

# RULE OF REASON WITHOUT A RHYME: USING “BIG DATA” TO BETTER ANALYZE ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM

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*Accountable Care Organizations (ACOs), a major component of the Affordable Care Act, seek to provide patients with better quality health care at a lower cost and have been praised for their ability to help repair our country’s broken health care system. Despite their potential benefits, however, ACOs also raise significant antitrust concerns—concerns that may pit consumer surplus and total surplus against one another. In an attempt to address these concerns, the Department of Justice and Fair Trade Commission announced that they will use market share screens and rule of reason treatment to evaluate ACOs participating in the Medicare Shared Savings Program. The use of market share screens and rule of reason treatment allows the antitrust agencies to avoid prioritizing either consumer surplus or total surplus in the first instance but leaves open two critical questions: What will the rule of reason treatment afforded to ACOs look like? And how will the antitrust agencies ultimately determine whether ACOs benefit or harm consumers? In order to address these questions, this Note proposes that the antitrust agencies use the “big data” collected under the Affordable Care Act to conduct a structured rule of reason review of ACOs that takes into account both the consumer surplus and total surplus through a burden-shifting framework.*

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INTRODUCTION

“Consumer welfare” is largely accepted as the guiding principle behind the application of United States antitrust law.<sup>1</sup> “Judges have spoken of antitrust law as a ‘consumer welfare prescription’ for so long that the phrase seldom produces anything but yawns.”<sup>2</sup> As one scholar has explained, “[i]f ‘consumer welfare’ is to be the goal of antitrust, who could be against it?”<sup>3</sup>

Despite its prominence, “[t]he term consumer welfare is the most abused term in modern antitrust analysis.”<sup>4</sup> Scholars, attorneys, and judges sharply disagree about how exactly consumer welfare is defined and exactly what interests antitrust law should protect.<sup>5</sup> Two main camps have developed. To some, consumer welfare measures the effects of anticompetitive conduct on consumer prices in a particular market—it seeks to protect consumer surplus.<sup>6</sup> To others, consumer

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<sup>1</sup> See Barak Y. Orbach, *The Antitrust Consumer Welfare Paradox*, 7 J. COMPETITION L. & ECON. 133, 133 (2010) (“All antitrust lawyers and economists know that the stated instrumental goal of antitrust laws is ‘consumer welfare . . . .’”); J. Thomas Rosch, *Monopsony and the Meaning of “Consumer Welfare”: A Closer Look at Weyerhaeuser*, 2007 COLUM. BUS. L. REV. 353, 353 (“Today, there is at least a consensus over basic terminology. Courts and federal law enforcement officials routinely invoke ‘consumer welfare’ as the guiding principle behind their application of the antitrust laws.”).

<sup>2</sup> HERBERT HOVENKAMP, *THE ANTITRUST ENTERPRISE: PRINCIPLE AND EXECUTION* 31 (2005).

<sup>3</sup> Harry First, *No Single Monopoly Profit, No Single Policy Prescription?*, 5 COMPETITION POL’Y INT’L 199, 200 (2009). As First notes, “[t]he real issues come when one tries to get behind the label to see what its user has in mind.” *Id.*

<sup>4</sup> Joseph F. Brodley, *The Economic Goals of Antitrust: Efficiency, Consumer Welfare, and Technological Progress*, 62 N.Y.U. L. REV. 1020, 1032 (1987).

<sup>5</sup> See *id.* at 1020 (“[E]fficiency and consumer welfare have become the dominant terms of antitrust discourse without any clear consensus as to what they exactly mean.”).

<sup>6</sup> See, e.g., Robert H. Lande, *Wealth Transfers as the Original and Primary Concern of Antitrust: The Efficiency Interpretation Challenged*, 34 HASTINGS L.J. 65, 68–69 (1982) (“Congress intended to subordinate all other concerns to the basic purpose of preventing

welfare captures the impact of behavior on efficiency and societal wealth more broadly—it seeks to protect total surplus.<sup>7</sup>

In some instances, this divide has little practical significance.<sup>8</sup> If behavior undoubtedly harms consumers and decreases both consumer surplus and total surplus, it will be condemned regardless of which standard is adopted. Similarly, if behavior undoubtedly benefits consumers and increases both consumer surplus and total surplus, it will not be condemned regardless of which standard is adopted. In between these two extremes, however, the tension between how to prioritize consumer surplus and total surplus has tremendous importance. The health care market is an increasingly stark example of this tension.

In the health care market, the potential to provide consumers with better quality care at a lower cost<sup>9</sup> and increase consumer surplus is often intertwined with (and sometimes dependent on) the ability of health care providers to become more efficient and increase total sur-

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firms with market power from directly harming consumers.”); Russell Pittman, *Consumer Surplus as the Appropriate Standard for Antitrust Enforcement*, 3 COMPETITION POL’Y INT’L 205, 207 (2007) (arguing that a consumer surplus standard is necessary to achieve consumer welfare); Steven C. Salop, *Question: What Is the Real and Proper Antitrust Welfare Standard? Answer: The True Consumer Welfare Standard*, 22 LOY. CONSUMER L. REV. 336, 338 (2010) (explaining that the consumer surplus standard is the “standard currently used by antitrust agencies and our judicial system”).

<sup>7</sup> See, e.g., Dennis W. Carlton, *Does Antitrust Need To Be Modernized?*, 21 J. ECON. PERSPECTIVES 155, 157 (2007) (“The proper objective of antitrust should be total surplus, not consumer surplus.”); Ken Heyer, *Welfare Standards and Merger Analysis: Why Not the Best?*, 2 COMPETITION POL’Y INT’L 29, 29 (2006) (advocating the use of a total welfare standard in merger analysis).

<sup>8</sup> See Thomas O. Barnett, *Substantial Lessening of Competition—The Section 7 Standard*, 2005 COLUM. BUS. L. REV. 293, 297 (“[T]he consumer welfare and total welfare standards can diverge, although I think it is a rare case in practice.”).

<sup>9</sup> The meaning of “cost” when it comes to health care can be elusive because of the varying parties who may ultimately pay for the care received by a patient (e.g. the provider, the patient, a private insurance company, or the government). This Note assumes that any changes in “cost” will ultimately be passed along to the patient (consumer) in some proportion even if such changes are initially borne by another party. See U.S. DEP’T OF HEALTH & HUMAN SERVS., *CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM* 7 (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf> (explaining that increasing health care costs are ultimately passed on to the “Federal Government—and thus every taxpayer who pays federal income and payroll taxes” to fund Medicare, Medicaid, and other public health care programs); Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 518 (2004) (noting that “insurers base their insurance rates on their expected costs,” which are primarily driven by patient claims); David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 336–37 (2012) (“In recent years, employers and insurers have addressed the rising cost of healthcare by making patients responsible for a larger share of the costs.”).

plus.<sup>10</sup> Nonetheless, there is often no guarantee that the resulting benefits will be passed along to consumers even if health care delivery is made more efficient and total surplus is increased. This places the antitrust agencies in a difficult position when deciding how to regulate behavior that is central to health care reform yet may ultimately prove to be anticompetitive. How should they prioritize consumer surplus and total surplus in the health care industry when such standards are interrelated and possibly contradictory?

This dilemma can be illustrated by examining Accountable Care Organizations (ACOs), a major component of the Patient Protection and Affordable Care Act (Affordable Care Act).<sup>11</sup> ACOs are defined as “clinically integrated organizations of primary care physicians and other providers that, through various payment mechanisms, are rewarded for both raising the quality and lowering the cost of care provided to their patients.”<sup>12</sup> ACOs can take a number of different forms—including integrated or organized delivery systems, multi-specialty group practices, physician-hospital organizations, independent practice associations, and “virtual” physician organizations—and can contract with either private payers or Medicare.<sup>13</sup> Regardless of their form, all ACOs are “legal entit[ies] comprised of and controlled by providers that . . . assume financial responsibility for the cost and care of a defined population” in order to provide better quality health care at a lower cost.<sup>14</sup> In essence, ACOs seek to leverage provider integration and coordination to make health care delivery more efficient.<sup>15</sup>

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<sup>10</sup> See *infra* Part II.A. (discussing health care reform).

<sup>11</sup> 42 U.S.C. § 1395jjj (2012).

<sup>12</sup> Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393, 1393 (2012).

<sup>13</sup> Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293, 1294–95 (2010); see also Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 983 (2010) (“ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations.”). For a description of these various models, see Andrew A. Kasper, *Antitrust Review of Accountable Care Organizations: An Assessment of FTC and DOJ’s Relaxed Approach to Regulating Physician-Hospital Networks*, 90 N.C. L. REV. 203, 220–23 (2011).

<sup>14</sup> Thomas L. Greaney, *Accountable Care Organizations: A New New Thing with Some Old Problems*, 3 HEALTH L. OUTLOOK 6, 6 (2010). Proponents also typically identify three essential characteristics of all ACOs: (1) the ability to provide and manage patient care across various institutional settings, (2) the ability to plan budgets and resource needs, and (3) adequate size to support performance measurement. KELLY DEVERS & ROBERT BERENSON, *CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES?* 1–2 (2009).

<sup>15</sup> See *infra* Part II.A. (examining ACOs and the possibility of health care reform).

If ACOs are successful, the efficiencies they create will be passed along to consumers in the form of lower prices and/or higher quality care. Because of this possibility, ACOs have been praised for their potential to help repair our country's broken health care system.<sup>16</sup> If ACOs are unsuccessful and the efficiencies they create are not passed along to consumers, however, they may lead to higher prices, less variety, and lower quality care.<sup>17</sup> "Antitrust assumes that competition—not coordination—leads to pricing, output, and innovation levels that most benefit consumers. As a general rule, when firms coordinate their activities, they tend to fix prices at a higher level . . . and leverage their combined market power. These activities harm consumers."<sup>18</sup> Given the uncertainty that ACOs create, the antitrust agencies must decide how their enforcement approach will balance consumer surplus and total surplus.

To address these concerns the Department of Justice (DOJ) and Federal Trade Commission (FTC) issued a joint "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program" (ACO Enforcement Statement) in October 2011.<sup>19</sup> This statement outlines the enforcement approach that the agencies will take in analyzing the potential anticompetitive effects of ACOs approved to participate in the Medicare Shared Savings Program.<sup>20</sup> Most significantly, the DOJ and FTC decided to use market share screens and rule of reason analysis to evaluate ACOs participating in the Shared Savings Program.<sup>21</sup> Rule of reason analysis involves a flexible "factual inquiry into an agreement's overall competitive effect . . . and varies in focus and detail depending on the nature of the agreement and market circumstances."<sup>22</sup>

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<sup>16</sup> See, e.g., DEVERS & BERENSON, *supra* note 14, at 9 (noting that the creation of ACOs is "one of the few serious attempts" being made at achieving health care payment and delivery reform); Elliott Fisher, Mark McClellan & Stephen Shortell, *The Real Promise of 'Accountable Care,'* WALL ST. J., Mar. 5, 2013, at A17 ("Accountable care organizations at their heart are about aligning provider financial incentives with patient needs for better health and lower-cost care.")

<sup>17</sup> See *infra* Part II.B. (discussing potential anticompetitive conduct).

<sup>18</sup> Bruce Abramson, *Antitrust Implications for Accountable Care Organizations*, ACCOUNTABLE CARE L. & POL'Y (June 6, 2012), <http://www.accountablecarelaw.org/2012/06/antitrust-implications-for-accountable-care-organizations/>.

<sup>19</sup> 76 Fed. Reg. 67,026 (Oct. 28, 2011) [hereinafter ACO Enforcement Statement].

<sup>20</sup> See *id.* ACOs can be formed to serve private patients, Medicare beneficiaries, or both. The Shared Savings Program was specifically designed to facilitate the creation of ACOs to serve Medicare beneficiaries. See *id.*

<sup>21</sup> *Id.* at 67,027–29.

<sup>22</sup> FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 3 (2000). See also *Cal. Dental Ass'n v. F.T.C.*, 526 U.S. 756, 780–81 (1999) (explaining that rule of reason analysis is applied on a case-by-

This decision allows the antitrust agencies to avoid prioritizing either consumer surplus or total surplus in the first instance. Avoiding such prioritization is appealing given the complicated relationship between consumer surplus and total surplus in the health care industry. Nonetheless, by using market share screens and affording ACOs rule of reason treatment, the ACO Enforcement Statement merely delays the critical examination of ACOs that the antitrust agencies must undertake. Specifically, the ACO Enforcement Statement leaves open two critical questions: What will the rule of reason treatment afforded to ACOs look like, and how will the antitrust agencies ultimately determine whether ACOs benefit or harm consumers?

This Note argues that by leaving open these two critical questions, the ACO Enforcement Statement, as currently formulated, is all bark and no bite. As a solution, this Note proposes that the antitrust enforcement agencies use the “big data” collected under the Affordable Care Act to more adequately monitor the benefits and anticompetitive threats that ACOs create. Specifically, the antitrust agencies should use this data to conduct a structured rule of reason review that takes into account both the consumer surplus and total surplus through a burden-shifting framework.

Part I outlines the current disagreement about the appropriate measure of consumer welfare and explains the impact that this divide can have on antitrust enforcement, particularly within the health care market. Part II examines the formation of ACOs, detailing both the health care benefits they generate and the antitrust concerns they raise. Specifically, this part demonstrates that ACOs create a potential conflict between consumer surplus and total surplus, forcing the antitrust agencies to make difficult enforcement decisions about how to prioritize the two standards. Lastly, Part III argues that the ACO Enforcement Statement does not adequately establish how the agencies will prioritize consumer surplus and total surplus when examining ACOs, but rather delays such analysis without providing sufficient guidance on how it will ultimately be conducted. This Part concludes by proposing that the antitrust agencies use “big data” collected under the Affordable Care Act to help remedy this problem by conducting a structured rule of reason review, taking into account both consumer surplus and total surplus through burden shifting.

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case basis); *Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of the Univ. of Okla.*, 468 U.S. 85, 103–13 (1984) (explaining that the rule of reason analysis requires looking into the details of the case).

# I

## THE CONSUMER WELFARE DEBATE

The underlying goal of United States antitrust law is “consumer welfare,” an uncontroversially worthy purpose.<sup>23</sup> More important, however, is that scholars, attorneys, and judges sharply disagree over how consumer welfare should be defined.<sup>24</sup> The main divide is between those who argue that consumer welfare should mean “consumer surplus” and those who argue that consumer welfare should mean “total surplus.”<sup>25</sup> These two interpretations diverge in a simple, albeit significant, way. Consumer surplus refers solely to the welfare of buyers in a particular market and is largely measured by the price buyers must pay for specific goods.<sup>26</sup> Total surplus, in contrast, refers to the aggregate welfare of buyers *and* sellers in a particular market, irrespective of wealth transfers from one group to the other.<sup>27</sup> Measuring total surplus thus requires consideration of not only the price charged for specific goods but also the cost of producing such goods, which is heavily influenced by changes in efficiency. The key difference between total surplus and consumer surplus is the consideration (or lack thereof) of the producer surplus, which represents efficiencies that are not passed along to consumers.

In the health care industry, this distinction has significant practical implications. The United States spends far more on health care per capita and as a percentage of GDP than any other country.<sup>28</sup> According to the Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services (DHHS), health care costs in the United States totaled \$2.8 trillion in 2012, or \$8915 per person, and are projected to increase by 5.7% per year between 2013 and 2023.<sup>29</sup> One significant factor behind this projected increase is the traditional “fee-for-service” model of health care delivery in the United States, under which providers of health care are

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<sup>23</sup> See *supra* notes 1–3 and accompanying text.

<sup>24</sup> See *supra* notes 4–5 and accompanying text.

<sup>25</sup> See *supra* notes 6–7 and accompanying text.

<sup>26</sup> See ALFRED MARSHALL, PRINCIPLES OF ECONOMICS 124 (8th ed. 1936) (“The excess of the price which [a person] would be willing to pay rather than go without the thing, over that which he actually does pay, is the economic measure of this surplus satisfaction. It may be called *consumer’s surplus*.”).

<sup>27</sup> See *id.* at 487 (stating that the net benefits to the producers and consumers is the total benefit).

<sup>28</sup> DAVID A. SQUIRES, EXPLAINING HIGH HEALTH CARE SPENDING IN THE UNITED STATES: AN INTERNATIONAL COMPARISON OF SUPPLY, UTILIZATION, PRICES, AND QUALITY, COMMONWEALTH FUND 1–3 (2012).

<sup>29</sup> NHE Fact Sheet, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (last modified Dec. 3, 2014, 3:15 PM).

paid a fee for each service performed.<sup>30</sup> This model tends to reward providers for delivering a higher volume of service but does not create significant incentives for providers to coordinate care or otherwise improve patient health.<sup>31</sup> Despite attempts at coordination under the current fee-for-service model, the U.S. health care system remains highly fragmented.<sup>32</sup> Patients in need of care typically see several separate providers,<sup>33</sup> each with their own specialty<sup>34</sup> and each lacking a complete understanding of their patients' medical histories.<sup>35</sup> This fragmentation in the existing system results in more frequent health care delivered at a higher cost and lower quality.<sup>36</sup> Thus, the ability to provide consumers in the health care industry with better quality care at a lower cost is intertwined with (and possibly dependent on) the ability of health care providers to become more efficient.

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<sup>30</sup> Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 288–89 (1995).

<sup>31</sup> See INST. OF MED., *REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 4* (2007) (“The current Medicare fee-for-service payment system is unlikely to promote quality improvement because it tends to reward excessive use of services; high-cost, complex procedures; and lower-quality care.”); McClellan et al., *supra* note 13, at 982 (“The current system, based on volume and intensity, does not disincentivize, but rather pays more for, overuse and fragmentation.”).

<sup>32</sup> See Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44, w55 (2006) (“Many of the deficiencies in U.S. health care are reflections of the disjointed and poorly coordinated care that patients receive as they move across settings and among providers . . .”). For a more detailed examination of the causes of such fragmentation, as well as potential solutions, see generally INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001).

<sup>33</sup> See David A. Hyman, *Health Care Fragmentation: We Get What We Pay for*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 21, 21 (Einer Elhauge ed., 2010) (“A visit to the hospital results in bills from multiple actors—each individually itemized, reflecting the particular goods and services that were provided.”).

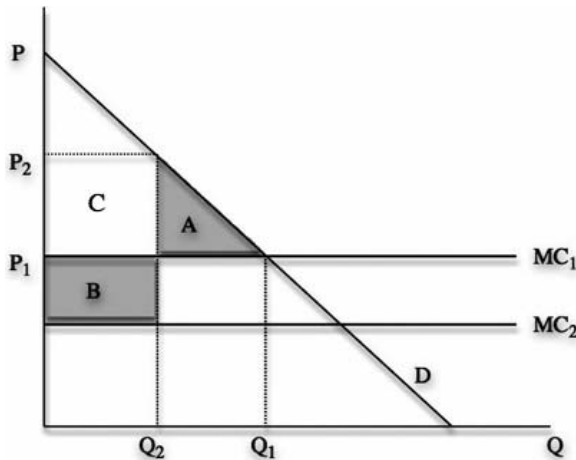
<sup>34</sup> See *id.* at 23 (“[C]are is typically provided by a host of specialists, each focused on the discrete symptoms and/or body parts within their jurisdiction.”); Hoangmai H. Pham et al., *Care Patterns in Medicare and Their Implications for Pay for Performance*, 356 NEW ENG. J. MED. 1130, 1130 (2007) (noting that a typical Medicare beneficiary sees two different primary care physicians and five different specialists in a given year).

<sup>35</sup> See Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 1, 1 (Einer Elhauge ed., 2010) (“Individual decision makers responsible for only one fragment of a relevant set of health care decisions may fail to understand the full picture, may lack the power to take all the appropriate actions given what they know, or may even have affirmative incentives to shift costs onto others.”); Dave Olicker, *Better Coordination vs. Price-Fixing—the Accountable Care Organization Dilemma*, HEALTH CARE PERSPECTIVES (Dec. 7, 2010), <http://mvponhealthcare.wordpress.com/2010/12/07/better-coordination-vs-price-fixing—the-accountable-care-organization-dilemma/> (explaining that the lack of provider collaboration leads to providers knowing less about their patients).

<sup>36</sup> See Fisher et al., *supra* note 32, at w54–w55. See generally Katherine Baicker & Amitabh Chandra, *Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care*, 23 HEALTH AFF. 184 (2004) (examining this dynamic).



If health care reform is successful and newfound provider efficiencies are passed along to consumers in the form of lower prices and/or better quality care, consumer surplus will increase with total surplus. If health care reform creates efficiencies that are ultimately not passed along to consumers, however, the antitrust agencies are forced to make a difficult decision. Under a consumer surplus standard for consumer welfare, conduct is “condemn[ed] . . . if it reduces the welfare of buyers, irrespective of its impact on sellers.”<sup>37</sup> Under a total surplus standard for consumer welfare, however, conduct is condemned “only if it decreases the sum of the welfare of consumers (i.e., buyers) *plus producers* (i.e., sellers plus competitors).”<sup>38</sup> Under a consumer surplus standard, potential benefits that arise from an increase in efficiency created by health care reform are only considered if those benefits pass through to consumers, while under a total surplus standard, such benefits are always considered.<sup>39</sup> The classic Williamson trade-off diagram,<sup>40</sup> reproduced below, illustrates the situation in which these standards can diverge.



For example, consider a hypothetical ACO formed by a hospital and independent physician group. As a result of the joint venture, the previously independent (but now joined) firms may experience an increase in efficiency by eliminating information asymmetries and redundant services or by improving patient coordination. This increase in efficiency gives the ACO the ability to lower costs, as illus-

<sup>37</sup> Salop, *supra* note 6, at 336.

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 336–37 (2010). This important distinction is examined with regard to Accountable Care Organizations *infra* Part II.B.

<sup>40</sup> Oliver E. Williamson, *Economies as an Antitrust Defense: The Welfare Tradeoffs*, 58 AM. ECON. REV. 18, 21 (1968).

trated by a shift from MC1 to MC2, and leads to an increase in the producer surplus, as represented by shaded rectangle B. In addition to their newfound ability to lower costs, however, the hospital and physician group may also obtain the power to raise prices above the precombination level. This price increase, illustrated by a shift from P1 to P2, creates a deadweight loss in consumer surplus (shaded triangle A) and also transfers part of the consumer surplus to the ACO (rectangle C).

When the increase to producer surplus (rectangle B) outweighs the decrease to consumer surplus (triangle A), the ACO increases total surplus and is deemed efficient even though consumers are harmed in the form of higher prices. For purposes of antitrust enforcement, such a combination would be condemned if consumer welfare were defined as consumer surplus, but it would not be condemned if it were instead defined as total surplus—as only the latter standard takes the producer surplus into consideration.<sup>41</sup> Given this significant distinction, determining the appropriate measure of consumer welfare is of primary importance, as it can dictate whether the antitrust agencies should seek enforcement against an ACO. Only after this issue has been settled can the relevant agencies develop a coherent antitrust enforcement regime.<sup>42</sup>

## II

### THE FORMATION OF ACCOUNTABLE CARE ORGANIZATIONS

ACOs are expected to play a large role in improving the nation's health care system by making health care service delivery more efficient. Reformers hope that efficiency gains will lead to better quality care and lower prices for consumers. At the same time, however, ACOs also raise significant antitrust concerns. The increased provider integration necessary to form an ACO may lead to anticompetitive effects and harm consumer surplus. These dueling possibilities place the antitrust enforcement agencies in a difficult position and highlight

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<sup>41</sup> Even if an ACO is deemed “efficient” under a total surplus standard, the antitrust agencies will likely be interested in measuring how much of the consumer surplus is transferred to the ACO, as measured by rectangle C.

<sup>42</sup> See ROBERT H. BORK, *THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF* 50 (1993) (“Antitrust policy cannot be made rational until we are able to give a firm answer to one question: What is the point of the law—what are its goals?”); Roger D. Blair & D. Daniel Sokol, *The Rule of Reason and the Goals of Antitrust: An Economic Approach*, 78 *ANTITRUST L. J.* 471, 474 (2012) (“The welfare standard matters precisely because one cannot undertake a rule of reason analysis without knowing what standard to apply.”).

the importance, for antitrust enforcement purposes, of the decision to prioritize consumer surplus or total surplus when regulating ACOs.

A. *The Possibility of Health Care Reform—Will ACOs Increase Total Surplus?*

As part of a large-scale effort to address the problems in the U.S. health care market, Congress passed the Affordable Care Act,<sup>43</sup> which “seek[s] to improve the quality and reduce the costs of health care services in the United States by, among other things, encouraging physicians, hospitals, and other health care providers to become accountable for a patient population through integrated health care delivery systems.”<sup>44</sup> In passing the Affordable Care Act, Congress recognized that realigning payment incentives and promoting integration among providers is necessary to achieve significant systematic health care reform. Only once these steps have been taken can health care be delivered more efficiently and at a lower cost. These goals motivated one of the key components of the Affordable Care Act, Section 3022, which encourages the formation of ACOs under the Medicare Shared Savings Program.<sup>45</sup>

1. *Accountable Care Organizations Generally*

ACOs can be formed in a number of different ways, ranging from integrated delivery systems to physician-hospital organizations, and they can contract with private payers, Medicare, or both.<sup>46</sup> Regardless of their design, all ACOs are legal entities formed to provide better quality health care at a lower cost.<sup>47</sup> For example, by coming together and coordinating their operations, ACO member providers can create economies of scale, eliminate unnecessary or duplicative procedures, better communicate patient information, and deliver care in innovative ways.<sup>48</sup> Essentially, the hope is that financial incentives will

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<sup>43</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395-99 (2010) (codified as amended at 42 U.S.C. § 1395jjj (2012)).

<sup>44</sup> ACO Enforcement Statement, *supra* note 19, at 67,026.

<sup>45</sup> § 3022, 124 Stat. 119 at 395.

<sup>46</sup> See Shortell et al., *supra* note 13, at 1294-95 (describing ACO models); McClellan et al., *supra* note 13, at 983 (same). For a description of these various models, see Kasper, *supra* note 13, at 220-24.

<sup>47</sup> See DEVERS & BERENSON, *supra* note 14, at 1-2; Greaney, *supra* note 14, at 6 (2010) (stating that the law allows the Secretary of DHHS to implement several alternative methods that will improve quality and efficiency).

<sup>48</sup> Spencer D. Dorn, *Gastroenterology in a New Era of Accountability: Part 3. Accountable Care Organizations*, 9 CLINICAL GASTROENTEROLOGY & HEPATOLOGY 750, 751 (2011); see also David Orentlicher, *Rationing Health Care: It's a Matter of the Health Care System's Structure*, 19 ANNALS HEALTH L. 449, 462 (2010) (“[ACOs] have the ability to coordinate patient care more effectively and to invest in information technology, the

encourage ACOs to invest in provider integration, become more efficient, and deliver better quality care at a lower cost.<sup>49</sup> The formation of ACOs is designed to directly address the fragmentation and incentive problems plaguing the current health care system, a dynamic that can be clarified by examining how an ACO operates in practice.

First, a group of health care providers, taking any one of the forms previously mentioned,<sup>50</sup> comes together and commits to deliver coordinated health care services to a defined population of patients. The providers in this group sign an agreement creating a central management structure, detailing their individual obligations and reporting obligations, and specifying how any bonus payments will be shared.<sup>51</sup> Once the agreement is in place, the ACO central management contracts with payers (such as employers) to deliver health care services to an assigned patient population (such as employees) on behalf of its member providers.<sup>52</sup> As part of each contract, the ACO and payer must agree on one of numerous available payment models, so as to enable the ACO to share in any savings it generates.

Under an asymmetric (“one-sided risk”) model, the ACOs continue to generate fees for each service provided.<sup>53</sup> The ACO and payer negotiate a cost target based on past health care spending by the ACO’s assigned patient population, and if the cost of health care provided by the ACO to that same population is less than the target by a certain percentage, the ACO splits the savings with the payer by a designated ratio (e.g., 80:20).<sup>54</sup> Under this model, spending above the target does not engender any penalties, and the ACO bears no burden if costs rise.<sup>55</sup> Under a symmetric (or “two-sided risk”) shared savings model, in contrast, the ACO is entitled to share in a larger proportion of the cost savings it generates by agreeing to face penal-

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development of patient management protocols, and other initiatives that can yield more cost-effective care.”).

<sup>49</sup> See ACO Enforcement Statement, *supra* note 19, at 67,026 (stating that the Affordable Care Act creates the Medicare Shared Savings Program which promotes the use of integrated health care providers through ACOs, and that ACOs can share in the savings).

<sup>50</sup> See *supra* note 13 and accompanying text.

<sup>51</sup> Dorn, *supra* note 48, at 750.

<sup>52</sup> *Id.* at 751. Significantly, while the specific population for which each ACO will be held accountable must be defined, patients are free to see providers outside of the ACO. *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> For this reason, some critics have argued that the asymmetric model does not provide adequate financial incentive for an ACO to improve quality and reduce unnecessary services. *E.g.*, Robert A. Berenson, *Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?*, 16 AM. J. MANAGED CARE 721, 722 (2010).

ties in the event that costs rise.<sup>56</sup> Regardless of which payment model is selected, the ACO member providers now have at least some incentive to be more efficient and lower the cost of the health care services they provide.

## 2. *Accountable Care Organizations Under the Medicare Shared Savings Program*

Health care reformers are particularly interested in the potential for ACOs that choose to participate in the Shared Savings Program. This program, established by Section 3022 of the Affordable Care Act, was specifically designed to promote the formation of ACOs to serve Medicare fee-for-service beneficiaries.<sup>57</sup> The Shared Savings Program provides that “groups of providers of services and suppliers meeting criteria specified by the [DHHS] Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an [ACO].”<sup>58</sup> CMS published a final rule detailing such criteria on November 2, 2011.<sup>59</sup>

Under the final rule, prospective ACOs must satisfy numerous governance, quality, and accountability requirements to participate in the Shared Savings Program.<sup>60</sup> Specifically, to receive bonuses for shared savings, an ACO must establish a formal management struc-

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<sup>56</sup> Dorn, *supra* note 48, at 751. Proponents of the symmetric model have argued that the desire to avoid penalties and receive greater financial rewards provides a more significant incentive for ACOs to lower costs. *Id.* A third alternative model—partial capitation—is also a possibility. Under this model, an ACO would receive a mix of fee-for-service payments and prospective lump-sum payments that are paid out regardless of the quantity of care provided, thereby creating even greater financial incentives for lowering costs. *Id.*

<sup>57</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395–99 (2010) (codified as amended at 42 U.S.C. § 1395jjj (2012)). In addition to the Shared Savings Program, CMS has also established a Pioneer ACO Model for those organizations that already have experience operating as ACOs or are already experienced in coordinating care for patients across care settings. CTRS. FOR MEDICARE & MEDICAID SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL: GENERAL FACT SHEET (2012) [hereinafter PIONEER ACO MODEL FACT SHEET], <http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>. ACOs participating in this program will receive a greater financial reward for the cost savings they generate but will also assume a greater financial risk than ACOs under the Shared Savings Program. *Id.* Additionally, in year three of the Pioneer ACO Model, participating ACOs that have demonstrated a specified level of savings over the previous two years will be eligible to receive a monthly per-beneficiary payment in lieu of part or all of the ACO’s normal fee-for-service payment. *Id.* Thirty-two ACOs were selected to participate in this program. *Id.*

<sup>58</sup> § 3022, 124 Stat. at 395.

<sup>59</sup> Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802 (Nov. 2, 2011) [hereinafter CMS Final Rule]. The eligibility criteria are now published at 42 C.F.R. §§ 425.100–.114 (2013).

<sup>60</sup> These requirements resemble those applicable to ACOs formed to contract with private payers.

ture,<sup>61</sup> have the capacity to care for a minimum of five thousand Medicare beneficiaries,<sup>62</sup> and agree to participate in the program for at least three years.<sup>63</sup> Furthermore, an ACO must implement procedures to promote efficient health care delivery and must publicly report its performance,<sup>64</sup> ensuring that enumerated “patient-centeredness criteria” are satisfied.<sup>65</sup> Medicare will continue to pay individual providers who participate in the Shared Savings Program under a fee-for-service model, but the final rule allows an ACO to choose either an asymmetric or a symmetric shared savings model in order to encourage the formation of ACOs among organizations with varying levels of experience and varying appetites for risk.<sup>66</sup>

Although Section 3022 of the Affordable Care Act was designed to increase coordination and lower health care costs specifically for Medicare beneficiaries, Congress envisioned broader reform. Congress recognized that ACOs were better positioned to transform the health care system if they were accepted by commercial insurers and employers, and therefore designed the Shared Savings Program to facilitate ACO expansion into the private sector as well.<sup>67</sup> As a result, ACOs quickly moved to begin contracting with both Medicare and private payers. As of February 2013, it was estimated that over half of the U.S. population lives in localities served by an ACO, and between 37 million and 43 million patients, or about 14% of the U.S. population, now receive care from providers participating in ACOs.<sup>68</sup> Those ACOs that contract with both Medicare and private payers have the greatest potential to increase total surplus and reform the health care system.

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<sup>61</sup> § 425.108(a).

<sup>62</sup> § 425.110.

<sup>63</sup> § 425.200(a).

<sup>64</sup> § 425.308.

<sup>65</sup> § 425.112. These criteria include promoting evidence-based medicine, promoting patient engagement, and communicating to patients in a way that is understandable to them. *Id.*

<sup>66</sup> PIONEER ACO MODEL FACT SHEET, *supra* note 57. Significantly, any ACO participating in the Shared Savings Program that selects the asymmetric risk model in their initial contract must shift to the symmetric risk model in future contracts if they wish to continue participating in the Shared Savings Program. § 425.600(b).

<sup>67</sup> Thomas L. Greaney, Regulators as Market-Makers: Accountable Care Organizations and Competition Policy 6 (July 30, 2012) (unpublished manuscript) (on file with the New York University Law Review).

<sup>68</sup> Press Release, Oliver Wyman, Accountable Care Organizations Now Serve 14% of Americans (Feb. 19, 2013), [http://www.oliverwyman.com/media/ACO\\_press\\_release\(2\).pdf](http://www.oliverwyman.com/media/ACO_press_release(2).pdf).

*B. The Possibility of Anticompetitive Conduct—Will ACOs Decrease Consumer Surplus?*

Although ACOs may address some of the major cost and quality issues plaguing the current health care system, they also raise significant antitrust concerns. The promise of ACOs relies directly on more closely integrating health care service delivery and increasing coordination among individual health care providers.<sup>69</sup> Increasing coordination among otherwise independent competitors, however, can generate anticompetitive effects. Specifically, ACOs raise the potential for at least three major forms of anticompetitive conduct: horizontal price-fixing and price collusion, undue market concentration and market power, and cost shifting.

CMS can terminate an ACO's participation in the Shared Savings Program for any violation of antitrust law,<sup>70</sup> but potential violations will be difficult to anticipate when CMS conducts its initial review of an ACO's eligibility for the program. This forces the DOJ and FTC to closely monitor the anticompetitive effects ACOs may create, placing them in the difficult position of both promoting health care reform (the overarching goal of the Affordable Care Act) and protecting consumers (the traditional goal of antitrust enforcement).

*1. Horizontal Price-Fixing and Price Collusion*

The most direct form of anticompetitive conduct encouraged by the formation of ACOs is horizontal price-fixing. Horizontal price-fixing occurs when "competitors selling the same products or services in the same or overlapping geographic markets[ ] agree, either directly or through a common agent negotiating on their behalf, on the prices they will charge for their products or services."<sup>71</sup> Although horizontal price-fixing is a concern any time there is a combination between competing firms, this concern is exacerbated in the case of ACOs because ACO member providers are by definition encouraged to share information and collaborate with one another on issues that may include price.<sup>72</sup> Such collaboration is the touchstone of the ACO movement and is designed to foster innovation and efficiency in health care delivery. Because ACOs ordinarily comprise otherwise independent competing providers, however, this collaboration may also incentivize

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<sup>69</sup> See *supra* notes 46–49 and accompanying text (describing the basic structure and fundamental aims of ACOs).

<sup>70</sup> § 425.218(b).

<sup>71</sup> Patricia M. Bruns, Symposium Comment, *An Antitrust Analysis of Accountable Care Organizations: Potential Abuses from Allowing Reduced Scrutiny Under the Affordable Care Act*, 28 J. CONTEMP. HEALTH L. & POL'Y 268, 271 (2012).

<sup>72</sup> See *supra* notes 46–49 and accompanying text.

providers to fix prices when negotiating contracts with commercial health plans.<sup>73</sup>

For example, consider a hospital and a general physician group that have joined together to form an ACO. In order to receive the largest bonus possible, the ACO is encouraged to increase integration and capitalize on newly available efficiencies. This can be achieved by sharing patient records, best practices, and other information about how each provider operates. Amidst all of this coordination, providers will be tempted to mutually set the prices they charge for specific services. Such an agreement would allow the providers to push prices beyond their competitive level, transferring to them some of the consumer surplus.

Given that any “combination formed for the purpose and with the effect of raising, depressing, fixing, pegging or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se” under the Sherman Act,<sup>74</sup> some might argue that ACOs will be sufficiently deterred from engaging in such behavior. Even if ACO member providers do not engage in express horizontal price-fixing, however, incentives abound for such providers to negotiate jointly with private payers and engage in price collusion. This type of conduct could raise anticompetitive concerns similar to horizontal price-fixing, but it would not be as easily detectable and might even be permitted under antitrust laws.<sup>75</sup>

For example, individual ACO member providers may agree to have all payment offers made to them by private payers forwarded to the ACO’s central management. Instead of having to bargain as individual providers, the ACO could use this information to negotiate with private payers as a single entity. While each ACO member provider would still be paid individually for the health care services it provides, the price would be uniformly set. This would give the ACO significant bargaining leverage in the negotiation process and could lead to higher prices.<sup>76</sup>

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<sup>73</sup> *E.g.*, Bruns, *supra* note 71, at 271–72.

<sup>74</sup> *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). Despite this general principle, ACOs participating in the Shared Savings Program are actually afforded rule of reason treatment. *See infra* Part III.2.A. (discussing potential concerns surrounding the DOJ and FTC’s decision to treat ACOs as such).

<sup>75</sup> *See* U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 49–52 (1996) [hereinafter HEALTH CARE ENFORCEMENT STATEMENT], <http://www.justice.gov/atr/public/guidelines/0000.pdf> (discussing antitrust safety zones for provider participation in exchanges of price and cost information).

<sup>76</sup> *See id.* at 129 (discussing physician joint ventures and the anticompetitive risk of uniform prices).



If individual ACO member providers were unsatisfied with the jointly negotiated price, they may or may not be allowed to negotiate individually with the private payer once the ACO joint negotiation has ceased, depending on the scope of the initial ACO agreement. Even if member providers are allowed to negotiate individually after the ACO joint negotiation has ceased, providers might still use the price data they were given about the other members (or simply use the ACO negotiated price) in determining the individual prices they will charge when operating outside of the ACO.<sup>77</sup> This could similarly lead to higher prices than the normal situation in which ACO member providers would be forced to negotiate completely independently.

Because CMS administratively sets provider reimbursement rates for Medicare patients,<sup>78</sup> horizontal price-fixing and price collusion do not pose significant concerns with regard to those ACOs formed solely to participate in the Shared Savings Program. Nonetheless, the Affordable Care Act seeks to promote ACOs that will contract with both Medicare and private payers, and many ACOs are expected to operate in both markets.<sup>79</sup> Given this reality, the antitrust agencies must recognize that even those ACOs participating in the Shared Savings Program can pose a heightened risk of horizontal price-fixing and price collusion.

## 2. *Undue Market Concentration and Provider Market Power*

Because ACOs “encourage some mergers, joint ventures, and alliances” that otherwise would not take place, there is also a significant concern that ACOs may unduly increase health care market concentration and thereby increase provider market power.<sup>80</sup> Greater

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<sup>77</sup> See Douglas C. Ross & Charles S. Wright, *FTC to Give Antitrust Guidance on ACOs; Providers Can Prepare Now Using Existing Law*, DAVIS WRIGHT TREMAINE LLP (Sept. 28, 2010), [http://www.dwt.com/advisories/FTC\\_to\\_Give\\_Antitrust\\_Guidance\\_on\\_ACOs\\_Providers\\_Can\\_Prepare\\_Now\\_Using\\_Existing\\_Law\\_09\\_28\\_2010/](http://www.dwt.com/advisories/FTC_to_Give_Antitrust_Guidance_on_ACOs_Providers_Can_Prepare_Now_Using_Existing_Law_09_28_2010/) (discussing such “spillover” collusion concerns).

<sup>78</sup> Medicare Part A providers, which typically include hospitals, are reimbursed through a prospective payment system. See Judith R. Lave, *The Impact of the Medicare Prospective Payment System and Recommendations for Change*, 7 YALE J. ON REG. 499, 505–07 (1990) (describing the basic structure of the Medicare prospective payment system). This system gives providers a single payment for all the services provided to a particular beneficiary diagnosis during a single episode of care. *Id.* at 505–06. Medicare Part B providers, in contrast, are reimbursed on a fee-for-service basis where payment rates are set by CSM in an annual fee schedule. See Alice G. Gosfield, *Value Purchasing in Medicare Law: Precursor to Health Reform*, 20 AM. J.L. & MED. 169, 173–77 (1994) (describing the conceptual basis for the fee system and how rates were intended to be calculated).

<sup>79</sup> See *supra* notes 67–68 and accompanying text.

<sup>80</sup> Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 N. ENG. J. MED., no. 1, 2011, at e1(1)–(2); see also Barbara J. Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471, 1491

market concentration has long been viewed as a useful indicator of the likely anticompetitive effects caused by a combination of competing firms,<sup>81</sup> as it can increase producer market power both by eliminating competition between formerly independent firms and by increasing the risk of coordinated behavior among competitors.<sup>82</sup> This increased market power enables firms to raise prices<sup>83</sup> and can lead to “reduced product quality, reduced product variety . . . or diminished innovation.”<sup>84</sup> If the formation of ACOs “lead[s] to more integrated provider groups that are able to exert market power in negotiations—both by encouraging providers to join organizations and by expanding the proportion of patients for whom provider groups can negotiate rates—private insurers could wind up paying more, even if care is delivered more efficiently,” directly threatening consumer surplus.<sup>85</sup>

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(2012) (“Another shortcoming of the ACO movement is the fear that the movement will push provider consolidation, further escalating the costs of health care.”). *See generally* U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES 3 (2010) [hereinafter HORIZONTAL MERGER GUIDELINES] (“Mergers that cause a significant increase in concentration and result in highly concentrated markets are presumed to be likely to enhance market power . . . .”); Janusz A. Ordover & Robert D. Willig, *The 1982 Department of Justice Merger Guidelines: An Economic Assessment*, 71 CALIF. L. REV. 535, 553 (1983) (“It is a well-supported and generally accepted presumption that, other things being equal—or as economists are fond of saying, *ceteris paribus*—a firm has greater ability to exercise market power: (1) the larger its market share; and (2) the more concentrated the market.”).

<sup>81</sup> *See* *United States v. Phila. Nat’l Bank*, 374 U.S. 321, 362–63 (1963) (“[A] merger which . . . results in a significant increase in the concentration of firms in that market . . . is . . . inherently likely to lessen competition substantially . . . .”); Jonathan B. Baker, *Mavericks, Mergers, and Exclusion: Proving Coordinated Competitive Effects Under the Antitrust Laws*, 77 N.Y.U. L. REV. 135, 142 (“Coordination and supracompetitive pricing commonly were thought to be nearly inevitable when an industry had only a small number of firms.”). The presumption that increased market concentration results in anticompetitive effects has weakened over time. *See* *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 497–504 (1974) (holding that in addition to market concentration, one must look at a market’s structure, history and probable future when judging the anticompetitive effects of a merger); Jonathan B. Baker & Steven C. Salop, *Should Concentration Be Dropped from the Merger Guidelines?*, 33 UWLA L. REV. 3, 4 (2001) (“In the past twenty-five years, the virtually irrebuttable presumption of harm from increases in concentration . . . has been significantly weakened.”).

<sup>82</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 80, at 2. These are generally known as the “unilateral” and “coordinated” effects of market power. *Id.*

<sup>83</sup> *See* AM. HEALTH INS. PLANS, ACCOUNTABLE CARE ORGANIZATIONS AND MARKET POWER ISSUES 3 (2010) (“Several studies have shown that prices go up in markets where large healthcare organizations have amassed substantial market power.”). Given that delivery providers can increase profits by providing more service or by raising prices under a fee-for-service model of health care, both the change in price and change in quantity of service provided must be considered when measuring provider market power. *Id.* at 4.

<sup>84</sup> HORIZONTAL MERGER GUIDELINES, *supra* note 80, at 2.

<sup>85</sup> Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 700 (2010).

In the few years since it was passed, the Affordable Care Act has already encouraged a new wave of mergers, joint ventures, and alliances in the health care industry that raise these precise concerns.<sup>86</sup> For example, an integrated physician organization in Houston, Texas composed of two previously independent hospitals was approved to participate in the Shared Savings Program in 2013.<sup>87</sup> Formed to achieve greater provider integration and combat the city's fragmented health care system,<sup>88</sup> the resulting ACO controls approximately 34% of the city's inpatient market, a larger share than any other competitor.<sup>89</sup> Similarly, an ACO formed in northern California that includes both hospitals and physician groups commanded roughly one-third of the local health care market in 2010.<sup>90</sup> As a result of combinations such as this one, preliminary evidence suggests that ACOs in California "have been able to use their market clout to extract high payments from health plans."<sup>91</sup> As one scholar has noted, "[t]he risk that dominant providers and dominant insurers may exercise their market power, individually or jointly, has never been greater."<sup>92</sup>

Beyond the general threat that market power poses to consumer surplus, there is reason to believe that heightened concern should be given to the formation of ACOs because of the unique characteristics of the health care industry. Ordinarily, the negative effects of market concentration and market power on price and quality are constrained by the unwillingness of consumers to pay more than they can afford or believe a product is worth. In the health care industry, however, this restraint is largely absent. Most consumers do not pay for services directly but instead purchase insurance—and "[f]or legal, regulatory,

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<sup>86</sup> See Robert Pear, *As Health Law Spurs Mergers, Risks Are Seen*, N.Y. TIMES, Nov. 21, 2010, at A1 ("[E]ight months into the new law there is a growing frenzy of mergers involving hospitals, clinics and doctor groups eager to share costs and savings, and cash in on the incentives.").

<sup>87</sup> See Christopher Lloyd, *Moving Ahead with Memorial Hermann ACO and Beyond*, 5 MHMD NEWSLINK (MEMORIAL HERMANN PHYSICIAN NETWORK, HOUSTON, TEX. 1), Winter 2013, at 1 (2013), [https://www.mhnp.org/news/MHMDfallnewslink\\_Winter13.pdf](https://www.mhnp.org/news/MHMDfallnewslink_Winter13.pdf) (announcing Memorial Hermann's approval to participate in the Shared Savings Program and the hospital's goals for the program).

<sup>88</sup> See KEITH D. MOORE & DEAN C. CODDINGTON, MCMANIS CONSULTING, ACO CASE STUDY: MEMORIAL HERMANN: HOUSTON, TEXAS 3 (2011) (describing the Houston health care market and the hospital's transformation into an "effective clinically integrated network").

<sup>89</sup> *Id.*

<sup>90</sup> JAMES C. ROBINSON & EMMA L. DOLAN, INTEGRATED HEALTH ASSOC., ACCOUNTABLE CARE ORGANIZATIONS IN CALIFORNIA: LESSONS FOR THE NATIONAL DEBATE ON DELIVERY SYSTEM REFORM 11 (2010).

<sup>91</sup> *Id.* at 3.

<sup>92</sup> Pear, *supra* note 86, at A1 (quoting statement by Thomas L. Greaney, professor at St. Louis University).

and other reasons, health insurers in the United States cannot refuse to pay the high prices imposed by health care organizations, even when the price exceeds the likely value of the service to the patient.”<sup>93</sup> Health insurers are expected to pay for any service deemed “medically necessary,” thereby enabling providers with market power to exact even more of the consumer surplus than would otherwise be economically possible.<sup>94</sup>

This dynamic is worsened by the fact that large hospitals have so far been the dominant provider involved in the formation of many ACOs.<sup>95</sup> Large hospitals are often “must-have providers,” because consumers will refuse to purchase an insurance plan that does not include them within their network.<sup>96</sup> Such hospitals are “like the sun at the center of the solar system”<sup>97</sup> and can use their market power to demand supracompetitive prices.<sup>98</sup> ACOs that incorporate or are formed around these hospitals thus “bring more planets into the system . . . making the whole entity more powerful, with a commensurate ability to raise prices.”<sup>99</sup> Because ACOs have thus far been dominated by large hospitals, there has been a “concentration of power not in the most efficient and highest quality health care organizations, but in the largest—simply because they control large segments of the market share.”<sup>100</sup>

The detrimental effects that large hospitals with market power can have on consumer surplus have been well documented. A report by the Robert Wood Johnson Foundation showed that hospital consolidation in the 1990s raised overall inpatient health care prices by at

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<sup>93</sup> Barak D. Richman & Kevin A. Schulman, *A Cautious Path Forward on Accountable Care Organizations*, 305 JAMA 602, 602 (2011).

<sup>94</sup> *Id.*

<sup>95</sup> See DAVID MUHLESTEIN ET AL., LEAVITT PARTNERS CTR. FOR ACCOUNTABLE CARE INTELLIGENCE, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: JUNE 2012 UPDATE 11 tbl.1 (2012), available at <http://leavittpartners.com/wp-content/uploads/2012/06/Growth-and-Dispersion-of-ACOs-June-2012-Update.pdf> (finding that 118 of 221 ACOs formed as of May 2012 were sponsored by a hospital system); Pear, *supra* note 86, at A23 (“Hospitals have taken the lead in forming these new entities.”).

<sup>96</sup> LIORA BOWERS ET AL., ACCOUNTABLE CARE ORGANIZATIONS AND ANTITRUST CONFERENCE: BRIEFING DOCUMENT 13–14 (2011), available at <http://petris.org/wp-content/uploads/2013/02/ACOs-and-Antitrust-Conference-Briefing-Paper-FINAL.pdf>.

<sup>97</sup> Pear, *supra* note 86, at A23 (quoting statement by Elizabeth L. Gilbertson, chief strategist of a union health plan for hotel and restaurant employees).

<sup>98</sup> BOWERS ET AL., *supra* note 96, at 14 (“Such providers often recognize their ‘must-have’ status and utilize it for negotiating leverage with insurers.”).

<sup>99</sup> Pear, *supra* note 86, at A23.

<sup>100</sup> Rita E. Numerof, *Why Accountable Care Organizations Won’t Deliver Better Health Care—and Market Innovation Will*, BACKGROUND (Heritage Found., Washington, D.C.), Apr. 2011, at 2.

least five percent and raised prices by forty percent or more when merging hospitals were located in the same geographic region.<sup>101</sup> A study by the Massachusetts Attorney General found that prices for health care services in the state were uncorrelated with either cost or quality, but they were instead positively correlated with provider market power.<sup>102</sup> Similarly, the National Bureau of Economic Research found that hospital mergers between 1990 and 2001 contributed to a 3.2% increase in premiums and a \$42.2 billion loss to consumer surplus.<sup>103</sup> Despite this decrease in consumer surplus, total surplus remained relatively unchanged; thus “the primary impact of [the] hospital mergers was to transfer consumer surplus to hospitals.”<sup>104</sup> Given that “[e]vidence from two decades of hospital mergers and acquisitions . . . demonstrates that consolidating hospital markets drives up prices, with disagreement only over the magnitude of the increases,”<sup>105</sup> the current wave of new ACOs forming around large hospitals is especially troubling.

Since CMS sets provider reimbursement rates for Medicare beneficiaries, those ACOs formed solely to participate in the Shared Savings Program will not be able to exert market power by raising Medicare prices, just as they will not be able to engage in horizontal price-fixing with regards to such beneficiaries. Nonetheless, there is still a concern that these ACOs in highly concentrated markets may be able to use their market power to harm consumer surplus by reducing output, decreasing the quality of care they provide, or avoiding innovation.<sup>106</sup> For example, multiple doctors participating in an ACO within a concentrated market may agree to limit business hours or restrict access to certain services in order to cut costs, or two hospitals may agree to specialize in different fields so as not to compete with

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<sup>101</sup> WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., *HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?* 4 (2006). *But see* Robert A. Connor et al., *Which Types of Hospital Mergers Save Consumers Money?*, 16 *HEALTH AFF.* 62, 68–70 (1997) (analyzing 122 hospital mergers between 1986 and 1994 and finding that mergers were generally financially beneficial to consumers, providing average price reductions of approximately seven percent). Hospital mergers may be more beneficial to consumers when the hospitals are low-occupancy hospitals, similar-size hospitals, hospitals with greater premerger service duplication, or hospitals that offer managed care. *Id.* at 69–70.

<sup>102</sup> MASS. ATT’Y GEN., *EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)* (2010) 16–33, available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>.

<sup>103</sup> Robert Town et al., *The Welfare Consequences of Hospital Mergers* 31–33 (Nat’l Bureau of Econ. Research, Working Paper No. 12,244, 2006).

<sup>104</sup> *Id.* at 33.

<sup>105</sup> Berenson, Ginsburg & Kemper, *supra* note 85, at 699.

<sup>106</sup> Tara Adams Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, 42 *SETON HALL L. REV.* 1443, 1447–48 (2012).

one another.<sup>107</sup> Any of these actions, made economically possible by increased provider market power, could serve to transfer some of the consumer surplus from Medicare beneficiaries to providers. Furthermore, as previously noted, most ACOs are expected to operate in both the Medicare and private market.<sup>108</sup> Even if ACO providers are unable to use their market power to increase prices for Medicare beneficiaries, there is still a substantial concern that they will be able to do so for their private patients. Furthermore, ACOs with market power may simply choose not to participate in the Shared Savings Program at all, instead choosing to operate only in the private market where they can raise prices on consumers.<sup>109</sup> Therefore, the DOJ and FTC cannot ignore the threat that ACOs with market power pose to consumer surplus simply because prices for Medicare are administratively set.

### 3. *Cost Shifting*

While the anticompetitive concerns discussed thus far relate primarily to ACOs contracting with private payers, it is precisely those ACOs designed to participate in the Shared Savings Program that raise a heightened threat of “cost-shifting.” Hospitals are reimbursed different amounts by different payers, and because Medicare payments are administratively set, they are typically lower relative to the costs a provider is able to recoup from private insurers.<sup>110</sup> Studies have demonstrated that hospital rates for private payers can be as much as 400% higher than hospital rates for Medicare patients.<sup>111</sup> To offset this reduction in revenue from treating Medicare patients, health care providers may engage in cost-shifting: charging some payers (often private insurers) higher amounts for the same services because they received less from other payers (often government programs).<sup>112</sup> Cost-shifting is essentially a “dynamic response by

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<sup>107</sup> See Ken Glazer & Catherine A. LaRose, *Accountable Care Organizations: Antitrust Business as Usual?*, ANTITRUST SOURCE, Dec. 2011, at 7–8 (noting that ACOs with market power might restrict hours, reduce patient care quality, or drive potentially expensive “at-risk” patients to other providers).

<sup>108</sup> See *supra* notes 67–68 and accompanying text.

<sup>109</sup> AM. HEALTH INS. PLANS, *supra* note 83, at 4.

<sup>110</sup> See Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 91–92 (2011) (“Public payments—from Medicare or Medicaid—go down . . . and as a consequence, private payments go up, taking health insurance premiums along with them.”).

<sup>111</sup> See PAUL B. GINSBURG, WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER 4 (studying average inpatient hospital payment rates in eight major health care markets).

<sup>112</sup> See Frakt, *supra* note 110, at 91 (describing cost-shifting as a process that occurs when hospitals receive less from certain payers and, as a result, charge other payers more).

[providers] to a reduction in Medicare payments, in the form of a fully or partially compensating increase in prices charged to private insurers.”<sup>113</sup>

While provider cost-shifting and the impact of Medicare rates on private insurance prices has been well documented,<sup>114</sup> ACOs pose a risk of increased provider cost-shifting because of the potentially high start-up and operating costs likely to be associated with developing an ACO and increasing provider integration. To achieve the core objectives of the ACO movement—integration and efficiency—health care providers will likely have to invest in new technologies, personnel, and forms of communication. Just as many health care providers currently engage in a “medical arms race” to compete with one another in a constantly evolving market,<sup>115</sup> forming an ACO will require significant monetary investment. According to the American Hospital Association, a large hospital-centric ACO could cost as much as \$12 million to start up and incur more than \$14 million in ongoing annual costs.<sup>116</sup>

In order to qualify for bonus payments under the Shared Savings Program, participating ACOs must reduce their costs of providing care to Medicare beneficiaries.<sup>117</sup> Instead of accomplishing this reduction by increasing efficiency, as is the goal of the Shared Savings Program, ACOs and their member providers may instead simply provide less care to, and underutilize necessary resources for, Medicare patients. Achieving shared savings in such a manner would further create an incentive for providers to increase the fees they charge private payers and provide excessive care to private patients. In essence, much like the way commercial payers already subsidize some of the

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<sup>113</sup> James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFF. 1265, 1266 (2011).

<sup>114</sup> See, e.g., THE LEWIN GRP., ANALYSIS OF HOSPITAL COST SHIFT IN ARIZONA 1 (2009) (“[P]rivate insurers in Arizona pay 40 percent above the costs of treating their patients in order to cover losses incurred from Medicare . . . .”); David Dranove, *Pricing by Non-Profit Institutions: The Case of Hospital Cost-Shifting*, 7 J. HEALTH ECON. 47–48 (1988) (presenting evidence that hospitals in Illinois engaged in cost shifting in the early 1980s in response to substantial reductions in Medicaid payments); Robinson, *supra* note 113, at 1266 (presenting empirical evidence that “when hospitals suffer Medicare payment shortfalls, they are able to raise prices to private insurers”); Jack Zwanziger & Anil Bamezai, *Evidence of Cost-Shifting in California Hospitals*, 25 HEALTH AFF. 197, 197 (2006) (“[A] 1 percent relative decrease in the average Medicare price is associated with a 0.17 percent increase in the corresponding price paid by privately insured patients . . . .”).

<sup>115</sup> Greaney, *supra* note 67, at 14 (quoting Robinson, *supra* note 113, at 1267).

<sup>116</sup> AM. HOSP. ASS’N, THE WORK AHEAD: ACTIVITIES AND COSTS TO DEVELOP AN ACCOUNTABLE CARE ORGANIZATION 2 (2011).

<sup>117</sup> See *supra* note 57 and accompanying text (describing eligibility requirements for bonus payments under the Shared Savings Program).

cost of providing care to Medicare beneficiaries, the “ACO [Shared Savings P]rogram may exacerbate this trend by causing providers to shift more of their costs to commercially insured patients in order to qualify for the Medicare cost-reduction bonuses.”<sup>118</sup>

### III

#### THE ACO ENFORCEMENT STATEMENT AND THE PROMISE OF BIG DATA

To address the antitrust concerns that ACOs raise, the DOJ and FTC issued the ACO Enforcement Statement, which outlines the general enforcement policies that the agencies will apply in analyzing the potentially anticompetitive effects of ACOs participating in the Shared Savings Program.<sup>119</sup> Most notably, the DOJ and FTC decided to use market share screens and rule of reason treatment to evaluate ACOs participating in the Shared Savings Program.<sup>120</sup> Some scholars praise the ACO Enforcement Statement, while others criticize it for articulating an overly lenient approach.<sup>121</sup> Both proponents and opponents, however, fail to recognize that by using market share screens and affording ACOs rule of reason treatment, the ACO Enforcement Statement simply delays antitrust review of ACOs to a later date. By allowing the antitrust agencies to avoid prioritizing either consumer surplus or total surplus in the first instance, the statement leaves open two critical questions. First, what will the rule of reason treatment afforded to ACOs look like? And second, how will the antitrust agencies ultimately determine whether ACOs benefit or harm consumers?

The ACO Enforcement Statement does not provide an adequate answer to these questions and, as currently formulated, is all bark and no bite—specifically, it does not create an effective enforcement mechanism to analyze the potential anticompetitive effects of ACOs approved to participate in the Medicare Shared Savings Program. Nonetheless, the antitrust enforcement agencies can use the “big

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<sup>118</sup> J. Thomas Rosch, Comm’r, Fed. Trade Comm’n, Remarks Before the Houston Bar Association: Will the Affordable Care Act Stand? Assessing the Constitutional and Competitive Concerns Raised by Health Care Reform 26 (Mar. 22, 2012), available at <http://www.ftc.gov/speeches/rosch/120322houstonspeech.pdf>.

<sup>119</sup> ACO Enforcement Statement, *supra* note 19, at 67,026–27.

<sup>120</sup> *Id.* at 67,027–28.

<sup>121</sup> Compare Glazer & LaRose, *supra* note 107, at 8 (“After more than a year of workshops, proposals, comments, and revisions, the Final Statement . . . provide[s] some additional clarity . . . for ACOs participating in the Shared Savings Program . . .”), with Bruns, *supra* note 73, at 273 (describing the “antitrust problems that may be overlooked in the approach taken by the FTC and the DOJ in the Antitrust Statement”), and Kasper, *supra* note 13, at 208 (“FTC and DOJ went too far in relaxing the antitrust review regime for hospital networks for purposes of the ACO program.”).



data” collected by CMS under the Affordable Care Act to monitor the benefits and anticompetitive threats that ACOs create. Specifically, the antitrust agencies can use this data to conduct a structured rule of reason review that takes into account both the consumer surplus and total surplus by using a burden shifting framework.

### A. *The ACO Enforcement Statement*

The ACO Enforcement Statement was intended to provide newly developed ACOs with the necessary antitrust clarity and guidance to ensure their participation in the Shared Savings Program and foster the creation of procompetitive integrated health care networks.<sup>122</sup> The ACO Enforcement Statement was the product of a contentious rulemaking process, however, due in part to disagreement between the agencies over how rigorous antitrust review for ACOs should be.<sup>123</sup> Before the final statement was published, the agencies issued a draft version, which many providers criticized as being “overly burdensome and insufficiently flexible to allow for robust participation in the program.”<sup>124</sup> Given the importance of health care reform, some providers and ACO participants called for immunity from antitrust enforcement so long as they met the Shared Savings Program eligibility requirements, arguing that such protection was needed to encourage participation in the program.<sup>125</sup> Although the final ACO Enforcement Statement does not immunize ACOs from antitrust enforcement, it does provide for a relaxation of the antitrust scrutiny ACOs would otherwise receive in two significant ways.

First, the ACO Enforcement Statement provides that the antitrust agencies will apply the “rule of reason” test to joint price negotiations of ACOs with commercial health plans if they meet CMS’s eligibility criteria for participation in the Shared Savings Program, exempting such joint negotiations from traditional per se antitrust challenge.<sup>126</sup> Second, in applying the rule of reason analysis to assess an ACO’s market power, the ACO Enforcement Statement creates an

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<sup>122</sup> See Kasper, *supra* note 13, at 207 (explaining that the FTC and DOJ released the ACO Enforcement Statement in order to provide guidance to ACOs operating in the private market).

<sup>123</sup> See Robert Pear, *Antitrust Concerns Are Raised on New Law’s Doctor-Hospital Collaborations*, N.Y. TIMES, Feb. 9, 2011, at A19 (discussing the disagreement between agencies during the rulemaking process).

<sup>124</sup> Kasper, *supra* note 13, at 207.

<sup>125</sup> See *id.* (describing how prospective participants in the program requested immunity from antitrust enforcement).

<sup>126</sup> ACO Enforcement Statement, *supra* note 19, at 67,028.

antitrust “safety zone” for ACOs with market shares less than 30% absent “extraordinary circumstances.”<sup>127</sup>

### 1. *The 30% PSA Safety Zone*

The level of antitrust scrutiny given to a commercial ACO participating in the Shared Savings Program depends on the ACO’s market share. ACOs with market shares exceeding 30% will be subject to standard rule of reason review, while ACOs with market shares below 30% will not be subject to any antitrust review absent extraordinary circumstances.<sup>128</sup> The ACO Enforcement Statement frames the relevant market as a primary service area (PSA), which is defined as “the lowest number of postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients].”<sup>129</sup>

PSAs are calculated using a three-step process. First, the agencies identify each service that is offered by at least two independent participants in the ACO.<sup>130</sup> For physicians, a service is defined as the physician’s primary specialty; for inpatient and outpatient facilities, a service is defined using preexisting CMS billing categories (such as cardiac care or radiation therapy).<sup>131</sup> Second, the agencies identify the PSAs for each participant in the ACO that provides any common service.<sup>132</sup> Third, the agencies calculate the ACO’s share in each PSA for every service that is offered by more than two of the participants in the ACO.<sup>133</sup> For physician services and outpatient services, the data used to calculate PSA shares is gathered from the total Medicare fee-for-service payments made during the most recent calendar year. For inpatient services, such data is collected from state-level all-payer hospital discharge data.<sup>134</sup>

The use of PSAs, and the 30% safety zone in particular, raises numerous concerns that are not adequately addressed in the ACO Enforcement Statement. First, the antitrust agencies concede that a PSA “does not necessarily constitute a relevant antitrust geographic market.”<sup>135</sup> An ACO, therefore, may actually possess more market power than their PSA suggests. This is problematic because in most

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<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> *Id.* (quoting Medicare Program: Physicians’ Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16,054, 16,095 (Mar. 26, 2004)).

<sup>130</sup> *Id.* at 67,031.

<sup>131</sup> *Id.* at 67,028, 67,031.

<sup>132</sup> *Id.* at 67,031.

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at 67,028.

instances, once an ACO with a PSA under 30% is approved to participate in the Shared Savings Program, it will be subject to little or no antitrust review, making it difficult for the agencies to adequately protect consumers from the anticompetitive behavior market power enables.<sup>136</sup>

In addition, PSA calculations are done by the ACOs themselves, creating a clear incentive for an ACO to manipulate its PSA to remain in the 30% safety zone. The potential for such behavior is enhanced because PSA values can change at any time as health care providers enter and leave the market. While an ACO is required to notify CMS within thirty days of any additions in their participants, providers, or suppliers,<sup>137</sup> there is currently no mechanism under the ACO Enforcement Statement to reevaluate an ACO's PSA when such a change in the market occurs.

## 2. Rule of Reason Treatment

The most wide-sweeping decision that the DOJ and FTC had to make when issuing the ACO Enforcement Statement was how to treat ACO joint price negotiation with private payers. Horizontal price-fixing agreements are typically *per se* violations of the Sherman Act<sup>138</sup> and are ordinarily presumed to be illegal because they are “so likely to harm competition and to have no significant procompetitive benefit that they do not warrant the time and expense required for particularized inquiry into their effects.”<sup>139</sup> Despite this presumption, the agencies decided that ACOs meeting CMS's eligibility criteria should automatically qualify for rule of reason treatment.<sup>140</sup> Rule of reason analysis involves a “factual inquiry into an agreement's overall competitive effect . . . and varies in focus and detail depending on the nature of the agreement and market circumstances.”<sup>141</sup> It requires the agencies “to decide whether under all the circumstances of the case the [ACO] imposes an unreasonable restraint on competition.”<sup>142</sup>

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<sup>136</sup> See *supra* Part II.B.2.

<sup>137</sup> CMS Final Rule, *supra* note 59, at 67,839–40.

<sup>138</sup> See *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940) (explaining how the Supreme Court has “consistently and without deviation adhered to the principle that price-fixing agreements are unlawful *per se* under the Sherman Act”).

<sup>139</sup> FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 3 (2000); see *Arizona v. Maricopa Cnty. Med. Soc'y*, 457 U.S. 332, 351 (1982) (“The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some.”).

<sup>140</sup> ACO Enforcement Statement, *supra* note 19, at 67,028.

<sup>141</sup> FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 139, at 3.

<sup>142</sup> *Maricopa*, 457 U.S. at 343.

This decision was not without precedent,<sup>143</sup> but it still raises potential problems. Under the existing Statement of Antitrust Enforcement Policy in Health Care (Health Care Statement),<sup>144</sup> multiprovider networks of physicians and other providers that jointly market and contract with health plans are afforded rule of reason treatment “if the providers’ integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network providers are reasonably necessary to realize those efficiencies.”<sup>145</sup> In other words, for all provider joint ventures outside of the ACO context, the DOJ and FTC conduct an initial analysis of whether the joint venture is actually likely to produce significant efficiencies and benefits to consumers, as well as whether the coordinated behavior is reasonably necessary to realize those efficiencies, before affording such joint venture rule of reason treatment.

Under the ACO Enforcement Statement, however, this prerequisite is presumed. The ACO Enforcement Statement explains that all ACOs meeting CMS’s eligibility criteria “are reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs, of providing medical and other health care services through their participants’ joint efforts.”<sup>146</sup> Furthermore, the agencies “will treat joint negotiations with private payers as reasonably necessary to an ACO’s primary purpose of improving health care delivery.”<sup>147</sup> This represents one of the only instances where DOJ and FTC antitrust review is “peg[ged] . . . to standards created by a different agency.”<sup>148</sup>

The anticompetitive effects that ACOs may have will be difficult to reverse, regardless of whether they are eventually able to make health care delivery more efficient.<sup>149</sup> Instead of requiring mandatory

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<sup>143</sup> See Taylor Burke & Sara Rosenbaum, *Aligning Health Care Market Incentives in an Information Age: The Role of Antitrust Law*, 5 J. HEALTH & BIOMEDICAL L. 151, 171 (2009) (noting that “[o]ver the years, Congress, federal and state regulators, and the courts have developed certain exemptions and ‘safety zones’ to adjust the law of market competition for special markets” such as health care).

<sup>144</sup> U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) [hereinafter HEALTH CARE ENFORCEMENT STATEMENT], <http://www.justice.gov/atr/public/guidelines/0000.pdf>.

<sup>145</sup> *Id.* at 136.

<sup>146</sup> ACO Enforcement Statement, *supra* note 19, at 67,027–28.

<sup>147</sup> *Id.* at 67,028.

<sup>148</sup> Toby G. Singer & David R. Pearl, *A Not So Modest Proposal? The FTC/DOJ Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, CPI ANTITRUST CHRON. 3 (May 2011).

<sup>149</sup> See Bruns, *supra* note 73, at 283 (“The harm that results from anticompetitive behavior is extremely damaging to a market and very difficult to reverse after it has become entrenched in the market.”).

antitrust review for new ACOs or implementing additional requirements beyond those imposed by CMS, the DOJ and FTC decided to afford nearly all ACOs rule of reason treatment. This decision pushes almost all antitrust review of ACOs to the back end, after the impact of any potential anticompetitive effects are felt, leaving open million-dollar (or million-patient) questions: What will the rule of reason treatment afforded to ACOs look like? And how will the antitrust agencies ultimately determine whether ACOs benefit or harm consumers?

Under the current ACO Enforcement Statement, the answer is unclear. The antitrust agencies have identified four types of conduct that raise competitive concerns that ACOs with market shares above the safety zone may wish to avoid.<sup>150</sup> The agencies have not identified, however, what possible efficiencies and procompetitive justifications this anticompetitive behavior will be balanced against. What if an ACO simply generates no savings, or does not result in better quality care or lower prices? Will the antitrust agencies tolerate ACOs that accumulate high market share but only pass along some efficiencies to consumers in the form of better quality care or lower prices? Unlike merger enforcement, the DOJ and FTC have provided no guidance on whether they will force anticompetitive ACOs to dissolve, and if not, what consent decrees might look like.<sup>151</sup> These questions are not answered by the ACO Enforcement Statement.

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<sup>150</sup> The four types of conduct include:

(1) Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most-favored-nation,” or similar contractual clauses or provisions. (2) Tying sales (either explicitly or implicitly through pricing policies) of the ACO’s services to the private payer’s purchase of other services from providers outside the ACO (and vice versa), including providers affiliated with an ACO participant (e.g., an ACO should not require a purchaser to contract with all of the hospitals under common ownership with a hospital that participates in the ACO). (3) Contracting on an exclusive basis with ACO physicians, hospitals, ASCs, or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO, either individually or through other ACOs or analogous collaborations. (4) Restricting a private payer’s ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Shared Savings Program. ACO Enforcement Statement, *supra* note 19, at 67,030.

<sup>151</sup> See Elizabeth L. Rowe, *Accountable Care Organizations: How Antitrust Law Impacts the Evolving Landscape of Health Care*, 2012 U. ILL. L. REV. 1855, 1881 (2012) (arguing that if an ACO is unable to pass the rule of reason test “it will be necessary to impose some sort of penalty without rendering the entire joint venture unlawful” given that “[t]he

### B. *The Promise of Big Data*

Although the ACO Enforcement Statement leaves open important questions, the antitrust enforcement agencies have a unique opportunity to implement meaningful rule of reason review of ACOs participating in the Shared Savings Program. The Affordable Care Act recognizes that “[p]roducing health care is not like producing widgets: the evidence suggests that improving health care takes extensive and ongoing collaboration among key players in a joint, information-driven, approach that causes those who otherwise might be competitors to come together to confront problems and devise solutions.”<sup>152</sup> Section 3022 of the Act and the final rule implementing Section 3022 authorize CMS to collect a significant amount of “big data” from ACOs that apply to and choose to participate in the Shared Savings Program.<sup>153</sup> This data will provide a concrete picture of the effect that these ACOs have on the cost and quality of the care they provided. By analyzing this data, the DOJ and FTC can measure the benefits and anticompetitive threats that these ACOs create, allowing them to conduct a meaningful rule of reason review that takes into account both consumer surplus and total surplus.

#### 1. *What Information Is Collected?*

The Affordable Care Act authorizes CMS to collect two types of information: cost data and quality data. Under the final rule implementing Section 3022, “CMS will collect and evaluate cost, utilization, and quality metrics relating to each ACO’s performance in the Shared Savings Program.”<sup>154</sup> Cost data describes the costs incurred by providers in delivering care to beneficiaries within the ACO and is gathered from claims-based statistics and other information supplied by beneficiaries and providers. Importantly, the ACO itself does not need to be involved in this data collection, as CMS will work with government contractors to obtain the necessary Medicare claims information.<sup>155</sup> This data “could be of great use to the agencies in assessing whether consumers are really receiving improved care at lower costs in a given area, which could be useful to the agencies in

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system of retroactive antitrust review will not encourage physicians into ACOs if they can be dismantled just as quickly as they were created”).

<sup>152</sup> Burke & Rosenbaum, *supra* note 143, at 155.

<sup>153</sup> See 42 U.S.C. § 1395jjj (2012) (noting that the Secretary may require the ACO to submit data concerning, for example, hospital discharge planning in order to evaluate the quality of care furnished by the ACO).

<sup>154</sup> ACO Enforcement Statement, *supra* note 19, at 76,028.

<sup>155</sup> RTI INT’L & TELLIGEN, ACCOUNTABLE CARE ORGANIZATION 2012 PROGRAM ANALYSIS 3 (2011), [http://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/aco\\_qualitymeasures.pdf](http://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/aco_qualitymeasures.pdf).

assessing whether ACOs are having an overall net benefit to the consumers.”<sup>156</sup>

The quality data gathered by CMS will describe the quality and effectiveness of the care received by Medicare beneficiaries within the ACO. Specifically, ACOs within the Shared Savings Program are required to report on thirty-three quality measures across four domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventative Health, and At-Risk Populations.<sup>157</sup> The ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System and the Electronic Health Record Incentive Programs.<sup>158</sup> CMS alone will gather some of the quality data, while ACOs will need to provide other quality information using patient surveys and a pre-populated web interface.<sup>159</sup> CMS has administered and paid for the patient surveys in 2012 and 2013, but ACOs are now responsible for selecting and paying for a CMS-certified vendor to administer the patient survey.<sup>160</sup>

## 2. *How the Information Can Be Used*

Considering the data that CMS is collecting under the Affordable Care Act, the crucial question is how the antitrust agencies can use such information to measure whether ACOs within the Shared Savings Program are benefiting consumers. Meaningful antitrust enforcement using the rule of reason must provide some guidance on how potential anticompetitive effects are balanced against procompetitive justifications. Rather than maintaining an amorphous standard of “consumer welfare,” I propose that the antitrust agencies use the cost and quality data provided by CMS to implement a structured rule of reason review and burden-shifting framework to evaluate those ACOs participating in the Shared Savings Program. This should be implemented through an amendment to the ACO Enforcement Statement.

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<sup>156</sup> Rowe, *supra* note 151, at 1880.

<sup>157</sup> CMS Final Rule, *supra* note 59, at 67,889–90. Examples of individual quality measures include “Shared Decision Making” (Patient/Caregiver Experience); “Reconciliation After Discharge from an Inpatient Facility” (Care Coordination/Patient Safety); “Adult Weight Screening and Follow-up” (Preventative Health); and various “Diabetes Composite” scores. *Id.* at 67,889. ACOs will submit data on these measures using one of four mechanisms: (1) patient surveys; (2) claims filed with CMS; (3) Electronic Health Record Incentive Program Reporting; and (4) Group Practice Reporting Option Web Interface. *Id.* An individual with legal authority to bind the ACO must certify that the accuracy, completeness, and truthfulness of all data submitted. *Id.* at 67,979.

<sup>158</sup> RTI INT’L & TELLIGEN, *supra* note 155, at 3.

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

A structured rule of reason approach “would clarify the parties’ burden of proof at each stage of a case, and allow for early resolution when a party fails to meet that burden.”<sup>161</sup> The plaintiff bears the initial burden of adducing evidence that the defendant’s conduct resulted in a substantial adverse effect on competition.<sup>162</sup> If that burden is met, the burden of production shifts to the defendant to articulate a procompetitive justification for its conduct.<sup>163</sup> If the defendant is able to do so, the burden shifts back to the plaintiff to either challenge the justification or introduce further evidence of adverse effect.<sup>164</sup> A structured rule of reason framework “favors defendants because it places the initial burden on the plaintiff to prove that a restraint has anticompetitive effects in the relevant market.”<sup>165</sup> This is consistent with the Affordable Care Act’s efforts to promote provider efficiency and integration.

The plaintiff’s initial burden may ordinarily be satisfied by showing market power,<sup>166</sup> obvious anticompetitive effect,<sup>167</sup> or actual anticompetitive effect.<sup>168</sup> With regards to ACOs in the Shared Savings Program, however, the DOJ and FTC decided that potentially anticompetitive behavior (such as joint price negotiation)<sup>169</sup> and high market shares alone should not constitute anticompetitive effect.<sup>170</sup> The antitrust agencies should thus clarify that they will rely only on evidence of actual anticompetitive effect when challenging an ACO. Unlike ordinary plaintiffs, who face an often insurmountable challenge demonstrating actual anticompetitive effect, the antitrust agencies can use the data collected to meet this burden. Specifically, the antitrust agencies must show that an ACO has resulted in either increased costs or decreased quality using the aggregate claims data and quality-metric results provided by CMS.

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<sup>161</sup> Thomas A. Piraino, Jr., *A Proposed Antitrust Approach to Collaborations Among Competitors*, 86 IOWA L. REV. 1137, 1151 (2001).

<sup>162</sup> See Andrew I. Gavil, *Moving Beyond Caricature and Characterization: The Modern Rule of Reason in Practice*, 85 S. CAL. L. REV. 733, 760–61 (2012) (describing structured rule of reason analysis).

<sup>163</sup> *Id.* at 760.

<sup>164</sup> *Id.* at 760–61.

<sup>165</sup> Piraino, Jr., *supra* note 161, at 1151.

<sup>166</sup> See *United States v. Phila. Nat’l Bank*, 374 U.S. 321, 364 (1963) (finding 30% market share sufficient to satisfy this burden in a merger analysis).

<sup>167</sup> See *Cal. Dental Ass’n v. F.T.C.*, 526 U.S. 756, 770–71 (1999) (examining types of behavior that cause anticompetitive effects).

<sup>168</sup> See *F.T.C. v. Ind. Fed’n of Dentists*, 476 U.S. 447, 461 (1986) (concluding that the “finding of actual, sustained adverse effects on competition” is legally sufficient to support that a challenged restraint is unreasonable).

<sup>169</sup> See *supra* Part III.A.2.

<sup>170</sup> See *supra* Part III.A.1.



If the DOJ and FTC can show that an ACO has increased costs and/or decreased quality, the burden would shift to the ACO to put forth a procompetitive justification for its conduct. Rather than rely on the purported benefits of coordination that underlie the Shared Savings Program, an ACO must point to its actual operations to show that it has created, or is in the process of generating, procompetitive benefits in order to meet its burden of production. Since the hope is that ACOs will significantly improve quality of care in addition to lowering costs, a focus on costs alone may give a false indication of an ACO's competitive effect. For example, Intermountain Health Care, an early model organization for developing ACOs, discovered that administering prophylactic antibiotics to patients two hours prior to surgery significantly lowered the risk of wound infection.<sup>171</sup> Intermountain Health Care used this information to develop clinical protocols that reduced its rate of post-surgical infections by 50%. Such a procompetitive justification could offset a temporary increase in costs and shift the burden back to the antitrust agencies to show that the anticompetitive effects outweigh this benefit.

If an ACO can show some procompetitive justifications for either an increase in price or decrease in quality, the burden of production shifts back to the antitrust agencies. The agencies may choose to examine more closely the quality metric information provided by CMS, or may similarly choose to investigate the nature of any "savings" supposedly generated by an ACO. Savings generated by an ACO may be illusory, such as those that arise from the under-provision of services or strategic changes in the ACO's patient population.<sup>172</sup> The antitrust agencies could rebut procompetitive justifications by showing that an ACO achieved shared savings or positive quality assessment scores by providing less service or avoiding at-risk patients who are most likely to complain.

Admittedly, the ability of the antitrust agencies to engage in comprehensive review of ACOs will be limited by the data provided by CMS. CMS collects data only for Medicare beneficiaries within the Shared Savings Program and does not collect information regarding patients covered by private insurance. Without private market data, the antitrust agencies can obtain only a partial picture of the impact

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<sup>171</sup> Mantel, *supra* note 12, at 1417.

<sup>172</sup> See Gregory J. Peinar & Gretchen M. Weiss, *Rule of Reason Analysis for Accountable Care Organization*, ANTITRUST SOURCE, Dec. 2011, at 2 (explaining how the savings "that arise from underprovision of services . . . will not improve the quality of care and thus should not be counted by the antitrust authorities").

ACOs are having on consumers.<sup>173</sup> In addition, the cost data collected by CMS may not precisely correlate with the prices consumers are actually charged, particularly in the private market where providers have substantial autonomy in setting prices. Accurate price information is important in order to completely measure the impact that ACOs have on consumer surplus. Furthermore, some commentators argue that “[w]hile well intentioned, quality metrics may not reliably measure the quality of care provided.”<sup>174</sup> Survey measures in particular are subjective and may be influenced by patient attitudes towards their providers.

These limitations can be at least partially overcome, however, after the antitrust agencies have reviewed the data gathered by CMS. Retrospective analysis of the data amassed by ACOs “can reveal areas where significant gaps exist between actual practice and known best practices, gaps the ACO can then address through staff training or the development of patient care protocols. Analysis of patient outcomes also may identify certain practices that . . . reduce the risk of complications requiring costly care.”<sup>175</sup> Even if the data does not provide concrete proof of anticompetitive conduct, it will show where the antitrust agencies should investigate further.

In coordination with CMS, the antitrust agencies can request that an ACO participating in the Shared Savings Program provide additional price or patient information when necessary. This would be particularly useful when investigating those ACOs that operate both in the Medicare and private insurance markets. CMS acknowledged that it does “not hold the private sector claims data that would be necessary for a complete analysis,” but that it would “work in consultation with the [antitrust agencies] . . . to identify any needed responses.”<sup>176</sup> ACOs may resist requests for private claims data, but even litigation on the matter would provide the antitrust agencies with more information regarding an ACO’s competitive effect. The agencies may even consider expanding the scope of the ACO Enforcement Statement to cover ACOs operating in the private market once they have experience evaluating ACOs under the Shared Savings Program.

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<sup>173</sup> In addition, if ACOs participating in the Shared Savings Program engage in significant cost-shifting, data on the private market side will be necessary to fully understand the impact of such ACOs.

<sup>174</sup> Peinar & Weiss, *supra* note 172, at 8.

<sup>175</sup> Mantel, *supra* note 12, at 1417.

<sup>176</sup> 76 Fed. Reg. 67,956 (Nov. 2, 2011).

## CONCLUSION

Consumers in all markets want lower prices. In the health care market, however, concerns about quality are equally, if not more, important. In passing the Affordable Care Act, Congress recognized that the potential to provide consumers with better quality care at a lower cost was often intertwined with (and sometimes dependent on) the ability of health care providers to become more efficient. Accountable Care Organizations are a prime example. Nonetheless, ACOs raise significant antitrust concerns as a result of provider integration, which the DOJ and FTC have attempted to address through the ACO Enforcement Statement. Despite its laudable goals, the ACO Enforcement Statement merely delays the critical examination of ACOs that the antitrust agencies must undertake without providing sufficient guidance on how they will ultimately be examined. Fortunately, the “big data” collected under the Affordable Care Act provides a unique opportunity to more comprehensively monitor the benefits and anticompetitive threats that ACOs create. The antitrust agencies should amend the ACO Enforcement Statement and use this data to conduct a structured rule of reason review that will take into account both consumer surplus and total surplus through a burden-shifting framework.

