steer them to competing hospitals that are less expensive—and less expensive precisely because they do not provide those services—that would deter CHS from continuing to invest in its prestigious tertiary and quaternary level services.

Free riding is often difficult to prove, in part because the defendant usually has the option to charge more for the separate services at issue. As one court has observed, "[w]hen payment is possible, free-riding is not a problem because the 'ride' is not free." (*Chicago Professional Sports Ltd. v. NBA*, 961 F.2d 667 , 675 (7th Cir. 1992)). In this case, that would involve CHS charging more for its more advanced services, which raises the same issue discussed above about mixed price effects and whether cross subsidizing different hospital services is a good or bad thing. In a 2015 FTC workshop on health-care competition, a former DOJ economist discussed tiered and narrow networks and opined that cross subsidization should not be a justification for resisting those steering mechanisms:

A big one that I hear a lot is that cross-subsidization is necessary. We couldn't have a psychiatric ward unless we had high prices in orthopedics. And we don't want orthopedics carved out, because that will put the rest of our business at risk. I think most economists would say that that's really not a great idea, that society really benefits from clear price signals. If psychiatry is expensive, or brain surgery is expensive, we sort of need to know that it's expensive, and then we can design public policy to subsidize it, or to raise money for it, or to tax people to provide it. And if broken legs are cheap, we should pay a low price for broken legs. So the cross subsidization doesn't work for me, personally. (Feb. 24, 2015 Workshop Transcript: Examining Healthcare Competition (Feb. 24, 2015) (statement of Fiona Scott Morton), at 34).

Judge Conrad is likely to hear much about that issue, and we will see whether that argument works for him.

5. Will the DOJ or FTC bring more anti-steering cases in the future?

This is a test case for anti-steering provisions in the health-care industry. Whether the government will bring more such cases likely depends on the outcome in the CHS case. While we await the outcome in Charlotte, hospital systems can minimize their risk by doing the following:

• Hospitals with a substantial share of the inpatient hospital market in their Metropolitan Statistical Area (MSA) should be very cautious about using anti-steering provisions in their contracts with health plans. CHS has an alleged 50 percent share in its hospital market. In general, shares below 30 percent are not viewed with great concern by the DOJ and FTC;

• Hospitals should avoid using anti-steering provisions in contracts with health plans that collectively represent a significant percentage of the commercially insured residents in their MSA. CHS has allegedly used those provisions, in one form or another, with four large plans comprising 85 percent of the commercial market in Charlotte. Again, foreclosure rates below 30 percent are usually not viewed with concern by the agencies;

• If cross subsidization is a reason for such practices, consider charging more for the higher-level services of concern instead of cross subsidizing them. It is not illegal to charge higher prices on services for which hospitals have market power; and

• Do not deny your competitors the benefits of steering if you enjoy those benefits yourself. The DOJ emphasized in its Complaint that CHS has gained patient volume and revenue from encouraging insurers to steer towards CHS, but has prevented insurers from steering away from it.