DOJ & North Carolina AG Target Same Insurer-Provider Contract Clauses as California's Sutter Plaintiffs

Last week, the Justice Department's Antitrust Division, along with the North Carolina Attorney General's Office, filed suit against Carolinas Healthcare System ("CHS"), challenging the large provider's use of certain contract provisions in its agreements with insurers. DOJ claims that CHS, the dominant and most expensive provider in the Charlotte, North Carolina area, uses its market power to insist that the four largest insurers in the area agree not to steer their subscribers to lower-cost/higher-value providers. The last major DOJ case involving insurer-provider contracts was the Antitrust Division's 2010 challenge to Blue Cross/Blue Shield of Michigan's use of most-favored nations clauses, which prevented providers from negotiating competitive rates with BC/BS' competitors. DOJ agreed to drop that case after the Michigan state legislature banned the contested clauses. Here, DOJ claims that the steering restrictions CHS uses in its insurer contracts violate Section 1 of the Sherman Antitrust Act, and request that the court declare the steering restrictions illegal under the Sherman Act and enjoin CHS from using the provisions and from retaliating against insurers who engage in lawful steering.

DOJ is challenging CHS' inclusion of various contract provisions it categorizes as "steering restrictions." These provisions inhibit insurers from using financial incentives to steer subscribers to non-CHS, lower-cost providers. Typically, insurers accomplish steering through tools including (1)

tiered networks and (2) narrow-network plans. In a tiered network, the insurer separates "better value" (low-cost/high quality) providers and high-cost providers into distinct tiers, each of which is assigned its own co-pay. In this system, a better value provider in a top-tier is assigned a lower co-pay—*i.e.*, the patient bears less of the cost—than a lower-tier provider. Accordingly, the patient has a financial incentive to obtain healthcare services from the top tier, lower-cost provider, and visiting that provider saves both the patient and the insurer, who typically foots the bill beyond the co-pay, money. In the same vein, insurance companies often offer "narrow-network plans" to consumers who pay lower premiums and co-pays in exchange for agreeing to a more limited set of provider options. Under CHS' contracts, both tiered networks and narrow-network plans are prohibited, so patients have no reason to obtain healthcare services from CHS' lower-cost competitors. Also, because the contracts also contain confidentiality provisions, the patients don't even have the price and quality information they would need to shop around. And, because they can't really compete, CHS's competitors end up raising their own prices and don't bother innovating, and the entire market suffers.

Why would insurers agree to these contract provisions that end up costing them and their subscribers more money? DOJ says it's because CHS' contracts with insurers are not the products of arm's-length negotiations—instead, CHS uses its market power to obtain more-than-favorable, anticompetitive terms. DOJ explains that the same market power allows CHS to charge "premium rates," in addition to one-sided contract terms. According to the complaint, CHS has a 50% share of the relevant market (general acute care in-patient hospital services in Charlotte), and makes more than twice as much in revenue as its closest competitor. Importantly, CHS is considered a "must-have" provider, meaning that insurers need to include the provider in their networks to meet consumer demand, so they end up agreeing to the unfavorable terms.

If this all sounds familiar, and strikingly similar to a private antitrust enforcement case filed in state court in California, you're thinking of *UFCW &amp|Employers Benefit Trust v. Sutter Health*. In that case, the self-funded payer plaintiffs are challenging dominant California provider Sutter's use of similar contract provisions they call "anti-incentive" terms, or terms that prevent self-funded payers from giving enrollees incentives to select lower-priced alternatives to Sutter from the network. Those plaintiffs are also challenging Sutter's use of "price secrecy" terms that conceal the provider's prices from self-funded payers and their enrollees, so that they are unable to shop for providers based on price, and insurance entities who could otherwise compete horizontally with one another based on the prices they each negotiate with Sutter. The Sutter plaintiffs' case was brought under California's Cartwright Act, whereas DOJ's case is under the Sherman Act, but the facts and legal similarities are striking. We are following both cases closely and hope that others are connecting the dots here, too.