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Making Health Reform Work

Accountable Care Organizations and Competition

David Balto February 2011

Center for American Progress



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Introduction and summary

Almost 40 years ago Justice Thurgood Marshall wrote that the antitrust laws are a “consumer welfare prescription.” In few markets is competition as important as health care. This nation’s yearlong debate on health care reform illuminated many faults and weaknesses in our health care system while highlighting the potential for meaningful reform to improve health care results and better control costs. This paper attempts to explain how antitrust enforcers need to fully embrace the results of that inquiry and realign priorities in order for antitrust enforcement to become a tool and not an obstacle to improving our health care system.

One critical element under the Affordable Care Act is the formation of accountable care organizations, or ACOs, which seek to create integrated entities of hospitals, physicians, and other health care providers, to better control health care costs and deliver high-quality services. As explained in this paper, antitrust enforcers are frequently skeptical of integration, and in the past, administration antitrust enforcement—or the threat and cost of enforcement—was often a barrier to efficient collaboration. At the same time, reduced enforcement led to the growth of market power, especially in health insurance and hospital markets. The result was that if antitrust enforcement was an answer, it was the answer to the wrong problem.

Fortunately, in the Obama administration, health care antitrust enforcement is beginning to focus on the critical health care competition issues.¹ The Antitrust Division of the Department of Justice has challenged a health insurance merger, sending a clear signal that dominant insurers cannot reinforce their market power by merger. It has brought a critical case against exclusionary practices by a dominant insurer that reinforced barriers to entry. And the Federal Trade Commission has attacked two consummated hospital mergers, including an important case that would unwind a merger that would have resulted in increased costs for outpatient and imaging services in Roanoke, VA.

What are the important lessons from the health care reform debate that both regulators and antitrust enforcers need to embrace?

- **Many health insurance markets are highly concentrated.** This often results in supracompetitive profits, escalating numbers of uninsured, rapidly escalating costs, and in many cases, evidence of deceptive and fraudulent conduct. The congressional debate clearly and unequivocally established the need for the comprehensive reform that was enacted. Countless congressional hearings uncovered a disturbing pattern of egregious, deceptive, fraudulent, and anticompetitive conduct in some health insurance markets.²
- **Integration is not the problem in health care but is an important solution for improving quality and cost in the fee-for-service health care system.** Much of the health care debate focused on the lack of coordination among health care providers (typically hospitals and physicians) and how this led to excessive costs and poor health care results.³ The purpose of the ACOs is to provide entities that can better coordinate care and be held accountable for overall health care results.⁴
- **Aggregation of market power is a problem.** If there is a competitive problem in health care markets, it is due to aggregations of market power, such as in health insurance, and not because of improper integration among health care providers.

Many of these findings directly undermine the underpinnings of the current antitrust paradigm in health care. That paradigm suggests that it is necessary to harbor deep suspicion over integration by health care providers, particularly efforts by providers to collaborate. The priorities antitrust enforcement agencies set often appear to prefer a system of autonomous providers, who are fundamentally powerless to deal with insurance companies.

But this paradigm presents a significant problem for health care and consumers, highlighted by the health care debate. Providers acting autonomously are unable to effectively coordinate care because the “silo” problem leads to more costly and less efficient care, and delivers poorer health outcomes. The health care debate clearly demonstrated that a lack of integration led to more costly and lower-quality care.

This paper explains how the antitrust paradigm should be refocused to address the competitive issues surrounding the formation of ACOs. It begins by discussing the opportunity for ACOs to help transform the health care marketplace by permitting greater integration to help improve health care results and better control costs and utilization. It then assesses the recent overly skeptical approach

to health care integration and why that approach has deterred efficient health care collaboration, and finds that the problem in health care is not too much integration, but inadequate integration. The paper then assesses one of the most difficult issues in assessing ACOs: whether an ACO has market power. It suggests antitrust, market-driven, and regulatory approaches to dealing with issues of market power.

What is an accountable care organization?

The health care debate illuminated the significant fragmentation in the delivery of care. Health care providers such as physicians and hospitals often do not act with adequate coordination. This fragmentation has been identified as a major cause of the inefficiency of our current health care system. A lack of coordination at both the clinical and administrative level continues to degrade patient care and escalate costs.

An accountable care organization is a group of health care providers that work together to arrange all medical care for their patients. Providers enter into these arrangements with the understanding that they will share the savings reaped by the enhanced cooperation and improved patient care.⁵ The general idea behind ACOs is that by establishing a continuum of care among providers who have incentives to focus on strong primary care, cost will be contained while care improves.

ACOs aim to create incentives for health care providers to better coordinate care, and mark an important part of the Affordable Care Act's attempt to spur greater integration and efficiency. ACOs represent a single body that would be responsible for delivering quality, evidence-based medicine at a contained cost. As employers and insurers would be able to choose between various ACOs, as well as other providers, the ACO structure mimics the procompetitive nature of HMOs in controlling costs and improving health care delivery.⁶

The savings to be shared by the providers of an ACO would come from: more efficient care enabled by increased coordination; greater prevention of acute illness and the need for higher-cost medical attention including hospital inpatient and emergency room care; and a reduction in administrative costs due to collaboration across various components of patient care.

ACOs can be organized in a broad range of ways in order to foster the inclusion of health care providers of varying structure and size. ACOs can be physician group practices or a network of individual practices, physician-hospital partnerships, or hospitals employing physicians.⁷ To qualify as an ACO, a group of providers must possess the following:

- Leadership, management, and legal structures
- Processes to ensure the delivery of evidenced-based, coordinated patient care
- The capacity to report health outcomes, cost, and other indicators in order to measure the ACO's success and incentivize the quality and efficiency of its care⁸

A critical element to ACOs is payment and how payment creates incentives for cost control and enhancing quality. There are three primary pay reform models: shared savings, shared savings and risk, and partial capitation. In the shared-savings model, payments are made on a fee-for-service basis, but if costs fall significantly below a given threshold, the provider receives a percentage of these savings. Alternatively, the shared-savings-and-risk model offers ACOs a larger share of savings on the condition that they also bear a portion of the risk. This model would retain fee-for-service payments, but instead of setting a threshold as in the previous model, it would have a “corridor” in which the ACO could obtain all of the savings or be forced to bear all of the losses. Finally, partial capitation would utilize a target spending level as in the other models but would move away from fee-for-service payments. Regardless of the services utilized, providers in this model would be paid a lump sum, thus furthermore incentivizing cost containment.⁹

A recent Center for American Progress paper authored by Judy Feder and David Cutler recommends that ACOs utilize varying payment models in order to test them out and establish which one works best.¹⁰ As the success of each payment reform model depends on both lowered costs and improved care, it is important that ACO quality is judged on a number of measures, some of which focus on patient experience. In order to avoid forcing consumers and providers into ineffective arrangements, this report emphasizes that policy surrounding ACOs be seen as “evolutionary, not revolutionary.”¹¹ The specifications for ACO arrangements, the CAP paper argues, are intended to be adapted as we learn which models best control cost without sacrificing the quality of patient care.

The paper also offers a few specific recommendations for ACO implementation. Given the economic capability of hospitals to establish the infrastructure necessary for care integration, and the potential for substantial cost savings, it seems only intuitive that hospitals will play a central role in the creation of ACOs. But the CAP paper emphasizes the importance of facilitating the creation of physician-sponsored ACOs as an alternative. With physicians in charge, the paper explains, a greater focus can be placed on primary care and physician engagement. This change in focus should improve patient care as well as help reduce the cost of

unnecessary and preventable hospital admissions. Physician-led arrangements would also prevent hospitals from using their position as sponsors to secure patient referrals and limit consumer hospital choice. Instead, physician-sponsored ACOs would encourage hospitals to compete with one another for patient referrals, leading to higher-quality care at lower costs. CAP argues that the provider-sponsored model represents the ideal ACO structure for protecting competition in the health care system, capturing the most savings and improving the quality of care.

On payment incentives, the CAP paper finds that merely receiving a portion of the savings is a rather limited incentive for providers to contain costs and improve care. Instead, it suggests that in order to strengthen these incentives, ACOs should be encouraged or even forced to eventually move toward payment models that allow participants not only to benefit from saving but also to share the risk of overspending.

Finally, the paper stresses the importance of consumer sovereignty in the implementation of ACOs. Individuals should be able to freely decide if they would like to participate in an ACO and they should be protected by rules that ensure their care is not being sacrificed by efforts to contain costs. Consumers, CAP argues, should be partners in this process of securing better care at a lower cost.

The mistaken skepticism about integration

Accountable care organizations involve collaboration among competitors. Collaboration in health care has frequently raised antitrust concerns. Although collaboration is a necessary element of an efficient health care delivery system, at times groups of competing providers have attempted to engage in price fixing under the guise of collaboration. The agencies responsible for regulating antitrust issues try to distinguish between legitimate collaboration and more suspect efforts at price fixing. This inquiry focuses on the question of integration—whether the group of providers has integrated their practices by accepting commitments to cost savings and improved health care delivery, or whether the venture is a sham effort to engage in illegal price fixing.

Setting the standards for integration has not been a simple process. In fact, one result of the Clinton-era efforts at health care reform was the DOJ and the FTC issuing joint Statements of Antitrust Enforcement Policy in Health Care, also known as “guidelines” on collaboration in health care in 1993. These guidelines generated considerable controversy and were revised both in 1994 and 1996. Before the 1996 guidelines were issued, health care providers could engage in joint negotiations only if they were financially integrated; that is, they were at risk if they did not meet certain goals in reducing health care costs. The 1996 guidelines permitted a broader form of integration—clinical integration—a commitment at efforts to reduce health care costs without providers being placed at financial risk. When the 1996 guidelines were issued, then-FTC Commissioner Christine Varney cautioned that the guidelines “should reflect greater receptiveness to new and innovative forms of provider arrangements that do not necessarily involve financial risk sharing and suggesting factors that should be taken into account in reviewing provider arrangements that fall outside of the safety zones.”¹² The guidelines provide safety zones that explain that ventures with less than a 20 percent market share (or 30 percent if they are nonexclusive) do not face antitrust risk.

Initially, the antitrust agencies seemed to embrace Commissioner Varney’s advice. In the four years after the guidelines were issued, the DOJ and the FTC approved

more than 30 physician joint ventures to engage in collective negotiations with health insurers. In addition, they brought a relatively modest number of enforcement actions against physician collaborations. Many of these collaborations appeared to harm competition by threatening to raise the cost of health care services. The agencies seemed to be committed to a balanced approach to physician collaboration that enabled the formation of new innovative forms of health care delivery. In addition, the Clinton administration brought enforcement actions against anticompetitive conduct by health insurers.

Unfortunately, in the last administration, this balance was lost. There were no competition or consumer-protection enforcement actions against health insurers in the last administration despite the fact that anticompetitive and abusive conduct plagued some health insurance markets. There were more than 400 mergers and the DOJ required the restructuring of just two of those mergers.

At the same time, the FTC spent nearly all its health care enforcement resources against efforts by physicians to collectively negotiate. The FTC brought 31 cases in the past decade attacking physician groups while the DOJ brought only three. Some of these cases may have been helpful where the physician groups had some semblance of market power and there was evidence that they had increased prices. But less than a handful of cases had evidence of anticompetitive effects such as higher prices. From an antitrust perspective, physician collaboration has been living as a suspect class, facing a great risk of an antitrust challenge.

The legal standards applied illustrate this imbalance. In most situations, the antitrust agencies analyze collaboration among competitors under a “rule of reason” that requires the agencies (and the courts) to balance the procompetitive and anticompetitive effects. Under the rule of reason, the agencies do not condemn collaboration without evidence of likely harm to consumers. Collaboration among health care providers represents the only area where antitrust agencies apply the “per se” label and condemn endeavors without analysis of anticompetitive effects. The per se rule is the legal guillotine of the antitrust laws. Under the per se rule, the government need not demonstrate the conduct has harmed competition or consumers.

All of these cases brought against physician groups except one settled, probably because of the high cost of a government investigation. There was little evidence in the complaints filed by the government that these groups actually secured higher prices or that consumers were harmed. In fact, in none of the cases did consumers file any antitrust suits seeking damages for the alleged illegal conduct.

(There was only one case filed by an insurer and it lost.) This disproportionate focus on physician groups was supported by no evidence that higher physician costs were a significant force in escalating health care expenditures.

In addition to these unbalanced priorities, the FTC has demonstrated a disproportionate and unreasonable skepticism for collaboration by physicians. There is an approval process for these ventures; about 30 were approved in the last four years of the Clinton administration and only five were approved in the Bush administration. The process for approval has become remarkably complex, time consuming, and expensive. Even though the agencies are committed to providing advice in 90 to 120 days, in the past decade the approval process has averaged more than 436 days—just slightly less time than it took Congress to debate and enact reform of the entire health care system.

Matter	Year	Time for approval
Medsouth, Inc.	2002	236 days
Bay Area Preferred Physicians	2003	340 days
Suburban Health Organization	2006	573 days
Medsouth, Inc.	2007	348 days
Greater Rochester IPA, Inc.	2007	447 days
Tristate Health Partners, Inc.	2009	645 days

The cost of securing a business review letter from the FTC to permit collaboration has grown exponentially and is now well more than \$100,000—clearly out of reach for any group except a very large group of providers. Because of the elaborate standards necessary to demonstrate adequate integration to satisfy the FTC, these groups must increasingly involve large numbers of physicians. Most of the approved entities involve well more than 100 physicians. Ironically, the standards applied by the agencies are effectively forcing physicians to form groups that are so large that they may appear to acquire market power—precisely the problem the antitrust laws want to avoid.

At the same time, as almost all enforcement focused on physician groups, there was increased consolidation in hospital markets and among some groups of physician specialists. Some consolidation is not unexpected or problematic; there was significant overcapacity in hospital beds in many markets—overcapacity and hospital mergers offered a means of efficient rationalization. In addition, physi-

cian groups may have been compelled to merge into large single-specialty groups because of the difficult standards set by the agencies that prevented other forms of collaboration. Appropriately, the FTC refocused its efforts on hospital mergers. It did a comprehensive study of consummated hospital mergers and challenged one of the consummated mergers.

Again, the agencies appear to have dedicated the vast majority of enforcement resources to the question of *integration* of physician-negotiating groups, not the *market power* of health insurers, hospitals, or physician groups. Are these physician negotiation groups a significant competitive problem? Congress exhaustively examined problems in health care markets for more than a year. There was no mention of these alleged physician negotiation groups. Nor does the academic literature on rising health care costs identify these entities as a significant cause of rising health care expenditures. The results of the congressional health care examination are clear—the problem is market power in some health insurance and provider markets and that is where the agencies’ resources must be focused.

Recently, both the DOJ and the FTC have begun to refocus their attention to these concerns of market power. The DOJ has set a better balance in enforcement priorities and is paying some much-needed attention, at least, to broken health insurance markets. The DOJ conducted an interesting study of health insurance markets that focused on the key barriers to entry. The DOJ threatened to challenge the merger of two Michigan health insurers—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—this past March. The merger would have created an insurance behemoth with about 90 percent of the market in Lansing. Importantly, the DOJ recognized the merger would not only harm employers that need to purchase insurance but also physicians who would face reduced reimbursement. The companies called off their merger because of the DOJ’s threat, maintaining some level of competition in that market.

Moreover, in mid-October of last year, the DOJ sued Blue Cross Blue Shield of Michigan for “most favored nation,” or MFN, provisions. An MFN requires a hospital provides an insurer its best price and can prevent other health insurers from entering into the market. These provisions escalated prices and increased entry barriers in the commercial insurance market.¹³ The suit alleges that MFN clauses effectively made Blue Cross immune from competition by guaranteeing that no other health insurer could secure a better rate from a contracted hospital. According to the complaint, Blue Cross has used MFN provisions or similar clauses in its contracts with at least 70 of Michigan’s 131 general acute-care hos-

pitals, including many major hospitals in the state. The complaint alleges that the MFNs require a hospital either to charge Blue Cross no more than it charges Blue Cross's competitors, or to charge the competitors more than it charges Blue Cross, in some cases between 30 percent and 40 percent. In addition, the complaint alleges that Blue Cross threatened to cut payments to 45 rural Michigan hospitals by up to 16 percent if they refused to agree to the MFN provisions.

Similarly, the FTC has increased enforcement against hospital mergers. In 2009 the FTC ordered the Carilion Clinic of Roanoke, VA, to separate from two recently acquired competing outpatient clinics. Absent this remedy, the acquisition would have led to substantial lessening of competition and higher prices for outpatient imaging and surgical services, higher premiums, and the risk of reduced coverage for these needed services.¹⁴ And just last month the FTC sued ProMedica Health System, alleging that its acquisition of a rival hospital in Toledo, Ohio, will substantially harm competition in the general acute-care inpatient hospital services market as well as the inpatient obstetrical services market.¹⁵

Integration standards for ACOs

This issue of the appropriate standards to apply to collaboration by health care providers is particularly critical because an essential part of health care reform is the formation of accountable care organizations that provide incentives for the various providers delivering a patient's care to cut costs by coordinating care, focusing on prevention, or otherwise improving quality of care. ACOs can arguably raise some of the same concerns of permissible integration under the health care guidelines and those guidelines may be a major impediment to ACO formation. As the AMA has observed, "the current clinical integration standards published in the Statements and the FTC advisory opinions to date will deter the formation of ACOs. ... if the FTC/DOJ standards remain unaltered, the ACA's important invitation to physicians to form ACOs will be reduced to a mere gesture."¹⁶ As noted above, the FTC's past skepticism about physician collaboration can be a significant obstacle to physician integration.

There is a recent, hopefully positive sign that the antitrust enforcers are beginning to recognize the need to take a new approach to physician collaboration. On October 5, 2010, the FTC, HHS Office of Inspector General, and Centers for Medicare and Medicaid Services, or CMS, held a joint workshop to discuss the antitrust challenges facing the formation of ACOs. At this event, FTC Chairman Jon Leibowitz stated, "we want to explore whether we can develop safe harbors so doctors, hospitals, and other medical professionals know when they can collaborate and when they cannot." Leibowitz also remarked, "we are also considering whether we can put in place an expedited review process for those ACOs that fall outside of the safe harbors."¹⁷ These statements offer hope for changes in antitrust enforcement and the creation of a market where health care providers can effectively collaborate to create ACOs and deliver less-costly and higher-quality care.

Numerous groups at the ACO hearing provided input on the need for increased guidance for ACOs. As the earlier CAP report noted, it is important for physician-sponsored ACOs to be able to form and flourish and the cost of the antitrust process poses a significant impediment to these ventures. For physician-

sponsored ACOs to be formed effectively, the antitrust agencies need to issue new guidance clarifying the standards for evaluating physician integration and provider integration generally.

ACOs should be able to overcome the agencies' traditional skepticism about integration. The question the agencies focus almost entirely on—whether there is adequate integration—should be a nonissue for ACOs. As Christi Braun, a leading health care antitrust attorney, observed, the criteria for the formation of an ACO—that it “promotes accountability for a patient population and coordinates items and services ... and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery”—are very similar to the standards set by the agencies for determining that there is adequate clinical integration.¹⁸ Thus, there should be a presumption that an ACO is sufficiently integrated, at least to avoid the suggestion that it may be per se illegal.

There are several other suggestions to the process and standards applied to ACOs that may refine the antitrust process. Obviously, the process of the past, with exhaustive, time-consuming, and expensive reviews, cannot work if ACOs will be formed. In addition, as the FTC chairman and others have suggested, there is a significant need for safe harbors so firms can have a clear sense that they do not face antitrust risk (indeed, it may be difficult for ACOs to get funding if there is antitrust uncertainty). Here are our suggestions:

- The FTC and the DOJ should adopt a review process similar to that of the National Cooperative Research and Production Act for review of ACOs. The NCRPA provides that in certain circumstances, companies that are engaged in certain innovative activities and wish to collaborate may file a proposal with the FTC and the DOJ. This proposal is then approved in a review process that is governed by “rule of reason” analysis, which makes it easier for organizations to be allowed to collaborate.¹⁹
- Financial integration and clinical integration should be treated similarly. The current guidelines offer more straightforward approval for health care ventures, which have financial integration. This preference is outdated, as consumers have rejected the limited forms of financial integration, which often resulted in arduous preapproval requirements. There is greater interest in broad forms of clinical integration and the agencies should treat clinical integration in the same fashion as financial integration.

- Extend the health care safety zones to cover all provider collaborations. The guidelines provide safety zones that explain that ventures with less than a 20 percent market share (or 30 percent if they are nonexclusive) do not face anti-trust risk. These safety zones are currently limited to physicians but should be extended to collaborations between hospitals and other providers.
- Provide a safety zone for nonphysician providers such as pharmacies and affiliated health care providers to collectively contract with an ACO. Allied health care providers such as pharmacies should play an important role in improving the delivery of efficient health care. Yet if sole entities like community pharmacies cannot collectively form networks, ACOs may be left with only being able to contract with chain pharmacies. Permitting collective negotiation will enhance access and competition.

Concerns over provider market power

The most difficult issue the agencies must grapple with in the formation of these ACOs is market power, not integration. Since reform has been enacted, some commentators and journalists have raised concerns that reform may not succeed because there are instances where there are powerful providers, primarily hospitals, and these providers may use their power to rapidly increase costs.²⁰ This raises an important concern, which certainly should be carefully evaluated by antitrust enforcers and regulators.

Unfortunately, the FTC's disproportionate focus on attacking integration makes them somewhat ill-prepared to grapple with these challenges. For example, the 31 cases brought against physician-negotiating groups would seem to provide a foundation of knowledge. Yet the vast majority of these cases were pursued without any analysis of market power or competitive effects. These cases generally did not provide any evidence of market power. On the other hand, the FTC's recent hospital merger cases and investigations did involve consideration of whether a hospital possessed market power and would provide guidance on whether hospital-sponsored ACOs might raise competitive concerns.

There have been some studies of the issue of provider market power. In late 2009 and early 2010, the Massachusetts attorney general conducted a study of rising health care costs.²¹ The attorney general compiled and analyzed data from five health plans and 15 providers chosen to give an accurate representation of the variety of health care services in the state. The study found large price variation for similar services within a single market. Arguably, this price variation did not correlate with quality of care; the sickness, complexity, affluence, or age of the population; or whether the provider is an academic teaching or research facility. The only thing that the study found to correlate with price was provider market leverage. The study suggested that large, influential providers use their bargaining power to demand price increases that are not based on the factors listed above.

Moreover, the study also found that health care costs went up because of these price increases, not because of increased utilization of health care. There was also evidence of a trend toward higher-priced hospitals gaining more market share over lower-priced hospitals, which the study suggested indicated that the chances the market will correct itself without intervention are slim. The report points to contracting practices like payment-parity agreements and product-participation provisions to explain these peculiarities of the Massachusetts health care market.

Paul Ginsburg conducted a similar investigation of the effect that concentration has had on eight U.S. health care markets in a study published by the Center for Studying Health System Change.²² Ginsburg, the president of the nonpartisan center, looked at payment rates across eight health care markets and compared them to each other and to Medicare reimbursement rates. Ginsburg found significant variation in hospital and physician payments across and within U.S. markets. While he admitted that it is extremely difficult to measure quality, he found it implausible that quality differences alone could account for price discrepancies. He suggested that provider leverage was an important source of cost increases and provided an example of how acquiring contracts with all anesthesiology groups could be used to drive up the cost of health care.

Robert Berenson also recently attempted to investigate market-power issues in California.²³ Dr. Berenson, an institute fellow at the Urban Institute, conducted approximately 300 structured interviews as the basis for his study. He found that “must-have” hospitals are able to charge what they want for care, and therefore have market power disproportionate to their size. While he admitted that the HMO movement, which has significant prominence in California, may have increased quality, he said it has most certainly driven up price, which is entirely contrary to the intention of the program. Berenson contended that antitrust regulation was ineffective at curbing provider market power in the current health care system.

These studies have spurred a lively debate and critique. Some commentators have noted that Berenson’s study was entirely based on interviews with health care payers and there was no examination of actual cost data in a statistical or scientific manner. The anecdotes tell an interesting story but the study needs a stronger empirical base.²⁴ The attorney general’s report attempts a more disciplined econometric approach but some commentators have posed criticisms. It does not demonstrate the existence of market power from a traditional antitrust perspective. It does not use multivariate analysis or longitudinal data. For instance, it does

not sufficiently take into account either the additional costs of very small, rural hospitals or the cost differences between a teaching hospital with two students and one with more than 500 students. In any case, these reports trigger the need for greater discussion of the concerns over provider power.

What should be the response of enforcers to the concerns of provider market power?

First, to the extent the concern is over ACO competition, it is critical that the agencies broaden the standards for integration, as suggested earlier, in evaluating proposed ACOs. If hospitals dominate some markets, it is even more important that the agencies provide a clear path for physician-sponsored ACOs to be formed. The agencies should permit ACOs to qualify based on clinical integration, not just financial integration. The current integration antitrust standards may create obstacles to physician-sponsored ACOs and that would reduce competitive alternatives in ACO markets.

Second, the FTC should focus its enforcement resources on market power by hospitals and specialized physician groups. The FTC has done an admirable job in reviving hospital-merger enforcement in the past several years. Recent cases against the Evanston/Northwestern and Inova/Prince William hospital mergers have demonstrated the importance of antitrust enforcement in preventing the creation of market power. A recent action against an acquisition of two outpatient imaging centers by Carilion Clinic, the dominant hospital system in Roanoke, VA, demonstrates how even smaller acquisitions of outpatient clinics may be anticompetitive. These clinics were potential competitors to the hospital and their acquisition harmed competition.

The agencies clearly need to focus greater attention in those situations where physicians may possess market power. The DOJ and the FTC have generally overlooked this area—the most recent enforcement action against a group of physicians for exercising market power was 1994. In that case, the FTC challenged joint ventures by two groups of pulmonologists that harmed the home oxygen-equipment market by bringing together more than 60 percent of the pulmonologists who could make referrals for this equipment.²⁵ This type of referral power by large groups of specialists can raise prices for many procedures. It is interesting to observe that the case was brought under Section 5 of the Federal Trade Commission Act, which declares illegal “unfair methods of competition.” The agencies should use their full range of powers including the FTC’s unique authority under Section 5.

Antitrust enforcement is an important solution but a limited one. The DOJ and the FTC have limited resources. In addition, antitrust enforcement does not break up monopolies or oligopolies that have been legally acquired nor does it restrict much of their exercise of market power.²⁶ While traditional antitrust enforcement should absolutely remain part of the solution, we must also look to legislative fixes and innovative market reforms like ACOs to address the potential exercise of market power. There are several examples worth considering.

Inspired at least partially by the Massachusetts attorney general's report, Massachusetts passed a law in August 2010 aimed at controlling health care costs.²⁷ The law requires the Division of Health Care Finance and Policy, or DHCFP, to encourage payers and providers to adopt bundled payment arrangements rather than fee-for-service arrangements. The goal is to implement pilot bundled-payment programs in 2011. The law extends DHCFP's ability to require providers to submit standardized data about their costs and payments. It requires insurers to file all new rate increases with the commissioner of insurance and the commissioner is directed to disapprove such increases if they are "excessive, inadequate, or unreasonable in relation to the benefits charged." Perhaps most importantly, it requires that provider networks with 5,000 or more enrollees offer limited-network or tiered-network plans. The base premium for this plan must be at least 12 percent lower than that of the carrier's "most actuarially similar" plan that does not include such a network. There are also some specific provisions in the law that ensure that the tiered or limited networks will engender cost savings. Taken together, these provisions may make some real impact on containing price increases.

Ginsburg also offers a number of suggestions for controlling costs as part of his study. He breaks the suggestions down into two categories: a market approach and a regulatory approach. In the market approach, the goal is to provide mechanisms that encourage individuals to obtain lower cost services. The vertical integration of the ACO model provides consumers with an understandable comprehensive cost of care that will then be easier to compare with other provider options. In the regulatory approach, the government may establish a common payment method across public and private payers and set a ceiling on the amount that providers can charge insurers. Maryland, for example, utilizes an all-payer rate setting for its hospitals.

Professor Tim Greaney has some specific recommendations to address some of the possible market-power problems posed by ACOs.²⁸ He encourages CMS not to certify ACOs that are likely to inhibit the creation of competing ACOs in the

same market. He recommends a requirement that ACOs be transparent on both cost and quality measures, and says ACOs should be restricted from adopting “most favored nation” clauses in their contracts with insurers. He also admits that there will be some locations where the creation of competitive ACOs is just not feasible, and in those locations he encourages CMS to consider regulatory measures such as directly capping premium increases.

Blue Shield of California, in its comments at the ACO workshop, offered suggestions for improving ACO competition that focus on disclosure.²⁹ The organization suggests that ACOs should be required to “allow all its contracted payers to publicly share quality, service, and aggregated cost information by individual provider for every provider” represented by the ACO. In addition, Blue Shield suggests that payers can use the ACO’s claims data to monitor cost and quality. Finally, the group suggests that an ACO be prevented from negotiation on an all-or-nothing basis.

All of these recommendations on potential regulation pose complex issues. It is important to recognize that the ultimate goal of the Affordable Care Act is improved access to improved health care delivery. In assessing the roles of ACOs and potential regulation, there are important tradeoffs to be made.

Endnotes

- 1 In the United States, antitrust enforcement is shared between two agencies: the Federal Trade Commission, or FTC, and the Antitrust Division of the Department of Justice, or DOJ. Both agencies have jurisdiction over health care issues though the DOJ has sole jurisdiction over health insurers. Work is allocated between the two organizations by means of a complex clearance agreement.
- 2 For two examples of such hearings, see: "Terminations of Individual Policies by Insurance Companies," available at <http://energy-commerce.house.gov/hearings/hearingdetail.aspx?NewsID=7100>; "Full Committee Hearing - Addressing Insurance Market Reform in National Health Reform," available at <http://help.senate.gov/hearings/hearing/?id=6c9284ec-5056-9502-5d8c-72ce17e6a828>.
- 3 For the purposes of this paper, "providers" are clinics, hospitals, physicians, pharmacists, nurses, and all other individuals and organizations involved in directly delivering health care services to patients.
- 4 For a very thoughtful analysis of the ACO model and the new regulatory challenges, see: Douglas A. Hastings, "Constructing Accountable Care Organizations: Some Practical Observations at the Nexus of Policy, Business, and Law," *Health Law Reporter* 19 (25) 2010; Douglas A. Hastings, "Accountable Care Organization Regulation and Enforcement: Coordinated or Siloed?," *Health Law Reporter* 19 (37) (2010).
- 5 *The Patient Protection and Affordable Care Act*, Public Law 111-148, Sec. 3022, 111th Cong., 2d sess. (March 23, 2010).
- 6 Thomas L. Greaney, "The Affordable Care Act and Competition Policy: Antidote or Placebo?," *Oregon Law Review*, forthcoming, available at <http://ssrn.com/abstract=1680115>.
- 7 *The Patient Protection and Affordable Care Act*.
- 8 *Ibid.*
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