A Few Thoughts about ACO Antitrust Issues from a Local Enforcement Perspective

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Abstract  Accountable care organizations (ACOs), joint ventures of commercial insurers and various groups of medical providers such as physicians, specialists, and hospitals whose development in California has been quickened by the Affordable Care Act, carry with them both promise and pitfalls. On the positive side of the ledger, ACOs may improve the quality of medical care even as they lower the costs of that care. On the negative side of the ledger, ACOs may lead to a gain in market power for their participants, allowing those participants to increase the prices they charge to commercial insurers. It is thus a key question for antitrust enforcers to figure out how to separate the sheep from the goats. This article, representing our personal views as state antitrust enforcers in the California attorney general’s office, offers our reflection on a number of ACO articles and studies in this special issue through the prism of this key question and sets out a number of additional issues that we believe warrant study in conjunction with ACOs.

Keywords  accountable care organization (ACO), Affordable Care Act (ACA), antitrust, California

If the Affordable Care Act (ACA; Pub. L. 111-148, § 1003, 124 Stat. 119 (2010)) were intended to unleash a wave of innovation in health care organization, integration, and delivery, it appears to have done just that in California. This sea change is most evident in the growth of accountable care organizations, or ACOs (Frech et al. 2014). They are joint ventures of

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commercial insurance companies (“payers”) and various groups of providers, for example, primary care physicians, specialists, or hospitals. In theory, ACOs, if properly designed and implemented, can use the increased coordination and integration to reduce health care costs while improving the quality of health care at the same time through, among other things, reducing morbidity rates and hospital readmissions (Grossman, Tu, and Cross 2013; Shortell et al. 2014; THINC 2011). In emphasizing integration and coordination among providers, ACOs may help shift health care away from a reimbursement model based on fee-for-services performed and toward a reimbursement model based on rewarding providers for improving patient health outcomes (Frech et al. 2014; THINC 2011).

However, there is a possible dark lining to this silver cloud: ACOs can also lead to the collective acquisition or enhancement of market power by the venture’s participants in localized geographic markets (Frech et al. 2014). This power would allow participants in such ventures to raise the prices they charge commercial insurance companies at the expense of employers and employees alike, who could experience a rise in their premiums, deductibles, and co-payments (Frech et al. 2014) that is not justified by the requirement to provide Medicare and Medicaid services (CMS 2011).

In California, financial and clinical integration affects both sides of the ledger. The rewards may be best exemplified by its homegrown Kaiser Permanente, a highly integrated health care organization of providers, with its own insurance arm, that has been thought of as one of the progenitors for ACOs. But the risks are also exemplified in the growth—through acquisitions—of large health care provider organizations that appear to have acquired market power and raised prices in localized geographic markets (Berenson, Ginsburg, and Kemper 2010). In raising health care costs, they may thereby be hindering the growth of what is often termed the eighth-largest economy in the world.

At the outset of the ACA, the California attorney general recognized both the promise and the pitfalls of the new order. In written comments to the US Department of Justice and the Federal Trade Commission, the attorney general pointed out that government enforcers should focus on those ACOs that, by their market share—or by associated anticompetitive conduct such as exclusive dealing, tying, or anti-steering and anti-tiering measures—have the greatest potential for creating or enhancing market power and charging higher prices (California Attorney General’s Office 2012: 5–12).1 But the attorney general cautioned that federal government

1. We noted with interest that this focus on ancillary conduct, in addition to market share, is one shared by Robert F. Leibenluft (2015 [this issue]).
enforcers need to carefully analyze the procompetitive benefits of ACOs to ensure that the asserted procompetitive benefits would in fact materialize (California Attorney General’s Office 2012: 5–6, 11–12).

The ACO articles in this special issue have caused us not only to take stock of the issues presented by ACOs at this point in time for antitrust laws but also to offer some metrics that may ultimately be used for separating beneficial ACOs from potentially anticompetitive ACOs. Though these articles further suggest future steps that can be taken toward this key goal, there are important, additional questions that, from our vantage points as enforcers of state and federal antitrust law, we believe could also be explored.

**Preliminary Findings on ACOs in California and Their Implications for the Antitrust Review of Health Care Markets**

California is clearly taking the lead in terms of the sheer number and diversity of ACOs serving commercial insureds as a means of bending the cost curve while improving health care (Fulton et al. 2015 [this issue]; Grossman, Tu, and Cross 2013), even if still a relatively small percentage of covered lives are in ACOs in California (Fulton et al. 2015). Initially, ACOs seem to have had promising results (Grossman, Tu, and Cross 2013; Shortell et al. 2014), though the jury is still out on whether ACOs will achieve these goals.

Studies have shown that ACOs can be quite innovative (Leibenluft 2015 [this issue]; Grossman, Tu, and Cross 2013). We have heard that there may be an ACO now experimenting with patient contracts under which patients with chronic, but treatable, illnesses agree to meet certain metrics (i.e., taking medication, exercise) in exchange for substantial discounts in their premiums. And integrated physician groups, especially those of a substantial size, seem to be quite willing to take the leap (and the lead) in establishing ACOs (Fulton et al. 2015; Shortell et al. 2014).

We welcomed that news, which we believed highlighted the importance of moving cautiously in analyzing the development of ACOs and the growth of ACO-type markets, before we try to separate the sheep from the goats. However, we also took stock, with great interest, of the initial findings of a study that certain environments, such as high market concentrations in the acute medical services provided by hospitals, seemed to hinder the formation of ACOs (Whaley, Frech, and Scheffler 2015 [this issue]). This followed on the heels of an earlier study on ACOs, finding, among other things, that a “prerequisite” for the formation of ACOs was the “availability of a community of relatively low-price providers that are
willing and able to form the basis of a limited network” (Grossman, Tu, and Cross 2013: 9–10).

As witnessed by California’s experience in which ACOs have been established that include the participation of hospitals (Grossman, Tu, and Cross 2013), the formation of ACOs can provide incentives to hospitals that encourage them to join, especially in the context of a preferred provider organization ACO. But one study highlighted preliminary, and to us potentially troubling, findings on how the formation of ACOs had been hindered in areas where hospital groups have market power (Whaley, Frech, and Scheffler 2015).

California has seen the growth of large hospital systems through acquisitions of other hospitals, ambulatory surgery centers, and physician groups (through affiliation) that have conferred market power on these systems in local geographic areas throughout northern and central California (Berenson, Ginsburg, and Kemper 2010; Tenn 2008). In turn, that market power, which some have reported, has led to higher prices being charged to employers and employees for health care services in those areas (Berenson, Ginsburg, and Kemper 2010; Tenn 2008). The escalation of health care costs due to market concentration among providers has become a pressing issue not just for California but also for other states (Frech et al. 2014).2

Insofar as ACOs hold great promise for reducing costs and improving health outcomes, this preliminary development highlights the ongoing need to scrutinize carefully hospital systems that may possess market power in local geographic markets (California Attorney General’s Office 2012: 5–12). As our attorney general pointed out, the need to review such systems may also be enhanced as they acquire their own insurance arms (California Attorney General’s Office 2012: 11). We have begun to see hospital systems offer such insurance through Covered California (California’s exchange marketplace under the ACA for individuals and small businesses to buy insurance) in certain local markets.3

**Preliminary Steps to Separate Good ACOs from Bad ACOs for Purposes of Antitrust Review and Next Steps**

The articles in this issue, taken together, constitute a valuable conversation on the need for, and nature of, metrics to allow us to determine whether

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2. See also Massachusetts Attorney General’s Office 2010: 2. We have found this report to be informative on health care market concentration and its potential effect on prices.

3. Though it goes beyond the scope of this article, we do wish to point out that it appears that Covered California has done an excellent job of ensuring that consumers have a wide range of choices in local geographic markets, where such choices are available.
ACOs are achieving the beneficial goals that they promise (see THINC 2011). How do we, for example, ensure that ACOs are adopting metrics that will lead to improvements in the quality of medical care as measured by reductions in morbidity or hospital readmissions? How do we overcome attribution problems with enrollees in multiple ACOs or who are in ACOs and see providers outside the ACO? How do we acquire data, determine an appropriate baseline for the existing quality of medical care, and then measure improvements in that care? Such quality improvements can be easily claimed and yet never materialize, as Patrick Romano and David Balan (2011) point out in their retrospective study of a hospital merger. Finding answers to these questions is especially important from an antitrust enforcement perspective, because enforcement may be in the form of conduct remedies in instances where a proposed integration may lead to quality improvements as well as price increases (see Leibenluft 2015). These articles helpfully suggest that such metrics may exist (Kessell et al. 2015 [this issue]). For example, one study looked at the kinds of evidence-based guidelines that health care providers in ACOs could follow as a general rule in treating their patients as well as outcome-based measures (Kessell et al. 2015). But we wonder whether other metrics, such as community baselines, can also be developed to measure quality improvements in the delivery of health care by ACOs. Accordingly, while these articles are an important first step in developing the necessary metrics, we believe that more work needs to be done to refine such metrics, understanding that, of course, a one-size-fits-all approach would not be desirable here.4

In fact, we believe that the continued development and refinement of such metrics in this area to be of the utmost importance. For example, large provider systems could well be able to claim that their ACOs lead to procompetitive efficiencies by the simple expedient of cutting the monopoly-level prices they previously charged. Though such a price cut in monopoly profits is not the kind of justification that we envision as being a procompetitive efficiency where it is accompanied by exclusionary conduct, we need to have appropriate metrics to figure out what kind of cost cutting is, in fact, beneficial.5 Where ACOs can work to structure deductibles so as to reward value-based decisions, for example, by offering preventive care for free or by offering discounts to consumers who enter

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4. See, e.g., Punke 2014 (discussing this issue); Terry 2014 (discussing this issue with regard to the Centers for Medicaid and Medicare Services ACOs).

into contracts with performance metrics, the results may lead to beneficial cost cutting. That purchasers of insurance on Covered California seem to prefer the high-deductible insurance plans offered there (see, e.g., California Healthline 2014) would seem to support this point.

We note, in particular, how the creation of ACOs for Medicare patients via the ACA has also been used as an excuse by health care providers to justify their ongoing program of acquisitions of physician practices, hospitals, and ambulatory surgery centers. The Centers for Medicare and Medicaid Services has been clear that, in its view, such acquisitions are not necessary to the creation of the kinds of integrated ventures envisioned by the ACA (CMS 2011: 67,843). Though we acknowledge that there may be cases in which such acquisitions do, in fact, lead to additional efficiencies, this development highlights the potential of using ACOs as a fig leaf to cloak the illegal acquisition or enhancement of market power.

Thus our hope is that the further developments of metrics and data on the quality side for ACOs will proceed in tandem with the development of metrics and data to measure the potential for (and actuality of) cost reductions for ACOs. These future steps would aid antitrust enforcers in determining when they could or should be potentially more flexible in the remedies they seek, as suggested in at least one article in this issue (Leibenluft 2015). It would also allow the California attorney general to meet the goal originally expressed in her letter to the federal antitrust authorities of reviewing closely only those ACO-associated transactions that have the greatest potential for, or have actually manifested, anticompetitive effects (California Attorney General’s Office 2012: 5–12). This is a goal also envisioned by the same article (Leibenluft 2015).

**Next Steps: Broadening the Review of ACO Issues**

While we found the articles in this special issue to be very helpful in thinking through the issues regarding ACOs, we believe that more needs to be done. First, most of the topics in these articles deserve follow-up and additional study. In particular, more data should be acquired regarding

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6. Though California’s bar on the corporate practice of medicine prevents hospital systems from the outright acquisition of physician groups (see Cal. Bus. & Prof. Code, §§ 2052, 2400 (2015)), a whole slew of exceptions exist to this bar, including the ability of hospitals to use not-for-profit foundations to employ physicians and the direct employment of physicians by hospitals in their emergency rooms, in certain rural areas, in certain federal organizations, in medical schools, and in the University of California. It is estimated that many of California’s physicians may fall within one of these exceptions. See Kim 2007: 2, 6–8 (discussing the multitude of exceptions). These exceptions may explain a preliminary study that found a lack of negative correlation between this law and ACO entry (Frech et al. 2014).
California markets so that we can better understand the effects of ACOs in those markets. For example, though one study provided some support for the commonly accepted view that Kaiser Permanente is a constraining force on the market as an ACO-type organization (Grossman, Tu, and Cross 2013), we wonder whether, in fact, this view is correct with regard to self-insured, and large, employers.

Second, there are additional topics that we believe should be explored in future articles. One such additional topic could be state regulatory requirements, including the current process by which ACOs are reviewed in California and other states (see Fulton et al. 2015). One article suggests that local antitrust enforcers should collaborate more closely with regulators in helping ensure that markets, including presumably ACO markets, are competitive (Leibenluft 2015). However, another study suggests that it would not be easy to determine when regulations would have a positive or negative impact on ACO formation (Frech et al. 2014). Correspondingly, a further exploration of regulatory issues would be very useful, including whether special regulations or legislation needs to be enacted for ACOs and, if so, in what set of circumstances. And, in particular, as part of any exploration of this topic, it would be useful to consider what, if anything, Covered California is doing or could be doing (see, e.g., Anthem Blue Cross 2014).

Third, as suggested by our discussion above, more work needs to be done on when an integrated structure should be deemed an ACO in the first instance (see Frech et al. 2014; Grossman, Tu, and Cross 2013). For example, would comanagement structures be the kinds of ventures envisioned as being ACO-like and leading to efficient health care delivery? Or would these structures be a cover for the coordination of prices and the enhancement of market power?

Fourth, we believe that one cannot overlook the localized nature of geographic markets when using up-to-date economic models of analysis (Capps, Dranove, and Satterthwaite 2003) that determine the relevant market by focusing on the bargaining between payers and health care providers over inclusion of those providers in the kind of network desired by employers and employees. Studies have suggested, albeit from different perspectives, that the localized geographic markets generated by such an analysis are, in fact, a proper focus for determining the market effects of ACOs (Dunn and Shapiro 2012; Gowrisankaran, Nevo, and Town 2013; Grossman, Tu, and Cross 2013; Robinson 2011). We would like to see future articles continue to explore this area in the specific context of ACOs.

Fifth, and finally, we would like to suggest that future articles examine whether the analysis of ACOs may be affected by the relationship between

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physician referrals and market power. There have been recent studies suggesting that such a relationship exists (Baker, Bundorf, and Kessler 2014; O’Malley, Bond, and Berenson 2011). Physician consolidation can lead to higher prices, and possibly the inefficient overuse of services, in localized markets (Dunn and Shapiro 2012). And a preliminary study even suggests that physician concentration may have a far larger impact than hospital concentration on the formation of ACOs, either insofar as there is a correlation between physician group size and the establishment of ACOs, which may imply a market power (nonefficiency) motive for the establishment of ACOs, or insofar as there is a correlation between high physician concentration in geographic markets and the lack of ACO formation altogether (Frech et al. 2014). Given the importance of physician groups in the creation of ACOs (Shortell et al. 2014), a further analysis of the relationship may be profitable in helping separate beneficial ACOs from more problematic ones worthy of closer review.

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