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# Competitor Collaborations in Health Care: Understanding the Proposed ACO Antitrust Review Process

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## I. INTRODUCTION

Health care markets involve a complex interaction of facilities, physicians, and health plans to deliver patient care. Under ideal circumstances, the forces of competition would lead inevitably to appropriate, high quality patient care at low prices. The competitive process, however, requires sufficient flow of information and aligned incentives. Absent these conditions, the competitive process can (and has been known to) break down. Indeed, the last decade has seen a dramatic increase in the United States' cost of health care as a percentage of gross domestic product. Health care commentators trying to understand this growth have pointed to increases in the price and use of certain services, which they attribute to a number of factors such as an aging population and at times, use of unnecessary care and insufficient competitive pressure.[2] To address some of these issues, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 encourage providers to better coordinate patient care through competitor collaborations called Accountable Care Organizations ("ACOs").

By incenting otherwise independent health care providers (through the Medicare Shared Savings Program) to better coordinate on patient care, the policy goal is to improve the quality and reduce the cost of health care. Unchecked, however, the same policy could facilitate competitor coordination on pricing and other aspects of behavior that may result in unintended and potentially undesirable effects. To address this concern, the Department of Justice and Federal Trade Commission ("the Agencies") have set forth a proposed antitrust policy statement regarding ACOs that describes a rule of reason approach to balance potential harm to competition from competitor collaboration in the form of an ACO with potential pro-competitive benefits to consumers.[3]

While it is too early to know what type of antitrust scrutiny ACOs will receive in practice, the Agencies' Proposed Policy contains some important structural guidance. In particular, the Proposed Policy contains behavior requirements to which ACO participants must adhere along with three tiers of antitrust review. Among them is the creation of safe harbors that

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[2] DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, (July 2004).

[3] Federal Trade Commission and Antitrust Division of the Department of Justice, *Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 (75) FEDERAL REGISTER, Tuesday, April 19, 2011 (hereinafter, "Proposed Policy").

appear to mirror the three tiers of antitrust review contained in the Agencies' Merger Guidelines.[4]

From a policy perspective, it is unclear whether the ACO review should be more or less stringent than the merger review process. On the one hand, one might expect the ACO review to be more stringent because of the financial incentives to participate in the Medicare Shared Savings Program. On the other hand, one might expect the reverse because, all else equal, the added behavioral stipulations by design help ensure that formation of an ACO presents less competitive risk than does a merger of the participants to a fully integrated firm.

This article uses numerical simulations to compare the proposed thresholds for ACO antitrust review to those established in the Merger Guidelines. For relatively unconcentrated markets, whether the ACO review process is more stringent than the merger review process depends on how restrictive the behavioral requirements are for the ACO participants. If they are not binding, the numerical simulations suggest that the ACO review process should be no more stringent than the merger review process for relatively unconcentrated markets and less stringent in relatively more concentrated markets. Otherwise, the ACO review may be more restrictive for some scenarios.

## II. ANTITRUST REVIEW PROCESS IN THE PROPOSED POLICY

The Proposed Policy involves a review that begins with an analysis of an ACO's share, by service line, within each participant's "primary service area" ("PSA"). In keeping with geographic market analysis in hospital merger review, a PSA is identified based on patient flows. Specifically, a PSA is defined as the smallest number of contiguous postal zip codes from which a participant draws at least 75 percent of its patients for that service. Then, based on an ACO's PSA share of common services, the Proposed Policy entails three tiers of antitrust review:

**A Safety Zone**: For ACOs whose participants' combined share of common services is no more than 30 percent and whose participating hospitals and ambulatory surgical centers are non-exclusive to the ACO, there will be a presumption that the competitor collaboration is unlikely to raise significant competitive concerns.[5] In this case, no initial competitive review would be required and the ACOs would be allowed to participate in the Shared Savings Program.[6]

**Mandatory Review**: For ACOs whose participants' combined share of common services exceeds 50 percent, there will be an *ex-ante* concern for potential competitive harm. These ACOs will be required to undergo a mandatory antitrust review to further evaluate the competitive risks. ACOs that receive an antitrust waiver letter from the Agencies upon completion of this review process would be allowed to participate in the Shared Savings Program.[7]

**Intermediate Zone**: For ACOs whose participants' combined share of common services is between 30 and 50 percent, there is less certainty as to the level of scrutiny the ACO would receive. According to the Proposed Policy, "an ACO in this category that does not impede the

[4] U.S. DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES (August 19, 2010).

[5] The ACO share may be permitted to exceed the 30 percent threshold in rural areas. There may also be additional non-exclusivity requirements for ACOs that include a provider whose share excluded 50 percent of any service that no other ACO participant provides to patients in a particular PSA.

[6] Proposed Policy, *supra* note 3, Section IV.A.

[7] Proposed Policy, *supra* note 3, Section IV.B.

functioning of a competitive market and that engages in procompetitive activities will not raise competitive concerns and may proceed without Agency scrutiny." The Proposed Policy further delineates five types of conduct that ACOs should avoid to reduce the likelihood of an antitrust investigation. These include: (i) practices steering patients to certain providers; (ii) tying sales of the ACOs' services to the commercial payers' purchase of other services from providers outside of the ACO (and vice versa); (iii) requiring exclusivity from participating physician specialists, hospitals, ambulatory surgical centers, or other providers (with the exception of primary care physicians); (iv) prohibiting or interfering with a commercial payer's ability to provide cost, quality, efficiency, and performance information to its enrollees that may assist them in selecting a provider; and (v) sharing of competitively sensitive price information among the ACO provider participants.[8]

## III. HOW THE SAFE HARBORS COMPARE TO THOSE IN THE MERGER GUIDELINES

To assess the relative stringency, consider the application of the proposed guidelines to a series of hypothetical scenarios. In each scenario, one can evaluate the formation of an ACO with firms 1 and 2, in a PSA with 10 firms. Table 1 presents different combinations of market shares. In the first row of Table 1, the ACO participants each have a market share of 7.5 percent, and each of the other 8 firms are equally sized, each with a 10.6 percent share. Moving down the rows, the ACO participants become larger and the other 8 firms become smaller. The last two columns summarize the initial screening the ACO participants would be expected to receive under the Proposed Policy. ACOS with share less than 30 percent would be safe from competitive review, provided they satisfy the non-exclusivity requirement. ACOs with share between 30 and 50 percent would be in the intermediate zone, and ACOs with shares greater than 50 percent would be subject to mandatory review.

**Table 1: ACO Review for Firms 1 and 2, with 10 Firms in a PSA**

| Shares by Firm | | | | | | | | | | ACO | ACO Review |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Share** | **Treatment** |
| **7.5** | **7.5** | 10.6 | 10.6 | 10.6 | 10.6 | 10.6 | 10.6 | 10.6 | 10.6 | 15 | Safe with non-exclusivity |
| **12.5** | **12.5** | 9.4 | 9.4 | 9.4 | 9.4 | 9.4 | 9.4 | 9.4 | 9.4 | 25 | Safe with non-exclusivity |
| **17.5** | **17.5** | 8.1 | 8.1 | 8.1 | 8.1 | 8.1 | 8.1 | 8.1 | 8.1 | 35 | Intermediate |
| **22.5** | **22.5** | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 45 | Intermediate |
| **27.5** | **27.5** | 5.6 | 5.6 | 5.6 | 5.6 | 5.6 | 5.6 | 5.6 | 5.6 | 55 | Mandatory Review |
| **32.5** | **32.5** | 4.4 | 4.4 | 4.4 | 4.4 | 4.4 | 4.4 | 4.4 | 4.4 | 65 | Mandatory Review |

Under the Merger Guidelines, the Agencies generally classify markets into three types based on the Herfindahl-Hirschman Index ("HHI"): unconcentrated markets (HHIs below 1500), moderately concentrated markets (HHIs between 1500 and 2500), and concentrated markets (HHIs above 2500). There is a presumption that mergers involving an increase in the HHI (known as the "delta") of less than 100 points or mergers resulting in unconcentrated markets are unlikely to have an adverse competitive effect and therefore require no further analysis. This is what is known as the "safe harbor" in merger review. Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points "potentially

[8] Proposed Policy, *supra* note 3, Section IV.C.

raise significant competitive concerns and often warrant scrutiny." One might view this treatment as somewhat analogous to the "Intermediate" treatment under ACO review, though the actual language is somewhat different. Finally, mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points "potentially raise significant competitive concerns and often warrant scrutiny." Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points "will be presumed to be likely to enhance market power." This presumption may be rebutted by evidence showing that the merger is unlikely to enhance market power. ACO participants would be afforded a similar opportunity, to rebut the presumed effect of their formation, under a mandatory ACO review.

Table 2 summarizes how the merger review process would treat as an initial screen a merger of two firms that might otherwise form an ACO, assuming that the PSA is the properly defined antitrust market. Each row of Table 2 should be interpreted with reference to the same row in Table 1. In these scenarios, the two reviews produce essentially the same initial treatment, with the exception of the behavior stipulations. At the lower shares, the ACO participants must agree to non-exclusivity, while the merger participants need not.

**Table 2: ACO and Merger Review Treatment for Scenarios in Table 1**

| ACO Share | ACO Review Treatment | Post-HHI | Delta | Merger Review Treatment |
|---|---|---|---|---|
| 15 | Safe with non-exclusivity | 1128 | 113 | Safe |
| 25 | Safe with non-exclusivity | 1328 | 313 | Safe |
| 35 | Intermediate | 1753 | 613 | Intermediate |
| 45 | Intermediate | 2403 | 1013 | Intermediate |
| 55 | Mandatory Review | 3278 | 1513 | Mandatory Review |
| 65 | Mandatory Review | 4378 | 2113 | Mandatory Review |

Table 3 presents a similar set of calculations for more concentrated PSA. Compared to Table 1, the number of firms is reduced from 10 (in Table 1) to 5. In each of the scenarios below, the merger of firms 1 and 2 would result in highly concentrated markets that involve an increase in the HHI of more than 200 points and as such, "will be presumed to be likely to enhance market power." By comparison, the ACO review process would create a safe harbor (provided hospital and ambulatory surgical center participants remain non-exclusive) in the first two scenarios and an intermediate concern in the next two scenarios.

**Table 3: ACO vs. Merger Review for Firms 1 and 2, with 5 Firms in a PSA**

| Shares by Firm | | | | | ACO | ACO Review | Post- | | Merger Review |
|---|---|---|---|---|---|---|---|---|---|
| **1** | **2** | 3 | 4 | 5 | **Share** | **Treatment** | **HHI** | **Delta** | **Treatment** |
| **10.0** | **10.0** | 26.7 | 26.7 | 26.7 | 20 | Safe with non-exclusivity | 2533 | 200 | Mandatory Review |
| **15.0** | **15.0** | 23.3 | 23.3 | 23.3 | 30 | Safe with non-exclusivity | 2533 | 450 | Mandatory Review |
| **20.0** | **20.0** | 20.0 | 20.0 | 20.0 | 40 | Intermediate | 2800 | 800 | Mandatory Review |
| **25.0** | **25.0** | 16.7 | 16.7 | 16.7 | 50 | Mandatory Review | 3333 | 1250 | Mandatory Review |
| **30.0** | **30.0** | 13.3 | 13.3 | 13.3 | 60 | Mandatory Review | 4133 | 1800 | Mandatory Review |

## IV. CONCLUSIONS

This article uses numerical simulations to compare the proposed thresholds for ACO antitrust review to those established in the Merger Guidelines. The analysis assumes that the PSA used to evaluate ACO share is the same as the relevant geographic market that would be appropriate for antitrust analysis under the Merger Guidelines. For relatively unconcentrated markets, whether the ACO review process is more stringent than the merger review process depends on how restrictive the non-exclusivity requirement on hospitals and ambulatory surgical centers are to the ACO participants. If they are not binding, the numerical simulations suggest that the ACO review process is no more stringent than the merger review process for relatively unconcentrated markets and less stringent in relatively more concentrated markets.