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DOJ Provides Additional Insight into Its Recent Anti-Steering Settlement

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Last month the Antitrust Division of the Department of Justice (the "DOJ") announced a proposed settlement in its anti-steering case against Atrium Health (formerly known as Carolinas HealthCare System) ("Atrium"). *US v. The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System*, No. 3:16-cv-00311 (W.D. N.C., Nov. 15, 2018). The DOJ filed this week its Competitive Impact Statement ("CIS"), providing a window into its underlying theory of the case beyond what is apparent from the complaint. The DOJ had alleged that Atrium used its market power to insist on contract provisions with payors that limited or prohibited steering by the payors to lower-cost providers. The proposed settlement, discussed here, would prohibit Atrium from using anticompetitive steering restrictions in its payor contracts.

In its CIS, the DOJ explained:

Atrium's steering restrictions reduce the competitive incentive that Atrium's competitors would otherwise have to lower prices in order to win more business. This interference in the competitive process has reduced competition between Atrium and other healthcare providers in the Charlotte area. In addition, because many of the most innovative healthcare plans in the country today are based on steering to more efficient providers, Atrium's steering restrictions have also curbed the introduction of such plans, and reduced choices for Charlotte-area consumers.

The DOJ's discussion of the anticompetitive effects of Atrium's steering restrictions focused on the following: 1) Atrium is the dominant hospital system and has market power in the Charlotte area; 2) Steering is part of the competitive process; and 3) Atrium required the steering restrictions to insulate itself from competition. On the first point, the DOJ noted that Atrium was able to use its market power to secure higher prices—*not explained by any measure of quality*—from payors relative to other hospital systems in the area. As a result, patients' out-of-pocket costs in the Charlotte area are among the highest in North Carolina.

Next, the DOJ provided several examples of steering that are potential procompetitive mechanisms that can foster competition among hospitals to address rising healthcare costs. As described in the CIS, narrow and tiered networks are both steering mechanisms that can reduce costs. A payor forms

a narrow network by using cost and/or quality criteria to contract with a subset of providers. Consumers enrolled in the narrow network are steered toward the in-network providers. This in turn likely increases the patient volume to those in-network providers, thus allowing the payors to negotiate lower prices that are then passed along to the consumer in the form of lower premiums. Similarly, a payor creates a tiered network by designating a subset of providers for each tier based on quality and price, with one tier being “preferred.” Consumers enrolled in the tiered network can choose any provider among the tiers, but the providers in the preferred tier typically will have the best mix of quality and price.

Referenced-based pricing and centers of excellence are two additional forms of steering highlighted in the CIS as potentially procompetitive. For reference-based pricing, the payor establishes a market-wide standard price for a service, typically based on average local prices or other sources such as Medicare reimbursement rules. The plan then covers a member’s expense up to that reference price. This steers members towards providers that have prices at or below that point, and motivates high-priced providers to reduce their prices. Alternatively, a payor might designate certain providers as centers of excellence based on its quality and/or cost efficiency for a particular service. Consumers then receive a financial incentive from the payor to use those centers of excellence. For all forms of steering, the CIS emphasized the importance of transparency about price, cost, quality, and patient experience, and noted that transparency itself may act as a form of steering.

Finally, the DOJ underscored its conclusion that Atrium required steering restrictions precisely to insulate itself from competition. The CIS states that “[t]o protect its dominant share and high prices and insulate itself from competition, Atrium has used its market power to require every major insurer in the Charlotte area … to accept contract terms that restrict the insurers from steering their members to Atrium’s lower-cost competitors.” Atrium used contract provisions that expressly prohibited steering, or imposed financial penalties for steering. The CIS further noted that “[d]eprived of any mechanism to reward low prices with more patient volume, insurers cannot create incentives for Atrium’s rivals to compete on price. Atrium’s steering restrictions, therefore, reduce competition … by impeding its competitors’ ability to attract patients by offering lower prices to insurers and their members.”

In short, the current Antitrust Division is four-square supportive of insurance product designs that incentivize patients to pick lower-cost providers. To the degree that leading providers attempt to block or undercut those efforts through contractual restrictions with payors, they are appropriating to themselves significant antitrust risk.

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