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The Interplay Between Competition and Clinical Integration: Why the Antitrust Agencies Care About Medical Care

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I. INTRODUCTION

The *Affordable Care Act* provides for the formation of Accountable Care Organizations (“ACOs”). These ACOs will be composed of health care providers (hospitals and physicians) that will work together to manage and coordinate care for Medicare beneficiaries.² Through this coordination of care—sometimes referred to as clinical integration—Medicare hopes that ACOs will lead to lower costs and increased quality of care for Medicare beneficiaries.³

Medicare, however, is not the only government agency interested in ACOs and the clinical integration that will likely characterize those entities. In particular, state and federal antitrust agencies (“the Agencies”) are also quite interested in ACOs.⁴ The Agencies’ interest in ACOs, however, differs somewhat from Medicare’s, and stems from the concern that, under some circumstances, ACOs may not benefit consumers, but instead lead to higher healthcare costs and lower quality of care.⁵

This paper outlines why the Agencies care about clinical integration, an issue that might seem primarily an issue of concern to the healthcare community and not antitrust enforcers, and how the Agencies typically evaluate the competitive significance of clinical integration. This discussion should help prospective ACOs understand how to pursue the benefits envisioned by the *Affordable Care Act* while avoiding antitrust concerns.

II. THE RELEVANCE OF CLINICAL INTEGRATION TO ANTITRUST

A brief discussion of the mandate of antitrust agencies such as the DOJ and FTC helps explain why they care about clinical integration.

¹ Vice President, Charles River Associates, Washington, DC. The opinions expressed in this paper are solely those of the author, and should not be attributed in any way to any other individual or to any organization.

² *Affordable Care Act*, Section 3022. Full a full text of the law, *see* www.docs.house.gov/energycommerce/ppacacon.pdf

³ Burke & Rosenbaum, *Accountable Care Organizations: Implications for Antitrust Policy*, at p. 2, *available at* www.rwjf.org/files/research/57509.pdf.

⁴ At the federal level, the principal antitrust agencies are the Antitrust Division at the U.S. Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”), while at the state level the principal antitrust agency is the state attorney general.

⁵ To explore these issues, in October 2010 the FTC held a joint hearing with the Centers for Medicare and Medicaid Services and the Office of the Inspector General of the Department of Health and Human Services to “address circumstances under which collaboration among independent health care providers in an ACO permits ACO providers to engage in joint price negotiations with private payers without running the risk of engaging in illegal price fixing under the antitrust laws.” *See* www.ftc.gov/opp/workshops/aco/index.shtml.

A. The Agencies' Focus is on Competition

The Agencies' principal focus is on protecting and promoting competition. This goal of promoting competition applies across all industries, including the healthcare industry. By ensuring consumers' ability to choose among competing providers, the Agencies hope that competition to attract consumers will lead those providers to offer lower prices, higher quality of care, and greater innovation. Thus, the Agencies care about competition because competition benefits consumers.

The Agencies' perspective with respect to the healthcare industry is not significantly different than its perspective with respect to other industries: Competition among physicians creates incentives for those physicians to offer the best product or service, at the most attractive price, and that this competition benefits consumers.⁶ Thus, as a general goal, the Agencies seek to ensure that consumers will enjoy sufficient choice among attractive alternative healthcare physicians that those physicians will have incentives to compete to offer the best service at the most attractive price.

B. Integration Can Reduce Competition and Harm Consumers

The Agencies' concern with clinical integration is that integration among physicians may reduce competition.⁷ In particular, successful integration may also require physicians to begin cooperating in ways that prevent them from offering their services as independent, competing entities. First, integrated physicians may end up contracting as a single entity rather than offering their services as distinct, competing entities. Second, integrated physicians may find it necessary to collectively agree on a price to charge, rather than independently choosing a price. This has the effect of reducing, or even eliminating, the competition that would otherwise emerge between those physicians. Thus, while the Agencies are not concerned about the direct competitive effects of integration among physicians, they are concerned that the ways in which physicians will change their organizational structure in order to achieve that integration may have the undesirable effect of reducing competition.

A reduction in choice, with an attendant reduction in competition, can harm consumers in several ways. First, with less competition, physicians will have fewer incentives to reduce (or at least avoid increased) prices; this incentive effect is no different for physicians than for any other group of competitors. Second, reduced competition means decreased physicians' incentives to pursue cost-saving efficiencies; after all, with less need to compete through lower prices, there will be less need to lower costs in order to be able to offer those lower prices. Thus, whatever the potential benefits that clinical integration may offer, if there is too little competition, physicians' incentives to pursue those benefits may be limited. Finally, reduced competition can result in reduced innovation that would otherwise benefit consumers. This reduced innovation may take the form of slower adoption of new beneficial medical technologies or practices, or less emphasis on keeping current with medical advances. This potential for clinical integration across otherwise

⁶ See, for example, a speech by FTC Commissioner Jon Leibowitz, *A Doctor and a Lawyer Walk into a Bar: Moving Beyond Stereotypes*, June 14, 2010, available at www.ftc.gov/speeches/leibowitz/100614amaspeech.pdf.

⁷ Although the focus of this paper is on clinical integration among physicians, the discussion also extends to cover clinical integration that includes hospitals.

competing physicians to reduce consumer choice, and thus harm consumers, provides the principal basis for the Agencies' concern with clinical integration.⁸

To the extent that ACOs limit their operations to how they deliver care to traditionally insured Medicare beneficiaries, the Agencies' concerns may be limited. Under Medicare's traditional insurance program, the prices that Medicare pays to physicians is determined administratively, not through competition. Thus, whatever effect an ACO may have on competition, it will not affect Medicare prices.⁹ It seems likely, however, that once physicians invest in the creation of an ACO, those physicians will seek to offer their services in the commercial market where prices are determined through the competitive process. This potential competitive effect in the commercial market provides the basis for the Agencies' potential concerns with ACOs.

C. Cooperation Among Competing Physicians May Benefit Consumers

It would be wrong, however, to focus just on the potential downside of ACOs. After all, the impetus behind the formation of ACOs is that the resulting integration of physicians offers the opportunity for consumers to benefit. Fortunately, while cognizant of potential competitive problems associated with ACOs, the Agencies are also keenly aware of these potential benefits. In fact, whether in healthcare or in other markets, the Agencies have long recognized that consumers can sometimes benefit when individual competitors get together. In some cases, this may take the form of individual competitors merging into a single, unified entity in which there are efficiencies that allow the merged entity to offer lower costs or more innovative services.¹⁰ Similarly, the Agencies recognize that cooperation short of a full-blown merger can also lead to efficiencies that benefit consumers. The Agencies typically refer to these situations, in which individual competitors remain independent entities but nevertheless coordinate on some aspects of how they compete, as "joint ventures." Depending on the nature of the coordination between those providers, those joint ventures may also result in efficiencies that benefit consumers.¹¹

In assessing the likelihood that physician network joint ventures ("PNJVs") were likely to yield significant efficiencies, the Agencies initially focused principally on whether the joint venture assumed substantial financial risk.¹² That focus reflected the Agencies' view that the adoption of substantial financial risk was likely to create strong incentives for physicians within the joint venture to reduce costs because any cost savings would be realized, at least in part, by

⁸ See, for example, the FTC's 2002 Advisory Opinion regarding the MedSouth physician organization in Denver, CO and its 2009 Advisory Opinion regarding TriState Health Partners in Hagerstown, MD. (Advisory Opinion letters available at www.ftc.gov/bc/adops/medsouth.shtm and www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf, hereafter *MedSouth* and *TriState*.)

⁹ There may, however, be effects related to non-price dimensions of competition.

¹⁰ The Agencies state that, "a primary benefit of mergers to the economy is their potential to generate significant efficiencies ... which may result in lower prices, improved quality, enhanced services, or more products." DOJ/FTC 2010 *Horizontal Merger Guidelines* at Section 10 (See www.justice.gov/atr/public/guidelines/hmg-2010.pdf)

¹¹ DOJ/FTC 2000 *Antitrust Guidelines for Collaborations Among Competitors* (www.ftc.gov/os/2000/04/ftcdojguidelines.pdf, hereafter *Collaboration Guidelines*).

¹² See Statement 6 in the initial DOJ/FTC *Statements of Antitrust Enforcement Policy in Health Care* (hereafter *Health Care Statements*) that were issued in 1993. While recognizing that efficiencies could result if the joint venture resulted in "a new product producing substantial efficiencies," the 1993 *Health Care Statements* advised that the "[e]fficiencies that the Agencies are most likely to recognize include any cost savings associated with the assumption of financial risk by participating physicians." (These 1993 *Health Care Statements* were subsequently revised in 1994, and again in 1996. The 1996 version of the *Health Care Statements* is available at www.justice.gov/atr/public/guidelines/1791.pdf.)

the PNJV itself. More recently, however, the Agencies have been more sympathetic to recognizing that the adoption of financial risk is not the only means by which a PNJV might realize substantial efficiencies, with one possibility being that those efficiencies might be the same benefits identified by the *Affordable Care Act*: Clinically integrated entities may be able to offer higher quality of care, and lower costs, by coordinating on how that care is delivered, by better coordinating information flows across healthcare providers, and creating internal incentives within the group to operate more efficiently and cost-effectively.¹³

It follows that two effects may arise simultaneously: ACOs may reduce competition but, at the same time, create an organizational structure that allows for lower costs and higher quality. The Agencies need to balance these two effects and assess whether, on net, consumers are likely to be helped or hurt by the ACO.

D. The Antitrust Agencies' Ultimate Goals are Similar to Those of Medicare

Both the antitrust agencies and Medicare care about clinical integration for similar reasons: both want to increase quality of care and create an environment in which physicians can lower costs. Medicare's focus on clinical integration rests on the belief that clinical integration *can* create an environment in which healthcare providers can lower costs and provide higher quality care. The Agencies, however, also focus on whether clinical integration will leave physicians with the incentive to lower costs and reduce prices. Thus, the Agencies' can be viewed as seeking to ensure that sufficient competition remains that physicians will have the incentives to realize the benefits envisioned by Medicare.

III. HOW DO THE AGENCIES ANALYZE THE POSSIBLE EFFECTS OF INTEGRATION?

The Agencies follow the same steps to analyze the likely competitive effects of an ACO as they do to analyze joint ventures in other industries. Inasmuch as that approach is discussed in detail elsewhere, I provide only a basic outline of those steps below.¹⁴

A. Who are the Relevant Competitors?

In this stage of the analysis, the Agencies seek to define the product and geographic markets in which the members of the ACO compete, as well as identify all the physicians that compete in that market. Thus, if an ACO spans both primary care and specialty physicians, the Agencies may conclude that the ACO potentially affects competition in several relevant markets, such as the market for primary care services, the market for cardiology services, and the market for orthopedic services. The Agencies then assess the geographic bounds of the market by assessing the extent to which physicians in other areas are a significant competitive constraint on the physicians in the ACO.

B. Is the ACO Doing Something Other Than Naked Price-Fixing?

¹³ It was not until the FTC's *MedSouth* Advisory Opinion in 2002 that either of the Agencies recognized efficiencies from clinical integration associated with a particular physician network as being likely and of significant magnitude. Since *MedSouth*, the FTC has recognized likely efficiencies in several other cases. *See*, for example, *TriState*, as well as the FTC's 2007 Advisory Opinion in *Greater Rochester Independent Practice Association* (<http://www.ftc.gov/os/closings/staff/070921finalgripamcd.pdf>). Note, however, that the FTC has not concluded that clinical integration is always likely to yield significant efficiencies. *See*, for example, their 2006 Advisory Opinion in *Suburban Health Organization, Inc.* (<http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf>).

¹⁴ For a more detailed discussion, *see* the *Health Care Statements* or the *Collaboration Guidelines*.

Once the Agencies determine that the ACO includes physicians that would otherwise be competing, they ask whether it is reasonably likely that there will be some benefit that stems from any coordinated pricing that takes place among the ACO physicians. If not, the Agencies will likely conclude the ACO is *per se* illegal, at which point analysis ends. But as long as there is some evidence that the joint pricing will likely yield at least some consumer benefits, and as long as the joint pricing is reasonably necessary for those benefits to be realized, the Agencies will then move to the second phase of their analysis: the rule of reason analysis in which they assess whether those efficiencies are likely to outweigh any harm caused by a reduction in competition among those otherwise competing physicians.

The Agencies' determination of whether the clinical integration associated with an ASO warrants rule of reason analysis may be influenced by Medicare's determination of whether an the physician group qualifies for ACO status. Section 3021 of the *Affordable Care Act* authorizes the Secretary to test whether ACOs improve the quality of care for Medicare beneficiaries and reduce unnecessary costs for the Medicare program. Such a determination by the Secretary would make it difficult for the Agencies to conclude the ACO offered sufficient efficiencies to warrant rule of reason treatment. Thus, for physician organizations that have already been qualified as an ACO by Medicare, the Agencies' focus on efficiencies may move from the question of whether there are sufficient efficiencies to avoid *per se* condemnation to instead ask whether there are sufficient efficiencies to avoid condemnation under a rule of reason analysis.

C. Determine Whether the ACO Qualifies for an Antitrust Safety Zone

An ACO that includes few of the physicians in a market is unlikely to have much effect on competition. The *Health Care Statements* recognize this and specify certain market share thresholds under which the Agencies will conclude the ACO will have no anticompetitive effects. The criteria for qualifying for what the *Health Care Statements* call a "safety zone" criteria are:¹⁵

- For physician groups that are *exclusive* (i.e., where ACO members only enter into contracts through the ACO), the physician cannot include more than 20 percent of physicians in a relevant market.
- For physician groups that are *non-exclusive* (i.e., where ACO members also enter into contracts independently of the ACO), the physician cannot include more than 30 percent of physicians in a relevant market.

D. Outside the Safety Zone, a Full Analysis is Necessary

For ACOs that do not meet the criteria set forth by the *Health Care Statements'* safety zones, the antitrust analysis involves assessing a variety of factors including the extent to which physicians in the ACO contract exclusively through the ACO, the market share of the physicians represented by the ACO, whether entry into the market is likely, the degree of differentiation between different physicians in the market, and what historical effect the ACO may have had on price.¹⁶ The rule of reason analysis is also where the Agencies will focus on assessing the magnitude of the any claimed efficiencies made possible by the ACO.

Assessing the magnitude of any efficiencies stemming from an ACO is likely to be very difficult. In part, this difficulty will likely stem from the ex-ante nature of these efficiencies. Unless the ACO can point to benefits that were realized while the ACO was operating solely within the

¹⁵ *Health Care Statements* at Statement 8.

¹⁶ See, more generally, *Health Care Statements* at Statement 8, *MedSouth* or *TriState*.

Medicare world, the ACO will be pointing to future efficiencies rather than historical efficiencies, yet assessing future efficiencies is always difficult. This assessment will also be made more difficult by the fact that benefits from clinical integration are likely to be phased in over time. Thus, the Agencies will be forced to assess just how quickly those efficiencies are likely to be realized, and how to balance that stream of efficiencies over time with any anticompetitive effect.¹⁷

IV. IMPLICATIONS FOR PHYSICIANS INTERESTED IN FORMING AN ACO

Physicians interested in forming an ACO should consider several factors that may affect whether the Agencies ultimately view the ACO as likely to benefit, or instead to harm, consumers:

- **Size matters.** Although the Agencies have made it clear that physician groups that fall outside the safety zones are not necessarily anticompetitive, it remains clear that size still matters: ACOs with market shares in excess of 50 percent of the physicians in a market are likely to be heavily scrutinized.¹⁸ This concern with market share may be particularly relevant in rural areas where there are relatively few physicians that practice within any particular specialty, and thus is an area where an ACO may end up with a high share of physicians in a particular specialty.¹⁹
- **Qualification as an ACO is only half the battle.** Designation as an ACO by Medicare seems likely to cause the Agencies acknowledge sufficient efficiencies to allow ACOs to avoid *per se* condemnation and, instead, require a rule of reason analysis by the Agencies. Yet, to offset any concerns about high market share, an ACO will need to convince the Agencies that efficiencies are real and significant. Being able to show a track record of Medicare-related efficiencies will help, but for newly forming ACOs that seek to simultaneously begin serving the commercial non-Medicare market, ACOs will need to rely on prospective efficiency claims. Moreover, as the ACO's market share increases, the Agencies are likely to become increasingly concerned that reductions in competition may significantly reduce the ACO's incentive to pursue possible efficiencies through clinical integration.
- **How will customers react to the ACO?** Ultimately, the Agencies may have a very difficult time assessing efficiencies and then balancing those efficiencies against possible

¹⁷ See, for example, *MedSouth* in which the FTC discusses the difficulty of assessing the magnitude of prospective efficiencies and the difficulties of determining whether claimed efficiencies are likely to be realized.

¹⁸ See, however, *TriState*, in which the FTC concluded that despite its belief that “TriState physicians represent a very substantial majority of the physicians,” as long as those physicians contracted on a non-exclusive basis, the competitive concerns were sufficiently limited, and the expected efficiencies sufficiently great, that TriState would not be anticompetitive.

¹⁹ There has been some concern that the requirement that ACOs cover at least 5,000 Medicare lives will further exacerbate this problem by effectively requiring the participation of so many physicians to cover those lives that the ACO will end up with high market shares. This concern may only end up relevant in the most rural of areas. Based on National Health Statistics Reports, patients make approximately 1.14 visits per year to general acute primary care physicians (general and family practice, and internal medicine, physicians). (See National Ambulatory Medical Care Survey: 2006 Summary at Table 1, available at <http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf>) If Medicare patients make up approximately 30 percent of those physicians patient load, and if they can see approximately three patients/hour over the course of an eight-hour day, then an ACO would need approximately three general acute primary care physicians to treat a Medicare member base of 5,000 enrollees. In many areas of the country, three physicians would not constitute a significant share of competing primary care physicians. Of course, expanding the ACO's practice to also include non-Medicare patients would require more physicians, at which point the ACO's market share might begin to raise competitive concerns.

competitive effects. A good (and readily observable) signal, however, of whether an ACO is likely to be pro-competitive or anticompetitive will be the reaction of the health plans with which the ACOs will contract.²⁰

ACOs that offer clinical integration that benefits consumers, while not reducing competition, are likely to be welcomed by health plans. Moreover, as long as the formation of the ACO does not significantly reduce competition, then even those health plans that do not like what the ACO has to offer should voice no concerns since they can simply contract with other physicians.²¹

If, however, health plans voice concerns about an ACO, it is more likely that the ACO is not offering any significant benefits. Similarly, health plan concerns about an ACO are more likely to arise when the formation of the ACO has reduced competition since, absent that reduction, health plans could have simply switched physicians if they were unhappy with the ACO.

²⁰ This is not to suggest that the Agencies will (or should) base their analysis solely on what customers says. But those customers' views, and the reason behind those views, can provide very valuable information to be used in assessing competitive effects.

²¹ This approach is evident, for example, in *MedSouth*. At that time, the FTC stated, "As long as MedSouth's physician members actually are available and willing to contract individually with payers who prefer not to contract with the network, at prices that do not reflect the aggregate power of the group ... implementation of the arrangement is not likely to endanger competition." Similarly, see *TriState* at note 50 in which the FTC stated, "We are not in a position to specify prospectively when those efficiencies must be achieved, or what level of efficiencies would be 'significant.' The best judges of that are likely to be ... customers 'voting with their feet' if the program fails to achieve acceptable results within what they view as a reasonable period of time."