DOJ Lawsuit Against Carolinas HealthCare May Impact Contracting in Other Markets

Rob Fuller was quoted in an article by Health Plan Week titled "DOJ Lawsuit Against Carolinas HealthCare May Impact Contracting in Other Markets." Now that the Dept. of Justice (DOJ) has filed a lawsuit against Carolinas HealthCare System (CHS) for allegedly anti-competitive contracting with health insurers *(HPW 6/13/16, p. 7)*, industry stakeholders are assessing what widespread impact, if any, the action will have nationally in the provider-payer contracting universe. One leading lawyer in the space says it is too broad to say the actions by DOJ will cause contract reviews in every locale, but the charges could herald a change in areas where dominant hospital systems can leverage their market power to the hilt.

On June 9, DOJ and the North Carolina Attorney General's Office filed a suit in which they alleged Charlotte-based CHS's contracting drove up costs for consumers at its 40 hospitals. DOJ said CHS used its market power (with a 50% market share) in the Charlotte area to prevent insurers from "steering" their customers to lower-cost providers, via tiering or narrow network strategies.

CHS denies the allegations and will fight in court to explain its business strategies, Teri Porter, CHS spokesperson, tells *HPW*. "Our arrangements with insurers are similar to those in place between insurers and health care systems across the country. We have neither violated any law nor deviated from accepted health care industry practices for contracting and negotiation," Porter says. "In fact, we have been applauded by the U.S. government for the quality care and cost reduction programs we've implemented, programs it hopes to model in other parts of the country."

DOJ Challenges Hospital Pacts

The suit's influence on other locales depends in part on the particular market in question, according to Robert Fuller, a health care analyst and attorney at Nelson Hardiman LLP in Los Angeles who served as chief operating officer of Downey Regional Medical Center in Los Angeles from 2001 to 2013.

"I believe that the impact will be in markets where you've got some degree of a dominant hospital or hospital chain. So the super-large cities like Los Angeles where I am, there is no dominant hospital system. There are 74 hospitals in the basin and lots of competition, so it is not going to affect any health plans in a large city like L.A., Chicago or New York," Fuller tells HPW. By contrast, Charlotte, with 809,000 residents, is the 17th largest city in the U.S. "I think this is kind of a unique situation in Charlotte where you've got a fairly substantial size city, but you've also got a hospital system with half the beds. And so they are in a position where the health plan is paying attention because the book of business is large enough."

Payers Feared Out-of-Network Rates

"They started flexing their wings a little bit, and the health plans for whatever reason agreed with them [to the

allegedly anti-competitive contracts], feeling the dual pressure of having to pay full-gross charges if the hospital system just dumped the health plan, which is nothing the health plan wants to do," Fuller explains.

"And the other piece of pressure on the health plan in that situation is while there aren't all that many things they [insurers] react to, they would react to employers being told by their employees that 'gee whiz, these hospitals aren't on our health plan; it's a terrible health plan.' Employers are not going to want to put up with that," he says.

So the health insurers, like Blue Cross and Blue Shield of North Carolina, over time would have to have CHS hospitals in their employer-based plan networks, and possibly limit the ability of a customer to use a provider listed in less costly narrow networks. *"If CHS threatened to dump the health plan, they would face full-gross charges. And since they've got half the ERs in Charlotte, that could be very expensive for a plan that wishes to penetrate and have a book of business in that market. So I think they are reacting to that pressure and caved to some clauses that are very questionable in my mind on how they would be enforced under the antitrust law," Fuller says.*

What makes the CHS situation unusual, he continues, is the concept of a hospital chain dictating terms to health plans. "That is very unusual. There are a few other cities where this might occur where again you have a big enough city where the health plan pays attention and also a dominant hospital system," he says.

Providers, Not Plans, Are Under the Microscope

The DOJ action also shifts the attention from how health plans contract to how providers negotiate deals. DOJ has in the past investigated Blues plans for use of most favored nation contract terms, like in Michigan, where it eventually dropped its probe of the way Blue Cross Blue Shield of Michigan utilized MFN terms*(HPW 4/18/13, p. 3)*.

"The flip side is where Blue Cross plans across the country have for some time, at least in the last 15 years, tried to consider MFN and also an 'all-comers' clause in contracts." With MFN clauses, the insurer says, "if you give anyone a lower price, you have to give us the lower price," while with an all-comers clause, "we will let anyone use our contract [terms] we want to," Fuller explains. "So if you are a hospital and you think you've gone out and got a local regional plan, and you think you've negotiated a good reasonable rate, then you are all excited about that and all of the sudden they start adjudicating their cases not at the rate you negotiated with that plan but under a Blue Cross plan with a lower rate, then you get upset at that."

This resentment over MFN and all-comers is ironic in the eyes of antitrust law, however, since MFN and all-comers clauses actually work in favor of consumers, he stresses. "Those clauses that Blue Cross has put in actually lower the price for consumers and is exactly what the antitrust laws are supposed to promote, not to hinder. So it may look a lot like the same situation where you've got somebody with market power exercising it and pushing clauses forward, but the huge difference in the CHS situation is that [their actions allegedly] tend to raise prices for consumers by reducing competition. And Blue Cross MFN and all-comers tend to reduce prices for health insurance and procedures for consumers over time. It's a lot more defensible in the Blue Cross case than in the CHS one, which is like an upside down MFN clause."

From the CHS point of view, Fuller expects the arguments against the DOJ suit to focus on how its contracting preserves the viability of the assets the nonprofit provider has invested in for the benefit of the community.

Under that argument, "It has to achieve certain protections for its patient base and its pricing, or those assets will be lost to the community and the community will be worse off 10 years from now," he says. "But asset preservation from an economist's standpoint doesn't ring true because you've got to assume the hospital itself is fully efficient and there is no over-expense in the hospital to begin….It is kind of a false argument," Fuller contends.