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Christopher Bays

Health Care Finance

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I. Intro

The problem the United States health care industry faces today is one of fragmentation. The Institute of Medicine has pointed out that this problem, specifically, is jeopardizing the lives and well-being of many Americans as well as contributing to the excessive level and unsustainable growth rate of expenditures on health care.¹

Accountable Care Organizations (ACOs) are designed to promote care coordination, higher quality, and lower costs.² ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily as a group to give coordinated high quality care to their Medicare patients.³ The goal of coordinated care is to ensure that patients,

¹ Harvard Law School, Center for Health Law Policy, Biotechnology and Bioethics, Our Fragmented Health Care System: Causes and Solutions (Jun. 13-14, 2008) http://www.law.harvard.edu/programs/petrie-florence/workshops_conferences/Conferences/Fragmentation/ProgramMay29.pdf; also see Auerbach DI and Kellermann AL, *A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average U.S. Family*, Health Affairs, Vol. 30, No. 9, September 2011 (In the ten-year period between 1999 and 2009, U.S. health care spending nearly doubled, climbing from \$1.3 trillion to \$2.5 trillion. In 2009, while the rest of the U.S. economy plunged into recession and millions lost their jobs, health care costs grew by 4 percent. As a result, the percentage of our nation's gross domestic product (GDP) devoted to health care reached 17.6 percent, up from 13.8 percent only ten years earlier. Although these numbers are striking, they do not easily translate into figures that are meaningful to individual Americans.)

² Maulik Joshi, American Hospital Association, *Accountable Care Organizations AHA Research Synthesis Report*, American Hospital Association Committee on Research, (June 10) available at <http://www.hret.org/accountable/resources/ACO-Synthesis-Report.pdf>

³ See *Id.*; Centers for Medicare & Medicaid Services: Accountable Care Organizations (Last modified 04/05/2012) <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/> (The ACO concept envisions multiple providers assuming joint accountability for improving health care quality and slowing the growth of health care costs. The concept was also included in national health care reform legislation as one of several demonstration programs to be administered by Medicare (Patient Protection and Affordable Care Act, 2010). However, ACOs described in health reform legislation are operationally different from other ACO models. The role of ACOs in integrating and aligning provider incentives in care delivery requires participating organizations to possess certain key competencies.)

especially the chronically ill, get the appropriate care while avoiding unnecessary duplication of services and preventing medical errors. This is a shift from the old health care model, fee for service, which took into account the value or volume of referrals generated between the parties⁴, towards a joint cooperation model amongst providers. As long as the group meets defined quality benchmarks, its providers can share in any financial rewards that result from cost savings. Most importantly, the providers also share in the collective risk of penalties for poor performance and therefore have an incentive to control the quality of care that could help shape health care delivery costs. In order for the ACO model to flourish, waivers must be put in place. One of the major restraints with the old model of clinical integration was the tendency to fall into the trap of either over-utilization, under-utilization (i.e., the withholding of necessary items or services), or referrals that are based on considerations other than what might be in the best interest of the patient.⁵ ACOs provide potential solutions to fragmentation. ACOs are intended to achieve greater coordination of care by linking together physician practices and hospitals that will be financially rewarded if they improve quality while at the same time lowering costs. Recent trends show an increase in health care marketplace consolidation.⁶

⁴ Claire Turcotte and Bryn Hunt, *OIG Issues One Negative and One Favorable Advisory Opinion on Hospital-Based Arrangements*, Bricker and Eckler Publications (November 29, 2010) available at <http://www.bricker.com/publications-and-resources/publications-and-resources-details.aspx?publicationid=2069>

⁵ American Medical Association, *Trend watch: Clinical Integration—Key to Real Reform*, 10 (February, 2010) available at <http://www.aha.org/research/reports/tw/10feb-clinicinteg.pdf> As apply to Medicare and Medicaid patients there is an aimed at curbing arrangements that involve financial incentives to providers that could result in either over-utilization, under-utilization (i.e., the withholding of necessary items or services), or referrals that are based on considerations other than what might be in the best interest of the patient. While well intended, statutes are either broadly written or interpreted so as to also prohibit – or create uncertainties about – a broad range of benign arrangements that could better align hospitals and physicians and pose little or no potential risk of abuse.

⁶ America's Health Insurance Plan Coverage, *Fact Check: Provider Consolidation Drives Up Prices* (February 17, 2012), <http://www.ahipcoverage.com/2012/02/17/fact-check-provider-consolidation-drives-up-prices/> An analysis of

When insurers, hospitals and physician practices consolidate, however, anti-competitive arrangements result, leading to a decrease in cost control measures. These outcomes have potential to violate federal laws established in the Sherman Act, Clayton act and Federal Trade Commission Act.⁷ Despite the Federal Trade Commission (FTC) and Department of Justice (DOJ) developing safe harbors in order to provide clearance for providers to collaborate without running afoul of federal anti-trust laws, the proposed anti-trust enforcement declined to address state anti-trust concerns.

This paper will specifically deal with the issues concerning ACOs role in antitrust violations and will present the argument that while federal safe harbors alone may initially prove to be sufficient protection at the inception of ACOs, their longevity at effectiveness is uncertain. The lack of preemption within Patient Protection and Affordable Care Act (PPACA), provides state antitrust enforcement the power to ensure the greatest level of protection. Part II will explain the problem of fragmentation; describe the formation, requirements, and objectives of ACOs. This section will also provide a scenario analysis of most ideal illustration of clinical integration. Part III will focus how integration of

provider consolidation found that “in 2009, hospital ownership was ‘highly concentrated’ in over 80% of the 335” areas studied. Also See Cory Capps ,PhD and David Dranove, PhD, *Market Concentration of Hospitals*, (June 2011) available at <http://www.ahipcoverage.com/wp-content/uploads/2011/10/ACOs-Cory-Capps-Hospital-Market-Consolidation-Final.pdf>

⁷ Caswell O. Hobbs, FTC Enforcement: Antitrust Unfair and Deceptive Trade Practices, Corporate Law and Practice Handbook Series, 524 PLI/Corp 437, PLI Order No. B4-6755 (May 1, 1986) (Sherman Act prohibits contracts, combinations and conspiracies which unreasonably restrain competition. Clayton Act, 15 U.S.C. § 18, prohibits mergers and acquisitions which may lessen competition or tend to create a monopoly. Clayton Act, 15 U.S.C. § 18(a), known as the “Hart-Scott-Rodino Antitrust Improvements Act of 1976,” requires parties to certain mergers, acquisitions, joint ventures and corporate and non-corporate formations to notify the FTC and DOJ about the transaction before the transaction closes. FTC Act, 15 U.S.C. § 45, prohibits unfair methods of competition. The FTC Act can also be used to challenge merger which are not technically covered under Section 7 of the Clayton Act. See *FTC v. Brown Shoe Co.*, 384 U.S. 316, 321 (1966). Only the FTC has jurisdiction to sue under the FTC Act.

providers could lead to arrangements that are centered around price fixing and joint negotiations. In addition, the worst case scenario is discussed and the viability of such a scenario to come to fruition. Part IV will show how Federal Trade Commission (FTC), Department of Justice (DOJ) and Health and Human Services (HHS) plan to provide antitrust clearance to protect ACOs against any federal suits under existing antitrust laws. These exceptions will be made to those ACOs that are productive, competitive and have become fully integrated while operating in the commercial market. Part V examines the dynamic scenario, looking forward to the years following the initial implementation of ACOs. The theory of what might be helpful and effective at one point in time (during the initial phase of inception of ACOs), may not be the solution for the long term. The risk that federally approved ACOs can gain enormous market power despite the parameters under antitrust clearance can influence the overall efficiency. Lastly, Part VI addresses the possibility of state and private lawsuits against dominant ACOs and explains why such actions provide a necessary second level of defense for patients when ACOs become market dominate.

II. Accountable Care Organizations (ACOs)

A. Fragmentation

Fragmentation comprises the core of the ineffectiveness in our increasingly frantic efforts to foster improvement to a health care system which has produced unsustainable cost increases, poor quality, and inequalities.⁸ The underlying cause in a fragmented system is the patients and families navigating across different providers and care settings.

⁸ Elhauge ed., *The Fragmentation in US. Health Care: Cases and Solutions*, Oxford (Jan. 15, 2010) <http://www.law.harvard.edu/faculty/elhauge/pdf/Elhauge%20The%20Fragmentation%20of%20US%20Health%20Care%20--%20Introductory%20Chpt.pdf>

This experience fosters frustrating and dangerous patient experiences due to poor communication and lack of clear accountability.⁹ The inadequacy of accountability has led to medical errors, waste of resources, and duplication of services; ultimately high-cost.¹⁰ This fragmentation is found on the national, state, community, and practice levels. Health spending has soared over the past decades from a National health expenditure of \$27.1 billion in 1960 to today over \$2.6 trillion.¹¹ Lack of competition created supracompetitive profits¹², an escalating number of uninsured, an epidemic of deceptive and fraudulent conduct, and rapidly escalating costs. Over 47 million Americans are now uninsured and premiums have risen over 120 percent in the past decade for those who do have coverage.¹³ Health insurers engage in an endless list of deceptive, fraudulent, and unfair practices that deny millions of consumers adequate coverage. Meanwhile, 10 of the largest health insurers saw their profits balloon from \$2.4 billion in 2000 to \$13 billion in 2007.¹⁴ No single national entity or set of policies governs or guides the health care system; states divide their responsibilities among multiple agencies, while providers practicing in the same community and caring for the same patients often work

⁹ Ani B. Satz, *Overcoming Fragmentation in Disability and Health Law*, 60 Emory L.J. 277

¹⁰ Randall D. Cebul, James B. Rebitzer, Lowell J. Taylor, and Mark Votruba, “*Organizational Fragmentation and Care Quality in the U.S. Health Care System*” NBER Working Paper No. 14212 (August 2008) JEL No. D2,I11,I12,I18,IO

¹¹ Julie Barnes, *The Many Legal Barriers Standing in the way of Health Care Reform*, The Atlantic (March 15, 2012, 9:02 AM ET), reprinted in *Bipartisan Policy* (Posted March 16, 2012) <http://www.theatlantic.com/health/archive/2012/03/the-many-legal-barriers-standing-in-the-way-of-health-care-reform/254259/>

¹² David Balto, *Make the Market Work for Health Care*, Center for American Progress (February 9, 2010) available at http://www.americanprogress.org/issues/2010/02/market_health_care.html (Supracompetitive pricing is pricing above what can be sustained in a competitive market. This may be indicative of a business that has a unique legal or competitive advantage, or possibly of anti-competitive behavior that has driven competition from the market.)

¹³ Health Care for America Now, *Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States*, Small Businesses (2009) available at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltdl.pdf.

¹⁴ *Id.* at 1

independently from one another.¹⁵ Take this scenerior: A patient tells one nurse she is allergic to some medicine but the nurse does not communicate this information. The nurse on the next shift then administers that medicine.¹⁶ This example exemplifies the problems of fragmentation. A broader conception and more of a macro approach to fragmentation focuses on lack of coordination between different providers that a patient might see for different illnesses. This might occur if, say, a surgeon used a high-sugar intravenous therapy after an operation on a diabetic patient without consulting with the diabetic specialist treating the patient.¹⁷ Fee for service encourages care fragmentation, poor coordination across different provider settings, and in some instances, unnecessary care that exposes patients to risk without providing any value to health.¹⁸ Today, chronic disease accounts for about 75 percent of total health care spending. An acute disease-focused, per-intervention model of care delivery and payment cannot address America's current needs.¹⁹ These fragmented organizational structures have led to disrupted relationships, poor information flows, and misaligned incentives that combine to degrade care quality and increase costs.²⁰

Providers can improve the method in which they deliver care simply by increasing the role of information technology and the ability of information to flow freely across providers. Under the provisions of the PPACA, twenty-two of the sixty-

¹⁵ A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008. <http://www.commonwealthfund.org/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx>

¹⁶ Elhauge ed., *The Fragmentation in US. Health Care: Cases and Solutions*, supra note 8, at 3

¹⁷ *Id.* at 3.

¹⁸ Barnes, *The Many Legal Barriers Standing in the way of Health Care Reform*, supra note 11, at 3

¹⁹ *Id.* at 3

²⁰ *Id.* at 3

five quality measures pertain to “meaningful use” of information technology.²¹ This will not only allow providers to work together, but also allow ACOs to meet additional quality measures which maybe result in larger shared savings. This entails patient information being available to all providers at the point of care and to patients through electronic health record systems.²² Information technology pushes the health care model in the right direction towards implementing a clear standard of accountability for the total care of patients. Accessibility to information allows providers accountability to each other, ability to review each other's work, and collaborate to deliver reliably, high-quality, high-value care.

With a seamless flow of information across providers, from insurers to hospital to physicians, modern information technology offers many tools to facilitate coordination.²³ Physicians exposed to the system had reduced resource utilization and have experienced fewer unresolved gaps in care.²⁴ Clinical integration is a way for physicians to work together in a team style environment and collaborate within virtual or physical wall of the medical center. Previous research and experience has shown that greater care coordination and integration can lead to higher quality care as well as more efficient care.²⁵ Clinical

²¹ Amy K. Fehn, “*The importance of Health Information Technology for Accountable Care Organization*, The Atlantic (June 2, 2011), <http://www.theatlantic.com/health/archive/2012/03/the-many-legal-barriers-standing-in-the-way-of-health-care-reform/254259/> (Last Visited 4/29/12).

²² A. Shih, *Organizing the U.S. Health Care Delivery System for High Performance*, *supra* note 15

²³ Amy K. Fehn, “*The importance of Health Information Technology for Accountable Care Organization*, *supra* note 21.

²⁴ Chernew, Michael E., Allison B. Rosen, and Mark A. Fendrick, *Value-Based Insurance Design*, Health Affairs, 26 no. 2 (2007) , pp. 8, (published online January 30,2007), <http://content.healthaffairs.org/content/26/2/w195.full.pdf+html>.

²⁵ Leighton Ku, Peter Shin, Masha Regenstein and Holly Mead, “*Promoting the Integration and Coordination of Safety-net Health Care Providers Under Health Reform: Key Issues*” The Commonwealth Fund (October 13, 2011) 1552 Vol.22 http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Oct/1552_Ku_promoting_integration_safetynet_providers_under_reform_ib_v2.pdf

integration is also the initial platform toward implementing an ACO, the future of healthcare delivery in America. On March 23, 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA)²⁶, designed to integrate the model in which patient care is delivered in Medicare and the Medicare Shared Savings Program (MSSP) by using the ACO model. The Affordable Care Act is in place to improve the quality of health care services and to lower healthcare costs by encouraging providers to create integrated health care delivery systems.

B. ACOs

ACOs are collaborations that integrate groups of providers formed from a variety of entities. These include physicians (particularly primary care physicians), individual physicians, hospitals, partnerships and others forms of joint-ventures.²⁷ These providers work to manage and coordinate care for Medicare and commercial beneficiaries. A common feature of successful ACOs will be its ability to connect and synchronize the interests of the providers, payers and patients.²⁸ In doing so, these ACOs may receive shared-saving bonuses from a payer by achieving measured quality targets and

The Affordable Care Act includes several provisions designed to encourage greater coordination and integration among health care providers, including the promotion of accountable care organizations. Such providers face particular challenges in coordinating care for their low-income and uninsured patients, and no single approach is likely to meet their diverse needs. Successful efforts will require federal, state, and local financial resources to sustain the safety net and make the investments needed to upgrade capabilities. In addition, they will require flexible strategies that can accommodate variations in community and state needs. These strategies are likely to be adopted by Medicare and private insurers alike.

²⁶ H.R. 3590 (111th): Patient Protection and Affordable Care Act (2009-2010); also see <http://www.govtrack.us/congress/bills/111/hr3590>

²⁷ Timony K. Lake, Kate A. Stewart and Paul B. Ginsburg, *Lessons from the Field: Making ACOs Real*, National Institute for Health Care Reform, No.2 (Jan. 2011)

²⁸ Elizabeth G. Litten. "ACOs: Getting More for Less?" *New Jersey Law Journal* Vol. 204- No. 8 (May 23, 2011) available at <http://www.foxrothschild.com/newspubs/newspubsArticle.aspx?id=4294967686> (last visited April 29, 2012)

demonstrating real reductions in overall spending growth for a defined population of patients²⁹

The majority of ACO proposals assume that providers within each community will come together to form these integrated delivery models and solicit other providers in the community to voluntarily join the ACO.³⁰ This focus on coordinated patient-centered care has led to strict requirements which an ACO must satisfy prior to (prior to what?) to be eligible for the benefits. The following requirements must meet to form ACOs under the Medicare Shared Savings Program as well as non-Medicare ACOs:

- Define processes to promote the practice of evidence-based medicine and provide data to evaluate quality and cost measures.
- Build a management and leadership structure that includes administrative and clinical systems.
- Develop a formal legal structure that allows the organization to receive payments and distribute shared savings among participating providers.
- Have enough primary care providers to provide care to a minimum of 5,000 Medicare beneficiaries.
- Establishing, reporting, and ensuring compliance with health care quality criteria, including quality performance standards.
- Contract with a core group of specialist physicians.
- Agree to participate in the program for a minimum of three years³¹

²⁹ David Newman, “*Accountable Care Organizations and the Medicare Shared Savings Program*” Congressional Research Service (November 4, 2010), pp. 1. (Quoting Aaron McKethan, Mark McClellan, Elliott Fisher, et al., *Moving from Volume-Driven Medicine Toward Accountable Care*, Health Affairs, Health Affairs Blog, August 20, 2009. <http://www.healthaffairs.org/blog>.) available at http://assets.opencrs.com/rpts/R41474_20101104.pdf .

³⁰ Centers for Medicare & Medicaid Services: Accountable Care Organizations, *supra* note 3.

³¹ Department of Health and Human Services, *Medicare Program; Medicare Shared Saving Program: Accountable Care Organizations*, Federal Register, Vol. 76, No. 67 (Thursday April 7, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>

ACOs aim to change both the philosophy and practice patterns of providers and in turn, benefit all patients from the delivery of higher-quality, lower-cost, and better integrated services.³² Philosophically, the attention of the health care system changes under ACOs from the traditional focus on treating patients with truly urgent problems to preventing those conditions in the first place. On the financial side, ACOs shift away from paying based on the *quantity* of services rendered and more toward paying based on the *quality* of services.³³ Although ACOs may contract with any payer (Medicare, Medicaid, or private insurer) to provide services and share in any resulting savings, the results from this shift are assumed to be far reaching and favorable for the health care delivery system.

Certification of ACOs for participation in the Medicare Shared Savings Program (MSSP) therefore must qualify under certain performance standards set forth by the Health and Human Services.³⁴ Experts expect MSSP will improve growth of integrated delivery systems, and some experts think as many as 270 ACOs will be created as a result and serve an estimate of 1-5 million Medicare beneficiaries.³⁵ To be eligible to participate in the Shared Savings Program, the ACO must define, establish, implement, and periodically update processes to promote patient engagement. An ACO must describe in its application

³² Stephen G. Pelletier, *ACOs: Controlling Costs While Improving Care*, Association of American Medical Colleges Reporter (February 2011)

https://www.aamc.org/newsroom/reporter/feb11/174756/controlling_costs_while_improving_care.html

³³ Barnes, *The Many Legal Barriers Standing in the way of Health Care Reform*, supra note 11, at 3.

³⁴ Federal Trade Commission and Department of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Saving Program*, Federal Register, Vol. 76 No. 209 (October 28, 2011) available at <http://www.ftc.gov/os/fedreg/2011/10/111020aco.pdf> (The final Policy Statement differs from the proposed Policy Statement issued Apr. 19, 2011, in two significant respects. First, the entire final Policy Statement applies to all providers and provider groups that are eligible to participate in the MSSP regardless if they were formed after March 23, 2010. Second, MSSP will no longer require a mandatory antitrust review. Nevertheless, Agencies will continue to protect competition in markets served by ACOs monitoring information collected by CMS concerning competitive effects of ACOs).

³⁵ Interview by Jennifer Prestigiacomo with Richard Gilfillian, M.D., Director of the Center for Medicare and Medicaid Innovation at CMS, *Industry Exclusive: Pioneers in Accountable Care*, (January 26, 2012) available at <http://www.healthcare-informatics.com/article/industry-exclusive-pioneers-accountable-care>

how it intends to evaluate the health needs of the ACO's assigned population, communicate clinical knowledge and evidence-based medicine to beneficiaries, engage with beneficiaries in shared decision-making, provide written standards for beneficiary access and communication, and establish a process for beneficiaries to access their medical records.³⁶

C. Best Case Scenario

In evaluating the ACO health care model, ACOs best case scenario guides us in determining the maximum potential for their success. CMS concludes ACOs would save Medicare about \$1.9 billion between 2012-2014 and drastically improve quality and efficiency.³⁷ A prime example of the “Best Case Scenario” consists of an ACO in a large urban area that is competitive with 2 or 3 other ACOs.³⁸ This ensures equal competitiveness amongst providers, deeply integrated in information technology and has prominent primary physicians within its provider. Medicare recipient and commercial consumer alike benefit alike from this scenario. Providers working together to manage and coordinate care allows consumers to take advantage of the option to select from identical care that is of the utmost quality. Several supporters of ACOs point to Kaiser Permanente

³⁶ Department of Health and Human Services, *Medicare Program; Medicare Shared Saving Program Accountable Care Organizations*, Federal Register, Vol. 76 No. 212 (Wednesday, Nov. 2, 2011) available at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> (This final rule contains provisions relating to Medicare payments to providers of services and suppliers participating in ACOs under the Medicare Shared Savings Program. Providers can continue to receive traditional Medicare fee-for-service (FFS) payments and be eligible for additional payments if they meet specified quality requirements)

³⁷ David Hogberg, *Your Health care in 429 Easy-to-Read Pages!*, Investors Business Daily Blog (April 1, 2011, 2:44pm), <http://blogs.investors.com/capitalhill/index.php/home/35-politicsinvesting/2552-your-health-care-in-429-easy-to-read-pages>

³⁸ Press Release, United States Census Bureau, *Growth in Urban Pop. Outpaces Rest of Nation*, (March, 26, 2012) http://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html (The nation's urban population increased by 12.1 percent from 2000 to 2010, outpacing the nation's overall growth rate of 9.7 percent for the same period, according to the U.S. Census Bureau. Urban areas — defined as densely developed residential, commercial and other nonresidential areas -- now account for 80.7 percent of the U.S. population, up from 79.0 percent in 2000. Although the rural population -- the population in any areas outside of those classified as “urban” — grew by a modest amount from 2000 to 2010, it continued to decline as a percentage of the national population.)

and Healthcare Partner Medical Group as notable examples of the success and potential of ACO type models.³⁹ At Kaiser Permanente, providers have cut the number of senior visits by about 40 percent by delivering team care to them, and identifying all the seniors at high risk and making sure they get the right prescriptions, the right follow-up and the right coaching.⁴⁰ This type of harmonization saves hundreds of millions of dollars a year. Although neither anticipates joining the MSSP, both provider groups currently have the level of integration and coordination that will be established by ACOs.⁴¹

III. Road Block to Integration

However, because most Medicare ACOs serve private insurers as well, provider dominance concerns in negotiations may raise a valid anticompetitive claim under antitrust law. These anticompetitive concerns result from both horizontal and vertical integration.⁴² Such concentration is significant because, with health insurance in the picture, consumers must be mindful that the expected savings from ACOs is dependent on perfect competition. An organization integrates horizontally or vertically when it enters the new market as a competitor, and the increased market presence creates the required competition. Horizontal

³⁹ James C. Robinson and Emma L. Dolan, *Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform*, Integrated Healthcare Assc. White Paper (2010) ACOs in California care for 15.7 million prepaid enrollees covered by commercial HMO, Medicare, and Medicaid managed care, plus numerous Medicare fee-for-service enrollees. Kaiser Permanente is the most successful ACO in California. In California, approximately 56% of individuals with commercial insurance, 45% of Medicare beneficiaries, and 52% of Medicaid beneficiaries receive their care from an ACO, collectively these account for 54% of all persons with health insurance in the state. California's provider organizations span a wide spectrum of sizes and structures, from the fully integrated Kaiser Permanente with 6.7 million enrollees to small medical groups and IPAs, some with fewer than 5,000 patients.

⁴⁰ Interview by Joanne Silberner with George Halvorson, CEO, Kaiser Permanente, Head of Major HMO Sees Opening for ACOs, Kaiser Health News (July 25, 2011), <http://www.kaiserhealthnews.org/Stories/2011/July/25/halvorson-Q-and-A-kaiser-permanente-accountable-care-organizations.aspx> (last Visited 3/29/12)

⁴¹ Press Release, Kaiser Permanente, *2011 Aon Hewitt Value Initiative Benchmarking Study*, (March 2011) available at <https://brokernet.kp.org/broker/wcm/connect/704ae100482fc6a681369fcc62f09f01/CO-Health-care-reform-ACO.pdf?MOD=AJPERES&lmod=725315576> (Last Visited 3/29/12)

⁴² *Anderson Foreign Motors, Inc. v. New England Toyota Distributor, Inc.* 475 F.Supp. 973(D. Mass 1979)

integration is partnering of providers with other providers across the same or similar level within the healthcare field⁴³, for example when a cardiologist and an urologist combine services to provide more uniform care. Conversely, vertical integration is the partnering of healthcare organizations that provide some service in the supply chain to the healthcare industry, for example insurance companies teaming up with hospitals and providers to improve quality. Although vertical integration is not prohibited *per se*, vertical integration may be unlawful under Sherman Act if it creates monopoly power and is accompanied by intent to exclude competition.⁴⁴

Although antitrust laws permit integration, these network structures create a vehicle for troubling concerns.⁴⁵ Particularly ACOs run the risk of price fixing, engaging in joint price negotiations, and they may be able to exercise extreme market power particularly in rural markets.⁴⁶ Market power measures the degree to which an organization has the ability to raise prices or exclude rivals. As with other industries, the laws of market power and its impact on competition affect the health care system. Several studies show that prices go up in markets where large healthcare organizations have amassed substantial market power.⁴⁷

⁴³ Laura Summer, M.P.H., *Integration, Concentration and Competition in Provider Marketplace*, Academy Health Brief http://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf (Horizontal integration refers to the consolidation of two or more organizations fulfilling the same roles within a single industry – e.g. hospital mergers or mergers among different physician groups.)

⁴⁴ Sherman Antitrust Act, § 1 et seq., 15 U.S.C.A. § 1 (Vertical integration involves participants who are not direct competitors because they are at different levels. These participants are from one or more providers, hospitals, and insurers. This distinction under the Sherman Act becomes significant in determining whether to apply a *per se* rule of illegality or the *Rule of Reason*. Vertical integration is typically subject to the rule-of-reason test.)

⁴⁵ *GAF Corp. v. Circle Floor Co.*, 329 F.Supp 823 (S.D.N.Y 1971)

⁴⁶ J. Thomas Rosch, Commissioner, Remarks at the ABA Section of Antitrust Law Fall Forum Washington, DC, *FTC Care Organizations: What Exactly are We Getting?* (November 17, 2011) (transcript available at <http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf>)

⁴⁷ *America's Health Insurance Plans Coverage, Accountable Care Organizations and Market Power Issues* (October, 2010), as reprinted in <http://www.ahipcoverage.com/wp-content/uploads/2011/08/AC-Summary-04.15.2011.pdf>

This problem increases with respect to negotiations with private payers because, unlike Medicare sets their own rates, leaving patients powerless against joint venture providers.⁴⁸ Furthermore, any decline in savings from the Medicare Shared Saving Program will simply be passed on to the commercial payer and subsequently increase the market share and power of the provider.⁴⁹

The potential draw backs of ACOs,, the worst-case scenario, involve their potential to harm our nation’s healthcare industry. Critics like Tim Greaney, and even some supporters, concur that large amounts of collaboration produce a wave of regional consolidations among providers that would locate around large hospitals and become monopolies or duopolies that increase, rather than decrease, cost.⁵⁰ Rural areas illustrate such an example, with only a single quality hospital and a large service area. These providers choose the primary physicians and the clientele as well as set prices to the level that benefits the ACO the most. Instances such as this give the dominant provider essentially the ability to cherry pick practices and patient panels that will be able to yield the greatest investment in value and will receive the greatest benefit from the ACO arrangement.⁵¹ Another scenario involves the provider as simply the better organization and naturally forces out competitors within its service area. Federal antitrust laws, like Sherman Act, do not penalize efficient monopolies or natural monopolies so private patients and insurers might end up paying more because the new, larger organizations

⁴⁸ Id.

⁴⁹ America’s Health Insurance Plans Coverage, *Accountable Care Organizations and Market Power Issue*, *supra* note 47.

⁵⁰ Thomas Greaney and John J. Ammann, *No Mandate? Ok, but be prepared to pay later*, Saint Louis Today (March 28, 2012 12:00am) available at http://www.stltoday.com/news/opinion/guest-commentary-no-mandate-ok-but-be-prepared-to-pay/article_b0dc1d06-e613-5504-9c41-29fdc7bc05f7.html#ixzz1qW7TDzng

⁵¹ Craig Evan Pollack and Katrina Armstrong. *Accountable Care Organizations and Health Care Disparities*, Journal of the American Medical Association, Vol 305, No. 16 American Medical Association (April 27, 2011) <http://jama.ama-assn.org/content/305/16/1706>

would inhibit competition.⁵² Without other ACOs acting to force rivalries among providers, or between them and other networks in the market, large ACOs may entrench market power in any of the provider markets. If the ACO movement contributes to market dominance by large providers, it is counterproductive to the entire premise and any benefit is lost.⁵³

Empirical studies show the viability of that scenario and suggest that health care reform legislation has already prompted a number of mergers among health care providers.⁵⁴ Furthermore, a substantial body of economic evidence indicates that market concentration has been a major factor spurring escalation in the cost of health insurance. Studies show that hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.⁵⁵ Furthermore, a study undertaken by the Massachusetts Attorney General showed delivery costs were driven largely by hospitals and physician groups market dominance, not by quality or cost of providing care.⁵⁶

⁵² Sherman Antitrust Act § 2 15 U.S.C.A § 2 (Section 2 of the Sherman Act was enacted to address monopoly power by anticompetitive conduct. The concern with monopoly refers to certain types of strategic behavior that may be unlawful when engaged in by a firm seeking to obtain or maintain monopoly power. Anticompetitive conduct is employed to acquire monopoly power, exposing consumers to the price, output, and innovation effects that can result from monopoly. Sometimes the anticompetitive conduct is employed to maintain a monopoly position, preventing rivals from entering or effectively competing with the monopolist, and thereby prolonging consumers' exposure to the potentially harmful effects of monopoly).

⁵³ Fred Barbash, *Teamwork: A New Concept in Health*, Congressional Quarterly, December 10, 2011 <http://public.cq.com/docs/weeklyreport/weeklyreport-000003997654.html> (Last Visited 4/29/12) (Quoting Thomas Greaney, a Saint Louis University Law School Expert in Antitrust Issues)

⁵⁴ Thomas L. Greaney. "Accountable Care Organizations – The Fork in the Road" *N Engl J Med* 2011 (January 6, 2011) <http://www.nejm.org/doi/full/10.1056/NEJMp1013404#t=references> (Quoting Pear R. Consumer risks feared as health law spurs mergers. *New York Times*. November 20, 2010.)

⁵⁵ Williams CH, Vogt WB, Town R., *How has hospital consolidation affected the price and quality of hospital care?*, Princeton, NJ: Robert Wood Johnson Foundation, 2006. (<http://www.rwjf.org/files/research/no9policybrief.pdf>.)

⁵⁶ Office of the Attorney General of Massachusetts Report for Annual Public Hearing *Examination of Health Care Cost Trends and Cost Drivers* (June 22, 2011), <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>

In spite of the upsides to the ACO, providers must be aware of the potential for antitrust litigation to slow down or even block integration in some instances. Private suits are less of a concern to ACOs because individual plaintiffs have a more difficult time, at large, proving key elements of an antitrust violation.⁵⁷ In order to prove an antitrust violation, the plaintiff must provide sufficient evidence that they suffered an injury to their “business or property,” actual harm or damage in fact, proximate cause and scienter.⁵⁸ The most difficult of the elements to prove is actual harm and scienter.⁵⁹ For example, in April 2010, the U.S. District Court for the Northern District of Illinois denied class certification in an antitrust action against the January 2000 Evanston Northwestern Healthcare Corporation’s acquisition of Highland Park Hospital, ruling that the plaintiffs did not prove “common impact.”⁶⁰ Nonetheless, ACO are susceptible to numerous amounts of frivolous lawsuits that could delay integration.

On the other hand, federal investigations pressure the ACOs. Doctors, hospitals, insurance companies and drug manufacturers will be running huge legal risks if they get together and agree on a strategy that involves negotiation of prices and reduces the growth of health spending.⁶¹ Furthermore, in a recent letter to the Senate Finance Committee, the

⁵⁷ Daniel L. Rubinfeld, *Antitrust Damages*, Research Handbook on the Economics of Antitrust Law (Nov. 21, 2009) <http://ec.europa.eu/competition/antitrust/actionsdamages/rubinfeld.pdf> (The complexity of the U.S. system of private antitrust enforcement raises many important but difficult damages-related issues. To obtain a financial recovery in a private action, the plaintiff must prove three distinct elements: (1) an antitrust violation; (2) antitrust injury; and (3) damages – a measure of the extent of the injury); Also see Ester Lee, *Cooper v. Mclure: The Difficulty Proving Antitrust Violations and the Need for a False Claims Act*, Journal of Business & Technology Law Vol. 4 No. 2 2009 available at http://www.law.umaryland.edu/academics/journals/jbtl/issues/4_2/4_2_395_Lee.pdf

⁵⁸ John M. Desiderio, *Private Treble Damage Antitrust Actions: An Outline of Fundamental Principles*. 48 Brook. L. Rev. 409 (Spring, 1982)

⁵⁹ Ester Lee, *Cooper v. Mclure: The Difficulty Proving Antitrust Violations and the Need for a False Claims Act*, *supra* note 57

⁶⁰ Austin Frakt, Health Economist, Department of Veterans Affairs, *The Future of Health Care Costs: Hospital-Insurer Balance Power*, National Institution For Health Care Management, November 2010 http://nihcm.org/pdf/EV_Frakt_FINAL.pdf

⁶¹ Robert Pear, *Antitrust Laws a Hurdle to Healthcare Overhaul*, New York Times (May 26, 2009) <http://www.nytimes.com/2009/05/27/health/policy/27health.html> (Last visited 3/29/12)

American Hospital Association said uncertainty about enforcement of the antitrust laws “makes it difficult for a hospital and doctors to collaborate to improve care” and lower costs.⁶² The threat of a Federal Investigation, signifies the realization that the ACO is about to embark on a lengthy legal process resulting in years of legal problems. Although not an analogous business, Microsoft Corporation faced identical antitrust investigations in the 1990’s and the results were damaging for the software giant.⁶³ A similar lengthy investigation could be devastating to ACO and the modernization of the health care delivery system in America.

In order to sort out effectuated and continual mergers facilitated by encouragement of ACOs, the Center for Medicare & Medicaid Services (CMS), working with the FTC (which has announced a final policy statement regulating of ACOs both within the means of the Shared Savings Program as well as in commercial markets), can take a number of steps to reduce the risk of anticompetitive effects.

IV. Protection of Clinical Integration

The Federal Trade Commission and the Antitrust Division of the Department of Justice (the “Agencies”) recognize that ACOs could reduce competition and harm consumers through enormous bargaining power which would result in higher prices and

⁶² Pear, *Antitrust Laws a Hurdle to Healthcare Overhaul*, *supra* note 61.

⁶³ Michael H. Berkens, “FTC May Open Anti-Trust Investigation on Google” *The Domains* (June 23, 2011) <http://www.thedomains.com/2011/06/23/federal-trade-commission-to-investigate-google-on-whether-it-has-abused-its-dominance-on-the-web/> (last visited 3/29/12) (Microsoft has spent 21 years — more than half its lifetime) Also see Sharon Pain Chan, *Long Antitrust saga ends for Microsoft*, *Seattle Times* (May 12, 2011, 7:53pm) http://seattletimes.nwsourc.com/html/microsoft/2015029604_microsoft12.html

lower quality of care.⁶⁴ Pursuant to these concerns, the Agencies released enforcement policies addressing federal antitrust uncertainties and ensuring that ACOs have an opportunity to achieve maximum efficiency while protecting patients from potential anticompetitive harm. In order to strike a balance among the providers to encourage the formation of ACOs while avoiding service area dominance, the Agencies set forth safety zones in which providers can facilitate with little to no challenge or agency review.⁶⁵

Despite these concerns by the DOJ and FTC, those ACOs falling into an exemption or comply with the FTC guidelines avoid a mandatory review and are only subject to voluntary disclosure. The significant feature of voluntary disclosure consists of transparency and accessibility of information regarding costs and quality to consumers and regulators. This ability to monitor, share, and publicize statistical data, improves competition and provide clearance for ACO to operate within several of the FTC safe harbors.⁶⁶

An ACOs falls within the safety zone if the participants combine common service share is 30% or less within their Primary Service Area (PSA) and does not raise concerns of exclusivity.⁶⁷ Because exclusivity increases the likelihood of an ACO being able to gain provider dominance and exercise market power, regulators must be aware of these characteristics when determining whether an ACO sufficiently fulfills the safe harbor

⁶⁴ Press Release, Department of Justice, *Guidance Will Help Health Care Providers Form Procompetitive ACOs and Protect Health Care Consumers from Higher Prices and Lower Quality Care* (Oct. 20, 2011)(On file at http://www.justice.gov/atr/public/press_releases/2011/276482.htm)

⁶⁵ Notice by Federal Trade Commission and Antitrust Division, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, Federal Register: The daily Journal of the United States Government (April 19, 2011) available at <https://www.federalregister.gov/articles/2011/04/19/2011-9466/proposed-statement-of-antitrust-enforcement-policy-regarding-accountable-care-organizations#h-13>

⁶⁶ Greaney, *Accountable Care Organizations – The Fork in the Road*, *supra* note 54.

⁶⁷ FTC, *Statement of Antitrust Enforcement*, *supra* note 34.

requirement. This safe harbor from mandatory review protects any service provided in PSA including physician specialties, major diagnostics, in & out patient facilities. The PSA is a screening mechanism used by the FTC and DOJ which constitutes the relevant antitrust geographic market, with the intention to evaluate potential competitive problems within a region. Joint ventures with low PSA shares reflect a low risk of an ACO being able to exercise market power and produce anticompetitive fears, while high PSA shares indicate a likelihood of an ACO having exclusivity, market power and ability to drive up prices. Thus, the agencies agree that ACOs with less than 30% PSA shares are unlikely to raise any anticompetitive concerns.⁶⁸

The Agencies agree that through incorporation of the final version of the Policy Statement, that ACOs will not be challenged if classified under a safety zone and will, therefore, no longer require mandatory review, absent extraordinary circumstances. Nevertheless, any ACO that exceeds 50% of the PSA threshold risks mandatory review, with a few exceptions. These exceptions are as follows: first, rural providers who include only 1 physician group practice per specialty for each county that contains at least “isolated rural” zip code, and secondly dominant provider’s limitation, which encompasses ACO’s that exceeds 50% but there are no other ACO providers to compete with within the PSA.⁶⁹

On the other hand, there are ACOs on the spectrum that fall outside the safety zone but below the mandatory review levels of 50%. The FTC developed a list identifying high market power behavior that would subject ACOs to particular level of scrutiny. ACOs can significantly avoid the likelihood of an investigation by: (1) forcing private payers (i.e., insurance companies) to purchase services exclusively from the ACO by restricting their

⁶⁸ FTC, *Statement of Antitrust Enforcement*, *supra* note 34.

⁶⁹ *See Id.*

ability to steer patients to certain providers, such as providers outside the ACO; (2) tying sales of ACO services to sales of non-ACO services, such as requiring private payers to buy non-ACO services from an affiliate of an ACO participant as a condition of being able to buy ACO services; (3) requiring ACO participants to participate exclusively in the ACO (rather than having the ability to contract with insurance companies outside the ACO umbrella); and (4) telling insurance companies that they cannot distribute information about the ACO's costs and quality of care to health plan enrollees.⁷⁰

The FTC and DOJ however, apply “rule of reason” analysis to any ACO participating in the MSSP because the agencies recognize that organizations meeting the MSSP eligibility requirements within a safety zone are likely to be bona fide arrangements intended to improve healthcare quality and costs through collaboration.⁷¹ Under the rule of reason analysis, anti-competitive effects of collective negotiations weigh against pro-competitive efficiencies that result from concerted activities among provider network members (*e.g.*, cost savings and quality improvement).⁷² Without a rule of reason analysis, collective negotiations and fee agreements are *per se* illegal under the antitrust laws.⁷³ Furthermore, the rule of reason applies equally to joint ventures that accommodate

⁷⁰ HHS, *Medicare Program; Medicare Shared Saving Program Accountable Care Organizations*, *supra* note 36.

⁷¹ R. Brent Railings, McGuire Woods LLP, *Agencies Issue Final Antitrust Guidance for Medicare ACO's*, ABA Health eSource (December 2011)

http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_12_11_aco_rawlings.html (last visited March 29,2012) (The key differences between the final and Proposed statements include is The Final Statement explains treatment of ACOs participating in the MSSP, but anticompetitive issues regarding antitrust enforcement still remain: Final Statement only applies to ACOs with a valid MSSP agreement with CMS; ACO agreements with CMS are subject to termination for failure to meet the criteria set forth by CMS and such a loss means potential antitrust actions against the provider. Significant modifications in an ACO's composition can remove it from the safety zone).

⁷² Gregory J. Pelnar and Gretchen M. Weiss, “Rule of Reason Analysis for Accountable Care Organizations” The Antitrust Source (December 2011)

http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/dec11_pelnar_12_21f.authcheckdam.pdf (last visited 3/29/2012)

⁷³ Railings, *Agencies Issue Final Antitrust Guidance for Medicare ACO'*, *supra* note 71.

commercial payors, as long as provider maintains the requisite governance structure and clinical process similar to that employed in the MSSP.

V. Dynamic Scenario

Despite these safeguards provided by the Agencies, excessive market power remains obtainable by ACOs, and counteract the objective of market defragmentation. In encouraging participants to collaborate by incentivizing care providers to join forces, consolidation in the forms of mergers, joint ventures, and alliances undoubtedly exacerbate anti-competitive concerns. Furthermore, a substantial body of economic evidence indicates that market concentration has been a major factor spurring escalation in the cost of health insurance.⁷⁴ Studies show that hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.⁷⁵

ACOs utilize a 3 year contract⁷⁶, in which providers must abide by the regulations and performance measures set forth by the ACA and CMS, but the long term effects of ACOs are still unknown. How much enforcement power will federal safe harbors have on ACO market dominance 10 years down the road? The dynamic scenario analysis attempts to illustrate the effects changes in the environment will have on the model outcome. Just as the potential exists for ACOs to naturally become anti-competitive, the same potential

⁷⁴ See Greaney, *Accountable Care Organizations – The Fork in the Road*, *supra* note 34.

⁷⁵ See *Id.*; Amy Vaughan, Alberto Coustasse. (2011) *Accountable Care Organization Musical Chairs: Will There Be a Seat Remaining for the Small Group or Solo Project?*. *Hospital Topics* 89:4, 92-97 available at <http://www.tandfonline.com/doi/abs/10.1080/00185868.2011.627814>

⁷⁶ Patient Protection and Affordable Care Act 3022, 124 Stat. at 395–99; also *see supra* note 34. (The Affordable Care Act requires an ACO that wishes to participate in the Shared Savings Program to enter into an agreement with CMS for not less than three years.)

exists for driving up prices and lowering the quality of care as dominate providers that are *per se* anti-competitive or subject to mandatory FTC review. However, that antitrust laws do not reach every corporation or entity that has attained a dominant position in the marketplace by simply being the best, or even just by being lucky. Antitrust laws intend to promote and protect robust competition, not to punish big companies merely on account of their size, nor have antitrust laws ever been anti-market or anti-business in their underlying conception.⁷⁷ Ultimately, antitrust issues occur and subsequently investigated when buyers or sellers, more so in the case of sellers than buyers, raise prices as a result of a merger in a narrowly defined market.⁷⁸ In defining these relevant markets, the Agencies focus primarily on the alternatives available to consumers in the face of a decrease in the price paid by a hypothetical monopsonist.⁷⁹ The commentary to the Horizontal Merger Guidelines specified horizontal mergers are likely to lessen competition substantially through coordinated interaction if it creates likelihood that, after the merger, competitors would coordinate their pricing or other competitive actions, or would coordinate them more completely or successfully than before the merger.⁸⁰

An ACO achieves market dominance despite the FTC safe harbors in several scenarios. The first scenario centers on the idea of natural competition, an objective at the heart of PPACA and the objective in including ACOs in the passage of the Congressional Bill. Competition embodies the concept that poorly run companies are forced out of

⁷⁷ Thomas M. Jorde and David J. Teece, *Innovation, Dynamic Competition and Antitrust Policy*, Cato Review of Business and Government, 43 (Fall 1990)

⁷⁸ Peter C. Casrtensen, *Buyer Power and Merger Analysis – The Need for Different Metrics*, Workshop on Merger Enforcement by FTC (Feb. 17, 2004)

⁷⁹ Federal Trade Commission and U.S Department of Justice, *Horizontal Merger Guidelines*, (August 19, 2010) <http://www.justice.gov/atr/public/guidelines/hmg-2010.html#12> (The Horizontal Merger Guidelines, like the Antitrust enforcement policy, is one of the few acts in which the federal government has carved out antitrust safety zones.)

⁸⁰ Federal Trade Commission and Department of Justice, *Commentary on Horizontal Merger Guidelines*, (March 2006) <http://www.justice.gov/atr/public/guidelines/215247.htm#17>

business. The result of natural competition causes fixed cost of services to become so high that it is not profitable for a second firm to enter and compete.⁸¹ An established small-scale organization or large-scale organization trying to break into the service area lacks efficiency and ultimately fails because competition has had an adverse effect. The quality measures which PPACA wishes to impose on providers in order to facilitate transparency and promote integration contribute to this problem, having a negative effect on competition within a PSA. The availability of information to the public regarding CMS quality measures, performance and other data potentially leads to patients choosing the higher quality ACO over the less prominent. This possibility allows the dominant provider to raise prices and enforce bargaining power because that specific ACO knows individual patients will choose them over other less prominent ACOs.

A second scenario involves the concept of “Too big to fail.” ACOs concentrate more and more power in fewer organizations, allowing them to become “Too big to fail.”⁸² These large groups of providers classified as “too big to fail” will have increased leverage with payers; or, without effective competition, they receive little incentive to reduce spending or improve quality of care.⁸³ Eligibility requirements suggest they favor larger more complex organizations and place a burden on small to mid-size practices. Groups of independent practitioners as well as other types of small and mid-sized practices may lack the

⁸¹ Ben W.F. Depoorter, *Regulation of Natural Monopoly*, Center for Advanced Studies in Law and Economics, 498- 502 available at <http://encyclo.findlaw.com/5400book.pdf>; also see Fred E. Foldvary, *Natural Monopolies*, Progress Report (1999) <http://www.progress.org/fold74.htm>

⁸² Rita Numerof, Ph.D., *Why Accountable Care Organizations Won't Deliver Better Health Care - and Market Innovation Will*, Backgrounder published by The Heritage Foundation, No. 2546 (April 18, 2011) available at http://thf_media.s3.amazonaws.com/2011/pdf/bg2546.pdf reprinted in The Institute for Health Care Consumerism at http://www.theihcc.com/en/communities/health_plans_managed_care/why-accountable-care-organizations-won't-deliver-b_gmy42ph1.html?s=6sU0EWur4Ntujdix

⁸³ Oliver E. Williamson, *Economies as an Antitrust Defense: The Welfare Tradeoffs*, 58 *Am. Econ. Rev.* 18, 24, 28–32 (1968), available at http://www.encore.nl/documents/Williamson_Welfare.pdf

infrastructure, Internet technology, or other resources needed to qualify and succeed on their own. Also, smaller, entrepreneurial organizations that want to venture alone may find themselves competing against similar physicians' practices that have joined ACOs or have been acquired by larger organizations and as a result, will be under less financial and clinical pressure to improve efficiency and quality than the smaller newcomer.⁸⁴

VI. Why Preemption is an inferior protection

Although PPACA appears to achieve the benefits it has advanced for Medicare and its beneficiaries by means of vertical integration, it inevitably invites horizontal integration that creates new market power in private markets. ACOs, therefore, should be subject to close antitrust scrutiny.⁸⁵ With these relaxed enforcement guidelines, including safety zones, the possibility of ACOs gaining exceptional market power could be apparent only several years after inception. Are patients then left powerless, subject to the will of the provider and deprived of any remedy? Opponents of state intervention support their position by the fact that states seldom bring anticompetitive actions and only rarely file consumer protection actions.⁸⁶ In six of the seven service areas with a market concentration of health insurers, no significant consumer action was taken against health insurers.⁸⁷ State

⁸⁴ Numerof, *Why Accountable Care Organizations Won't Deliver Better Health Care - and Market Innovation Will*, *supra* note 82.

⁸⁵ Robert P. Charrow and Nancy E. Taylor, *ACO: The Real Journey Begins*, *National Law Review* (April 11, 2011)

⁸⁶ Press Release, David Balto and Stephanie Gross, *Unlocking Competition: the need to Eliminate the antitrust exemption for health insurers*, Center for American Progress (October 28, 2009) http://www.americanprogress.org/issues/2009/10/pdf/unlocking_competition.pdf (Last Visited 5/3/12)

⁸⁷ See *Id.* at 2.; Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses." (Suits are rarely brought for enforcement actions for market concentration. In six of the seven most concentrated markets for health insurance—Rhode Island, Alabama, Maine, Alaska, Hawaii, and Montana—the state Department of Insurance has taken no significant consumer protection actions against health insurers in the past five years.)

laws fail to rise to the level of substitutes for federal antitrust and consumer protection laws.⁸⁸

Congress, however, directly or indirectly addressed this concern when drafting the preemption laws of the ACA. HHS clarified that ACOs are not preempting any state laws or state law requirements and “to the extent that State law affects an ACO's operations, we expect the ACO to comply with those requirements as an entity authorized to conduct business in the State. These preemption provisions set a federal floor under which state law cannot go. “We do not believe it is necessary to make ACOs attest to do what they otherwise would be required to do under State law.”⁸⁹ Hence, federal laws supercede state laws below the standards or which set lower standards than those established in PPACA. This drafting of the preemption clause allows the states’ laws to supplement, duplicate and even strengthen federal law to the States particular liking.⁹⁰ State power, essentially, protects the rights of its patients and provides the overall best chance of success for ACOs within its borders. State enforcement plays an important role in improving the quality of health care services and lowering health care costs by encouraging integrated health care systems.⁹¹

In addition to congressional intent, the Supreme Court held in Parker v. Brown, that states have the ability to grant immunity as a defense to parties in violation of federal antitrust claims as long as the parties are acting (1) pursuant to clear articulated and

⁸⁸ See Press Release, David Balto and Stephanie Gross, *Unlocking Competition: the need to Eliminate the antitrust exemption for health insurers*, Center for American Progress (October 28, 2009)

http://www.americanprogress.org/issues/2009/10/pdf/unlocking_competition.pdf

⁸⁹ HHS, *Medicare Program; Medicare Shared Saving Program Accountable Care Organizations*, *supra* note 36.

⁹⁰ Tess J. Ferrera, PowerPoint Presentation, *The Dangers of State Oversight in Health Care Reform: Where is ERISA Preemption*, available at <http://www.dccaptives.org/files/public/ferrera.pdf>

⁹¹ See Litten. *ACOs: Getting More for Less?* *supra* note 28.

affirmatively expressed state policy and (2) that the state is engaged in the active supervision of the conduct.⁹² If states have the ability to grant immunity, they likewise retain power to restrict conduct and impose more severe regulations that are required under the federal safe harbors.

Private antitrust lawsuits and State antitrust claims provide a second level of protection against ACOs that can qualify for a safety zone and subject ACOs to a heightened level of scrutiny far more burdensome than federal law. With regards to State lawsuits, State Attorney Generals (AG) bear the authority to enforce federal and state antitrust laws. State AGs have merger enforcement authority under their state antitrust statutes and under the Clayton Act.⁹³ Typically, states investigating a matter arising under the federal antitrust laws jointly investigate with either the DOJ or the FTC, or they conduct a separate investigation.⁹⁴ In addition, state attorneys general retain authority to seek restitution on behalf of the citizens of their states that have been harmed as a result of violations of either the federal or state antitrust laws.⁹⁵ State antitrust enforcement generally focuses on the interests of consumers and the proprietary interests of the states. Generally, state attorneys general possess the authority to protect the state's consumers, the

⁹² Taylor Burke, Lara Cartwright-Smith, Erica Pereira and Sara Rosenbaum, *The Antitrust aspects of Health Information Sharing by Public and Private Health Insurers*, The Bureau of National Affairs, Inc., BNA's Health Law Reporter, Vol. 18, No. 29 (July 23, 2009) <http://www.rwjf.org/files/research/leglabarriersantitrustanalysis.pdf>

⁹³ States can file antitrust suits under state statutes, e.g., N.Y. Gen. Bus. Law Section 342, and federal statutes because states and their political subdivisions are considered "persons" under Section 4 of the Clayton Act, 15 U.S.C. Section 15. *Georgia v. Pennsylvania R.R. Co.*, 324 U.S. 439 (1945). States can also file for injunctive relief under Section 16 of the Clayton Act, 15 U.S.C. Section 26, or as *parens patriae* for actual or threatened harm to their general economy. *Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972). Robert Hubbard and Sondra Roberto, "State Merger Enforcement" New York Office of the Attorney General, Antitrust Bureau New York, NY. Sedona Conference Journal 6 Sedona Conf. J.1 (Fall, 2005)

⁹⁴ Washington State Office of Attorney General, *Guide to Antitrust Laws*, available at <http://www.atg.wa.gov/antitrustguide.aspx>

⁹⁵ *Id.*

state's proprietary interests, and the general welfare and economy of the state.⁹⁶ The bulk of the State's involvement deals with local price-fixing, price maintenance and mergers of entities dealing specifically with public establishments.⁹⁷ The Supreme Court in *California v. American Stores Co.*⁹⁸ and lower federal courts in other cases, recognized that antitrust enforcement decisions by federal officials do not preclude state enforcers from taking an entirely different course of action.⁹⁹ Professor Casalino, a strong proponent of ACOs, recommends the Agencies use antitrust regulations to weed out sham organizations, who are trying to obtain the benefits of MSSP without complying with CMS, or well-meaning incompetent organizations that are certain to fail.¹⁰⁰

Over recent years, there have been several cases in which States took charge and filed antitrust claims, particularly in the context of healthcare mergers, despite the lack of federal involvement. One case in particular, *California v. Sutter Health Care Sys.*, demonstrated a joint investigation between the FTC and State officials may arrive at completely different conclusions moving forth with the matter.¹⁰¹ The Attorney General decided to pursue the claim challenging hospital mergers and successfully did so. Similarly, in New York after investigation by the DOJ antitrust division produced no action, the State Attorney General successfully unwinded a price-fixing arrangement

⁹⁶ Robert Hubbard and Sondra Roberto, "State Merger Enforcement" New York Office of the Attorney General, Antitrust Bureau New York, NY. *Sedona Conference Journal* 6 Sedona Conf. J.1 (Fall, 2005)

⁹⁷ Joel I. Klein, Assistant Attorney General U.S. Department of Justice, *State Antitrust Enforcement*, (June 5, 2003)

<http://www.nysba.org/Content/ContentFolders4/CommercialandFederalLitigationSection/ComFedReports/StateAntitrustEnforcementReport.pdf>

⁹⁸ *California v. American Stores Co.*, 495 U.S. 271 (1990)

⁹⁹ See Klein, *State Antitrust Enforcement*, *supra* note 97.

¹⁰⁰ Andrew A. Kasper, Comment, *Antitrust Review of Accountable Care Organization: An Assessment of FTC and DOJ's Relaxed Approach to Regulating Physician-Hospital Networks*, 90 N.C. L. Rev. 203 (2011)

¹⁰¹ *California v. Sutter Health Care Sys.*, 84 F.Supp.2d 1057 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000)

between New York hospitals.¹⁰² As with the case of ACOs, federal antitrust authorities declined to take action in investigating and pursuing mergers of service providers who meet the MSSP criteria and fall within the safe harbors.

The ability for States to play a vital role in the antitrust enforcement shines through in the passage of past bills of legislation. In enacting the Hart-Scott-Rodino Act, which granted States the power to seek monetary relief as well as injunctive relief, congress envisioned that states would supplement federal antitrust efforts by tackling anticompetitive practices in areas the federal government had neither the resources nor the expertise to investigate.¹⁰³ The support of state involvement serves as recognition that the States have different levels of concern and focus than their federal counterparts. Although consolidation of providers to form ACO in a specific rural region might not have an overall effect on the health care market at a federal level, individual citizens of a State might be burdened. Without such action by the State Attorney Generals, ACOs retain excessive market power, creating hardships, and defeating the objectives of ACOs. Additionally state antitrust laws assist because the FTC and DOJ possess limited resources to investigate every formation of an ACO and determine if, despite falling in a safe harbor the ACO is still exhibiting pro-competitive effects. For example, if the FTC exhibits the competitiveness of large scale Hospitals (A) and (B), the FTC might decide that, based on constraints, it cannot look into the competitive restraints of smaller more local concerns.¹⁰⁴

¹⁰² *NY v. Jones*, 862 F.Supp. 1030 (S.D.N.Y), aff'd without published opinion

¹⁰³ H.R. Rep. 94-499, The Hart-Scott-Rodino Antitrust Improvements Act of 1976, at 3, *reprinted at* 1976 U.S.C.C.A.N. 2572) (1977) ("H.R. Rep.").

¹⁰⁴ Joshua Ratner, *Conflicting Federal and State Enforcement of Federal Antitrust Law: Statutory Crises or Celebration of Diversity?*, Multi Litigation Seminar Project February 2, 2001, (available at Columbia Law School student papers)

http://www.law.columbia.edu/center_program/ag/resources/Library?exclusive=filemgr.download&file_id=9

The DOJ or FTC might decide not to bring a challenge or a complaint because they deem the matter too local or otherwise small in scope to expend the federal government's limited resources.¹⁰⁵

CONCLUSION

ACOs possess the potential to remedy the problem of fragmentation within the United States health care system and reduce cost across the board for Medicare beneficiaries and private consumers alike. However, these potential benefits carry with them the associated risk of ACOs obtaining excessive market power, despite potentially qualifying for a federal safe harbor. Antitrust experts express a concern especially when pertaining to consolidation and pooling of funds and/or risks occurring on a horizontal level. As this paper reflects, outcomes that might be efficient when ACOs are first established or during their first three years contract might not produce the desired result years down the road. This concern stands out in areas where there is only one provider for service a large area or in the case where one superior ACO surpasses all competitors, eligibility criteria identified by CMS, and becomes known as the provider everyone wants to use. In either instance, the ACO retains the ability to negotiate substantial price increases, block competition and cause competitive harms that disrupt the benefits that PPACA can provide to the uninsured, underinsured and private consumers of the United States.

Competition serves as the driving force of the marketplace and ensures consumers are adequately protected; health care markets are at their most efficient when competition

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¹⁰⁵ See *id.*

prevails. State involvement assists in accomplishing a significant health care reform. With no clear supremacy clause regarding state enforcement of antitrust laws, PPACA has provided an opportunity for States to strengthen antitrust protection against ACOs that might potential raise anticompetitive concerns. In addition to the oversight of CMS, HHS and FTC, State enforcers continue to function as a legitimate second level of safeguard to give ACOs the best chance of success. Subjecting providers to stronger antitrust scrutiny and enforcement of fraud will provide a necessary check on the negative effects that could result from ACO formation years down the road.