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Patricia M. Bruns

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AN ANTITRUST ANALYSIS OF ACCOUNTABLE CARE ORGANIZATIONS: POTENTIAL ABUSES FROM ALLOWING REDUCED SCRUTINY UNDER THE AFFORDABLE CARE ACT

*Patricia M. Bruns**

I. INTRODUCTION

According to the Centers for Medicare and Medicaid Services (“CMS”), health care costs in the United States in the year 2009 totaled \$2.5 trillion dollars, or \$8,086 per person, and are projected to increase by 6.1% per year between 2009 and 2019.¹ To put this in perspective, the 2009 health care costs represent an overwhelming 17.6% of the United States Gross Domestic Product and are expected to reach 19.3% by 2019.² As part of an effort to curtail these steadily increasing costs, President Barack Obama signed into law the Patient Protection and Affordable Care Act (“Affordable Care Act”) on March 23, 2010.³ In particular, section 3022 of the Act encourages health care providers to form “Accountable Care Organizations” (“ACOs”) in order to participate in the new “Medicare Shared Savings Program.”⁴ The

* J.D. Candidate, The Catholic University of America, Columbus School of Law, May 2013; B.S. in Business Administration, emphasis in Finance and Economics, The University of Dayton, 2010. The author would like to thank her friends and family, especially her parents Elizabeth and Joseph, for their unending support throughout the writing process. She would also like to personally thank her Expert Readers, Mr. John J. Miles, Attorney at Ober Kaler, and Mrs. Leigh L. Oliver, Attorney at Hogan Lovells. In addition, she would like to thank the editors and staff of the *Journal of Contemporary Health Law and Policy* for all their help in the completion of this Comment.

1. *NHE Fact Sheet*, CTRS. FOR MEDICARE AND MEDICAID SERVS., https://www.cms.gov/nationalhealthexpenddata/25_NHE_fact_sheet.asp. (last updated Apr. 11, 2012, 6:24 AM).

2. *Id.*

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 395 (2010) [hereinafter PPACA].

4. *Id.* § 3022 (“[N]ot later than January 1, 2012, the Secretary shall establish a shared savings program . . . that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in

goal of these ACOs will be to promote collaboration among health care providers, increase overall efficiency in caring for patients, and reduce the cost of providing health care to Americans.⁵ ACOs will consist of competing providers who will work together to deliver care in a more coordinated, efficient, and cost effective manner and will “negotiate contracts on behalf of their participating providers including price terms.”⁶ These efficiency benefits are at odds with anti-competitive behavior, which is inherent whenever otherwise competing healthcare providers collaborate.

On October 20, 2011, the Federal Trade Commission (“FTC”) and the Antitrust Division of the U.S. Department of Justice (“DOJ”), recognizing that newly formed ACOs will need guidance in order to avoid price-fixing violations of the antitrust laws, jointly issued the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (“Antitrust Statement”).⁷ The Antitrust Statement contains two particularly important facets. First, it provides that the antitrust agencies will apply the “rule of reason” test to joint price negotiations of ACOs with commercial health plans if they meet CMS’s eligibility requirements for participation in the Medicare Shared Savings Program, relieving their joint negotiations from *per se* antitrust challenges.⁸ Second, in applying the rule of reason analysis

infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’); and (B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings.”).

5. *Id.*

6. Jeff Miles, Accountable Care Organizations and the Enforcement Agencies’ Proposed Statement of Antitrust Enforcement I (unpublished manuscript) (on file with author).

7. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 20, 2011) (“[T]o maximize and foster opportunities for ACO innovation and better health for patients, the Agencies wish to clarify their antitrust enforcement policy regarding collaborations among independent providers that seek to become ACOs in the Shared Savings Program.”) [hereinafter Statement of Antitrust Enforcement Policy].

8. *Id.* at 67,027. See generally WILLIAM C. HOLMES, ANTITRUST LAW HANDBOOK, *infra* note 36.

to assess the ACO's market power, the Antitrust Statement creates an antitrust "safety zone" for ACOs with market shares in all the "common services" it provides that are less than 30%, absent "extraordinary circumstances."⁹ The Antitrust Statement further provides that any ACO may request a voluntary ninety-day expedited antitrust review letter from the agencies to help assess its potential antitrust liability.¹⁰

The Antitrust Statement was issued to provide newly developed ACOs with the "antitrust clarity and guidance" necessary for their participating providers to create pro-competitive integrated networks rather than risk engaging in *per se* antitrust violations when contracting with payers.¹¹ The Antitrust Statement applies only to ACOs formed through collaboration among otherwise independent providers that "are eligible and intend, or have been approved, to participate in the Shared Savings Program."¹² In contrast, it does not apply to other networks that contract with commercial health plans but do not participate in, or intend to participate in, the Shared Savings Program.¹³ Under the Shared Savings Program, ACOs are entitled to share in the savings to the Medicare program generated by the ACO if they meet certain quality and savings requirements, in addition to their traditional Medicare fee-for-service payments.¹⁴ Those CMS eligibility requirements include:

- (1) a formal legal structure that allows the ACO to receive and distribute payments for shared savings;
- (2) a leadership and management structure that includes clinical and administrative processes;
- (3) processes to promote evidence-based medicine and patient engagement;
- (4) reporting on quality and cost measures;
- and (5) coordinated care for beneficiaries.¹⁵

9. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,028.

10. *Id.* at 67,030.

11. *Id.* at 67,026.

12. *See id.* at 67,027.

13. *Id.*

14. Medicare Program, Medicare Shared Savings Program, Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425) [hereinafter Medicare Program].

15. *See* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,027.

Collaboration among competing health care providers inherently raises antitrust issues, particularly the possibility of horizontal price-fixing schemes in violation of section 1 of the Sherman Act, and the potential to exercise market power by increasing the providers' reimbursement to supra-competitive levels.¹⁶ Moreover, the ACOs that constitute single entities, such as those formed through the merger of all ACO participants, may violate section 7 of the Clayton Act¹⁷ or the monopolization or attempted monopolization provisions of section 2 of the Sherman Act.¹⁸ The primary issue, though, with ACOs is horizontal price-fixing in violation of section 1 of the Sherman Act given that ACOs are comprised of otherwise independent providers working together but that have not merged into one entity.

Horizontal price-fixing agreements result when competitors selling the same products or services in the same or overlapping geographic markets, agree, either directly or through a common agent negotiating on their behalf, on the prices they will charge for their products or services.¹⁹ ACO participants—such as physicians, hospitals, and perhaps other providers—are encouraged to share information and collaborate with each other in order to improve patient care.²⁰ By encouraging this collaboration, health care providers may be incentivized to fix prices artificially in negotiating contracts with commercial health plans to the detriment of consumers. Given that ACOs are comprised of otherwise competing providers, the ACO's actions result in agreements or "conspiracies" subject to section 1 of the Sherman Act.²¹ When ACOs negotiate prices on behalf of their

16. 15 U.S.C. § 1 (2006); *see also* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

17. 15 U.S.C. § 18 (2006).

18. 15 U.S.C. § 2 (2006).

19. *See, e.g.*, *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). A price-fixing agreement is "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity." *Id.*

20. *See* PPACA, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010).

21. *E.g.*, *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 356 (5th Cir. 2008) (holding that a group of independent competing physicians' agreements on price constituted unlawful horizontal price-fixing) ("[W]hen an organization is controlled by a group of competitors, it is considered to be a conspiracy of its members.").

otherwise competing participants, horizontal price-fixing agreements result.²²

Horizontal price-fixing agreements are typically *per se* violations of section 1 of the Sherman Act.²³ As a result, these types of agreements are generally presumed to violate section 1 without proof that they actually restrain competition, regardless of the participants' intent, and regardless of any pro-competitive justifications or effects the actions generate.²⁴ If the participants have sufficiently integrated their operations in ways to achieve significant efficiencies, such as forming an integrated joint venture, and their price-fixing agreement is reasonably necessary for achievement of those efficiencies, the more lenient "rule of reason" standard applies in assessing their effect on competition.²⁵ The "rule of reason" analysis requires that a plaintiff challenging the action must prove that the defendant has market power and that its effects predominate over any pro-competitive effects the challenged conduct might purport to have.²⁶ Joint price negotiations by

22. *See, e.g.*, *United States v. Masonite Corp.*, 316 U.S. 265, 276 (1942) (holding that a principle fixing prices for otherwise independent agents to sell the principle's products constitutes unlawful price-fixing) ("[T]he fixing of prices by one member of a group pursuant to express delegation, acquiescence, or understanding is just as illegal as the fixing of prices by direct, joint action.").

23. *E.g.*, *Arizona v. Maricopa Cnty. Med. Soc'y*, 457 U.S. 332 (1982) (holding that price-fixing agreements would be held *per se* illegal despite the fact that they were horizontal).

24. *E.g., id.* ("[T]he anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if pro-competitive justifications are offered for some.").

25. *See generally* *Broadcast Music, Inc. v. Columbia Broad. Sys.*, 441 U.S. 1, 23 (1979) (holding that the blanket license in this case was not a naked restraint on trade but rather increased economic efficiency and rendered markets more competitive) ("[N]ot all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints.").

26. *See generally* *Geneva Pharms. Tech. Corp. v. Barr Labs.*, 386 F.3d 485, 507 (2d Cir. 2004) ("[U]nder the rule of reason, the plaintiffs bear an initial burden to demonstrate the defendants' challenged behavior 'had an *actual* adverse effect on competition as a whole in the relevant market' . . . If the plaintiffs satisfy their initial burden, the burden shifts to the defendants to offer evidence of the pro-competitive effects of their agreement . . . Assuming defendants can provide such proof, the burden shifts back to the plaintiffs to prove that any legitimate competitive benefits offered by defendants could have been achieved through less restrictive means.") (quoting *Capital*

networks, including competing providers contracting with payers, may or may not result in *per se* violations, depending on the degree of their integration in providing healthcare services and the necessity for the restraint in providing the groups' services.²⁷

This Comment argues that heightened levels of collusion among health care providers, as a result of their participation in ACOs, raises antitrust problems that may be overlooked in the approach taken by the FTC and the DOJ in the Antitrust Statement. In encouraging the creation of ACOs, the Affordable Care Act's goal is to reduce costs and improve quality of care to patients,²⁸ however, this Comment suggests that this invitation for health care providers to work together, including negotiating prices collectively with commercial health plans, may, in fact, result in higher aggregate costs and open the door to antitrust abuse. The antitrust agencies should consider providing greater explanation for how they choose to define the relevant market shares for ACOs. Additionally, the agencies should consider lowering the 30% market share threshold providing a "safety zone" protection from challenge. Also, given that review by the agencies is not mandatory, a level of transparency should be required of ACOs. This transparency could be accomplished by making it necessary for the ACO to provide information regarding their joint negotiations to the FTC and DOJ as they apply for the Shared Savings Program. Mandatory disclosure would ensure the agencies are able to identify and challenge potential antitrust concerns before they are implemented. Lastly, the new standards in the Antitrust Statement are untested.²⁹ Pursuant to its untested nature, the agencies should err on the side of caution when defining market shares that allow ACOs to go unchallenged for antitrust liability.

Imaging Assocs., P.C. v. Mohawk Valley Med. Assocs., Inc., 996 F.2d 537 (2d Cir. 1993)).

27. See, e.g., FTC Staff Advisory Opinion to TriState Health Partners (Apr. 13, 2009), <http://www.ftc.gov/os/closings/staff/090413tristateoletter.pdf>.

28. See Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026, 67,026 (Oct. 20, 2011).

29. Letter from Joseph M. Miller, General Counsel, America's Health Insurance Plans and Michael Spector, Senior Counsel, America's Health Insurance Plans, to Federal Trade Commission and U.S. Department of Justice (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00109-60306.pdf> [hereinafter Letter from Joseph Miller and Michael Spector].

II. ANTITRUST PRINCIPLES

A. Background

The antitrust agencies recognize from basic antitrust principles regarding price-fixing that anytime health care providers are permitted to collaborate regarding price, there is potential for harm to consumers “through higher prices or lower quality of care.”³⁰ In 1890, Congress passed the Sherman Antitrust Act to address these anticompetitive behaviors.³¹ In particular, section 1 of the Sherman Act made it illegal to form an agreement that restrains trade and established price-fixing as *per se* illegal.³² Further, the Clayton Act of 1914 prohibits exclusive dealings, price discrimination, tying arrangements, and mergers that substantially reduce market competition.³³

The potential for reduced competition is very serious,³⁴ given that ACOs may be comprised of groups of otherwise competing health care providers and hospitals working together to coordinate care and negotiate prices for their patients under the Shared Savings Program.³⁵ By allowing health care providers that would otherwise be competitors to collaborate on prices without closely monitoring such collaboration, the agencies could be overlooking what might otherwise amount to a horizontal price-fixing scheme.³⁶

One of the most crucial distinctions in antitrust law is the difference between *per se* and “rule of reason” analyses.³⁷ Certain business practices are so inherently anticompetitive that they are deemed *per se* illegal without any additional inquiry into the actual effect of the practices on the market or

30. See Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

31. 15 U.S.C. §§ 1-2 (2006).

32. *Id.*

33. 15 U.S.C. §§ 12-27 (2006).

34. See Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

35. Medicare Program, 76 Fed. Reg. 67,802, 67,802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

36. See generally WILLIAM C. HOLMES, ANTITRUST LAW HANDBOOK § 2:2 (2011).

37. *Id.* § 2:10.

the intentions of the actors in choosing that course of business.³⁸ A traditional example of a *per se* violation is a horizontal price-fixing agreement.³⁹ In contrast, the “rule of reason” analysis is far more flexible, allowing consideration of all circumstances relating to the challenged business practice in determining if it unreasonably restrains trade.⁴⁰

The “rule of reason” analysis begins with a definition of the relevant market within which the business practices occur.⁴¹ If the company has sufficiently high market shares, typically defined as the power to “control price or exclude competition,” then the “rule of reason” analysis looks to the “nature of the challenged restraint and its likely competitive effect.”⁴² In sum, the “rule of reason” analysis weighs the anticompetitive effects of the business practice against the potential pro-competitive efficiencies of the practice and allows the practice to continue if the latter significantly outweighs the former.⁴³ This distinction is particularly important in evaluating ACOs because the Antitrust Statement allows the “rule of reason” analysis for joint price agreements between competing health care providers provided that they are “financially or clinically integrated and the agreement is reasonably necessary to accomplish the precompetitive benefits of the integration.”⁴⁴

B. *Application of the Antitrust Law to Health Care and Provider Contracting Networks*

In the landmark decision, *Goldfarb v. Virginia State Bar*, the Supreme Court of the United States held that “learned professions” are not exempt from antitrust violations.⁴⁵ This decision was one of two decisions that

38. *Id.* § 2:8.

39. *Id.*

40. *Id.* § 2:10.

41. *Id.*

42. See HOLMES, *supra* note 36, § 2:10.

43. *Id.*

44. See Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026, 67,027 (Oct. 20, 2011).

45. *Goldfarb v. Virginia*, 421 U.S. 773, 787 (1975) (“[W]e cannot find support for the proposition that Congress intended any such sweeping exclusion [for learned

opened the health care sector to coverage by the antitrust laws.⁴⁶ As a result, there has been enforcement of the antitrust laws against hospitals and physicians over the last thirty-five years.⁴⁷ The antitrust agencies have pursued investigations against health insurance plans, physicians, and hospitals, with many of these investigations resulting in successful challenges to anticompetitive conduct.⁴⁸

The seminal antitrust decision on the price-fixing activities of provider-controlled networks contracting with health plans comes from the United States Supreme Court's holding in *Arizona v. Maricopa Medical Society*.⁴⁹ In this case, numerous physicians had formed a physician-controlled network to contract with health plans on their behalf.⁵⁰ As part of the network's operation, the physician participants agreed among themselves on the maximum prices that they would charge health plans contracting with the network.⁵¹ The Supreme Court, in a narrow four-to-three decision, held that the physician's agreement on maximum prices constituted a *per se* violation of section 1 of the Sherman Act despite its purported pro-competitive

professions]. The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . [i]n the modern world it cannot be denied that the activities of lawyers play an important part in commercial intercourse, and that anticompetitive activities by lawyers may exert a restraint on commerce.”).

46. *Id.* See also *Accord Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738 (1976) (holding that even the local activities of health-care providers could affect interstate commerce to the extent necessary to meet the requirements for an antitrust violation).

47. See FEDERAL TRADE COMMISSION: HEALTH CARE DIVISION, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2011), <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf> [hereinafter OVERVIEW OF FTC ANTITRUST ACTIONS]; see also *Proposed Statement of Antitrust Enforcement Regarding Accountable Care Organizations*, OKLA. CNTY. MED. SOC'Y, <http://o-c-m-s.org/proposed-statement-antitrust-enforcement-regarding-accountable-care-organizations> (last visited Oct. 11, 2011).

48. See OVERVIEW OF FTC ANTITRUST ACTIONS, *supra* note 47; see also Thomas Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 HOUS. J. HEALTH L. & POL'Y 189, 190 (2007).

49. *Arizona v. Maricopa Cnty. Med. Soc'y*, 457 U.S. 332 (1982).

50. *Id.* at 339-341.

51. *Id.*

effects.⁵² The Court, however, distinguished the physician's non-financially integrated network from those "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."⁵³ Thus, the Court implicitly indicated that the "rule of reason" might apply to joint negotiations of prices by networks of providers who integrated their delivery of care by sharing the financial risk of any losses the network incurred.⁵⁴

Subsequent to the *Maricopa County Medical Society* decision, a number of enforcement actions were brought against networks of providers that jointly negotiated prices with health plans.⁵⁵ Because of this active enforcement of the antitrust laws against provider contracting networks after *Maricopa County Medical Society*, many industry participants, particularly physicians and hospitals, reached out for more guidance from the antitrust agencies about the circumstances in which contracting networks were likely to violate the antitrust laws and face enforcement actions.

The DOJ and FTC provided that guidance with their 1994 Statements of Antitrust Enforcement Policy in Health Care and its subsequent revisions in 1996.⁵⁶ Statement 8 discusses the antitrust principles applicable to Physician Network Joint Ventures, that is, contracting networks comprised exclusively of physicians that "collectively agree on prices or price-related terms and jointly market their services."⁵⁷ Furthermore, Statement 9 discusses antitrust principles that apply to Multiprovider Networks, contracting networks comprised of physicians and other types of providers that jointly market

52. *Id.* (two justices did not take part in the decision of the case).

53. *Id.* at 356.

54. *Id.*

55. *E.g.*, *Southbank IPA, Inc.*, 114 F.T.C. 783 (1991) (settled by consent order). The challenged conduct included that "the physician respondents agreed not to compete with respect to whether, and on what terms, they would treat subscribers or enrollees of at least some third-party payors' health care plans." *Id.* See also *United States v. Classic Care Network, Inc.*, 1995-1 Trade Cas. (CCH) 70,997 (E.D.N.Y. 1995) (settled by consent decree).

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

57. *Id.* at 76.

their services and jointly contract with health plans.⁵⁸ Statements 8 and 9 allow for a “rule of reason” analysis of such networks, provided that integration through the network is likely to result in substantial efficiencies and that the price agreements are necessary to achieve those efficiencies.⁵⁹

Statements 8 and 9 apply the “rule of rule of reason” treatment to both *financially* and *clinically* integrated physician groups.⁶⁰ Financial integration requires that the providers in the network accept substantial financial risk in contracting with health plans.⁶¹ They can do this in several ways, most notably, by their network accepting “capitation” payments—a set amount of monthly payment for each of the health plan’s members.⁶² This incentivizes the network physicians to provide the most efficient care, since they suffer a loss if the cost of caring for the health plan’s members exceeds capitation payments.⁶³ In the alternative, if the capitation amounts exceed the network’s costs in providing care, the physicians stand to profit.⁶⁴ Clinical integration, an indistinct concept, is more ambiguous however. Statements 8 and 9 describe clinical integration as an “active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”⁶⁵ Typically, this is accomplished by the adoption and enforcement of evidence-based clinical protocols by the network that results in more efficient and higher quality delivery of care.⁶⁶ The difference between financial and clinical integration is important because ACOs are, in essence, clinically integrated provider

58. *Id.* at 134.

59. *See id.* at 88-159.

60. *Id.*

61. *See* U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 2-35 (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> [hereinafter A DOSE OF COMPETITION].

62. *Id.* at 12.

63. *Id.*

64. *See id.*

65. *See* DOJ & FTC STATEMENT, *supra* note 56, at 90-91.

66. *See* A DOSE OF COMPETITION, *supra* note 61, at 2-37.

contracting networks.⁶⁷ The CMS eligibility requirements that an ACO must meet to participate in the Medicare Shared Savings Program are the same general types of requirements necessary for a clinically integrated network.⁶⁸

In response to criticism concerning the clarity of clinical integration in the 1996 Statements, the FTC and DOJ clarified their antitrust enforcement policy regarding ACOs in their 2011 Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.⁶⁹

III. DOJ AND FTC “ANTITRUST STATEMENT” CRITIQUE

Again, the Antitrust Statement provides that the “rule of reason” analysis applies to the joint negotiations of ACOs meeting CMS’s eligibility requirements that choose to participate in the Shared Savings Program.⁷⁰ In determining the potential for antitrust liability of ACOs, the antitrust agencies chose to differentiate ACOs based on their participants’ “common service” market shares because the higher those shares, all else equal, the greater probability the ACO will be able to exercise market power.⁷¹ In doing so, the agencies divide ACOs into two groups, those within the

67. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026 (Oct. 20, 2011).

68. *See id.* at 67,027. CMS eligibility requirements include: “(1) a formal legal structure that allows the ACO to receive and distribute payments for shared savings; (2) a leadership and management structure that includes clinical and administrative processes; (3) processes to promote evidence-based medicine and patient engagement; (4) reporting on quality and cost measures; and (5) coordinated care for beneficiaries.” *Id.* *See also* DOJ & FTC STATEMENT, *supra* note 56 (“Such [clinical] integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”).

69. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

70. *Id.* at 67,027.

71. *Id.* at 67,028.

antitrust “safety zone” and those that will receive traditional “rule of reason” antitrust analysis.⁷²

A. Market Power Calculation (“PSA”)

The Primary Service Area (“PSA”) serves as a surrogate relevant geographic market used to calculate ACO market shares, and the market shares serve as a type of proxy to estimate the ACO’s market power.⁷³ CMS, as the administrator of the Shared Savings Program, will make public the data necessary for ACO market share calculation.⁷⁴ This calculation will determine whether the ACO falls within the Antitrust Statement’s safety zone.⁷⁵ As the Antitrust Statement notes, the higher the ACO’s market shares, the greater the risk that the ACO will be able to exercise market power, which may result in anticompetitive behaviors.⁷⁶ Thus, the higher the ACO’s market shares, the greater the likelihood that the ACO will reduce quality and choice for Medicare and commercial patients, raise prices to commercial health plans, and establish barriers to entry for other potentially more efficient ACOs to join the market.⁷⁷

The first step in calculating a PSA is to determine the ACO’s “common services.”⁷⁸ These are services, such as urology, provided by two or more

72. *Id.* at 67,027-30.

73. Jan P. Levine, *Commentators Seek More Clarification and Less ‘Regulation’ From the Antitrust Agencies Following the Agencies’ ‘Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations,’* PEPPER HAMILTON LLP (Aug. 15, 2011), http://www.pepperlaw.com/publications_article.aspx?ArticleKey=2172.

74. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,031 n.53.

75. *Id.* at 67,028.

76. *See id.*

77. *Id.* at 67,026.

78. *Id.* at 67,031 (“A service is defined as follows: a. For physicians, a service is the physician’s primary specialty, as designated on the physician’s Medicare Enrollment Application. Each specialty is identified by its Medicare Specialty Code (‘MSC’), as defined by CMS. b. For inpatient facilities (*e.g.*, hospitals), a service is an MDC [ie: Major Diagnostic Category]. c. For outpatient facilities (*e.g.*, ASCs or hospitals), a service is an outpatient category, as defined by CMS.”).

ACO participants.⁷⁹ Thus, if two or more urologists in separate urology groups are participants in the ACO, urology is a “common service.”⁸⁰ The second step is to delineate, for each ACO participant—for example, each urology group—providing a common service, its PSA in providing that service.⁸¹ The PSA of each ACO participant is “the lowest number of postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients].”⁸² The final step is to calculate the combined market share of the ACO participants in each common service in each participant’s PSA.⁸³

The Antitrust Statement acknowledges that “[a]lthough a PSA does not necessarily constitute a relevant antitrust geographic market, it nonetheless

79. *Id.*

80. *See* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026, 67,031 (Oct. 20, 2011).

81. *Id.* (“Each independent physician solo practice, each fully integrated physician group practice, each inpatient facility (even if part of a hospital system), and each outpatient facility will have its own PSA. In addition, each inpatient facility will have a separate PSA for inpatient services, outpatient services, and physician services provided by its physician employees.”).

82. *Id.* at 67,028 (citing Medicare Program: Physician’s Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16,094 (Mar. 26, 2004)).

83. *Id.* at 67,031. Step three instructions specify: “Separately for each common service, calculate the ACO’s PSA share in the PSA of each participant that provides that service if at least two participants provide that service to patients from that PSA. If an entity owned by an ACO participant provides services in a PSA, those services should be included in the share calculation regardless of whether the affiliated organization participates in the ACO. a. For physician services, the ACO should calculate its shares of Medicare fee-for service allowed charges (i.e., the amount that a provider is entitled to receive for the service provided) during the most recent calendar year for which data are available . . . b. For inpatient services, the ACO should calculate its shares of inpatient discharges, using state-level all-payer hospital discharge data where available, for the most recent calendar year for which data are available. For ACOs located in a state where all-payer hospital discharge data are not available, the ACO should calculate its shares of Medicare fee-for-service payments during the most recent federal fiscal year for which data are available . . . c. For outpatient services, the ACO should calculate its shares of Medicare fee-for service payments for hospitals and fee-for services allowed charges for ASCs during the most recent calendar year for which data are available, or the ACO can use state-level all payer claims data, if available.” *Id.*

serves as a useful screen for evaluating potential competitive effects.”⁸⁴ The size of the ACO’s market shares is dependent upon the relevant geographic market chosen for purposes of calculating those shares. To use a variable such as the PSA, which admittedly “does not necessarily constitute a relevant antitrust geographic market,”⁸⁵ seems inappropriate. It may result in either overstated or understated market shares. Further, the use of PSA calculations could inevitably result in unintended consequences not stemming from competitive influences.⁸⁶ For example, large fluctuations in PSA shares over short periods of time due to changes in patient demographics could occur.⁸⁷ These changes in PSA values would have little to do with anticompetitive behavior⁸⁸ and further show the inappropriateness of the variable as a market share calculus. While PSA levels may be a factor to consider in the overall evaluation, they should not be used as the initial indicator of the level of market power of an ACO.

1. Safety Zone—0-30% PSA

If all the ACO market shares, calculated as described above, are 30% or less, the ACO qualifies for an antitrust “Safety Zone” under the Antitrust Statement.⁸⁹ This safety zone provides that the agencies will not challenge the ACO absent “extraordinary circumstances.”⁹⁰ Unfortunately, the agencies give only a brief indication of what may constitute an “extraordinary circumstance.”⁹¹ The agencies justify this safety zone on

84. *Id.* at 67,028.

85. *Id.*

86. Letter from Gail K. Boudreaux, Chief Exec. Officer, United Healthcare, to Fed. Trade Comm’n and U.S. Dep’t of Justice (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00073-60262.pdf>.

87. *Id.*

88. *Id.*

89. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,028.

90. *Id.*

91. *Id.*; see also *id.* at 67,028 n.24 (“Extraordinary circumstances could include, for example, ACO participants engaging in collusion or improper exchanges of price information or other competitively sensitive information with respect to their sale of competing services outside the ACO.”).

their belief that it will be unlikely that ACOs with no market shares above 30% will be able to exercise market power and/or successfully engage in anticompetitive behavior.⁹²

Any time that a safety zone is established, it should be done with caution and it should be conservative. The agencies concede that a PSA “does not necessarily constitute a relevant antitrust geographic market.”⁹³ Therefore, they should tread lightly when attempting to establish a safety zone—effectively protecting the ACO from an agency antitrust challenge—when the variable that provides the safety zone may not be accurate regarding the ACO’s market power.⁹⁴ The harm that results from anticompetitive behavior is extremely damaging to a market and very difficult to reverse after it has become entrenched in the market.⁹⁵ Allowing a portion of ACOs to escape automatically an antitrust challenge by relying on a market power evaluation method that has yet to be tested may reverse the efficiency effects that the ACOs were designed to create in the first place.

Moreover, PSA calculations are done by the ACOs themselves.⁹⁶ This creates an incentive for ACOs to manipulate their market power numbers when possible to remain in the 30% safety zone. This is plausible because PSA values can change at any time, given that health care providers can enter and leave the market at will.⁹⁷ ACOs are required to notify the CMS within thirty days of any additions in their participants, providers, or suppliers.⁹⁸ However, there does not appear to be any particular safeguards in place to ensure reevaluation of an ACO’s PSA should there be a change in

92. *Id.*

93. *Id.*

94. *Id.*

95. Letter from Paul W. Dennett, Senior Vice President, Am. Benefits Counsel and Kathryn Wilber, Senior Counsel, Am. Benefits Counsel, to Fed. Trade Comm’n and U.S. Dep’t of Justice (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00048-60116.pdf>.

96. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

97. Letter from the Consumer-Purchaser Disclosure Project to Fed. Trade Comm’n and U.S. Dep’t of Justice (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00113-60310.pdf>.

98. Medicare Program, 76 Fed. Reg. 67,802, 67,979 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

the market in which they exist.⁹⁹ If an ACO is acting anti-competitively, other providers may choose or be forced to exit the market. As other providers exit the market, the existing ACO's market share will inevitably increase. During the Antitrust Statement's period of public comment, many commenters recommended an ongoing program to monitor increases in market share and its impact on cost to the patient.¹⁰⁰ If there are no additional safeguards in place to ensure that ACOs that may have once been part of the "safety zone" have not begun to acquire market power and are no longer within the "safety zone,"¹⁰¹ these ACOs may be able to significantly alter the market free from antitrust challenge.

2. *Voluntary Expedited Review*

"Newly formed ACOs"¹⁰² have the opportunity to seek voluntary review from the DOJ and FTC regarding their likelihood of raising antitrust concerns.¹⁰³ The agencies have agreed to an expedited review of only ninety days or less for this evaluation prior to issuing a letter to the ACO regarding the agencies' level of concern of the ACO's proposed conduct.¹⁰⁴ By allowing themselves only ninety days to analyze an ACO's potential

99. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

100. Letter from the Consumer-Purchaser Disclosure Project to Fed. Trade Comm'n and U.S. Dep't of Justice, *supra* note 97 (stating "[i]n addition to the screening program and current antitrust reviews, it is imperative to establish an ongoing program to monitor the impact of increased market power that could result from ACO formations."). This letter further argues for a system to "[g]ather data regarding current market shares, market entries and exits, and pricing trends for the ACOs. This information should be collected initially in the application process to establish a baseline, and then on an annual basis to monitor and report publicly on potentially adverse market impacts of ACOs." *Id.*

101. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

102. *Id.* at 67,028 ("Newly formed ACOs' are those ACOs that, as of March 23, 2010, the date on which the Patient Protection and Affordable Care Act was enacted, had not yet signed or jointly negotiated any contracts with private payers, and have not yet participated in the Shared Savings Program."). The agencies only provide advisory opinions to proposed conduct, not to conduct that has already been implemented. Thus, the Antitrust Statement only applies to "Newly Formed" ACOs. *Id.*

103. *Id.* at 67,030.

104. *Id.*

antitrust concern,¹⁰⁵ the agencies may not be able to conduct an in-depth review of the ACO and truly pinpoint any potential antitrust concerns.¹⁰⁶

Conducting an accurate antitrust review requires significant fact-finding and investigation. For example, as part of the voluntary review, an ACO is required to submit the following eight pieces of information:

1. The application and all supporting documents that the ACO plans to submit, or has submitted, to CMS, including a sample of each type of participation agreement and each type of document that reflects a financial arrangement between or among the ACO and its participants, as well as the ACO's bylaws and operating policies.
2. Documents discussing
 - a. the ACO's business strategies or plans to compete in the Medicare and commercial markets, including those relating to the ACO's likely impact on the prices, cost, or quality of any service provided by the ACO to Medicare beneficiaries, commercial health plans, or other payers; and
 - b. the level and nature of competition among participants in the ACO, and the competitive significance of the ACO and ACO participants in the markets in which they provide services.
3. Information sufficient to show the following:
 - a. The common services that two or more ACO participants provide to patients from the same PSA, as described in the Appendix, and the identity of the ACO participants or providers providing those services.
 - b. The PSA of each ACO participant, and either PSA share calculations the ACO may have performed or other data that show the current competitive significance of the ACO or ACO participants, including any data that describe the geographic service area of each participant and the size of each participant relative to other providers serving patients from that area.
 - c. Restrictions that prevent ACO participants from obtaining information regarding prices that other ACO participants charge private payers that do not contract through the ACO.

105. *Id.*

106. Letter from John J. Miles, Attorney, Ober Kaler, to Fed. Trade Comm'n, Office of the Sec'y (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00118-60314.pdf>.

d. The identity, including points of contact, of the five largest commercial health plans or other private payers, actual or projected, for the ACO's services.

e. The identity of any other existing or proposed ACO known to operate, or known to plan to operate, in any market in which the ACO will provide services.¹⁰⁷

This is a wealth of information that must be reviewed, validated, and analyzed. In addition, the agencies reserve the right to seek additional information when necessary, although this does extend the ninety-day period in which the agency will respond to the request.¹⁰⁸ Limited by the time constraint of a ninety-day expedited review may allow potential anticompetitive conduct of an ACO to go undetected.

Given that the information used in the voluntary review is provided by the ACO under review,¹⁰⁹ it should also be examined with a keen eye towards potential self-interested statements. Further, this antitrust review is wholly voluntary.¹¹⁰ It is highly unlikely that an ACO engaging in anticompetitive behaviors is going to voluntarily seek expedited review. The Antitrust Statement provides no additional safeguards above what the agencies have historically used—for example, waiting for a harmed health plan to complain before bringing investigation—in reviewing anticompetitive behavior for ACOs.¹¹¹

When the Antitrust Statement was originally issued for public comment, it included a provision mandating review and approval by the FTC and DOJ for all ACOs with PSA values above 50%.¹¹² While the mandatory review provision of the then proposed Antitrust Statement has been removed, likely for good reason, there still should be a level of transparency with the agencies regarding the joint negotiation practices of ACOs as they are submitting for qualification to the Shared Savings Program. This

107. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,030-31.

108. *See id.*

109. *Id.*

110. *Id.*

111. *See id.*

112. Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 21,894, 21,901 (Proposed Mar. 31, 2011).

transparency should include documentation similar to the information requested for a voluntary review. Transparency would allow the agencies to proactively, rather than reactively, address anticompetitive concerns. If the goals of the Affordable Care Act are realized, there may be a multitude of ACO formations at the launch of the Shared Savings Program. The antitrust agencies admit that even if half of the expected new ACOs seek review, the number of reviews could be as high as 200.¹¹³ Without a system in place to ensure review of these entities, anticompetitive behavior could become entrenched in the market before the antitrust agencies detect it, if it is detected at all.

If the antitrust agencies do not identify and prosecute anticompetitive behavior by ACOs, it is highly unlikely that injured third parties will help them do so by bringing their own litigation.¹¹⁴ Despite the promise of treble damages that successful antitrust challenges bring, private litigation has not been the hallmark of antitrust enforcement in recent years.¹¹⁵ While the reasons are not entirely proven, antitrust scholars suggest that the cause of this lack of litigation may be the desire to maintain goodwill with providers in a community or collective action problems among those who have been harmed.¹¹⁶ One may argue that private litigants can just as easily complain to the agencies and allow them to bring charges, but this will only ferret out a certain number of problematic ACOs, because not all health plans will complain. Thus, if the antitrust agencies do not set out a strict enough standard in their Antitrust Statement to curtail potentially anticompetitive behavior by ACOs, creating an unintentional loophole that allows for

113. *Id.* During the proposed/comment period, the statement required that certain ACO's were to undergo a mandatory review by the Agencies. At that time, the Agencies calculated the number of ACOs that would seek voluntary and mandatory review. The mandatory review is no longer applicable, but the estimated number of ACO formations still applies. The proposed statement noted that "[f]or the purposes of this burden analysis, we estimate that the number of submissions for expedited antitrust review, both required and voluntary, will range from roughly one quarter to one-half of all ACO applications covered by the Policy Statement. This yields an estimated range of 38 to 200 ACO applicants that will seek antitrust review. Erring conservatively, the following burden estimate will use the upper bound estimate, i.e., 200 submissions." *Id.*

114. Greaney, *supra* note 48, at 198.

115. *Id.*

116. *Id.*

evasion from investigation and prosecution, there is little likelihood that private litigation will fill the enforcement gap.¹¹⁷

B. Applicability to ACOs Contracting with Commercial Health Plans

The Antitrust Statement applies to ACOs that are formed in order to participate in the Shared Savings Program.¹¹⁸ Because of the high costs of establishing an ACO, calculating their market shares, and applying to be a part of the Shared Savings Program, the agencies recognize that health care providers will be more likely to integrate their care delivery for Medicare beneficiaries through participation in the Shared Savings Program if they also can contract with commercial health plans through their ACO.¹¹⁹ As a result, the Antitrust Statement also applies the “rule of reason” analysis to the joint negotiations of ACOs participating in the Shared Savings Program when contracting with commercial health plans if the ACO “uses the same governance and leadership structures and clinical and administrative processes it uses in the Shared Savings Program to serve patients in commercial markets.”¹²⁰ In other words, the “rule of reason” analysis applies where the ACO is sufficiently clinically integrated. It is questionable whether meeting the CMS’s eligibility requirements is adequate to show that the ACO is sufficiently clinically integrated. It is also questionable whether CMS’s eligibility requirements are enough to justify providing a safety zone from antitrust challenge. It is also pertinent to note that commercial insurance rates and Medicare rates are very interrelated, so the effect of this program is difficult to determine.

Additionally, the Antitrust Statement makes clear that in calculating their market shares, ACOs are required to use data provided by CMS that is based on services provided to Medicare beneficiaries.¹²¹ Because ACOs are allowed to extend their integrated services into the commercial market, they could be providing services that Medicare seldom provides, such as “pediatrics, obstetrics, HIV services, and burn unit services”¹²² and therefore

117. *Id.*

118. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026, 67,027 (Oct. 20, 2011).

119. *Id.* at 67,028.

120. *Id.*

121. *Id.* at 67,031 n.51-n.53.

122. Levine, *supra* note 73.

lack appropriate data for their market share calculations. As a result, the ACO may be unable to calculate accurately their market shares for these services.¹²³ The Antitrust Statement briefly mentions that for services that are rarely used by Medicare beneficiaries, ACOs may use “other available data to determine the relevant [market] shares.”¹²⁴ The only example the Antitrust Statement gives of such “other available data” is “data on the number of active physicians within the specialty and located within the PSA.”¹²⁵ This difference in data may lead to inconsistent market shares because the data is coming from two different sources. Furthermore, this difference has the potential to make it challenging for the antitrust agencies to evaluate accurately and consistently the market shares of ACOs.

C. ACO Review—FTC vs. DOJ

All voluntary reviews of ACO market power and the corresponding antitrust liability are to be conducted by either the Antitrust Division of the Department of Justice or the Federal Trade Commission.¹²⁶ In his dissent in the FTC vote on the Proposed Antitrust Statement, Commissioner J. Thomas Rosch discusses that this joint review is quite problematic for multiple reasons.¹²⁷ First, according to Commissioner Rosch, the Antitrust Division “has far less expertise or experience than the Commission in reviewing the formation of ACOs or applying the antitrust laws to them.”¹²⁸ In essence, Commissioner Rosch is asserting that ACOs will be clinically integrated networks and that the FTC has more experience in applying the antitrust laws to clinically integrated networks.¹²⁹ In addition, Commissioner Rosch’s view is that the FTC is an independent agency, unlike the Antitrust Division, and is less susceptible to political pressures, lobbyists, and other

123. *Id.*

124. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,031.

125. *Id.*

126. *See id.*

127. Press Release, Fed. Trade Comm’n, FTC, DOJ Seek Public Comment on Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (Mar. 31, 2011), available at <http://www.ftc.gov/opa/2011/03/aco.shtm>.

128. *Id.*

129. *See id.*

particular interest groups.¹³⁰ While this is a hotly contested argument, it is certainly an important consideration in deciding who should analyze ACOs for antitrust review.

Further, the Antitrust Statement does not specifically provide for a dual agency review by both the FTC and DOJ.¹³¹ Either agency can be the one to review the documentations and issue a letter.¹³² There is no guarantee that the way in which one agency interprets the laws is going to be the same way that another agency interprets the laws. In practice, one agency may be more lenient than the other, providing ACOs with anticompetitive intentions an opportunity to circumvent the review system.

IV. POTENTIAL SOLUTIONS

Perhaps one of the most controversial facets of the Antitrust Statement is the use of PSAs as surrogate relevant geographic markets in calculating ACO market shares. These calculations determine whether the ACO enjoys safety-zone protection and, for ACOs requesting a voluntary review letter, are one factor the antitrust agencies will examine in determining whether the ACO may raise market-power concerns.¹³³ The fact that ACOs are to calculate their PSA values themselves¹³⁴ provides them with opportunities to either manipulate the calculations or, at the very least, incorrectly calculate their market share.

During a May 2011 forum held by the FTC to solicit feedback on the then proposed Antitrust Statement, numerous attorneys and providers with experience in clinical integration proposed that the agencies be the one to calculate PSA shares if that was what they intended to use to determine an ACOs antitrust scrutiny.¹³⁵ Moving the responsibility for the PSA

130. *Id.*

131. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

132. *See id.*

133. *Id.* at 67,028.

134. Sarah O'Hara, *Reaction to the ACO Antitrust Policy: Report from Last Week's FTC Forum*, THE ADVISORY BD. CO. (May 16, 2011), <http://www.advisory.com/Research/Health-Care-Advisory-Board/Blogs/Network-Advantage/2011/05/Reaction-to-the-ACO-Antitrust-Policy-Report-from-last-weeks-FTC-forum>.

135. *Id.* ("While the FTC, DOJ, and CMS are currently working to provide denominators for PSA ratios in all zip codes, panelists suggested that they also take the

calculations to the antitrust agencies would remove the substantial cost burden on the individual ACOs,¹³⁶ allowing them to use that cost savings to further the goals of the Shared Savings Program instead. Placing the antitrust agencies in charge of calculating PSA values would also ensure the accuracy and consistency of the data. Further, placing the market share calculation responsibility with the agencies would enable them to experience economies of scale by setting up an efficient process to calculate the shares for multiple ACOs. The ability of the agencies to ferret out any otherwise undetected anticompetitive actions of ACOs is worth the increased cost burden that would be placed on the agencies in requiring them to calculate the market shares. There are costs of implementing any new law, and the cost of calculating market shares to detect antitrust violations is a necessary burden that must be accounted for.

While there are proponents for and against using PSA as the indicia of market power, the antitrust agencies admit that it “does not necessarily constitute a relevant antitrust geographic market.”¹³⁷ The agencies give little explanation for their choice of the PSA other than that “it nonetheless serves as a useful screen for evaluating potential competitive effects.”¹³⁸ The PSA is an untested market share variable,¹³⁹ and the agencies’ off-handed explanation for its selection is unpersuasive given its significance in protecting consumers from anticompetitive behavior. The agencies should consider using small relevant geographic markets until the reliability of the variable is determined over time. If nothing else, the antitrust agencies need to provide a greater explanation for their choice of a 75% PSA threshold.¹⁴⁰

An important question is whether the safety-zone 30% threshold is too high, too low, or just right. If too low, ACOs that do not pose antitrust risk

time to develop the numerators—the billings, inpatient discharges, or outpatient payments for every Medicare-enrolled provider. While acknowledging this would require considerable work for the agencies, panelists argued that it would be more accurate and less onerous than asking providers to perform this calculation themselves.”).

136. *Id.*

137. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,028.

138. *Id.*

139. Letter from Joseph Miller and Michael Spector, *supra* note 29.

140. Letter from The Am. Bar Ass’n Sections of Antitrust Law and Health Law to Fed. Trade Comm’n and U.S. Dep’t of Justice (May 31, 2011), <http://www.ftc.gov/os/comments/aco-comments/00045-60109.pdf>.

will be subject to review.¹⁴¹ If too high, ACOs with the potential to cause anticompetitive harm will inappropriately enjoy safety-zone protection. Consumer harm from safety-zone protection for ACOs that are able to exercise market power is more likely to be significant than harm resulting from the error of denying safety-zone protection to competitively benign ACOs.¹⁴² Recall that safety zone protection is not something the agencies have to provide; it is something they have chosen to give. Given that the final Antitrust Statement makes no provision for mandatory review by the antitrust agencies,¹⁴³ lowering the “safety zone” threshold would simply ensure more ACOs are challenged for anticompetitive practices.¹⁴⁴ With the immense harm that anticompetitive behavior can have in the market once it becomes entrenched, the cost to evaluate more ACOs for antitrust liability seems minimal.¹⁴⁵

Additionally, the 30% safety zone should be assessed in the context of past policy guidelines from the antitrust agencies, particularly the 1996 Statements of Antitrust Enforcement Policy in Health Care.¹⁴⁶ Statement 8 provides a safety zone for financially integrated networks where its participants contract with health plans exclusively through the network if the network includes 20% or less of all physicians in a given specialty in the area.¹⁴⁷ Yet, an ACO with exclusive physicians enjoys safety-zone protection if the market share of its common services is 30% or less.¹⁴⁸ The Antitrust Statement provides no rationale for this change in policy. Additionally, Health Care Statements 8 and 9 did not contain a safety zone for clinically integrated networks.¹⁴⁹ Statements 8 and 9 only provided a

141. Letter from Joseph Miller and Michael Spector, *supra* note 29.

142. *See id.*

143. *See generally* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.

144. Letter from Joseph Miller and Michael Spector, *supra* note 29.

145. *Id.*

146. DOJ & FTC STATEMENT, *supra* note 56.

147. *Id.* at 79-80.

148. Letter from Joseph Miller and Michael Spector, *supra* note 29; *see also* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,028.

149. J. Thomas Rosch, Commissioner, Fed. Trade Comm’n, Remarks before the ABA Section of Antitrust Law Fall Forum, Accountable Care Organizations: What Exactly Are

safety zone for financially integrated networks.¹⁵⁰ Thus, under previous agency policy, ACOs would not have been afforded safety zone eligibility because they are clinically integrated networks.¹⁵¹ Given the agencies' past policy of imposing a 20% maximum safety zone for networks with exclusive relationships with their providers, the previous lack of safety zone for clinically integrated networks, and the fact that the safety zone effectively protects ACOs from challenge by the agencies, a 20% safety zone threshold seems more appropriate.¹⁵²

It appears that there has been dispute from the beginning as to which federal agency would be responsible for reviewing the antitrust liability of the newly formed ACOs as part of the Affordable Care Act.¹⁵³ A 2011 article in the *New York Times* confirms the conflict between the agencies on who would police the market.¹⁵⁴ In allowing both agencies to issue voluntary antitrust review letters to ACOs, there is an ever present risk of inconsistent application of the antitrust laws. This fear would be relieved if only one agency were to take the sole responsibility for reviewing ACOs.

There is evidence that the Federal Trade Commission may be the agency best equipped to do so. In the mid-1970s, the FTC formed the Health Care Division, a separate division within the Bureau of Competition at the FTC, specifically designed to investigate and bring charges against antitrust violations within the health care field.¹⁵⁵ The division currently has over thirty-five attorneys specifically trained to apply the antitrust laws to health care providers.¹⁵⁶ Although one of the responsibilities of the Antitrust

We Getting? 14 (Nov. 17, 2011), <http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf>.

150. DOJ & FTC STATEMENT, *supra* note 56, at 79-80.

151. *See* Rosch, *supra* note 149.

152. Letter from Joseph Miller and Michael Spector, *supra* note 29.

153. Robert Pear, *Health Law Provision Raises Antitrust Concerns*, N.Y. TIMES, Feb. 9, 2011, at A19.

154. *Id.*

155. MARKUS H. MEIER ET AL., FED. TRADE COMM'N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTHCARE SERVICES AND PRODUCTS 1 (2011), <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf>.

156. *Id.*

Division of the Department of Justice's Litigation I Section is to monitor antitrust in the health care sector, the DOJ does not have a separate division specifically devoted to health care. Additionally, the FTC has taken a more active role in bringing antitrust enforcement actions against potential anticompetitive entities in the health care field. From 1996-2007, the FTC initiated and settled approximately forty-one actions against networks for jointly negotiating prices while the DOJ has challenged such arrangements only five times.¹⁵⁷

V. CONCLUSION

The Department of Justice and the Federal Trade Commission are off to a good start by issuing the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.¹⁵⁸ However, the statement does not lay out a strong enough framework that is appropriate for the protection of consumers from the anticompetitive behaviors that are inherent in physician collaboration. Little explanation is given for the choice of PSA as surrogate geographic markets.¹⁵⁹ This is surprising given the significant weight that is put upon ACO market share calculations when determining the level of antitrust challenge that an ACO receives.¹⁶⁰ The agencies should consider lowering the threshold for the safety zone to better coincide with past policy precedent.¹⁶¹ Given that the safety zone provides a guarantee of no challenge, the threshold should be conservative. Additionally, a level of transparency should be required of ACOs by mandating them to provide information to the agencies as they apply for the Shared Savings Program to ensure that the agencies can quickly detect potentially anticompetitive conduct and take appropriate enforcement actions. This is especially important given that the Antitrust Statement provides a provision for voluntary, not mandatory, review by the agencies.

157. Greaney, *supra* note 48.

158. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. 67,026 (Oct. 20, 2011).

159. *Id.* at 67,028.

160. *Id.*

161. Letter from Joseph Miller and Michael Spector, *supra* note 29; *see also* DOJ & FTC STATEMENT, *supra* note 56, at 79-80.

As the agencies have admitted, the PSA market share calculation is not necessarily a good indicator of the relevant geographic market.¹⁶² In response, the agencies should err on the side of caution by delineating small relevant geographic markets until the reliability of the calculation is determined over time. Without such caution, the harmful effects of higher aggregate prices for consumers and reduced efficiency commonly associated with anticompetitive behavior¹⁶³ may go undetected by the antitrust agencies. By not allowing themselves adequate time to investigate fully these new physician collaborations¹⁶⁴ and by allowing ACOs to calculate PSA shares by themselves,¹⁶⁵ self-interested and inappropriate anticompetitive actions may result in higher, supra-competitive prices to commercial health plans.

162. Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,028.

163. *Id.* at 67,026.

164. *Id.* at 67,030.

165. O'Hara, *supra* note 134; *see also* Statement of Antitrust Enforcement Policy, 76 Fed. Reg. at 67,026.