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## STATE OPTIONS FOR MANAGING THE DOUBLE-EDGED SWORD OF VERTICAL HEALTH CARE INTEGRATION

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### ABSTRACT

The United States spends more on health care in absolute terms and per capita than any other nation. The United States has experienced more than a 400 percent increase in total health care expenditures since 1990.<sup>1</sup> By 2013, health care expenditures exceeded \$2.9 trillion and represented 17.4 percent of our GDP. Yet, while we pay more per capita for health care, the health of American citizens does not reflect this sacrifice. In large part, our health care costs so much because we both overuse and overpay for health care goods and services. The Affordable Care Act enacted several reforms to curb overutilization by shifting payment incentives from reimbursement models that reward high volume care to those that reward high value care and by encouraging integrated health care delivery systems that promote efficiency and eliminate waste. But, our commitment to integration and value based care will not bend the cost curve without a simultaneous and sustained effort to protect competition and prevent the systemic attainment and abuse of market power.

Health care integration presents a double-edged sword, with potential quality and efficiency benefits, but also risks of increasing market concentration and health care prices. While federal antitrust enforcement

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<sup>1</sup> Centers for Disease Control and Prevention, "Gross Domestic Product, National Health Expenditures, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: United States, Selected Years 1960-2013," Table 102, *available at* <http://www.cdc.gov/nchs/data/hs/2014/102.pdf>.

can counteract some of the potential anticompetitive impacts associated with increased health care concentration, states also have both an opportunity and an obligation to assist in health care cost containment. We offer several policy tools states can use to manage the double-edged sword of health care integration, by encouraging beneficial integration, but pairing it with price and quality oversight to avoid harm to competition. Each of these tools requires substantial amount of data so, at minimum, all states should create a mechanism to collect and analyze information on price, quality, utilization, and competition, such as an All-Payer Claims Database.

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## INTRODUCTION

It is no secret that U.S. health care costs are out of control. The United States has experienced more than a 400 percent increase in total annual health care expenditures since 1990,<sup>2</sup> exceeding \$2.9 trillion and representing 17.4 percent of GDP in 2013 alone. Insurance premiums are at their highest levels in history, costing the average family nearly \$17,000 a year, while annual out of pocket spending has risen to an average of \$800 per person.<sup>3</sup> Yet, while we pay more per capita than any other nation for health care, the health of American citizens does not reflect this additional spending.

In the lead-up to the passage of the Affordable Care Act (ACA), Dr. Atul Gawande laid out what has become the dominant narrative of U.S. health care cost containment in his highly influential *New Yorker* article, *The Cost Conundrum*.<sup>4</sup> The narrative was this: health care expenditures vary widely throughout the country in ways that cannot be explained by the sickness of the patient population, the quality of care provided, or even the cost of producing the health care. The most expensive regions in the country have higher health care utilization, and for that extra utilization, produce neither better quality care nor better patient health outcomes. In fact, leading researchers estimate that the federal government could eliminate nearly 30% of Medicare spending without sacrificing quality or outcomes if higher-spending regions mirrored the utilization patterns of lower-spending regions.<sup>5</sup> Following this logic, Dr. Gawande and several leading health

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<sup>2</sup> Centers for Disease Control and Prevention, "Gross Domestic Product, National Health Expenditures, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: United States, Selected Years 1960-2013," Table 102, available at <http://www.cdc.gov/nchs/data/hs/2014/102.pdf>.

<sup>3</sup> Kaiser Family Foundation and Health Research & Educational Trust, "2014 Survey of Employer Health Benefits," available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey>; Health Cost Institute, 2013 Health Care Cost and Utilization Report, available at <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

<sup>4</sup> Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009, <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum>.

<sup>5</sup> John E. Wennberg et al., *Geography and the Debate over Medicare Reform*, HEALTH AFF. Web Exclusive W96, W104 (Feb. 2002), <http://content.healthaffairs.org/content/early/2002/02/13/hlthaff.w2.96.short>.

economists argued that to bend the cost curve, the U.S. healthcare system needed to realign its payment and delivery systems to disincentivize and reduce overutilization, and to instead reward coordination, quality, and efficiency. Gawande's account was so compelling that it became required reading in President Obama's White House and Capitol Hill in the months leading up to the passage of the ACA, heavily influencing the translation of cost control policies into law.<sup>6</sup>

As a result, the cost containment mechanisms of the ACA and several other health care reform efforts focus heavily on reducing overutilization.<sup>7</sup> To do so, federal policy encourages and even incentivizes vertical integration among health care entities, with the goal being to improve communication, eliminate wasteful or repetitive services, encourage shared resources, and reduce overhead expenses.<sup>8</sup> Yet, in our effort to control utilization, we have often overlooked the other half of the equation: prices.

This article examines the other half of the narrative. Specifically, we consider the potential impact of vertical integration on health care prices, and argue that states have both an opportunity and an obligation to contribute to existing federal antitrust enforcement efforts to control health care prices.<sup>9</sup> We offer six policy initiatives for state governments to choose from in accordance with their specific political and health care environments to enable them to encourage beneficial integration while controlling price increases.

The United States will not bend the cost curve without also addressing private health care prices. High prices are the main reason the United States spends so much more on health care than other wealthy and developed

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<sup>6</sup> See Robert Pear, *Health Care Spending Disparities Stir a Fight*, N.Y. TIMES (Jun. 8, 2009), <http://www.nytimes.com/2009/06/09/us/politics/09health.html>; Bob Kocher & Farzad Mostashari, Opinion, *A Health Care Success Story*, N.Y. TIMES (Sept. 23, 2014), [http://www.nytimes.com/2014/09/24/opinion/a-health-care-success-story.html?\\_r=0](http://www.nytimes.com/2014/09/24/opinion/a-health-care-success-story.html?_r=0).

<sup>7</sup> Examples include the Medicare Shared Savings Program, Accountable Care Organizations, Patient Centered Medical Homes, and bundled payments.

<sup>8</sup> Kaiser Family Foundation, Summary of the Affordable Care Act, available at: <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>.

<sup>9</sup> In this article, we focus specifically on vertical integration because antitrust authority have generally treated its use as procompetitive, as a result, antitrust analysis and guidance for vertical integration efforts are much less robust than for horizontal integration.

countries, whether measured per capita or as a percentage of the economy.<sup>10</sup> Moreover, similar to the overutilization problem, the higher prices we pay do not result in more or better quality care, nor do they lead to better health outcomes.<sup>11</sup> While it may be true that nearly a third of Medicare spending is waste,<sup>12</sup> when looking at our total public and private health care spending, price increases explain most of the rise in U.S. health care costs,<sup>13</sup> eclipsing the effects of increasing utilization, the aging or sickness of the population, the supply of health care services, malpractice litigation, and defensive medicine.<sup>14</sup>

As a result, health care cost containment efforts must consist of two parts: reducing overutilization and constraining health care prices.<sup>15</sup> Just like going to the grocery store, the amount of your bill depends on how

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<sup>10</sup> Bruce C. Vladeck & Thomas Rice, Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers, 28 HEALTH AFF. 1305, 1305-06 (2009); Gerard F. Anderson et al, *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22 Health Aff. 89, 103 (2003)..

<sup>11</sup> See Vladeck & Rice, *Facing Up to the Power of Sellers*, *supra* note **Error! Bookmark not defined.**, at 1306.

<sup>12</sup> Wennberg et al., *supra* note 5, at W104.

<sup>13</sup> Hamilton Moses III et al., The Anatomy of Health Care in the United States, 310 JAMA 1947, 1949 (2013); Gerard Anderson et al., Health Spending in the United States and The Rest of the Industrialized World, 24 HEALTH AFF. 903, 904 (2005).

<sup>14</sup> Hamilton Moses III et al., *The Anatomy of Health Care in the United States*, 310 JAMA 1947, 1949 (2013) (“Between 2000 and 2011, increase in price (particularly of drugs, medical devices, and hospital care), not intensity of service or demographic change, produced most of the increase in health’s share of GDP.”); Gerard Anderson et al., *Health Spending in the United States and The Rest of the Industrialized World*, 24 HEALTH AFF. 903, 904 (2005) (“We conclude that supply constraints and waiting lists do not appear to translate into significant savings in other countries and that malpractice and defensive medicine are responsible for only a small portion of the U.S. spending differential.”); OFFICE OF ATTORNEY GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DIVERS PURSUANT TO G.L. C. 118G, § 61/2(B) 3, 16-27 (2010), <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf> [hereinafter MASSACHUSETTS AG 2010 REPORT]. (“Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.”)

<sup>15</sup> Erin C. Fuse Brown, The Blind Spot in the Patient Protection and Affordable Care Act’s Cost Control Policies, 163 ANNALS INTERNAL MED. \_\_\_, \_\_\_ (Forthcoming \_\_\_, 2015).

many items you buy as well as the price of each item. In the simplest of terms, we overuse care due to rampant inefficiencies in the system and payment incentives that reward higher volume care, rather than higher value care. We overpay for services due to several severe imperfections in the health care market;<sup>16</sup> first among them being high levels of provider concentration that facilitate the abuse of market power. We cannot effectively control our health care spending without addressing both overutilization and overpayment.

Unfortunately, the two are inextricably linked. Health care integration holds a lot of promise to reduce wasteful and unnecessary use of services, but it also has a dark side that has the ability to overwhelm any hard-won cost savings from reductions of unnecessary care. The dark side of health care integration is that it has the capacity to increase consolidation in the health care industry, which leads to increased health care prices.<sup>17</sup>

The U.S. health care pricing problem is a largely a provider market power problem.<sup>18</sup> Within the same geographic area, there can be a 60% difference between the highest and lowest-priced hospitals for the same inpatient service, and a twofold difference in prices for outpatient services.<sup>19</sup> A substantial body of research demonstrates that market power

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<sup>16</sup> Other market inefficiencies that contribute to overpayment for health care include asymmetric information between physicians and patients, a lack of price transparency, high barriers to entry, and an inelastic demand for health care.

<sup>17</sup> Katherine Baicker & Helen Levy, *Coordination versus Competition in Health Care Reform*, 369 N. ENGL. J. MED. 789, 789 (2013).

<sup>18</sup> See, e.g., Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, 16 RES. BRIEF (Ctr. for Studying Health Sys. Change), Nov. 2010, at 6.; Chapin White, Amelia M. Bond, James D. Reschovsky, *High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power 2* (Ctr. For Studying Health System Change, Research Brief No. 27, Sept. 2013), <http://www.hschange.com/CONTENT/1375/1375.pdf>; Robert A. Berenson, et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 Health Aff. 973, 973 (2012); Robert Berenson, *Acknowledging The Elephant: Moving Market Power And Prices To The Center Of Health Policy*, Health Aff. Blog, Jun. 3, 2014, 2:54 p.m., <http://healthaffairs.org/blog/2014/06/03/acknowledging-the-elephant-moving-market-power-and-prices-to-the-center-of-health-policy/>.

<sup>19</sup> Chapin White et al., *High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power 4* (Ctr. For Studying Health Sys. Change, Research

drives these unwarranted variations in prices between providers, not differences in quality, payer mix, demographics or health of the patient population.<sup>20</sup> In other words, when we pay more at a high-price provider, we rarely receive more or better care, we simply pay more for their market leverage.<sup>21</sup>

When entities abuse market power, the first policy response is often antitrust enforcement. Federal antitrust enforcement has an important role to play to curb anticompetitive consolidation in health care, but it has some serious limitations as a widespread bulwark against the risks of rising health care integration. First, the federal antitrust agencies simply do not have the resources or capacity to police the sheer volume of consolidation efforts throughout the country. Second, antitrust is better at preventing mergers than unwinding them, which means there is little antitrust enforcers can do for the majority of the country that is already highly concentrated. Finally, in comparison to horizontal integration,<sup>22</sup> vertical integration<sup>23</sup> presents greater potential quality, coordination, and efficiency benefits, so federal antitrust enforcers have generally granted more leeway to vertically integrated proposals.<sup>24</sup> The potential efficiencies created through clinical

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Brief No. 27, 2013), <http://www.hschange.com/CONTENT/1375/1375.pdf>.

<sup>20</sup> MASSACHUSETTS AG 2010 REPORT, *supra* note 14, at 2; Joseph P. Newhouse & Alan M. Garber, *Geographic Variation in Health Care Spending in the United States: Insights from an Institute of Medicine Report*, 310 JAMA 1227, 1227-28 (2013) (“[P]rice variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons. Variation in wage levels and variation in the quantity of services delivered are almost equally responsible for the remaining estimated 30% of spending variation.”); Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power* (Center for Studying Health System Change, Research Brief No. 16, 2010).

<sup>21</sup> MASSACHUSETTS AG 2010 REPORT, *supra* note 14, at \_\_; Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power* 6, (Ctr. For Studying Health Sys. Change, Research Brief No. 16, 2010), <http://www.hschange.org/CONTENT/1162/1162.pdf>.

<sup>22</sup> Horizontal integration is consolidation between immediate competitors in a market.

<sup>23</sup> Vertical integration is consolidation between two entities in a product delivery chain, e.g. a buy and a seller of a particular product.

<sup>24</sup> To date, no federal antitrust enforcement challenge has been brought against a health care entity. (Feinstein?)

and financial integration in health care and the relative lack of data on the impact of vertically integrated health care entities on different health care markets will further complicate antitrust enforcement efforts.

In light of the limits of federal antitrust enforcement, states have a central role to play in addressing the price-component of health care cost containment. States have an opportunity and an obligation to balance the benefits of vertical health care integration and the risks of further consolidation to competition and price. The way to address the double-edged sword of vertical health care integration is to offer incentives to encourage beneficial integration with a quid pro quo of submitting to oversight regarding price, quality, and competition.

States have a variety of oversight tools to choose from.

- First, states should start by gathering comprehensive pricing, quality, utilization, and provider data. Many states have created All-Payer Claims Databases (APCDs) to serve this function. Beyond simply improving price transparency, APCDs can supply the market data needed inform future policy decisions, such as what types of integration and market dynamics lead to price increases; what impact do ACOs have on quality metrics and patient outcomes; and if direct regulation is contemplated, what levels prices ought to be.
- Second, states can manipulate their antitrust enforcement power to either discourage or encourage integration in health care. State attorneys general can vigorously enforce the state and federal antitrust laws to police and exact ongoing oversight over the integrations that pose the greatest risk to competition. Alternatively, states can opt to incentivize integration by offering immunity from state and federal antitrust enforcement to ACOs and other health care collaborations via the state action immunity doctrine.
- Third, states can create a certification program that requires all health care collaborations to submit to ongoing price and quality oversight in exchange for a range of benefits such as permission to operate an ACO or health care collaborative, a



state “seal of approval,” and immunity from antitrust or state fraud and abuse laws.

- Fourth, states could adopt a rate oversight model through a health care rate commission or the Department of Insurance with authority to monitor, approve, and limit health care rate increases by providers or health plans.
- Fifth, states could impose caps on the prices providers may charge to private payers, but still permit prices to vary beneath the cap.
- Finally, states can adopt all-payer rate setting to regulate provider prices like a utility.

We consider each option in order of least to greatest amount of intervention into the state’s health care market. Other recommending that all states should create a mechanism for collecting and analyzing health care data, we do not make firm recommendations on which policies are best or most effective, because the most appropriate policy option will depend on each state’s political and market dynamics.

Normatively, states should address the competitive risks of health care integration for at least two reasons: first, health care markets are not uniform and state experimentation enables each state to tailor its policy approach to the characteristics of its politics and health care market dynamics; second, there is a dearth of empirical data on the effectiveness of many of these models, so allowing the states to experiment with a variety of policy options at the same time will speed understanding and analysis of their implications.

This article explores the opportunity and obligation states have to contribute to health care cost containment efforts. Part I explains the potential benefits of vertical integration in health care, as well as the legal incentives to integrate. Part II describes the emerging evidence warning that vertical integration in health care may also present a threat to competition and lead to increased prices. Part III explains that states have a key role to play in managing this threat because of the limits of federal antitrust enforcement, federal oversight, and market-based solutions. Part IV posits that the way to manage the double-edged sword of vertical health care

integration is to permit beneficial integration to proceed in exchange for price and quality oversight by states. Part IV goes on to examine five policy tools that all build upon robust all-payer claims data gathering to inform future health policy decisions.

## I. THE BENEFITS OF HEALTH CARE INTEGRATION

Health care in the U.S. is notoriously fragmented and inefficient.<sup>25</sup> Increased vertical integration and collaboration in health care promises to reduce waste, increase efficiency and improve quality by altering the financial incentives to overuse care and permitting physicians to more easily collaborate.<sup>26</sup> The recent health care reforms have created powerful incentives for providers and even plans to engage in vertical integration, whether to operate an accountable care organization (ACO), or better manage the shift away from fee-for-service to new payment models based on value.<sup>27</sup> But little is known about how increased vertical integration may affect different health care markets with varied levels of competition. Part I explores the promise of vertical integration both from a theoretical and empirical basis.

### A. *Theoretical Benefits of Vertical Integration*

From a theoretical perspective, vertical integration promotes efficiency. In microeconomics, vertical integration refers to the common ownership of two different stages of production of a product, such as a manufacturer and

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<sup>25</sup> See, e.g., *The Fragmentation of U.S. Health Care: Causes and Solutions* (E. Elhauge ed., Oxford University Press 2010).

<sup>26</sup> See David Cutler, *How Health Care Reform Must Bend the Cost Curve*, 29 HEALTH AFF. 1131, 1133-34 (2010).

<sup>27</sup> Similar incentives exist for horizontal consolidations between hospitals or between health insurers. Indeed, the pace of horizontal mergers in health care has also increased following the passage of the ACA. See Leemore Dafny, *Hospital Industry Consolidation—Still More to Come?* 370 New Engl. J. Med. 198, 198 (2014). The literature on the anticompetitive potential of horizontal integration is clearer than for vertical integration. See, e.g., Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUNDATION (June 2012), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261). Our analysis, therefore, focuses on the “harder case” of vertical health care integration. Thomas L. Greaney, *Competition Policy after Health Care Reform: Mending Holes in Antitrust Law’s Protective Net*, 40 J. HEALTH POL. POL’Y & L. 895 (2015).

distributor.<sup>28</sup> In health care, “vertical integration” refers to the integration of suppliers of different components of health care services, such as hospitals and physicians as well as integration of health systems and health plans, who are traditionally thought of as functioning as seller and buyer, but collectively supply different elements of the health care product to the ultimate consumer.

According to neoclassical economic models, vertical integration enhances efficiency by reducing transaction costs and arm’s length contracting across separate organizations.<sup>29</sup> Vertical integration in health care has traditionally been thought to improve efficiency, through improved care coordination and reduction of fragmentation among providers and payers in health care.<sup>30</sup> Common ownership of hospitals and physician inputs in the health care “supply chain” can align financial incentives between hospitals and referring physicians, reduce duplicative or unnecessary care, provide centralized administrative services, and reduce transaction costs by allowing joint contracting with third party payers.<sup>31</sup> Vertical mergers of hospitals and physicians or health plans into integrated delivery systems may reduce the costs of complex negotiations between providers and payers. Between hospitals and physicians, arm’s-length contracts are costly to establish, whether due to health care fraud and abuse laws that limit hospital-physician contracts or payment systems that separate hospital and physician payments.<sup>32</sup>

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<sup>28</sup> Austin B. Frakt et al., Plan-Provider Integration, Premiums, and Quality in the Medicare Advantage Market, 48 HEALTH SERVS. RES. 1996, 1999 (2013).

<sup>29</sup> Laurence C. Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, 33 HEALTH AFF. 756 (2014); Martin Gaynor & Robert J. Town, Competition in Health Care Markets, in 2 HANDBOOK OF HEALTH ECON. 499, 619-20 (Mark V. Pauly et al. eds., 2012).

<sup>30</sup> Thomas L. Greaney – Oxford chapter.

<sup>31</sup> Christopher Afendulis & Daniel P. Kessler, *Vertical Integration and Optimal Reimbursement Policy* 5 (Nat’l Bureau of Econ. Research, Working Paper No. 17316, 2011).

<sup>32</sup> Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, supra note 29, at 757; Sage, supra note \_\_\_, at 1078.

*B. Policy Incentives for Vertical Integration*

Based on these economic assumptions and the utilization-centered narrative of health care cost containment,<sup>33</sup> the ACA offers numerous incentives to promote vertical integration in health care. The primary example is the Medicare Shared Savings Program, which encourages providers to form ACOs for Medicare beneficiaries, with the intent that private payers would adopt the model as well.<sup>34</sup> ACOs are groups of providers organized into a formal legal entity that agrees to be collectively accountable for the cost and quality of the health care for a defined population of individuals.<sup>35</sup> The ACO structure rewards groups of providers for improving quality and care coordination while reducing unnecessary utilization by paying them a share of the amount they save for the payer.<sup>36</sup> To the extent that an ACO assumes insurance risk, the providers within the ACO have an incentive to reduce the overall volume of services and reduce waste.<sup>37</sup> The shared savings financial incentives offered for ACOs encourage both hospitals and physicians to vertically integrate to increase efficiency and reduce costs. Vertically integrated entities can more easily share data, eliminate redundancy, invest in interoperable health information technology, and implement clinical protocols that cross care settings.

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<sup>33</sup> See text accompanying notes **Error! Bookmark not defined.-Error! Bookmark not defined.**, *supra*. Federal cost-control policy also tends to focus on Medicare, and because the government sets the prices in Medicare, the opportunities to control Medicare spending focus on ways to reduce overutilization. However, these assumptions do not apply to private health care spending. See Joseph P. Newhouse & Alan M. Garber, *Geographic Variation in Health Care Spending in the United States: Insights from an Institute of Medicine Report*, 310 JAMA 1227, 1227-28 (2013) (“Whereas price variation explains almost none of the overall variation in Medicare expenditures (after adjusting for wage variation), price variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons.”).

<sup>34</sup> 42 U.S.C. § 1395jjj; 42 C.F.R. Part 425. See Greaney, *supra* note, at 16-17.

<sup>35</sup> Gary E. Bacher et al., *Regulatory Neutrality Is Essential To Establishing A Level Playing Field For Accountable Care Organizations*, 32 HEALTH AFF. 1426, 1426 (2013).

<sup>36</sup> Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. w219, w222 (2009), <http://content.healthaffairs.org/content/28/2/w219.full.pdf+html>.

<sup>37</sup> Jeff Goldsmith et al., *Nat’l Acad. Soc. Ins., Integrated Delivery Networks: In Search of Benefits and Market Effects* 1-2 (2015).

Further, vertical integration can make it easier to reduce “internal agency problems and take advantage of economies of scope.”<sup>38</sup>

Other Medicare pilot programs, such as the bundled payment program, also create incentives for fragmented providers to work together, to coordinate care, and collectively internalize the costs of disparate aspects of an entire care episode. The payment bundling program pays providers a single lump-sum payment to cover all inpatient, physician, outpatient, and post-acute services involved in the episode of care.<sup>39</sup> The ACA also contains significant payment cuts to hospitals, tied in many ways to measures of quality and value, including Medicare rate cuts for excessive readmissions<sup>40</sup> and hospital-acquired conditions,<sup>41</sup> and conditioning Medicare bonuses or penalties to measures of value.<sup>42</sup> The upshot of all these ACA Medicare payment reforms for hospitals is that they are assuming more financial risk and experiencing major changes to their business and revenue models, built on the old fee-for-service and diagnosis-based reimbursement methods.

Providers may look to consolidation to maximize their ability to assume financial risk. Bigger systems have more enrollees, ACOs need to be sufficiently large to be able to absorb financial risk and make the financial investments needed to achieve economies of scope necessary to generate cost savings on which ACO payments depend.<sup>43</sup>

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<sup>38</sup> Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. HEALTH ECON. 1, 4 (2006).

<sup>39</sup> PPACA § 3023, 42 U.S.C. § 1395cc-4; *see also* White et al., *Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients*, 2 (Nat’l Inst. for Health Care Reform, Research Brief No. 14, 2014), <http://www.nihcr.org/Episode-Spending-Variation>.

<sup>40</sup> 42 U.S.C. § 300gg-17(a)(1)(B). *See, e.g.*, Jordan Rau, *Half of Nation’s Hospitals Fail Again to Escape Medicare’s Readmission Penalties*, KAISER HEALTH NEWS (Aug. 3, 2015), <http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicare-readmission-penalties/>.

<sup>41</sup> 42 U.S.C. § 1395ww(p).

<sup>42</sup> 42 U.S.C. § 1395ww(o).

<sup>43</sup> Shortell et al., *Accountable Care Organizations: The National Landscape*, 40 J. HEALTH POL., POL’Y, & L. 645, 659-60 (estimating that ACOs need approximately 25,000-50,000 enrollees to make investments needed for success).

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which, among other things, repealed the formula that ties Medicare physician payments to a “sustainable growth rate” (SGR).<sup>44</sup> MACRA adds to the momentum of provider consolidation by shifting more physicians to value-based and alternative payment models. Also known as the “doc fix,” MACRA replaced the widely unpopular SGR-based formula with a plan to implement Medicare physician fee bonuses based on participation in alternative payment models, such as ACOs.<sup>45</sup> For physicians that do not participate in alternative payment models, MACRA adjusts their fee-for-service rates based on a merit-based incentive program that takes into account the physician’s quality measures, resource use, and adoption of electronic health records.<sup>46</sup> On top of the incentives already in the ACA, MACRA pushes more physicians to join ACOs. Even for physicians who stick with fee-for-service, the incentive-based adjustments to their fees nudge physicians toward integration with larger systems due to the administrative burden and expense of implementing quality reporting, electronic health records, and resource use analysis. Together, the payment reforms of the ACA and MACRA are driving an upsurge of nontraditional types of health care integration.

The ACA’s incentives go beyond payment changes. The regulatory environment also favors clinical and financial integration among hospitals, physicians, and other types of providers (such as post-acute providers) by providing valuable waivers of onerous regulatory regimes like the Stark Law, anti-kickback statute, and antitrust scrutiny to providers who implement a Medicare ACO or bundled payment pilot program.<sup>47</sup> Provider

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<sup>44</sup> Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. No. 114-10, §101(a)(1), \_\_ Stat. \_\_ (2015).

<sup>45</sup> MACRA, § 101(a)(2).

<sup>46</sup> MACRA, § 101(b); *see e.g., FAQ on MACRA and Medicare Payment Reform*, AMERICAN ACADEMY OF FAMILY PHYSICIANS, <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html> (last visited Aug. 11, 2015).

<sup>47</sup> 42 U.S.C. § 1899jjj(f) (granting Secretary of HHS the authority to waive requirements of the Stark Law, Antikickback Statute, and Civil Monetary Penalties statute as needed to carry out the Medicare Shared Savings Program); Medicare Program; Final Waivers in Connection with the Shared Savings Program, 76 Fed. Reg. 67992, 67999-68001 (Nov. 2, 2011); Statement of Antitrust Enforcement Policy Regarding Accountable

liability under the Stark Law, compounded with the False Claims Act's treble damages, create an environment of extreme financial risk for hospitals, physicians, and other providers who seek to more closely align financial incentives and clinical processes. The Stark Law's relatively looser requirements for physician compensation for employed physicians compared to independent contractors already created incentives for hospitals to use the tightest forms of integration (direct employment and ownership of physician practices) as opposed to more looser forms of integration (contractual relationships with independent physicians).<sup>48</sup> The greatest regulatory flexibility comes with forming a Medicare-approved ACO because then the ACO participants, and the payments made between them, are largely exempted from having to comply with the Stark Law, anti-kickback statute, certain IRS requirements for tax-exempt hospitals, and antitrust scrutiny. In addition, the antitrust review process for ACOs only applies to independent entities collaborating to form an ACO, which may also create an incentive for vertically situated health care entities to merge into a unified delivery system prior to applying to participate in the Medicare Shared Savings Program, to ease the approval process. While the prior merger would be subject to FTC oversight and review, the FTC has challenged only a handful of such mergers.<sup>49</sup> Thus, if a hospital or physician group is contemplating forming a relationship to coordinate care, share referrals, and assume responsibility for the health and spending of a population of patients, there are strong regulatory incentives to merge or form a fully integrated ACO rather than adopting looser forms of alignment (such as physician-hospital organizations or contractual relationships with independent provider organizations). These regulatory incentives are further enhanced by increases in market power and leverage that could arise from a merger or integration.

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Care Organizations Participating the Medicare Shared Savings Program, 76 Fed. Reg. 67025 (Oct. 28, 2011).

<sup>48</sup> 42 C.F.R. § 411.357. The Stark Law exception for bona fide employment relationships allows, for example, payment of productivity bonuses for services personally performed by the physician, whereas contracted physicians may not be paid such bonuses under the fair market value or personal services and management

<sup>49</sup> Feinstein, *supra* note XX, at \_\_\_. See, e.g. *St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791(9th Cir. 2015), *aff'g* 2014 WL 407446 (D. Idaho 2014).

However, many of the desired benefits of clinical and financial integration do not require health care entities to merge or formally integrate. Vertical integration can occur on several levels. The loosest form of vertical integration, the “open contract” form, would be a non-exclusive contractual relationship between a hospital and a group of physicians, such as the hospital’s medical staff or an independent practice association (IPA) in which the hospital provides some administrative support for health plan contracting and may engage in nominal care coordination activities.<sup>50</sup> An intermediate form of vertical integration, the “closed contract” form, would be an exclusive contractual relationship between the hospital and a select group of physicians, in which the hospital provides higher levels of administrative and management services (e.g., electronic health records, billing, utilization and quality review, etc.), private health plan contracting, and care coordination.<sup>51</sup> Whereas, the tightest form of vertical integration is when the hospital owns the physician practices or directly employ the physicians.<sup>52</sup> ACOs themselves can be organized along a spectrum from loose to tight integration between hospitals and physician-participants. While entities in these looser models can still engage in significant clinical and financial integration, such as shared electronic medical records systems, payment incentives, and quality of care reporting mechanisms, tighter forms of integration may be encouraged by financial and regulatory incentives.

Because of the promise of accountable care and the payment incentives through reform efforts, the pace of all types of vertical health care integration has increased. From 2004-2011, hospital ownership of physician practices, the tightest form of hospital-physician integration, increased from 24% to 49%.<sup>53</sup> Although not all ACOs necessarily involve vertical integration of hospitals and physicians, most do.<sup>54</sup> Following the passage of

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<sup>50</sup> Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, *supra* note 29 at 759.

<sup>51</sup> Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, *supra* note 29, at 759.

<sup>52</sup> Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, *supra* note XX, at 759.

<sup>53</sup> David M. Cutler & Fiona Scott Morton, Hospitals, Market Share, and Consolidation, 310 JAMA 1964, \_\_\_\_\_. Baker et al., Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending, *supra* note 29, at 759.

<sup>54</sup> Stephen Shortell et al., *A Taxonomy of Accountable Care Organizations for Policy*



the ACA, the growth of ACOs has been rapid, with more than 700 ACOs established nationwide by 2015, about evenly split between Medicare and commercial ACOs.<sup>55</sup> ACOs cover approximately 23.5 million individuals, and only about a third of this total (7.8 million) are Medicare enrollees.<sup>56</sup> It is projected that a majority of Americans will be covered by an ACO by 2018.<sup>57</sup>

Some of the same trends driving health care provider integration are also contributing to an increase in plan-provider integrations. Hospitals and health systems are assuming more financial risk under new payment models, like global payments, which entails being responsible for the cost of care for an entire population of patients. The larger a system is, the better it is able to assume population risk and invest in systems to meet quality targets, but as it does, the provider network must assume more of the functions and capacity of health insurers. An ACO or health system that is part of an ACO will be more likely to meet quality and cost-savings goals if it has the capacity to manage clinical, quality, and cost data and take on financial risk, and one of the easiest ways for providers to acquire this capacity is to merge with a health plan.<sup>58</sup>

From the payer's perspective, health insurers are increasingly regulated under the ACA even while its potential market is changing. Many plans are shifting more of the insurance/financial risk either to providers (through ACOs and alternative payment systems) or leaving insurance risk with self-insured employers. Health plans are marketing their capacities for financial risk management, data gathering and analysis, and care management to providers in collaborations that range from management services contracts

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*and Practice*, 49 HEALTH SERVS. RES. 1883, 1889 (2014).

<sup>55</sup> Shortell et al., *Accountable Care Organizations: The National Landscape*, *supra* note 43, at 646 (2015).

<sup>56</sup> David Muhlesein, *Growth and Dispersion of Accountable Care Organizations in 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>.

<sup>57</sup> *Id.*

<sup>58</sup> See Frakt, *supra* note 28, at 1997.

to merger into common entities.<sup>59</sup> The ACA's requirements, including Medical-Loss Ratios, limits on underwriting activities, guaranteed issue, and the Cadillac Tax on costly employer-sponsored health plans are altering the business models of health plans and putting limits on the amount of profit the plan can earn from its premium revenue. As a result, health plans are looking for ways to increase market share and shift their function to more of an administrative role, such as processing claims and gathering data on quality and cost. These trends are pushing more health plans to consider combinations with providers.

As a result, vertical integration between providers and health plans is becoming more frequent. In one report from 2012, approximately 20% of hospital networks offered an integrated insurance plan, with another 20% contemplating doing so.<sup>60</sup> Within the Medicare Advantage market, in which Medicare beneficiaries receive Medicare services through private managed care plans, about 17% of Medicare Advantage plans were integrated with providers in 2013.<sup>61</sup> A 2015 poll of fifty-eight health provider and plan chief executive officers found that 88% predicted more plan-provider collaboration in the next three to five years.<sup>62</sup> For instance, several hospital systems in California, other than Kaiser Permanente,<sup>63</sup> have begun offering insurance through Covered California (California's healthcare marketplace under the ACA).<sup>64</sup>

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<sup>59</sup> Victor R. Fuchs & Leonard D. Schaeffer, *If Accountable Care Organizations Are the Answer, Who Should Create Them?*, 307 JAMA 2261, 2262 (2012).

<sup>60</sup> Roni Caryn Rabin, *Some Hospital Networks Also Become Insurers*, WASH. POST (Aug. 25, 2012), [http://www.washingtonpost.com/business/some-hospital-networks-also-become-insurers/2012/08/25/53e90a72-eb1d-11e1-b811-09036bcb182b\\_story.html](http://www.washingtonpost.com/business/some-hospital-networks-also-become-insurers/2012/08/25/53e90a72-eb1d-11e1-b811-09036bcb182b_story.html).

<sup>61</sup> See Frakt et al, *supra* note 28, at 1997.

<sup>62</sup> Joseph Conn, *Closer Provider-Insurer Ties Bring New Challenges*, MODERN HEALTHCARE (Aug. 15, 2015), [http://www.modernhealthcare.com/article/20150815/MAGAZINE/308159969?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=externalURL&utm\\_campaign=am](http://www.modernhealthcare.com/article/20150815/MAGAZINE/308159969?utm_source=modernhealthcare&utm_medium=email&utm_content=externalURL&utm_campaign=am).

<sup>63</sup> Kaiser Permanente is the dominant integrated delivery system in California, which has offered fully integrated care since the 1940s.

<sup>64</sup> Foote & Varanini, *A Few Thoughts About ACO Antitrust Issues From a Local*

Whether between hospitals and physicians or plans and providers, vertical integration in health care is on the rise. How that increase will affect health care markets and prices is largely unknown, but it is unlikely to be uniform in nature.

## II. THE DOUBLE-EDGED SWORD OF VERTICAL HEALTH CARE INTEGRATION

Despite its many anticipated benefits, vertical health care integration presents a double-edged sword. While more care coordination and less fragmentation in health care is needed, the effort to promote beneficial integration also opens the door to health care consolidation all across the country. Emerging empirical data reveals that under certain circumstances, vertical integration carries significant downside risks to competition and consumer welfare through increases in market power, increases in referrals and reimbursement rates, and reductions in consumer choice.

### A. *Increased Market Power*

Theoretical models suggest that vertical integration between hospitals and physicians can harm competition by conferring greater market power on the merged entity. First, if one of the parties (either the hospital or physician group) has market power, then a merger of the two can increase market power vis-à-vis health plans, particularly if at least one of the parties possessed market power pre-merger.<sup>65</sup> In 1999, Ester Gal-Or argued that the profitability of vertical hospital-provider mergers depended on the relative competitiveness between the hospital and provider markets.<sup>66</sup> She reasoned that when the merging hospital and provider markets share similar levels of competitiveness, the merged entity can negotiate higher rates due to increased market power.<sup>67</sup> The market power increase is strongest when both merging entities are in highly concentrated markets. Whereas when the relative level of competitiveness differed significantly between the two markets, vertical mergers between physicians and hospitals may be

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Perspective, 40 J. HEALTH POL., POL'Y, & L. 885, 888.

<sup>65</sup> Afendulis & Kessler, *supra* note \_\_, at 5; Gaynor, *supra* note \_\_, at 180-81; Esther Gal-Or, *The Profitability of Vertical Mergers Between Hospitals and Physician Practices*, 18 J. Health Econ. 623, 625 (1999).

<sup>66</sup> Esther Gal-Or, *The Profitability of Vertical Mergers Between Hospitals and Physician Practices*, 18 J. Health Econ. 623, 625 (1999).

<sup>67</sup> *Id.* This was true even in the absence of exclusivity requirements.

unprofitable, unless the merger included a vertical restraint requiring exclusivity between the parties.<sup>68</sup>

One way vertical integration increases the market share of the merged entity is through tying hospital and physician services together. Hospitals that acquire physician groups can effectively lock up the referral pool of physicians and bundle hospital and physician services together when negotiating with payers.<sup>69</sup> This type of tying increases bargaining power of the merged provider entity because in order for an insurer to include one provider in its network, it must also include other tied providers or services, often at elevated rates.<sup>70</sup> In highly concentrated health care and health insurance markets with significant barriers to entry, tying and refusal to supply can lead to rival exclusion.<sup>71</sup> In its most extreme form, a vertically integrated entity will require “all or nothing” dealing, in which an insurer must either include all affiliated providers in its network or none at all.<sup>72</sup> One way of achieving an “all or nothing” bargaining position is to enter into exclusive agreements between hospitals and physician groups, where the parties are unable to bargain with health plans outside of the tied entity.<sup>73</sup> “All or nothing” dealing can lead to supracompetitive reimbursement rates across a wide range of providers in a particular provider organization.

Another way vertical mergers can increase the merged entities’ market power is through foreclosure. Foreclosure occurs when “actual or potential competitors are disadvantaged due to restricted access to one of the most favorable providers,” making their costs higher for equivalent services and quality.<sup>74</sup> The merger of a hospital with a physician group can foreclose rival hospitals from accessing the services of the integrated physicians,

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<sup>68</sup> Id.

<sup>69</sup> Baker et al., *supra* note \_\_, at 757.

<sup>70</sup> tying in hc cite.

<sup>71</sup> See, Part II B.2.

<sup>72</sup> National Academy of Social Insurance Panel on Pricing Power in Health Care Markets, Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets 17 (2015) (describing “all or nothing” bargaining by large, multi-hospital systems) [hereinafter NASI Panel on Pricing Power]

<sup>73</sup> Gal-Or,

<sup>74</sup> See Frakt et al, *supra* note 28, at 2000.

thereby increasing market power.<sup>75</sup> In particular, competitors may lose patient volume needed to support their facilities because they cannot access the integrated physicians' referrals.<sup>76</sup>

Empirical evidence supporting theoretical hypothesis that vertical health care mergers can be used to increase market power and prices has begun to emerge.<sup>77</sup> In an earlier study, Alison Evans Cuellar and Paul Gertler similarly found that tighter forms of hospital-physician integration in the 1990s showed significant positive effects on price and volume, supporting the theory that such vertical integrations are done to increase market power.<sup>78</sup> But Federico Ciliberto and David Dranove found that vertical

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<sup>75</sup> Martin Gaynor, Is Vertical Integration Anticompetitive? Definitely Maybe (But That's Not Final), 25 J. HEALTH ECON. 175, 180 (2005).

<sup>76</sup> Greaney Oxford text at \*6. Although courts have not applied the foreclosure theory to a challenged merger, in *St. Luke's* case involving the merger of St. Luke's health system and the Saltzer group of physicians, the private plaintiffs in the case, rival hospital St. Alphonsus and surgery center Treasure Valley Hospital, asserted an argument for competitive harms based on a foreclosure model. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791(9th Cir. 2015), *aff'd* 2014 WL 407446 (D. Idaho 2014). These private plaintiffs posited that St. Luke's would gain a monopoly share of the Nampa, Idaho market for adult primary care "foreclosing virtually all competition for the hospital admissions of the physician practices it acquires." The complaint went on to assert that the merger would harm the plaintiffs by causing the loss of admissions, referrals, and services performed by Saltzer physicians. Complaint, *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health System, Ltd.*, 2012 WL 5882652, at 2-3 (D. Idaho) (No. 1:12 Civ. 00560). Ultimately, the Ninth Circuit struck down the merger based on horizontal grounds (the merger of physician groups) and thus did not examine the anticompetitive impact of the vertical integration due to foreclosure.

<sup>77</sup> Cory Capps, David Dranove, & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* (Institute for Policy Research, Northwestern University, Working Paper No. WP-15-02, Feb. 2015); Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, 33 Health Aff. 756 (2014); Robert A. Berenson, Paul B. Ginsburg and Nicole Kemper, *Unchecked Provider Clout In California Foreshadows Challenges To Health Reform*, 29 Health Aff. 1 (2010); Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. HEALTH ECON. 1 (2006). *But see*, Federico Ciliberto & David Dranove, *The effect of physician-hospital affiliations on hospital prices in California*, 25 J. HEALTH ECON. 29 (2006) (finding no increase in costs due to physician-hospital affiliations in California).

<sup>78</sup> Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. Health Econ. 1, (2006).

integration during the 1990s did not affect hospital prices.<sup>79</sup> The opposite results in these two contemporaneous studies were seen as consistent with the theory that vertical integration can be both efficiency-enhancing and anticompetitive.<sup>80</sup> There are differences between the market conditions of the 1990s and today; one significant difference is that the hospital market is significantly more concentrated today, which may amplify the anticompetitive effects of vertical integration between hospitals and physicians.<sup>81</sup>

Indeed, more recent studies are starting to show that more current forms of vertical integration can lead to higher prices. Laurence Baker, M. Kate Bundorf, and David Kessler examined vertical integration between 2001 and 2007 and found that the tightest form of vertical integration—hospital ownership of physician practices—was associated with higher hospital prices, increased spending, and only modestly reduced utilization in the form of hospital admissions.<sup>82</sup> Regarding integration's effects on physician prices, Cory Capps, David Dranove, and Christopher Ody looked at vertical mergers between 2007 and 2013 and found that physician prices increased nearly 14% following integration with hospitals.<sup>83</sup> The price increase was not due to an increase in physician market power due to horizontal mergers between physicians. Rather, the price increase was greater the larger the hospital's market share prior to integration.<sup>84</sup>

James Robinson and Kelly Miller examined vertically integrated organizations in California between 2009 and 2012 and found that hospital ownership of physician organizations led to significantly higher total expenditures per patient than physician-owned organizations.<sup>85</sup> The

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<sup>79</sup> Federico Ciliberto & David Dranove, The effect of physician–hospital affiliations on hospital prices in California, 25 J. Health Econ. 29, 37 (2006).

<sup>80</sup> Martin Gaynor, Is Vertical Integration Anticompetitive? Definitely Maybe (But That's Not Final), 25 J. HEALTH ECON. 175, 181 (2005).

<sup>81</sup> James Robinson & Kelly Miller, Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California, 312 JAMA 1663 (2014)

<sup>82</sup> Baker et al., *supra* note \_\_, at \_\_\_\_.

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<sup>84</sup> *Id.* at 3.

<sup>85</sup> James Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned*

expenditures were 10.3% higher for physician organizations owned by a local hospital, and 19.8% higher when the physician organization was owned by a multi-hospital system.<sup>86</sup> The larger the market share of the vertically integrated hospital-owner, the greater the expenditures. The study showed little or no evidence that vertical consolidation of hospitals and physicians resulted in increased efficiency.

Empirical data on the effect of vertical integration between health plans and providers is even more limited than hospital-physician integration. In 2013, Austin Frakt, Steven Pizer, and Roger Feldman examined the impact of plan-provider integration on healthcare premiums and quality in the Medicare Advantage market.<sup>87</sup> The study revealed that plan-provider integration was associated with higher monthly premiums and also higher quality ratings than non-integrated plans.<sup>88</sup> However, seventy percent of the premium increase associated with integration was not due to improvements in quality.<sup>89</sup> Although some of the increased premiums could have been due to benefit enhancements, the authors did not observe a statistically significant increase in benefit generosity following integration for several benefits examined.<sup>90</sup> The authors hypothesized that the increase in premiums also could have resulted from an increase in market power conferred on the plan from the integrated provider organization.<sup>91</sup> While the Frakt *et al* study has several limitations related to its generalizability and conclusions,<sup>92</sup> it raises significant concerns regarding the ability plans and providers to use vertical integration as a means to increase market power

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*and Physician-Owned Physician Organizations in California*, 312 JAMA 1663, 1668 (2014). In this article, expenditures were measured as the amounts insurers paid health care providers on a per patient basis, excluding high cost patients (incurring >\$100,000 in health care expenses annually). *Id.* at 1665.

<sup>86</sup> *Id.* at 1668.

<sup>87</sup> See Frakt et al, *supra* note 28, at 1996.

<sup>88</sup> *Id.* at 2008.

<sup>89</sup> *Id.* at 2008-2009.

<sup>90</sup> *Id.* at 2009.

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

<sup>92</sup> *Id.* at 209-2010.

and leverage, which warrant significantly more attention from health services researchers and antitrust enforcers.

*B. Increases in Referrals and Reimbursement*

Another anticompetitive effect of vertical integration is that acquisition of physician groups by hospitals may increase health spending from greater utilization and patient volume by allowing the hospital to pay for referrals within the bounds of health care self-referral laws.<sup>93</sup> The federal Anti-kickback Statute and the Stark Law both provide greater flexibility for hospitals to compensate employed as opposed to contracted physicians. For example, hospitals can pay employed physicians productivity bonuses for services personally performed by the physician, which would not be permitted for non-employed physicians (i.e., independent contractors).<sup>94</sup> Moreover, when the integrated entities share fixed assets, it is easier for them to financially benefit from referrals within the integrated entity within the strictures of anti-referral and anti-kickback laws.<sup>95</sup> Hospitals, for example, are willing to acquire primary care physicians even if it is a money-losing proposition for the hospital because it allows the hospital to capture (and thus pay for) the primary care physicians' referrals for hospital services.<sup>96</sup> When explaining why hospital ownership of physician

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<sup>93</sup> Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* 1 (Institute for Policy Research, Northwestern University, Working Paper No. WP-15-02, Feb. 2015); Christopher Afendulis & Daniel P. Kessler, *Vertical Integration and Optimal Reimbursement Policy* 7 (Nat'l Bureau of Econ. Research, Working Paper No. 17316, 2011).

<sup>94</sup> The Stark Law exception for bona fide employment relationships provides that entities (including hospitals) may pay employed physicians "productivity bonuses for services personally performed by the physician. The exceptions for independent contracted physicians, including the exceptions for fair market value and personal services arrangements exceptions do not permit productivity bonuses. 42 C.F.R. § 411.357(c) (bona fide employment relationships; §411.257(d) (personal services arrangements); §411.357(l) (fair market value compensation). The Anti-kickback Statute safe harbor for employees permits "any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid, or any other health care organization." 42 C.F.R. § 1001.952(i).

<sup>95</sup> Afendulis & Kessler, *supra* note 93, at 17.

<sup>96</sup> Ann S. O'Malley et al., Center for Studying Health System Change, *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?* 2 (Issue Brief No. 136, 2011).



organizations led to higher total expenditures per patient, Robinson and Miller reasoned that higher expenditures could be driven by increased use of higher-priced services but it could also be due to higher volume of services, or both.<sup>97</sup>

A merger between hospitals and physicians may also allow the merged entity to charge higher prices for certain outpatient services by exploiting the fact that hospital-based services are typically reimbursed at higher rates than identical services provided in physician-based locations.<sup>98</sup> In Capps, Dranove, and Ody's research finding that vertical integration between hospitals and physicians increased physician prices, they estimate that about a quarter of the 14% price increase resulted from exploitation of reimbursement methodologies that allow hospitals to charge facility fees for employed physicians.<sup>99</sup>

### C. Agency Problems and Consumer Choice

Hospital ownership of physician practices may exacerbate agency problems between physicians and patients. Agency problems arise between patients (the principals) and physicians (their agents) when physicians' medical decisions on behalf of their patients are influenced by the physicians' financial incentives and practice norms that may be at odds with the patients' interests in obtaining the highest quality care at the lowest price.<sup>100</sup> In the context of hospital services, the physician both orders and performs the hospital service, thus driving demand not only for the type of service but also at which facility the service will be performed.<sup>101</sup>

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<sup>97</sup> Robinson & Miller, *supra* note \_\_\_, at 1664, 1668.

<sup>98</sup> Capps et al, *supra* note \_\_\_, at 6. Ann S. O'Malley et al., Center for Studying Health System Change, Rising Hospital Employment of Physicians: Better Quality, Higher Costs? 3 (Issue Brief No. 136, 2011).

<sup>99</sup> Capps et al, *supra* note \_\_\_, at 4.

<sup>100</sup> Thomas L. Greaney, Economic Regulation of Physicians: A Behavioral Economics Perspective, 53 ST. LOUIS U. L.J. 1189, 1199-2000 (2009); Paul A. Pautler & Michael G. Vita, Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?, 10 J. CONTEMP. HEALTH L. & POL'Y 117, 120 (1993).

<sup>101</sup> Peter J. Hammer, Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs, 98 MICH. L. REV. 849, 864-65 (2000).

Theoretically, it is unclear what effect vertical integration of hospitals and physicians may have on agency problems between physicians and patients. On the one hand, common ownership could align the financial incentives between hospitals and physicians, and thus improve care coordination and patient welfare.<sup>102</sup> However, hospital ownership of physicians could also create financial and other incentives for the physician to refer to the owner-hospital or to increase the volume or intensity of services ordered, rather than to choose the most cost-effective option for the patient.<sup>103</sup>

In a study that examined the impact of hospital-physician integration on the patient's choice of hospital, Laurence Baker, M. Kate Bundorf, and Daniel Kessler found empirical evidence that hospital ownership of physicians worsens the agency problem between physicians and patients.<sup>104</sup> They found that "a hospital's ownership of an admitting physician dramatically increases the probability that the physician's patients will choose the owning hospital. . . patients are more likely to choose a high-cost, low-quality hospital when their admitting physician is owned by that hospital."<sup>105</sup> Although they were unable to determine whether, on net, the harms of vertical integration to patient welfare outweigh the potential benefits, they did conclude that "hospital/physician integration affects patients' hospital choices in a way that is inconsistent with their best interests."<sup>106</sup>

Even when providers have the right motives for integrating, when large conglomerates gain market power, they tend to use it to command higher prices. Taken together, the empirical picture of vertical integration in health care suggests some emerging themes: first, tighter forms of integration (e.g., acquisition versus contractual affiliation) are associated with greater

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<sup>102</sup> Laurence C. Baker, M. Kate Bundorf, & Daniel P. Kessler, *The Effect of Hospital/Physician Integration on Hospital Choice* 3(Nat'l Bureau of Econ. Research, Working paper No. 21497, 2015).

<sup>103</sup> Ann S. O'Malley et al., Center for Studying Health System Change, *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?* 3 (Issue Brief No. 136, 2011).

<sup>104</sup> Baker, Bundorf, & Kessler, *supra* note 102, at 18.

<sup>105</sup> *Id.* at 17.

<sup>106</sup> *Id.* at 18-19.

increases in prices; second, the greater the market share of the hospital entity prior to consolidation, the more likely the merger will have anticompetitive effects; and third, the harms go beyond higher prices, but also include incentives to refer patients to lower-value facilities or higher-cost settings.

### III. THE CENTRAL ROLE OF STATES

Due to significant inefficiencies in the health care markets and the limits of federal antitrust enforcement, states have an important role to play in complementing and supporting federal efforts to address the competitive threats of health care integration. When market power abuses lead to higher prices and reductions in quality and consumer choice, the primary remedy has been federal antitrust enforcement. To address the anticompetitive threats of integration in healthcare, federal antitrust enforcement has a key role to play, but it cannot be the only weapon in the arsenal. First, given the rapid rate of collaboration and consolidation in healthcare, the Federal Trade Commission and the Department of Justice (the Antitrust Agencies) simply do not have the resources or capacity to police all of the consolidation efforts under way throughout the country.<sup>107</sup> Second, federal antitrust enforcement offers a powerful means of preventing anticompetitive mergers and collaborations, but has proven less successful at successfully balancing the pro- and anticompetitive effects of a proposed merger or correcting anticompetitive conduct following consolidation.<sup>108</sup> At a time when state and federal governments are attempting to correct for fragmentation and overutilization in health care through increased vertical integration and the overwhelming majority of healthcare markets in the US

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<sup>107</sup> Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088, 1090 (2014); Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 27 (2014); Clark Havighurst and Barak Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 871 (2011).

<sup>108</sup> See Deborah L. Feinstein, Director, Federal Trade Commission Bureau of Competition, *Antitrust Enforcement in Health Care: Proscription, not Prescription*, Address at Fifth National Accountable Care Organization Summit – Washington, DC 15 (Jun. 19, 2014) (“Conduct remedies do not restore the competitive status quo and raise several concerns.”); See also Greaney, *supra* note **Error! Bookmark not defined.**, at 12 (“A common misapprehension among legislators and policymakers is that antitrust law provides a reliable counterforce to monopoly.”)

are concentrated,<sup>109</sup> policymakers need more nuanced tools that they can deploy throughout the country.

Unfortunately, there is a dearth of guidance or evidence on how the FTC will or should analyze the anticompetitive effects of a proposed commercial vertical integration in healthcare.<sup>110</sup> In 2014, the Antitrust Agencies issued a Joint Statement on Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Policy Statement), but this statement only applies to ACOs that CMS evaluated and approved for participation in the program.<sup>111</sup> This limitation is significant for several reasons. First, the Policy Statement only applies to independent entities coming together to form an ACO, not mergers or previously integrated entities like large integrated delivery systems. Second, the entire Medicare program is subject to a greater degree of oversight, reporting, and analysis than entities participating in the commercial health care market. For instance, CMS requires participating ACOs to report claims data on both charges and utilization, which CMS will provide to the Antitrust Agencies to assist in antitrust analysis.<sup>112</sup> Third, the federal government sets reimbursement rates for Medicare services, and reviews premiums in the Medicare Advantage market, which limits price increases that might result from anticompetitive behavior.<sup>113</sup> Finally, the Antitrust Agencies presume that ACOs that satisfy CMS requirements to participate in the MSSP are “reasonably likely to be bona fide arrangements intended

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<sup>109</sup> See, Cutler and Scott Morton, *supra* note XX, at XX.

<sup>110</sup> ABA SECTION OF ANTITRUST LAW, PRESIDENTIAL TRANSITION REPORT: THE STATE OF ANTITRUST LAW 2012 7 (2013) [Hereinafter ABA REPORT], [www.americanbar.org/content/dam/aba/administrative/antitrust\\_law/at\\_comments\\_presidential\\_201302.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/antitrust_law/at_comments_presidential_201302.authcheckdam.pdf). See also STEVEN C. SALOP AND DANIEL P. CULLEY, POTENTIAL COMPETITIVE EFFECTS OF VERTICAL MERGERS: A HOW-TO GUIDE FOR PRACTITIONERS 5-6 (2014), <http://scholarship.law.georgetown.edu/facpub/1392>.

<sup>111</sup> Fed. Trade Comm’n & Dep’t of Justice, Statement on Antitrust Enforcement Policy Statement Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011) [Hereinafter MSSP Enforcement Statement].

<sup>112</sup> MSSP Enforcement Statement, *supra* note 111, at 67026.

<sup>113</sup> See Greaney, *supra* note **Error! Bookmark not defined.**, at 8.

to improve quality and reduce costs.”<sup>114</sup> However, these conditions do not apply in the commercial market.

Outside of the MSSP, the Antitrust Agencies offer significant guidance on antitrust enforcement for horizontal mergers and collaborations,<sup>115</sup> but comparatively little on vertical mergers and collaborations. The DOJ gave its most recent guidance on vertical mergers in the 1984 Merger Guidelines, in which it expressed concerns that vertical integration could 1) increase barriers to entry for competitors; 2) facilitate collusion between horizontal competitors; and 3) facilitate evasion of rate regulation by manipulating costs incurred at different levels of the distribution chain.<sup>116</sup> Notably, these concerns do not include discussion of potential foreclosure of competitors, nor potential gains in market leverage that might result from vertical integration. Further, the FTC has challenged fewer than one vertical merger per year on average, resulting in only a handful of cases to examine, none of which are in the healthcare industry.<sup>117</sup> In the few suits that have been brought, the courts have pointed to the following as relevant variables to assess: (1) the extent of market foreclosure resulting from the merger; (2) the stated purpose of the merger; (3) the level of concentration in the upstream and downstream markets; (4) the level of entry barriers into the upstream and downstream markets; (5) the market share needed to insure profitability at the upstream and downstream levels; (6) the market power of the merged entity; (6) the effect on potential competition; and (7) the trend toward vertical integration in the industry.<sup>118</sup> Despite these factors being

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<sup>114</sup> MSSP Enforcement Statement, *supra* note 111, at 67027.

<sup>115</sup> See Dep’t of Justice & Fed. Trade Comm’n, Horizontal Merger Guidelines (2010), <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>; Federal Trade Comm’n & U.S. Dep’t of Justice, Antitrust Guidelines for Collaborations Among Competitors (2000) [Hereinafter Collaboration guidelines], <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>; U.S. Dep’t of Justice and Fed. Trade Comm’n, Statements of Antitrust Enforcement Policy in Health Care (1996) [Hereinafter health care statements], [https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements\\_of\\_antitrust\\_enforcement\\_policy\\_in\\_health\\_care\\_august\\_1996.pdf](https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf).

<sup>116</sup> White et al., *supra* note XX, at 177.

<sup>117</sup> Deborah L. Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, 24 ANTITRUST 5, 5 (2010). Get numbers from Sallop and Culley.

<sup>118</sup> See, e.g., *Ford Motor Co. v. U.S.*, 405 U.S. 562 (1972); *Brown Shoe Co. v. U.S.*,

important, the FTC provided very little insight to how it might weigh these different factors in determining whether it will bring a vertical integration challenge.<sup>119</sup>

This lack of guidance has come under significant scrutiny in recent years. In 2007, the Antitrust Modernization Commission Report called for greater transparency and updated guidelines with respect to vertical mergers.<sup>120</sup> In 2012, the American Bar Association's Presidential Transition Taskforce recommended that President Obama direct the FTC to update the vertical merger guidelines.<sup>121</sup> More recently, antitrust scholars Steven Salop and Daniel Culley have argued that the 1984 Guidelines are largely out of date and "do not reflect current economic thinking about vertical mergers or agency practice."<sup>122</sup> Even Deborah Feinstein, the current Director of the FTC's Bureau of Competition, stated that "there seems little doubt that the agencies' thinking [on vertical mergers] has moved beyond the 1984 Guidelines."<sup>123</sup> And yet, there has been no move by the FTC to revise them.

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370 U.S. 294 (1962) (by foreclosing competitors of either party from a segment of market, arrangement may serve as clog on competition, depriving rivals of fair opportunity to compete; but foreclosure not dispositive, and other factors should be examined); *Fruehauf Corp. v. F.T.C.*, 603 F.2d 345 (2d Cir.1979) (factors considered were degree of concentration, entry barriers, effect of economies of scale, degree of foreclosure, trend toward vertical integration, motive for merger, and effect on potential entry); *Mississippi River Corp. v. F.T.C.*, 454 F.2d 1083 (8<sup>th</sup> Cir. 1972) (factors to consider include degree of foreclosure at either level, purpose for merger, any trend toward concentration, any trend toward vertical integration, and effect on barriers to entry; primary vice of vertical mergers is tying customers to a supplier permanently).

<sup>119</sup> See *Id.*

<sup>120</sup> Antitrust Modernization Commission, REPORT AND RECOMMENDATIONS 68 (2007).

<sup>121</sup> American Bar Association Section of Antitrust Law, PRESIDENTIAL TRANSITION REPORT: THE STATE OF ANTITRUST LAW 2012 (February 2013) (hereinafter ABA Report) at 7, available at [www.americanbar.org/content/dam/aba/administrative/antitrust\\_law/at\\_comments\\_presidential\\_201302.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/antitrust_law/at_comments_presidential_201302.authcheckdam.pdf).

<sup>122</sup> SALOP & CULLEY, *supra* note 102 at 3 (noting that the European Commission issued the most modern guidelines in 2008).

<sup>123</sup> Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, *supra* note 117,

In many respects, the agency's reluctance to draft new guidelines has been justifiable. First, merger analysis is highly fact specific.<sup>124</sup> The determination of the legality of any particular merger depends on "the nature of competition in the relevant market, the likelihood that the merger will facilitate a unilateral exercise of market power or increase the possibility of collusion among the remaining competitors, and the extent of any merger-specific efficiencies or other procompetitive benefits that will be passed on to consumers."<sup>125</sup> Despite the small number of challenges to vertical mergers brought by the FTC, the agency has found that vertical mergers may be anticompetitive in so many different ways that guidelines that attempt to be all-encompassing will also provide little utility.<sup>126</sup> Second, the agency officials have expressed hesitation about expending valuable time and resources drafting new guidelines for an area of law in which the Antitrust Agencies bring so few challenges.<sup>127</sup> Finally, drafting new guidelines may "overstate" the Antitrust Agencies' interest in engaging in additional enforcement in a particular area.<sup>128</sup>

However, vertical integration in healthcare continues to be encouraged by state and federal government entities as a means to control overutilization and promote quality. As a result, the need for improved information on how integration may lead to abuses of market power, greater guidance and transparency on the appropriate balance between pro- and anti-competitive effects, and more nuanced oversight and regulatory tools has become paramount, both for maintaining control over the amount of consolidation in the healthcare market and guiding entities in how to structure their integrations in ways that promote competition. With the limits of federal antitrust tools to address vertical integration in health care,

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at 6

<sup>124</sup> Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, *supra* note 117, at 4.

<sup>125</sup> White, et al., *supra* note XX, at 181.

<sup>126</sup> Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, *supra* note 117, at 4.

<sup>127</sup> Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, *supra* note 117, at 6.

<sup>128</sup> Feinstein, *Are the Vertical Merger Guidelines Ripe for Revision?*, *supra* note 117, at 4.

states are uniquely situated to manage the price and quality effects of the emerging forms of health care combinations. As set forth in the next Part, this federalized, “laboratory of the states” model allows jurisdictions to tailor policies to the specifics of the state’s own health care markets.

#### IV. STATE OPTIONS TO ADDRESS THE DOUBLE-EDGED SWORD

This need creates both an opportunity and an obligation for states to play a role in establishing the appropriate balance in integrated delivery systems between integrations designed to improve patient care and those that threaten competition. Part IV explores a range of different tools states can use to further these ends. The initiatives include all-payer claims databases (APCDs), antitrust enforcement, ACO certification programs, rate oversight models, rate caps, and provider rate regulation. States may pick and choose between these tools depending on their specific market and political dynamics.

##### *A. All-Payer Claims Databases*

In terms of evaluating the impact of integration on healthcare, states should primarily be concerned with getting access to reliable data about their health care prices, quality of care, and market dynamics. This information is essential to evaluating the impact of increased integration on prices and quality in health care. Further, it will inform the analysis of the role that market leverage, as opposed to value, plays in setting negotiated health care prices.

Obtaining negotiated health care prices will not be an easy task. Private health care prices are notoriously opaque and difficult to ascertain.<sup>129</sup> Different plans pay the same provider different prices for the same service. Providers’ charges vary wildly from each other for the same service in the same geographic areas.<sup>130</sup> Furthermore, nondisclosure agreements, trade

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<sup>129</sup> Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WILLIAM & MARY POL’Y REV. 319 (2013).

<sup>130</sup> See Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273, 273 (2003) [hereinafter *Regional Variations in Medicare Spending Part 1*]; Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288 (2003) [hereinafter *Regional Variations in Medicare Spending Part 2*].



secrets claims, and highly complex billing mechanisms shroud health care prices in a veil of secrecy.<sup>131</sup> But, states can get around many of these barriers by requiring disclosure of the information to a state entity.<sup>132</sup>

About a third of all states currently require disclosure of health care claims to an All-Payer Claims Database (APCD).<sup>133</sup> APCDs are large-scale, state-run databases that collect health care claims data and provider data from all payers in the state, including private insurers, Medicaid, SCHIP, self-insured employers, dental insurers, prescription drug plans, state employee health plans, and others. Furthermore, several APCDs pair price and quality data for providers.<sup>134</sup> States generally use APCDs to collect data on patient demographics, diagnosis, services rendered, charges, payments, and procedure codes.<sup>135</sup> According to the APCD Council, a non-profit entity that monitors APCD creation, eighteen states have enacted legislation to create an APCD, with another twenty states demonstrating a strong interest in doing so.<sup>136</sup>

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<sup>131</sup> Muir et al., *supra* note 129 at 319.

<sup>132</sup> *Id.* But see, *Gobeille v. Liberty Mut. Ins. Co.*, 746 F.3d 497 (2d Cir. 2014) (finding Vermont's APCD disclosure requirements for self-insured employers were preempted by ERISA). The Supreme Court granted cert in this case and will hear it this spring.

<sup>133</sup> APCD Council, Interactive State Report Map, <https://www.apcdouncil.org/state/map> (showing 18 states with APCDs) (last visited Oct. 16, 2015). As of October 15, 2015, the eighteen states that have enacted legislation to establish an APCD include: Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Tennessee, Vermont, Virginia, Washington, West Virginia. The twenty states that are seriously considering an APCD are: Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, Nebraska, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, and Wyoming.

<sup>134</sup> *Id.* at 7–8 .

<sup>135</sup> Massachusetts also requires certain provider organizations to register with the state and submit information on provider costs, charges, and services. The Center for Health Information and Analysis (CHIA) collects and maintains large databases of provider and payer information that policymakers and researchers can use to analyze market dynamics in the state. Center for Health Information and Analysis, <http://www.chiamass.gov/data-index/> (last visited Oct. 16, 2015).

<sup>136</sup> APCD Council, Interactive State Report Map, *supra* note 133.

APCDs are often thought of as tools for promoting consumer price transparency, but their functions go far beyond providing pricing information to consumers.<sup>137</sup> For example, APCDs will allow policymakers to monitor the impact of vertical integration on price and quality under various market conditions. Given the experimental nature of ACOs, being able to monitor whether they achieve their procompetitive goals of promoting quality improvement and innovative solutions, or whether their potential anticompetitive effects outweigh any consumer benefit, is essential to being able to adjust market regulations. For instance, policymakers will need to know whether vertical integration in their market changes provider referral patterns in ways that harm quality of care or patient outcomes. Being able to learn from experience and adapt regulations quickly in ways that respond to particular market dynamics will be essential as market dynamics shift in the wake of the ACA.<sup>138</sup>

The collection of APCD data both underlies and informs all of the subsequent policy options, which will likely form the basis for determining the approach states should pursue to manage the double-edged sword of health care integration and consolidation. Policymakers could use APCD data to implement policy incentives targeting consumers, purchasers, providers, and payers. For instance, in a highly concentrated market, in which one dominant provider used its market leverage to drive up prices to supracompetitive levels not reflective of its quality measurements, the state could consider bringing an antitrust enforcement action, implementing some form of rate regulation, or finding ways to incentivize market entry.

While the creation of an APCD presents numerous opportunities and benefits, doing so also raises significant challenges. First, the creation and maintenance of a statewide database will require substantial financial support and resources. Second, once the database has been built, it must be populated. Obtaining usable data from various payers and providers may be difficult and subject to significant regulation. For example, all quality,

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<sup>137</sup> See the consumer facing tools available in New Hampshire and Colorado - New Hampshire HealthCosts, available at <http://nhhealthcost.nh.gov/health-costs-consumers>; Colorado Medical Price Compare, available at <https://www.comedprice.org/#/home> (CO Medical Price Compare is limited to information on childbirth, knee replacement and hip replacement services).

<sup>138</sup> David Cutler, *How Health Care Reform Must Bend the Cost Curve*, *supra* note 26, at 1131–35.

price, and patient data must be converted to standardized metrics and all patient data must be de-identified. Given the confidential nature of the database, the state will also need to impose significant data security measures. Further, the Supreme Court recently granted certiorari in *Gobeille v. Liberty Mutual Insurance Co.*, an appeal from the Second Circuit Court of Appeals decision that ERISA preempted a state's ability to require self-insured employers to report claims data to an APCD.<sup>139</sup> A decision in favor of Liberty Mutual would limit a significant percentage of available patient data. States may also face challenges from providers and insurers claiming that the pricing data constitutes a trade secret or is subject to a non-disclosure agreement.<sup>140</sup> To best avoid these arguments, states should include provisions in the APCD enacting legislation that APCD reporting requirements are exempt from such provisions and claims. Finally, creation of an APCD requires significant thought regarding the amount and scope of data disclosure. Several antitrust enforcers and academics have expressed concerns that, depending on the market dynamics, widespread disclosure of all healthcare price and quality data could lead to increased prices or collusion.<sup>141</sup> Determining which data to disclose to whom in which market will require substantial analysis and oversight, which again requires resources. But these are all surmountable challenges, and they have to be for us to gain control over health care prices, as having reliable data will be essential to informing future state action.

### B. Antitrust Enforcement and Immunity

Having reliable data will greatly facilitate state decision making on when to incentivize or curtail health care integration. States have the ability to manipulate the use of state and federal antitrust laws to either vigorously challenge anticompetitive conduct or immunize certain actors from prosecution under the laws via the state action doctrine. A state with highly concentrated healthcare markets can actively enforce state and federal antitrust laws to prevent integration from harming competition. Alternatively, states can encourage health care integration by granting state

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<sup>139</sup> *Gobeille v. Liberty Mutual Ins. Co.*, 746 F.3d 497, cert. granted, 135 S.Ct. 2887 | Jun 29, 2015 (U.S. Feb. 4, 2014) (No. 14–181).

<sup>140</sup> Muir, *et al.*, *supra* note 129, at 326.

<sup>141</sup> See, e.g., Foote and Varinini, *supra* note 64, at XX. Muir, *et al.*, *supra* note 129, at 354.

action immunity from state and federal antitrust laws to integrated health care entities via legislation or Certificates of Public Advantage (COPAs).<sup>142</sup> Regardless of a state's chosen path, vigorous oversight and significant data monitoring will be essential to controlling costs and preserving quality in the face of increased concentration.

#### 1. Antitrust Enforcement

States can challenge anticompetitive conduct by enforcement of the federal or its own state antitrust laws. At the federal level, the Sherman Act and the Clayton Act prohibit anticompetitive mergers, collaborations, and conduct.<sup>143</sup> In addition, forty-nine states have their own antitrust laws that promote and protect competition.<sup>144</sup> Given the market-specific knowledge required to bring an antitrust enforcement challenge, state officials may be better positioned to identify integration proposals that threaten to harm competition. State attorneys general have the option to challenge mergers and collaborations and bring enforcement actions both independently and in conjunction with a federal action. Joining with the federal Antitrust Agencies to bring an action can be an especially effective means for states to leverage both the expertise and resources of the federal agencies as well as their knowledge of existing market dynamics.<sup>145</sup>

State attorneys general, like the federal Antitrust Agencies, generally have the opportunity to review a proposed integration, either a formal merger or a collaboration, both at the time of its creation and then on an ongoing basis. While the antitrust analysis typically differs between horizontal mergers, vertical mergers, and collaborations, the FTC generally considers similar factors when addressing health care provider integrations.<sup>146</sup> At the time of a proposed integration, antitrust enforcers

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<sup>142</sup> Robert A. Berenson & Randall R. Bovbjerg, the urban inst., *Certificates of Public Advantage: Can They Address Provider Market Power?* 4 (2015), <http://www.urban.org/research/publication/certificates-public-advantage>.

<sup>143</sup> 15 U.S.C §1-7 (2015); 15 U.S. C. §12-18 (2015).

<sup>144</sup> Pennsylvania, which is the only state without a separate antitrust law, enforces competition under its Unfair and Deceptive Practices statute. **Cite.**

<sup>145</sup> See e.g. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791(9th Cir. 2015), *aff'd* 2014 WL 407446 (D. Idaho 2014).

<sup>146</sup> Deborah L. Feinstein, Director, Federal Trade Commission Bureau of Competition, *Antitrust Enforcement in Health Care: Proscription, not Prescription*, Address at Fifth

initially consider whether a proposed merger or collaboration is per se illegal.<sup>147</sup> Initial concerns for enforcers include: 1) whether the integration could create potential efficiencies such as cost savings, quality improvement and transactional efficiencies; 2) whether the proposed integration is a legitimate attempt to achieve those efficiencies or a means to enhance market power; and 3) whether the efficiency goals could be obtained through a means that poses less of a threat to competition.<sup>148</sup> For an existing entity, enforcers consider whether the current conduct of the entity is on balance harming competition. If on initial review the state finds that its antitrust concerns are not satisfied, it can engage in further investigation.

Given the potential benefits of vertical integration in healthcare, the majority of proposed integrations should survive initial review and not be challenged as per se illegal. Once established as a bona fide integration, antitrust enforcers will review the integration under a “rule of reason” standard.<sup>149</sup> As Director of the FTC’s Bureau of Competition Deborah Feinstein pointed out at the Fifth National Accountable Care Organization Summit in June, 2014, “the rule of reason analysis applied to provider collaborations generally follows the same framework contained in the *Horizontal Merger Guidelines*.”<sup>150</sup> The rule of reason analysis compares

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National Accountable Care Organization Summit – Washington, DC 3-5 (Jun. 19, 2014) (explaining the FTC’s approach to enforcement in health care markets); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating the Medicare Shared Savings Program, 76 Fed. Reg. 67025 (Oct. 28, 2011); DEP’T OF JUSTICE & FED. TRADE COMM’N, 2010 HORIZONTAL MERGER GUIDELINES, [hereinafter 2010 HORIZONTAL MERGER GUIDELINES] <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>; Federal Trade Commission and Department of Justice, Antitrust Division, *Antitrust Guidelines for Collaborations Among Competitors*, 3 (April 2000).

<sup>147</sup> Feinstein, *supra* note XX at 4.

<sup>148</sup> Ramirez, NEJM 2014. Although, alliances and other collaborations have not yet been challenged on antitrust grounds, the FTC has expressed concerns that such collaborations could also harm competition. Feinstein, ACO Summit 2014.

<sup>149</sup> 2010 HORIZONTAL MERGER GUIDELINES, *supra* note 147, at \_\_\_\_; Federal Trade Commission and Department of Justice, Antitrust Division, *Antitrust Guidelines for Collaborations Among Competitors*, 3 (April 2000).

<sup>150</sup> Feinstein, *supra* note XX, at 4.

the state of competition with and without the proposed integration, and requires the parties to define the relevant product and geographic markets, identify the market participants, calculate market shares and concentration, consider the likelihood of market expansion, and determine whether any efficiencies are likely to result.<sup>151</sup> Antitrust enforcers will further examine whether the proposed integration will likely harm competition by increasing “the ability or incentive to raise prices or reduce output, quality, service, or innovation below what likely would prevail” in its absence.<sup>152</sup> Rule of reason analysis is flexible and market-specific in its inquiry, and no one factor is dispositive.<sup>153</sup>

The most challenging question facing antitrust enforcers in the case of vertical integration is whether the purported procompetitive effects of the integration will outweigh any anticompetitive effects. Before antitrust enforcers will credit any procompetitive efficiencies, the healthcare entities must demonstrate that the claimed efficiencies are sufficiently cognizable and explicit and require the proposed level of integration (merger, joint venture, or affiliation) to produce the procompetitive effects.<sup>154</sup> Doing so has proven extremely difficult.<sup>155</sup> For instance, the 9<sup>th</sup> Circuit Court of Appeals found in *Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke’s Health System* that the quality benefits obtained from sharing electronic medical records, standardizing treatment protocols, and integrating physicians across practices did not require a formal merger, i.e. they were

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<sup>151</sup> *Id.* at 4; 2010 HORIZONTAL MERGER GUIDELINES, *supra* note 147, at \_\_\_\_; Federal Trade Commission and Department of Justice, Antitrust Division, *Antitrust Guidelines for Collaborations Among Competitors*, 4 (April 2000) (hereinafter Antitrust Guidelines for Collaborations).

<sup>152</sup> *Id.* at \_\_\_\_; Antitrust Guidelines for Competitors, *supra* note XX at 4.

<sup>153</sup> *Id.* at \_\_\_\_; Antitrust Guidelines for Competitors, *supra* note XX at 4.

<sup>154</sup> Ramirez, NEJM 2014 (stating that the claimed efficiencies must be merger specific, explicit, and cognizable).

<sup>155</sup> Tasneem Chipty and Asta Sendonaris, Economists’ Perspective on the Efficiency Defense in Provider Consolidations: What Works, What Doesn’t Work, and What We Still Don’t Know, 19 AHILA CONNECTIONS 16, 17 (Sept. 2015) (stating no provider has convinced an antitrust enforcer that the claimed efficiencies are cognizable and sufficient to offset the potential harms to competition).

not “merger specific.”<sup>156</sup> Although the 9<sup>th</sup> Circuit decided *St. Luke’s* on based purely on the anticompetitive potential of the proposed horizontal merger of primary care physician practices in Nampa, ID, the principle that a merger was not necessary to achieve the goals of standardizing practice patterns and improving patient care through electronic medical records would also apply in the analysis of a vertical merger.

The complexity of recent health care integrations will significantly complicate antitrust analysis.<sup>157</sup> Vertical integrations can harm competition in upstream and downstream markets, as well as in entirely different markets.<sup>158</sup> For instance, Health First, an integrated delivery system in Brevard, FL, owns and operates health plans, hospitals, physician groups, urgent care centers, outpatient centers, rehabilitation facilities, diagnostic and treatment centers, and a network of fitness and wellness services.<sup>159</sup> In these cases, it will not be sufficient to analyze only the impact of the integration in each market in isolation, but instead antitrust enforcers and courts should analyze the more global impact of the integration on the particular healthcare market. This makes conducting the competitive effects analysis significantly more complex.<sup>160</sup> Further state enforcers may have to consider how to balance procompetitive effects in one market, such as primary care, with anticompetitive effects in an altogether different market, such as surgical procedures, or whether quality improvements for certain services out weigh across the board price increases. All of this will require

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<sup>156</sup> *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791(9th Cir. 2015), *aff’d* 2014 WL 407446 (D. Idaho 2014).

<sup>157</sup> Steven C. Salop & Daniel P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners*, 5-6, 2014, available at <http://scholarship.law.georgetown.edu/facpub/1392>.

<sup>158</sup> Steven C. Salop & Daniel P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners*, 5-6, 2014, available at <http://scholarship.law.georgetown.edu/facpub/1392>.

<sup>159</sup> Lisa Schenker, *Competitor Sues Florida System Health First*, *Modern Health Care*, September 2, 2015, available at: [http://www.modernhealthcare.com/article/20150902/NEWS/150909986?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=externalURL&utm\\_campaign=am](http://www.modernhealthcare.com/article/20150902/NEWS/150909986?utm_source=modernhealthcare&utm_medium=email&utm_content=externalURL&utm_campaign=am).

<sup>160</sup> Salop & Culley, *supra* note XX, at 6.

extensive amounts of time, resources, data, and analysis to accomplish in any meaningful way.

However, once a state has decided that a proposed or existing integration is anticompetitive, it must decide upon a remedy. The goal of any antitrust enforcement action is to restore the opportunity for the competitive market to function without the illegal restraints on competition.<sup>161</sup> Antitrust enforcers generally have two kinds of equitable remedies to choose from: structural and conduct remedies. Depending on the timing of the action and the market conditions, states can use structural and conduct remedies alone or in combination to address anticompetitive concerns arising from greater consolidation in healthcare.

a. Structural Remedies

Antitrust enforcers use structural remedies to prevent a proposed merger, undo a recent merger, or to require divestiture or other structural change in order to restore competition.<sup>162</sup> In the instance that a vertically integrated entity has not yet, or only recently formed, structural remedies offer a relatively straightforward means of restoring competition by dissolving the integration. Given the level of concentration in both the healthcare insurance and provider markets, antitrust enforcers have expressed a strong preference for structural remedies,<sup>163</sup> as preventing anticompetitive harms pre-consolidation has proven more successful than attempting to address them after the entities have fully integrated.<sup>164</sup>

While structural remedies are frequently used to prevent horizontal mergers, their use in vertical mergers has rarely occurred, because antitrust enforcers generally view vertical integration as pro-competitive.<sup>165</sup> However, given the evidence that vertical integration of healthcare providers can increase market leverage and result in price increases, antitrust enforcers should consider the possibility of a structural remedy when evaluating proposed vertical integrations both at the outset of a

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<sup>161</sup> Feinstein, *supra* note XX, at 14. .

<sup>162</sup> White, et al., *supra* note XX at 176.

<sup>163</sup> Feinstein, *supra* note XX, at 14.

<sup>164</sup> Tenn 2008. (Sutter Summit Analysis by FTC).

<sup>165</sup> Ramirez, 2011.



proposed vertical integration and if a highly consolidated entity continues to amass and abuse its market power.<sup>166</sup>

In the case of proposed integrations, antitrust enforcers should consider structural remedies in three instances. First, they should be especially wary of proposed integrations that appear over-inclusive in the number of hospitals and/or physicians participating in the integration, as this may signal an attempt to gain market power in ways that are unnecessary to the efficiency goals of vertical integration.<sup>167</sup> Second, in instances where the integration would involve a significant number of providers in a particular area, questions arise regarding whether those providers are eligible to see patients independently from the entity or subject to exclusivity requirements, and whether the integration will substantially limit consumer choice. Third, vertical integrations that consolidate market power across several different provider markets can create significant leverage in negotiating reimbursements, such that the entity becomes a “must have” and threatens the ability of other organizations to compete.<sup>168</sup>

Despite the oft-repeated reminder that mergers, once consummated, are difficult, if not impossible, to unwind, and given the highly concentrated nature of the U.S healthcare markets, antitrust enforcers should strongly consider using structural remedies to break down some of the market leverage amassed over the last several decades by certain healthcare entities. Currently, integrated healthcare entities have a strong incentive to consolidate, even in the face of increased monitoring or limitations via conduct remedies, because the limitations are only temporary, but the gain in market power is largely permanent. There are a handful of healthcare provider organizations around the country that have systematically accumulated market power and abused it in ways that have significantly increased costs and eliminated competitors. Market power could be broken

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<sup>166</sup> See e.g., Hollingshead, et al., *supra* note XX, at 17.

<sup>167</sup> Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating the Medicare Shared Savings Program, 76 Fed. Reg. 67025 (Oct. 28, 2011).

<sup>168</sup> For a more theoretical description of how amassing market power across a range of markets will increase leverage in negotiations with a single purchaser, see XXX on Portfolio Power. (signal here of more to come from us on this?).

down in two ways: division of a larger entity into several smaller entities,<sup>169</sup> or required divestitures in certain geographic regions.<sup>170</sup> If state or federal antitrust enforcers successfully brought a challenge that resulted in divestitures or other structural remedies dividing the entity into smaller parts, the victory would serve as a strong deterrent to other entities.

In sum, state antitrust enforcers should use structural remedies to prevent potentially anticompetitive collaborations and mergers from existing, and to break up those integrated entities that systematically amass and abuse market power.

b. Conduct Remedies

The majority of vertical integrations, however, are unlikely to require structural remedies, as they will present substantial procompetitive effects that are not so clearly outweighed by potential harm to competition. In these instances, conduct remedies are more frequently used to curb anticompetitive behaviors and prevent their reoccurrence. State and federal antitrust enforcers have typically used conduct remedies to address anticompetitive concerns arising from vertical mergers and joint ventures because the agencies' believed that conduct remedies would enable an entity to gain the benefits of the procompetitive efficiencies associated with the vertical integration while still restricting any potential anticompetitive conduct.<sup>171</sup>

Conduct remedies can be used in two ways to regulate the anticompetitive harms that may arise from vertical integration. First, given the significant amount of concentration among healthcare providers that has occurred in the last twenty years, conduct remedies provide a means to limit anticompetitive behavior in a healthcare entity that has obtained a significant amount of market power without requiring it to divest portions of its business in ways that may compromise patient care.<sup>172</sup> Second, for entities that are merging or integrating to create an ACO or other form of integrated delivery system, conduct remedies offer a significant tool to

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<sup>169</sup> AT&T into Baby Bells

<sup>170</sup> Community Health Systems and Health Management Associates.

<sup>171</sup> Department of Justice, Antitrust Division, Policy Guide to Merger Remedies, 13 (2011).

<sup>172</sup> Cite.

protect competition in ways that are tailored to the concerns of a particular market, while still enabling providers the opportunity to achieve the desired procompetitive effects of clinical integration.

The use of vertical integration and ACOs to control costs and improve quality in healthcare is still largely experimental. Like any experiment, the model will require iterative refinement and oversight to improve its results. Conduct remedies offer a range of tools to permit this iterative process to continue to try to maximize the benefits of integration, while minimizing the harm to competition. For instance, depending on the concerns in a particular market, antitrust enforcers have imposed direct price caps, limits on total healthcare expenditures, limits on contract provisions,<sup>173</sup> requirements to preserve existing services, prohibitions on employment restrictions, and limits on further acquisitions on healthcare providers in recent years.<sup>174</sup>

But using conduct remedies effectively will not be without its challenges. Historically, the Antitrust Agencies have not favored the use of conduct remedies to control the anticompetitive effects of a proposed mergers or collaborations that posed significant risks to competition.<sup>175</sup> Their logic is relevant to vertical integration in healthcare as well. First, unlike structural remedies, conduct remedies do not restore the status quo with respect to competition.<sup>176</sup> Instead, they provide restrictions and oversight over the newly integrated entity, which are often inferior substitutes for competition between independent providers.<sup>177</sup> For instance, direct price caps have been used to control cost increases following a merger, but it is not clear if the price caps are higher than what a competitive market would permit.<sup>178</sup> Further, conduct remedies often focus on price, but are unable to take account of other impacts of competition like

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<sup>173</sup> For example, prohibiting anti-tiering/anti-steering provisions, most favored nation clauses, all-or-nothing provisions, and exclusive contracting requirements.

<sup>174</sup> See notes from ACO.

<sup>175</sup> Feinstein, *supra* note XX, at 14-15; Ch. 9, Sherman Act §2 Remedies, 149.

<sup>176</sup> *Id.* at 15

<sup>177</sup> *Id.* at 15.

<sup>178</sup> *Id.* at 15.

quality improvement and innovation.<sup>179</sup> Second, conduct remedies are often difficult to enforce and have high administrative costs.<sup>180</sup> Enforcing conduct remedies either requires the enforcement agency to oversee enforcement itself or hire a third party to monitor the entity, both of which require substantial resources. In some instances, enforcement can be so expensive and burdensome that the remedy can be self-defeating. Finally, conduct remedies are generally for a limited time period, which begs the question of what happens at the end of the consent decree. Health care entities may find it financially rewarding to consolidate and accept the conduct remedies and oversight in the short term to obtain the market leverage and power in the future.

In comparison to their federal counterparts, state attorneys general may be better positioned and more willing to use conduct remedies. State officials will be more familiar with local stakeholders and market dynamics, and they may be more willing to engage in conduct oversight than to litigate a merger challenge. For instance, the Pennsylvania Attorney General has successfully negotiated three consent decrees since 2011 with Geisinger Health System.<sup>181</sup> The most recent decree involved Geisinger's acquisition of Lewiston Health Care Foundation, and required both caps on price increases and prohibited most favored nation and anti-tiering provisions.<sup>182</sup> In Massachusetts, former Attorney General, Martha Coakley, negotiated an extensive consent decree with Partners Healthcare conditioning its acquisition of South Shore Hospital and two Hallmark Hospitals on several factors including: 1) caps on price increases and total healthcare expenditures; 2) component contracting, which permits health plans to contract with all or some of Partners' four major components; 3) limitations on Partners' ability to contract with payors on behalf of affiliated providers; 4) preservation of existing services; and 5) A.G. approval for any further acquisitions.<sup>183</sup> The Partners consent decree was ultimately rejected after

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<sup>179</sup> *Id.* at 15-16.

<sup>180</sup> Cite.

<sup>181</sup> Cite.

<sup>182</sup> Cite.

<sup>183</sup> *Massachusetts v. Partners Healthcare System, Inc.*, Memorandum Of the Commonwealth of Massachusetts in Support of Entry of Final Judgment, June 24, 2014, available at: <http://www.mass.gov/ago/docs/press/2014/memo-in-support.pdf>.

substantial opposition from the Massachusetts Health Policy Commission (HPC),<sup>184</sup> which estimated that the merger would result in around \$40 million in increased health care expenditures and Partners having more discharges than the next four largest competitors in the state combined.<sup>185</sup> HPC's impact on the outcome of the Partner's merger demonstrates the importance of states having readily available access to price, quality, and utilization data for analysis.

Overall, antitrust enforcement is an essential tool for states to curb increases in health care costs driven by abuses of provider and payer market power. But it can be too blunt or unwieldy an instrument to strike the delicate balance between promoting beneficial integration in healthcare that cuts down on overuse and waste and granting providers and payers too much market power. If enforcers fear eliminating procompetitive efficiencies, they may opt to delay enforcement in ways that can cause lasting harm to competition. Likewise, if used too aggressively, the threat of antitrust enforcement will chill integration efforts.

## 2. State Action Immunity and Certificates of Public Advantage

In some instances, state and federal governments may wish to alleviate that chilling effect by signaling to healthcare entities that they favor promoting integration over protecting competition. The courts have granted states the ability to regulate the market in ways that promote other policy goals even if those ways may harm competition.<sup>186</sup> In *Parker v. Brown*, the Supreme Court granted states the ability to offer "state action immunity," which would displace the antitrust laws in favor of public supervision, so long as their actions did not unduly burden interstate commerce or violate the Constitution.<sup>187</sup> States seeking to exempt non-sovereign private actors from state and federal antitrust enforcement must demonstrate that the

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<sup>184</sup> The Massachusetts Health Policy Commission is an independent state agency created to monitor health care costs; develop policies to reduce overall healthcare costs and maintain quality; and provide objective, data-driven analyses of specific provider transactions.

<sup>185</sup> CITE.

<sup>186</sup> Phillip Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 HARVARD L. REV. 435, 436 (1981).

<sup>187</sup> *Parker v. Brown*, 317 U.S. 341 (1943). See also, Areeda, *supra* note XX, at 436 (n. 5).

exemption arises from a “clearly articulated and affirmatively expressed . . . state policy” and that the policy is “actively supervised by the state.”<sup>188</sup> States can grant non-sovereign entities immunity through a range of actions including direct legislation, agency action, or by granting a certificate of public advantage (COPA). Currently, ten states have statutes authorizing the state to grant COPAs.<sup>189</sup>

Whether state action immunity has been able to successfully promote beneficial integration while protecting competition has been difficult to ascertain. In recent years, use of state action immunity has come under significant scrutiny, especially in health care, as several states had granted immunity without proper articulation of state purpose or supervision.<sup>190</sup> Robert Berenson and Randall Bovbjerg performed an extensive case study of a COPA granted in North Carolina that enabled Mission Health System (Mission) in Asheville to acquire its major rival, St. Joseph’s Health System.<sup>191</sup> North Carolina granted Mission a COPA in exchange for an agreement to a “quasi-regulatory” regime that controlled Mission’s overall profit margins, its average inpatient and outpatient costs, and the share of primary physicians it could employ.<sup>192</sup> After analyzing years of data, the researchers were unable to conclude that the COPA effectively counteracted the loss of competition in the area, but did find that the model had some successes and with modifications “a COPA-like approach could provide a useful complement to antitrust enforcement in addressing market power.”<sup>193</sup>

COPAs, if carefully limited and executed properly, may offer states several benefits over antitrust enforcement alone. First, it could give states the ability to experiment with vertical integration in health care in ways that attempt to balance the benefits of clinical integration with the risks to competition. Second, protection from antitrust prosecution offers health

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<sup>188</sup> North Carolina Board of Dental Examiners v. FTC, 574 U.S. (slip op. 6) (2015).

<sup>189</sup> NY, KS, ID, ME, MT, NE, NC, SC, TX, WI.

<sup>190</sup> See e.g., North Carolina Board of Dental Examiners v. FTC, 574 U.S. (slip op. 6) (2015)(finding NC did not sufficiently supervise the Board of Dental Examiners); FTC v. Phoebe Putney Health System, Inc., 568 U.S. XX (2013).

<sup>191</sup> BERENSON & BOVBJERG. *supra* note 142, at \_\_\_\_.

<sup>192</sup> BERENSON & BOVBJERG. *supra* note 142, at 1.

<sup>193</sup> BERENSON & BOVBJERG. *supra* note 142, at \_\_\_\_.

care entities further incentive to submit to data reporting and monitoring that can provide essential information on the impact of vertical integration in different market conditions. Such data would also enable states to monitor the impact of various forms of antitrust immunity on price or utilization as a result of a merger over time. Finally, properly executed state action immunity could offer the opportunity to closely monitor and regulate far more health care entities than federal enforcement agencies could cover alone and for longer periods of time than conduct remedies.

However, federal antitrust enforcement officials have recently raised significant concerns about whether state action immunity may do more harm than good.<sup>194</sup> Edith Ramirez, Chairwoman of the FTC, recently expressed concerns that in some states the grant of antitrust immunity in an effort to promote collaboration and integration “betrays a misunderstanding of the crucial role that competition plays in the healthcare sector.”<sup>195</sup> She reiterated the careful balancing that federal antitrust enforcement agencies conduct when reviewing a proposed merger or collaboration, including a weighing of the procompetitive and anticompetitive effects of a proposed integration.<sup>196</sup> Without careful supervision and narrowly defined limits on the scope of antitrust immunity, COPAs and grants of state action immunity risk exacerbating antitrust concerns rather than ameliorating them.

The FTC further demonstrated its skepticism of COPAs and state action immunity recently with respect to New York’s COPA for health care collaboratives.<sup>197</sup> In reviewing an application for a COPA, New York considers: 1) the potential benefits of the health care provider collaborative activities, including preservation of needed health care services, improvement in quality and access to services, lower costs, and improvements in payment methodologies; 2) the health care provider landscape; 3) the potential disadvantages of the collaborative activities; 4) the availability of alternatives that would be less harmful to competition;

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<sup>194</sup> Edith Ramirez, *Antitrust Enforcement in Health Care*, 371 NEJM 2245 (December 11, 2014); Federal Trade Commission, Ltr to Center for Health Care Policy and Resource Development re: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1 (April 22, 2015).

<sup>195</sup> Ramirez, *supra* note 194, at 2246.

<sup>196</sup> *Id.*

<sup>197</sup> 10 NYCRR §1003.14 (2014).

and 5) the extent to which active supervision will mitigate the risks associated with the collaboration.<sup>198</sup> Despite its review process, New York's COPA immunity raised substantial concerns at the FTC that such immunity would promote anticompetitive behavior arising from healthcare integration.<sup>199</sup> On April 22, 2015, the FTC sent a letter to the Center for Health Care Policy and Resource Development in New York, claiming that the FTC fully recognized the potential procompetitive benefits that can arise from healthcare collaborations, but that the COPA exemptions "are based on inaccurate premises about the antitrust laws and the value of collaboration among health care providers."<sup>200</sup> The FTC found that a COPA was unnecessary to enable providers to engage in procompetitive collaborative activities, but it threatened to "immunize conduct that would *not* generate efficiencies, and therefore *not* pass muster under the antitrust laws."<sup>201</sup> The FTC went on to argue that the COPA risked increasing health care costs and decreasing access to consumers in New York. States considering offering state action immunity through legislation or a COPA program must be aware of FTC's concerns and carefully condition the immunity on significant data reporting requirements, regulatory oversight, and explicit boundaries of antitrust exemption.

States must determine how to best employ their antitrust laws to promote competition and efficiency in the health care markets. Data collection and analysis of health care prices, insurance premiums, utilization rates, and quality of care will be essential to this effort. Such data would enable state officials to identify anticompetitive collaborations as early as possible, and seek to revoke immunity or engage in some form of antitrust enforcement if entities violated the terms of the immunity. While states

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<sup>198</sup> *Id.*

<sup>199</sup> Federal Trade Commission, Ltr to Center for Health Care Policy and Resource Development re: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1 (April 22, 2015). The entities applying for the COPA at issue were part of the Delivery System Reform Incentive Program (DSRIP) for Medicaid recipients, however the COPA program applies to all healthcare provider collaborations, including ACOs.

<sup>200</sup> *Id.* at 1.

<sup>201</sup> *Id.* at 1.



have a significant role to play in antitrust enforcement, as Robert Berenson previously noted, antitrust enforcement “can only be one – and not the primary – approach to addressing provider pricing power.”<sup>202</sup>

### *C. Certificates of Authority*

To monitor the impact of vertical integration on price, quality and competition, some states have taken a more active role by creating Certificate of Authority programs for certain health care collaborations, like ACOs. States can tailor the Certificate of Authority requirements to enable them to achieve their particular policy goals. Key considerations include determining which state entity will oversee the certification, whether certification will be mandatory or voluntary, whether to require antitrust and solvency reviews, what price and quality disclosures to require, and whether to incentivize integration by granting antitrust immunity and exemptions to other state laws.<sup>203</sup> Certification programs also allow states to review these features of any particular collaboration both prior to certification and on an ongoing basis. Gathering price and quality data both prior to certification and on an ongoing basis will enable states to monitor market dynamics, inform future decisions regarding integration, and support antitrust enforcement actions.

To date, three states have established Certificate of Authority programs – Texas, Massachusetts, and New York.<sup>204</sup> The features of the three different programs reflect each state’s goals and concerns. Certification presents essentially a quid-pro-quo, where the state offers a range of benefits to the integrating entity, typically an ACO, in exchange for more searching antitrust review up front, and continued oversight.<sup>205</sup> For instance, the Massachusetts’ ACO Certification Program, governed by the Massachusetts Health Policy Commission (HPC), is voluntary, but it will require ACOs seeking certification to satisfy several minimum standards, including the use of alternative payment methodologies, providing medical

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<sup>202</sup> Robert Berenson, Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust, 40 J. HEALTH POL. POL’Y & L. 709, 710 (2015).

<sup>203</sup> Hollingshead, *et al.*, *supra* note XX, at 14-16.

<sup>204</sup> Statutes.

<sup>205</sup> Cite statute. New York only certifies non-risk bearing ACOs. Organizations that bear insurance risk or manage care must receive an appropriate license unde

and behavioral health services across the continuum, and allowing for health care price transparency in exchange for a HPC “seal of approval” and the opportunity for preferential contracting with state-funded insurance contracts.<sup>206</sup> As to data gathering, HPC already requires all provider organizations of a certain size and scope to register and submit data on costs and charges to the Center for Health Information and Analysis (CHIA), but any ACO applying for certification must also register as a provider and disclose such information regardless of size or scope.<sup>207</sup> While the ACO certification process and its requirements are still under development, HPC has yet to require a solvency review or offer further potential incentives for ACO formation, such as the offer of immunity or a safe harbor from state and federal antitrust laws, exemption from state self-referral or other consumer protection laws.<sup>208</sup> According to staff members at HPC, a seal of approval from the state “is a meaningful distinction in a competitive marketplace, such as Massachusetts,”<sup>209</sup> which may provide sufficient incentive for ACO certification, negating the need for the state to grant such legal exemptions.

In Texas, the Department of Insurance (TDI) governs the mandatory certification of all Health Care Collaboratives (HCCs), which focuses mostly on the antitrust implications of HCCs.<sup>210</sup> To obtain certification, an HCC must demonstrate the willingness and potential ability to increase collaboration and integration among health care providers, promote improvements in care quality and outcomes; reduce preventable medical errors, contain costs without jeopardizing quality, and has the ability to

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<sup>206</sup> Ch. 224 of the Acts of 2012: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation; Hollingshead, *et al.*, *supra* note XX at 15.

<sup>207</sup> Ch. 224 of the Acts of 2012: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation. (Provide more detail here on size requirements for registration.) available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ch-224-tracking-tool-2015-final.pdf>.

<sup>208</sup> HPC info; Hollingshead, *et al.*, *supra* note XX, at 17.

<sup>209</sup> Hollingshead, *et al.*, *supra* note XX, at 15 (quoting from interviews conducted by the authors with key officials at HPC).

<sup>210</sup> 6 Texas Insurance Code 848.001 (2015). Health Care Collaboratives are Texas’ version of an ACO.

gather, analyze and report statistics on health care costs, quality, access, and utilization.<sup>211</sup> In addition, the HCC must fund and engage in an in-depth antitrust review that provides evidence that the proposed collaboration is not likely to harm competition and that the procompetitive effects of the collaboration outweigh any anticompetitive effects of increased market power.<sup>212</sup> Having the applicants fund the reviews saves state resources, but may also discourage health care entities from forming HCCs. To date, no health care provider organization has applied for certification as a HCC in Texas, and so whether this type of certification serves to protect competition or discourage integration remains uncertain.

In contrast to Massachusetts and Texas, New York's voluntary certificate of authority for commercial ACOs both demands more of and offers more to applying ACOs. New York encourages clinical and financial integration by offering to exempt qualifying ACOs from prosecution under the corporate practice of medicine doctrine, state and federal antitrust laws, and prohibitions on fee splitting and self-referrals.<sup>213</sup> In exchange, the ACO must agree to "provide, manage, and coordinate health care for a defined population; be accountable for quality, cost, and delivery of health care to ACO patients; negotiate, receive and distribute any shared savings or losses; and establish, report and ensure provider compliance with health care criteria including quality performance standards."<sup>214</sup> In addition to the materials requested for initial certification application, ACOs applying for a COPA must submit any additional information requested by the state during the COPA review process described above.

State certification of health care collaborations offer an important means of both incentivizing beneficial integration and collaboration in health care, while offering states the opportunity to gather valuable cost and quality data to determine the impact of the collaborations on the dynamics in the health care markets. States considering certification should monitor the success of Massachusetts, Texas, and New York to determine which elements of their

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<sup>211</sup> 6 Texas Insurance Code § 848.057 (2015). *See also*, Hollingshead, *et al.*, *supra* note XX at 16 (stating that depending on complexity and extent, review costs could range from \$25,000 to \$250,000 for the initial review and up to \$10,000 per annual renewal).

<sup>212</sup> *Id.* at §848.057(a)(5-6) (2015).

<sup>213</sup> *See*, Hollingshead, *et al.*, *supra* note XX, at XX.

<sup>214</sup> 10 NYCRR §1003.6 (2014).

programs to emulate. For instance, mandatory certification enables states to guarantee oversight and access to essential cost and quality data, but it may create substantial barriers to collaboration. Whereas the promise of state action immunity via a COPA may incentivize collaboration, but protect entities that engage in anticompetitive behavior and abuse market power. Finally, voluntary certification programs that do not offer significant benefits may not enroll many entities, which would significantly hinder the state's ability to monitor and regulate the activities of integrating healthcare entities.

#### *D. Rate Oversight Models*

A step beyond collaboration certification models that only apply to certain forms of integration, like ACOs, is to vest more widespread rate oversight authority in an independent rate commission or the state department of insurance.

##### 1. Rate Oversight Commission

Some states are putting in place independent commissions to oversee health care prices in their states. A rate oversight commission's charge typically includes authority to study and make recommendations on proposed health care mergers and to monitor prices and quality data post-merger. In the states that have established an APCD, a commission could have authority to analyze statewide claims data from the APCD to evaluate the pricing power, efficiency, utilization, and quality of the existing provider landscape. Based on its findings, the commission then makes recommendations and supplies data to both the state's attorney general regarding proposed mergers or anticompetitive provider behavior and policymaking bodies regarding the need for regulatory intervention.<sup>215</sup> For example, if the commission observes that powerful providers are using anti-tiering provisions in contracts with health plans to limit the ability of those health plans to steer members to lower cost or higher value providers, the commission could recommend enforcement action by the state attorney general, or legislation prohibiting anti-tiering clauses in provider-plan contracts. A commission also could be given more direct regulatory

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<sup>215</sup> An example is Pennsylvania's Health Care Cost Containment Council, which has the authority to collect, analyze, and make recommendations on health care price data. 35 PA. CONS. STAT. ANN. § 449.17b (West 2015); NASI PANEL ON PRICING POWER, *supra* note 72, at 42.

authority beyond simply monitoring and making recommendations. For example, it might be granted the ability to implement price caps if prices rise beyond certain supracompetitive thresholds.

Perhaps the most prominent example of such a body is Massachusetts' Health Policy Commission (HPC). Created in 2012, the Massachusetts legislature charged HPC with setting the health care cost growth for the state, enhancing transparency of provider organizations, monitoring the development of new payment and delivery systems, like ACOs, overseeing the impact of all such changes on the health care markets, and protecting patient access.<sup>216</sup> HPC reviews all transactions with potential market impact.<sup>217</sup> For example, it was very active in monitoring the proposed acquisitions by health care giant Partners Healthcare, supplying information and recommendations to the State Attorney General's office. Massachusetts' Health Policy Commission also has some regulatory authority, with the ability to require providers that exceed cost growth benchmarks to implement performance improvement plans and fine them if the provider fails to comply.<sup>218</sup>

To date, six states, have established a rate oversight commission: Delaware, Maryland, Massachusetts, New York, Pennsylvania, and West Virginia.<sup>219</sup> Five of these have authority to analyze price and cost data and make recommendations, and two, Maryland and West Virginia, have additional authority to approve and set inpatient and outpatient rates and

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<sup>216</sup> Ch. 224 of the Acts of 2012: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation. Goals of the Act.

<sup>217</sup> MASS GEN. LAWS ch. 6D § 2 (2015).

<sup>218</sup> MASS GEN. LAWS ch. 6D § 3 (2015); *see also* NASI PANEL ON PRICING POWER, *supra* note 72, at 42.

<sup>219</sup> DEL. CODE ANN. TIT. 16, § 9902 (2015) (establishing the Delaware Health Commission); MD. CODE ANN., Insurance § 19-720 (2015) (establishing the state Health Services Cost Review Commission); MASS GEN. LAWS ch. 6D § 2 (2015) (establishing the Massachusetts Health Policy Commission); N.Y. INS. LAW § 213 (Consol. 2015) (establishing the New York State Health Care Quality and Cost Containment Commission); 35 PA. CONS. STAT. ANN. § 449.17b (West 2015) (establishing the Health Care Cost Containment Council); W. VA. CODE § 16-29B-5 (2015) (establishing the West Virginia Health Care Authority).

limit hospitals' total revenues.<sup>220</sup> In addition, in 2015 Colorado established a health care cost containment commission with a three-year mandate to study the drivers of health care cost growth, analyze the state's APCD and insurance rate review data, and make recommendations to the legislature.<sup>221</sup>

The challenge of establishing an independent rate oversight commission is making sure it coordinates with other existing government agencies and does not just add another regulatory body to the mix.<sup>222</sup> To be effective, a commission must closely communicate with the APCD authority, the state attorney general, the department of insurance, certificate of need authorities, and others. Nevertheless, it can be extremely valuable for a state to have an expert, independent commission to analyze APCD data and make policy or enforcement recommendations.

## 2. Insurance Rate Review

States could also increase the insurance rate review authority of the department of insurance. The ACA requires states to review proposed insurance rates for non-grandfathered health plans and determine the reasonableness of any proposed rate increase of more than 10%, but it does not require states to give prior-approval (or disapproval) authority over such rate hikes to the department of insurance.<sup>223</sup> Pursuant to these requirements, many states strengthened their insurance rate review functions. At the stronger end of the spectrum, health insurers must submit their rates to the department of insurance for prior approval, and the Insurance Commissioner has the authority to reject or reduce proposed rate increases.<sup>224</sup> Other states give the Insurance Commissioner weaker "file-

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<sup>220</sup> See Part IV.F, *infra*.

<sup>221</sup> Colo. Rev. Stat. Ann. § 25-46-101 et seq. (West) (establishing the Colorado Commission on Affordable Health Care).

<sup>222</sup> NASI PANEL ON PRICING POWER, *supra* note 72, at 42.

<sup>223</sup> 42 U.S.C. § 300gg-94(c); 45 C.F.R. § 154.200. If the state does not establish an effective rate review authority, the Department of Health and Human Service shall determine the reasonableness of the proposed rate increase above 10%, but it does not have the authority to disapprove the rate. For more on the ACA's insurance rate review requirements and state rate review activities, *see generally*, John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 Temple L. Rev. \_\_\_\_ (forthcoming 2016).

<sup>224</sup> [States with prior approval] "Prior approval" authority generally means that the state insurance commissioner can approve, reject, or reduce proposed rate increases from

and-use” authority, where rates go into effect once they have been filed and the Department has no ability to reject the rate increase.<sup>225</sup> States also vary in terms of which types of health insurance products (e.g., individual, group, HMOs, PPOs) are subject to their rate review requirements.<sup>226</sup> Recent research has shown that states with stronger forms of rate review authority, such as prior approval authority and loss ratio requirements, experienced lower premium increases in the individual market than states without rate review authority or with only file-and-use authority.<sup>227</sup>

Although insurance rate review focuses on premium rate increases rather than on provider prices, limiting the ability of insurance companies to raise premiums puts pressure on providers negotiating with the health plans.<sup>228</sup> When health plans are limited in their ability to raise premiums, they cannot simply pass high provider prices on to the policyholders.

In addition, insurance rate review can be given significant teeth by giving the insurance department authority to impose price caps. For instance, Rhode Island has expanded its insurance department’s authority to limit annual price increases for inpatient and outpatient services.<sup>229</sup> The state caps the amount of price increases to which insurers can contractually agree to Medicare’s rate increase plus 1%.<sup>230</sup> Rhode Island’s limits on the

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insurers. If a rate is not disapproved or reduced by a deadline, it goes into effect. Community Catalyst. Rate Review: What is It and Why Does It Matter? 2 (May 2013), <http://www.communitycatalyst.org/resources/publications/body/Rate-review-fact-sheet-FINAL.pdf>.

<sup>225</sup> [States with file-and-use]. “File-and-use” authority generally means that the insurance companies must file their proposed rates with the Department of Insurance, but the rates may go into effect without Department approval. The Department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process. Community Catalyst, *supra* note 224, at 2.

<sup>226</sup> [States with prior approval only for some]

<sup>227</sup> Pinar Karaca-Mandic et al., States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market, 34 HEALTH AFF. 1358, 1360 (2015).

<sup>228</sup> NASI PANEL ON PRICING POWER, *supra* note 72, at 44.

<sup>229</sup> RI Gen L § 42-14.5-3 [verify and see if are also regulations]

<sup>230</sup> [get cite]

rate increases insurance plans may accept from providers is a form of indirect rate regulation of providers via limits on insurers.

The advantages of strengthening insurance rate review authority are that stronger forms of insurance rate review seems to be effective at constraining premium growth, which may be especially important as the insurance market gets more concentrated.<sup>231</sup> States can also place limits on provider price increases as part of its insurance approval authority, and thus insurance rate review can also be used as an indirect way to regulate provider prices by giving insurers a backstop beyond which they cannot go in negotiating prices.

The challenges of insurance rate review are partly political. The further a state moves along the spectrum of regulation, the more political opposition the state may encounter from providers and insurers. Another risk is that with additional regulatory oversight, insurers may exit the market. Finally, to the extent insurance rate caps or targets are based on averages, they may widen the gap between the “must-have” and “have-not” providers.<sup>232</sup> Must-have health systems may still command monopoly prices, but to get under the cap, the insurers may force less powerful providers to lower prices below sustainable levels or exit the market.

#### *E. Rate Caps*

In a market with little functioning competition, in which dominant providers exert extensive pricing power, states have the option to cap providers’ private health care prices. The cap could apply to all private payers, including self-pay patients, and be set as a percentage of Medicare rates. For example, health economics and policy experts from Dartmouth suggested a private price cap of 125% of Medicare rates;<sup>233</sup> Robert Murray,

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<sup>231</sup> Karaca-Mandic et al., *supra* note **Error! Bookmark not defined.**, at 1365. [Testimony of Jaime S. King]

<sup>232</sup> See NASI PANEL ON PRICING POWER, *supra* note 72, at 44.

<sup>233</sup> Jonathan Skinner, Elliott Fisher, and James Weinstein, *The 125 Percent Solution: Fixing Variations in Health Care Prices*, Health Affairs Blog Aug. 26, 2014, <http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/>. (“If every patient and every insurance company always had the option of paying 125 percent of the Medicare price for any service, we would effectively cap the worst of the price spikes. No longer would the tourist checked out at the ER for heat stroke be clobbered with a sky-high bill. Nor would the uninsured single mother be charged 10



former Executive Director of Maryland's rate setting agency, suggested a cap of 150-175% of Medicare rates;<sup>234</sup> and a panel of policy experts writing for the National Academy of Social Insurance suggested price cap levels could range from 200-250% of Medicare rates.<sup>235</sup>

Rate caps offer substantial advantages. First, they can limit outlier prices at the top end of the scale, while still allowing for some competition below the cap.<sup>236</sup> Rate caps preserve the ability of providers to charge different prices from each other, which allows providers to compete within this range on the basis of price or quality, but the caps limit the extent of price variation by imposing a ceiling on prices.<sup>237</sup> Second, a broad cap on private payer rates would improve payers' bargaining position to resist price increases by powerful providers or at least put a regulatory backstop on the degree to which such providers can charge monopoly prices. Third, rate caps are simpler from a regulatory perspective than all-payer rate setting, where the administrative body has to set prices for each service, because rate caps piggy-back on the prices set in the Medicare system.

On the other hand, because rate caps piggy-back on Medicare rates, they incorporate all the flaws of the Medicare pricing system as well as its strengths. Rate caps also do not eliminate inefficiencies and administrative costs of price discrimination by providers, the practice of charging different rates to different payers for the same service.<sup>238</sup> Further, the rate cap level

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times the best price for her child's asthma care. This is not just another government regulation, but instead a protection plan that shields consumers from excessive market power.")

<sup>234</sup> See Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. Health Politics, Pol'y & L. 679, 689 (2012) [hereinafter, *The Case for a Coordinated System of Provider Payments*]; Robert Murray, *The Cost of Hospital Care: Experience from Maryland's All-payer Rate Setting System*, slide 21 (Oct. 8, 2010) [http://www.hscrc.state.md.us/documents/HSCRC\\_PolicyDocumentsReports/Presentations/TheCostofHospitalCareNHPFR\\_Murray2010-10-08.pdf](http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/Presentations/TheCostofHospitalCareNHPFR_Murray2010-10-08.pdf).

<sup>235</sup> NASI PANEL ON PRICING POWER, *supra* note 72, at 46.

<sup>236</sup> *Id.*

<sup>237</sup> Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L. J. \_\_\_\_ (2015).

<sup>238</sup> Uwe Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for A More Rational All-Payer System?* 30 HEALTH AFF.

set by a rate oversight commission, even if supported by substantial expertise and data, may not precisely replicate the maximum prices that would result in a competitive market in equilibrium. Some have criticized rate caps and other forms of rate regulation as potentially stifling financial incentives for innovation.<sup>239</sup> Rate caps are politically challenging as well, likely to be opposed by the most powerful providers whose pricing power will be limited by the caps. Rate caps should be supported, however, by health plans, employers, and other purchasers of health care because they could constrain the cost of including must-have providers in health plan networks.

To date, no state has implemented price caps, although Rhode Island's insurance rate caps look a bit like the price caps described here. To determine whether to implement a price cap or where to set the cap, states will require data from an APCD and perhaps a rate oversight commission with expertise to come up with the price cap levels.

#### *F. Provider Rate Regulation*

In highly concentrated provider markets, states can most efficiently address provider market power through direct regulation of provider prices. Two versions of rate regulation are discussed below, all-payer rate setting exemplified by Maryland's system and provider rate review as exemplified by West Virginia.

##### 1. All-Payer Rate Setting

The prototypical system of provider rate regulation is all-payer rate setting, which would set the rate for all payers, whether private insurers, government programs, or self-pay patients. To include Medicare and Medicaid in the all-payer model, the state must obtain a waiver from the Centers for Medicare and Medicaid Services.<sup>240</sup> Under an all-payer system, either a rate setting commission or a representative body of payers negotiates a uniform set of provider reimbursement rates.<sup>241</sup> Although

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2125, 2128-29 (2011).

<sup>239</sup> [cite]

<sup>240</sup> See Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1395-96 (2009).

<sup>241</sup> Bruce C. Vladeck & Thomas Rice, *Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers*, 28 HEALTH AFF. 1305, 1313 (2009).

traditionally applied to hospital services, in its broadest form, rate setting could apply to all provider services (whether hospital, physician, post-acute, lab, diagnostic, etc.), as well as drugs and devices.

Under the rate setting commission approach, the commission collects detailed information about costs, patient volumes, hospital finances, and services for each provider for use in rate setting.<sup>242</sup> The best-known example of this public utility model of rate setting is Maryland's all-payer rate setting system, where an administrative body sets hospital rates.<sup>243</sup> Maryland's system has controlled hospital costs-per-case, but must be paired with global budgets or ACO-type mechanisms to limit incentives to increase patient volume. In the 1970s, several states adopted rate setting systems, only to abandon them during the deregulatory era of the 1980s-90s when managed care seemed to be constraining health care costs.<sup>244</sup>

For the second model of rate setting through collective negotiation, there are no examples from the U.S., but Japan, Germany, France, Switzerland, and other OECD countries use this model.<sup>245</sup> This model combines the bargaining leverage of all payers together in an oligopsony.<sup>246</sup> To counteract provider pricing power, insurers combine their bargaining power and collectively negotiate with each provider separately, if permitting

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<sup>242</sup> Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 2395-96 (2009). The data collection and analysis is similar to that performed through an APCD, and could also be used for rate setting.

<sup>243</sup> *Id.*

<sup>244</sup> John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 145 (1997).

<sup>245</sup> See Uwe Reinhardt, *A Modest Proposal on Payment Reform*, Health Aff. Blog, July 24, 2009, <http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/> [hereinafter, Reinhardt, *A Modest Proposal*]; Uwe Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for A More Rational All-Payer System?* 30 HEALTH AFF. 2125, 2129 (2011); Vladeck & Rice, *supra* note \_\_\_, at 1313.

<sup>246</sup> Vladeck & Rice, *supra* note \_\_\_, at 1313.

providers' prices to vary, or with a consortium representing all providers.<sup>247</sup> For those concerned about concentration among health insurers, allowing payers to come together to bargain collectively with providers is not the same as increasing concentration in the insurance market. The individual health plans would still have to compete for their own customers on the basis of premiums, provider networks, and other benefits.<sup>248</sup>

Although rate setting eliminates price discrimination by a single provider against its various payers, rate setting generally allows providers to charge different prices from each other, which preserves some degree of competition. Competition can be amplified by reporting providers' percentage markup above the standard rate and quality ratings to allow price and quality comparisons with other providers.<sup>249</sup> Somewhat like Medicare, this approach allows for price differences to reflect differences in costs if, for example, the facility is a teaching hospital.<sup>250</sup> To the extent it encourages price- and quality-transparency, rate setting could also encourage competition among providers on the basis of value, while still limiting the pricing power of dominant providers.

## 2. Provider Rate Review

West Virginia provides a different model of provider rate regulation through review of providers' private prices.<sup>251</sup> West Virginia established its Health Care Authority in 1983 to gather information on health care costs and run the state's rate regulation and certificate of need programs to

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<sup>247</sup> See Austin Frakt, *All-Payer Rate Setting and Health Reform's Underpants Gnomes Strategy*, WASHINGTON POST WONKBLOG, Jun. 2, 2011, [http://www.washingtonpost.com/blogs/wonkblog/post/all-payer-rate-setting-and-health-reforms-underpants-gnomes-strategy/2011/06/02/AG3SfHHH\\_blog.html#pagebreak](http://www.washingtonpost.com/blogs/wonkblog/post/all-payer-rate-setting-and-health-reforms-underpants-gnomes-strategy/2011/06/02/AG3SfHHH_blog.html#pagebreak).

<sup>248</sup> Id.

<sup>249</sup> See Austin Frakt, *Simply Put: All-Payer Rate Setting*, The Incidental Economist Blog, Apr. 8, 2011, <http://theincidentaleconomist.com/wordpress/simply-put-all-payer-rate-setting/>; Uwe Reinhardt, *Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 66 (2006), at 66; Reinhardt, *A Modest Proposal*, *supra* note 245; Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. Health Politics, Pol'y & L. 679, 684 (2012).

<sup>250</sup> See Frakt, *supra* note 249; Reinhardt, *A Modest Proposal*, *supra* note 245.

<sup>251</sup> West Virginia's is not an all-payer system, because it does not include Medicare and Medicaid in its rate-setting authority.

control health care costs and capital expenditures.<sup>252</sup> All hospitals must submit a rate application to the Authority with their proposed private rates and their cost information, and the Health Care Authority may approve, disapprove, or seek modification of the hospital's rates for private payers.<sup>253</sup> A hospital can accept a guaranteed or pre-approved rate increase by tying its proposed increase to a benchmarking methodology, based on peer hospitals' costs and charges, or it can apply for a greater rate increase subject to more in-depth review.<sup>254</sup> In addition, the Health Care Authority sets limits on each hospital's annual revenue, and excess revenue must be returned before the following year's increases are approved. West Virginia's costs-per-case have grown slower than the national average, suggesting that it has been somewhat effective at controlling health care price growth.<sup>255</sup>

### 3. Advantages and Disadvantages of Provider Rate Regulation

The primary advantage of provider rate regulation is that it directly counteracts providers' pricing power in noncompetitive markets. It does this either through administrative rate setting like we see for utilities or in the Medicare program, or by combining the bargaining power of all purchasers and payers. Rate regulation also has the potential to dramatically reduce administrative costs for providers. By eliminating price discrimination among payers, providers could reduce the administrative costs of negotiating different rates and maintaining separate billing procedures for each payer. These administrative costs are significant drivers of health care costs, as the U.S.'s fragmented payer landscape explains much of why providers' administrative costs are so much higher in the U.S. than in other countries with similarly developed health systems.<sup>256</sup> To maximize

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<sup>252</sup> W. Va. Code Ann. § 16-29B-1 et seq. (West); W. Va. Code R. 65-5-1 et seq.

<sup>253</sup> W. Va. Code § 16-29B-19.

<sup>254</sup> Anna S. Sommers, Chapin White, & Paul Ginsburg, National Institute for Health Care Reform, Addressing Hospital Pricing Leverage through Regulation: State Rate Setting, May 2012, <http://www.nihcr.org/1t192>.

<sup>255</sup> Atkinson, *supra* note \_\_, at 11 ("From 1985 to 2007, costs per [inpatient admission] in West Virginia increased by 192 percent, compared with a nationwide increase of 213 percent.")

<sup>256</sup> David U. Himmelstein et al., *A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All By Far*, 33 HEALTH AFF. 1586, 1589, 1592 (2014) (explaining that U.S. hospitals spend more than 25% of all costs on administration, driven

transparency and administrative ease, the rate schedule could be based on Medicare rates, and to the extent that Medicare is not included in the payment system, the rate setting entity could express private rates as a simple multiplier of Medicare rate.

Rate setting could allow prices to vary between providers, but the variation in price would reflect differences in quality rather than market power as it does now. Thus, under a rate setting regime, you could still have an element of competition between providers on the basis of value and quality or services offered.

The biggest challenge of rate setting is political. The major hospital systems whose prices would be constrained the most are often extremely powerful entities, the engines of local economies and jobs. And as any regulatory regime, there is a risk of agency capture or bureaucratic complexity. Another big challenge with rate setting is that it only addresses the price half of the cost-control equation.<sup>257</sup> Rate regulation must be paired with ACOs, global budgets other payment reforms to control the tendency to increase utilization. Maryland has demonstrated that rate setting can control costs-per-case quite effectively, but not volume. So Maryland's new Medicare waiver adds global budgets to its rate-setting program, no easy feat.<sup>258</sup> Another lesson from Maryland is that all-payer rate setting appears to work best when it includes Medicare and Medicaid, making it truly an all-payer system, but doing so requires a waiver from CMS.

#### CONCLUSION

Bending the health care cost curve requires constraining both utilization and price. Reducing fragmentation in health care by offering incentives to promote collaboration and integration can help reduce overutilization. But

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by the complexity of the reimbursement system and the mode of capital funding).

<sup>257</sup> See, Mark Pauly & Robert Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency*, 37 J. Health Politics, Pol'y & L. 697, 699 (2012); Kevin Outterson, *All-Payer Rate Setting in JAMA: A "Maryland Miracle"?*, THE INCIDENTAL ECONOMIST BLOG, Sept. 14, 2011, <http://theincidentaleconomist.com/wordpress/all-payer-rate-setting-in-jama-a-maryland-miracle/#comments>.

<sup>258</sup> *Maryland All-Payer Model*, CTRS. FOR MEDICARE & MEDICAID SVCS. INNOVATION CTR., <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/> (last visited Oct. 18, 2015).

increased health care integration is a double-edged sword. Efforts to integrate health care have benefits in terms quality and reduced utilization, but can also lead to increased market power and prices, which could potentially defeat much or all of the cost-savings from reduced utilization.

There are currently few systemic checks on the growing pricing power of integrated health care providers. Federal antitrust and cost-control policies are limited in their abilities to control private health care price increases, particularly new forms of vertical integration driven by health reforms like ACOs. This creates both an opportunity and an obligation for states.

The way to manage the double-edged sword of health care integration is to encourage beneficial integration, but pair it with oversight on price and quality. States must have a means to collect and analyze price, quality, utilization, and market data, such as an APCD, in order to determine which policy choices to select and to evaluate their success. From there, states have a variety of policies they can pursue to try to address health care prices while still reaping the benefits of integrated delivery – each has challenges, but states must do something.

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