

UNACCOUNTABLE CARE: THE DANGERS OF FEDERAL SUPPORT FOR ANTICOMPETITIVE BEHAVIOR IN THE HEALTHCARE MARKET

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“Most people do not like to compete, and will seek ways of avoiding competition by agreement tacit or explicit, depending of course on the costs of agreeing.”

– Judge Posner, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

I. INTRODUCTION

In the ten years after the introduction of Accountable Care Organizations (ACOs) into the healthcare marketplace, counties which have high ACO adoption have seen a 4% increase in the number of large healthcare practices.¹ Small physician practices have decreased by 2.7%.² These changes are difficult to conceptualize in the abstract, but the reality of the situation is that patients in these areas are suffering from the pitfalls of consolidation.³

The ACO program was supposed to save the taxpayer and Medicare Beneficiaries money by improving continuity of care.⁴ Healthcare providers have always struggled with coordination of care.⁵ Tracking a patient’s status from one appointment to the next is difficult, while tracking a patient’s progress from one healthcare entity to the next can be almost impossible. The Obama Administration sought to improve this issue by introducing the ACO model in 2012.⁶

At its core, an ACO is an operating agreement between healthcare providers to work cooperatively and take financial responsibility for the outcomes of their

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1. Genevieve P. Kanter et al., *Changes in Physician Consolidation with the Spread of Accountable Care Organizations*, 28 HEALTH AFF. 1936, 1940 (2019).

2. *Id.*

3. *Id.* at 1942 (“These patterns suggest that the consolidation concerns initially raised regarding ACOs were warranted and that gains from care coordination facilitated by ACOs will have to be balanced against higher prices and possibly lower-quality care that could result from consolidation.”).

4. Elizabeth Fowler et al., *Accountable Care and Accountable Care Organizations*, CTR. FOR MEDICARE & MEDICAID SERV., <https://innovation.cms.gov/key-concept/accountable-care-and-accountable-care-organizations> [https://perma.cc/7GGX-DYV5] (last visited July 27, 2023).

5. *Care Coordination*, CTR. FOR MEDICARE & MEDICAID SERV., <https://innovation.cms.gov/key-concept/care-coordination> [https://perma.cc/XR9C-5MA2] (last visited Feb. 26, 2023).

6. TIANNA TU ET AL., *THE IMPACT OF ACCOUNTABLE CARE: ORIGINS AND FUTURE OF ACCOUNTABLE CARE ORGANIZATIONS* 3 (May 2015), <https://www.brookings.edu/wp-content/uploads/2016/06/Impact-of-Accountable-CareOrigins-052015.pdf> [https://perma.cc/E54L-HD8K].

patients.⁷ This value-based care means that the providers are reimbursed for quality of the care, not just for the quantity of care provided.⁸ To assist the delivery of high quality care among member providers, the federal government gave ACO members permission to share information regarding patients, pricing, and costs.⁹ The guidance was removed in July 2023, reverting ACO participants to the more general Horizontal Merger Guidelines.¹⁰

The information sharing of this arrangement is presents a strong risk of harm to competition.¹¹ However, ACO participants operate without fear of antitrust litigation because the federal government has given ACO members an exemption from the normal antitrust rules.¹²

With fewer unaffiliated community hospitals, and a rise in the number of healthcare large in 2021 and 2022, competition in the healthcare marketplace is at its tipping point.¹³ Before the ACO guidance was repealed, the question was why the federal government maintains support for an anticompetitive system? Now that it has been repealed in its entirety, the question is what will the agencies replace their guidance with?

A. *The Issue*

ACO participation has been linked to a decline in the number of independent healthcare providers. Small providers been replaced by larger healthcare networks.¹⁴ The disappearance of the local provider has been one of the

7. *Id.*

8. *Id.*

9. *See generally*, FED. TRADE COMM'N & ANTITRUST DIV. OF DEPT. OF JUSTICE, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM 1 (2011), <https://www.justice.gov/d9/atr/legacy/2011/10/20/276458.pdf> [<https://perma.cc/2VFJ-Y9NS>] [hereinafter REPEALED ACO GUIDELINES]; *see also* U.S. DEPT. OF JUSTICE & FED. TRADE COMM'N, *Statements of Antitrust Enforcement Policy in Healthcare*, ANTITRUST DIV. U.S. DEPT. OF JUSTICE 1 (Aug. 1996), <https://www.justice.gov/atr/statements-antitrust-enforcement-policyin-health-care> [<https://perma.cc/SY8V-U39E>] [hereinafter *Repealed Healthcare Guidelines*].

10. *Federal Trade Commission Withdraws Health Care Enforcement Policy Statements*, FED. TRADE COMM'N (July 14, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements> [<https://perma.cc/5N2X-M7PU>]; *see also Justice Department Withdraws Outdated Enforcement Policy Statements*, OFF. OF PUB. AFF. U.S. DEPT. OF JUSTICE (Feb. 3, 2023), <https://www.justice.gov/opa/pr/justice-department-withdraws-outdated-enforcement-policy-statements> [<https://perma.cc/HU4W-TBAS>].

11. FEDERAL TRADE COMM'N & DEPT. OF JUSTICE, HORIZONTAL MERGER GUIDELINES 34 (Aug. 19, 2010), <https://www.ftc.gov/legal-library/browse/horizontal-merger-guidelines-united-states-department-justice-federal-trade-commission> [<https://perma.cc/KUT3-BA4R>].

12. REPEALED ACO GUIDELINES, *supra* note 9, at 6 (establishing the “Safety Zone” for ACOs).

13. Sherry A. Glied & Stuart H. Altman, *Beyond Antitrust: Health Care And Health Insurance Market Trends And The Future Of Competition*, 36 HEALTH AFF. 1572, 1572 (2017).

14. Kanter et al., *supra* note 1, at 1940.

hallmarks of ACO adoption.¹⁵ With cost savings usurping the previous goal of patient outcomes, there is a new incentive to merge. Without any further intervention by regulators, the taxpayer will be left holding the bag for the unnecessary increases in healthcare costs.¹⁶ The new guidance, if there is any, must keep a closer eye on ACOs and remove parts of their antitrust exemptions, so that the benefits of the ACO model can be kept, without its negative side-effects.

To counteract the growing trend of conglomeration of ACO participants, the Federal and state governments have a duty to scrutinize the mergers and acquisitions of ACO participants. This requires a three-pronged approach: First, the agencies must issue new Guidance redefining the amnesty granted to ACOs which takes into consideration the merger of former ACO participants. Second, the new guidance must strip ACO participants of their automatic “rule of reason” treatment. The regulating agencies need to take advantage of tools like “quick look” analysis for any ACO merger. Third, the courts must accept the agencies’ guidance and interpret an ACO merger under the “quick look” standard to ensure that ACO dominated markets remain competitive.

B. Roadmap

This Note is an analysis of anticompetitive effects Accountable Care Organizations have had on the communities they serve. Section II provides background information to contextualize the issue. It begins with an explanation of healthcare antitrust concepts and relevant caselaw for this issue. Section II also explains the origins of the ACO scheme and the subsequent implementation by the Affordable Care Act. Section III will compare and contrast the positive patient care effects of ACOs with the negative anticompetitive results. Then the Note will turn to how the federal Guidance for ACOs can be improved and changed. The Note will argue that although the ACO scheme’s success at achieving the Triple Aim of healthcare, it cannot continue without intervention from the Federal and State governments. Next, the Note will change course and look prospectively at upcoming changes to the ACO program and discuss the validity of criticism from politicians and policymakers. Finally, section IV will summarize the findings and assert that based on the sum of the evidence new Guidance must be promulgated, or else the ACO program will lead to worse outcomes for patients and taxpayers.

15. *Id.* at 1936 (“A 4.0-percentage-point increase in large practices (those with fifty or more physicians) in counties with the greatest ACO penetration, compared to counties with zero ACO penetration, and a 2.7-percentage-point decline in the percentage of small practices (ten or fewer physicians) from 2010 to 2015.”).

16. *How is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-is-medicare-funded> [https://perma.cc/S8SG-7TWF] (last visited Feb. 26, 2023).

II. BACKGROUND

A. Antitrust Statutory Framework

Antitrust is the field of law which deals with how the government protects and promotes competition in the name of consumer welfare.¹⁷ This area was developed during the gilded age when anticompetitive behavior grew to untenable levels.¹⁸ Since then, it has adapted to the changes in the economy by lawsuits brought by the federal and state governments, as well as by individuals asserting their own private rights of action.¹⁹

At the federal level antitrust enforcement is handled by two agencies, the Department of Justice and the Federal Trade Commission. These two agencies are guided and authorized by the Sherman Antitrust Act and the Clayton Antitrust Act.²⁰ The agencies enforcing the laws act in conjunction with one another and protect consumers from the dangers of anticompetitive behavior.²¹

The first section of the Sherman Antitrust Act prohibits any conduct by two or more persons that “produces anticompetitive effects outweighing any procompetitive effects stemming from the agreement.”²² The second section prevents “unilateral conduct” to monopolize a specific industry.²³ The third section prevents independent industry participants from making contractual agreements with competitors to do things like fix prices.²⁴

The Clayton Act built on the Sherman Act by expanding the definition of anticompetitive behavior to include specific business practices.²⁵ These specified five practices which were prohibited: (1) price discrimination, (2) tying arrangements, (3) exclusive dealings contracts, (4) anticompetitive mergers and acquisitions, and (5) interlocks of directors and certain officers.²⁶ These enumerated practices put teeth in the government’s enforcement efforts.²⁷ Before this, there was relatively little that the government could do to prevent anticompetitive behavior.²⁸

17. PHILLIP E. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* § 100 (5th ed. 2022).

18. *See generally Id.* at § 101.

19. *Id.* at § 100.

20. *See generally* 15 U.S.C. §§ 2, 18-25.

21. AREEDA & HOVENKAMP, *supra* note 17, at § 2400 (State law generally tracks the federal government closely, with some even adopting statutes that makes federal jurisprudence binding on the state. In most states, the Attorney General is tasked with enforcing the antitrust laws, however, due to practical concerns, state enforcement is relatively rare.).

22. Sherman Antitrust Act, 26 Stat. 209 § 1 (1890).

23. 15 U.S.C. § 2; *see also* AREEDA & HOVENKAMP, *supra* note 17, at § 914 (defining “unilateral conduct”).

24. *See generally* 15 U.S.C. §§ 2, 18-25.

25. *See generally* 15 U.S.C. §§ 18-25.

26. *Id.*

27. AREEDA & HOVENKAMP, *supra* note 17, at § 101.

28. *Id.*

Of importance for this Note is the Clayton Act's prohibition on anticompetitive mergers and acquisitions. A merger, like any business practice, is anticompetitive if its effect "may be substantially to lessen competition or to tend to create a monopoly."²⁹

B. Antitrust Standards of Review

The caselaw on antitrust is vast, but for the purpose of ACOs, there are three relevant standards of analysis for a potentially anticompetitive merger or acquisition: *per se* analysis, rule of reason analysis, and quick look analysis.³⁰ *Per se* analysis has limited in its application by the Supreme Court, however some lower courts still favor it.³¹ This Note will focus on rule of reason analysis and quick look.

The basic requirement of the rule of reason approach is that the plaintiff must show that there is no competitive purpose reasonably accomplished by the defendant's anticompetitive behavior.³² "Rule of reason" analysis must be done on a case-by-case basis and requires an in-depth market analysis.³³ Market analysis requires an understanding of the market size and the market dominance of the defendant business.³⁴ As with many things, this seems simpler than it is. The requirement of a market analysis can be the death knell for an otherwise successful antitrust lawsuit.³⁵

Also, the burden placed on the plaintiff is heavy. Proving that there is an anticompetitive behavior in the first place can be difficult.³⁶ For instance, consider a regulator attempting to pre-emptively block a merger of two widget manufacturers. The regulator must not only show that the widget market would be dominated by the merged entity, but that the market dominance would not have otherwise happened *without the merger*.³⁷ This is a tremendous task requires an analysis of the relevant market's size, the competitors in the market, trends in the market, differences in the widgets produced, etc. A market analysis like this has extremely high financial and time costs to the point that it disincentivizes regulators from regulating. Placing the market analysis

29. 15 U.S.C. § 18.

30. AREEDA & HOVENKAMP, *supra* note 17, at §§ 1500-12.

31. *See generally Id.* at § 1500 (*Per se* analysis requires that if an activity violates an enumerated prohibition in the antitrust laws, then the court must find it illegal *per se*. However, this rigid enforcement has fallen out of favor with courts which see the enforcement as a negative. Courts favor rule of reason for its more flexible approach to the law.).

32. *Id.* at § 1508.

33. *Id.* ("Like all such general standards, reasonableness varies not only with the circumstances but also with the purpose of the inquiry.")

34. Matthew Lane, *Antitrust in 60 Seconds: Market Definition*, DISRUPTIVE COMPETITION PROJECT (Sept. 5, 2018), <https://www.project-disco.org/competition/090518-antitrust-in-60-seconds-market-definition/> [<https://perma.cc/SU6H-D5AJ>].

35. *Id.*

36. *Id.*

37. *Id.*

requirement on the regulator, or the plaintiff, means that the party with the least amount of information carries the heaviest burden.

Some courts have avoided rule of reason analysis in scenarios where a person with “even a rudimentary understanding of economics” could look at a proposal and determine that it would be anticompetitive.³⁸ In those cases, the court could opt for a “quick look” analysis of the anticompetitive behavior.³⁹ This standard resembles *per se* in its straightforward application to the facts of the case, but maintains aspects of the rule of reason balancing test.⁴⁰ But it is not as unyielding as *per se* because it requires that the anticompetitive behavior be so egregious and its effects be so obvious, that anyone would agree that there was a problem.⁴¹

To consumer protection activists, the quick look approach is enticing because it solves the burden of market analysis requirements. It places the burden of proof on the defendant, who would have the information necessary to prove that a potential action is not anticompetitive.⁴² Quick look accelerates litigation and reduces the financial costs for the regulator or the individual seeking to enforce the antitrust law.⁴³ Simply put, the quick look analysis puts the burden of information where it can best be borne, on the defendant.⁴⁴

So, in industries like healthcare where performing market analysis is especially difficult the quick look standard is ideal. It saves the plaintiff time and money by not having to prospectively find anticompetitive behavior, while providing the defendant the opportunity to show that their merger will be good for the consumer.⁴⁵

This does not mean that the quick look analysis is perfect, there certainly are questions of judicial fairness. However, it is important to understand that the quick look is not a “guilty until proven innocent” framework. Instead, it places a high bar for a *prima facie* showing that anticompetitive behavior will take place, and then shifts the burden of proof onto the defendant. This style of burden-shifting is common throughout the law and is not a novel concept.⁴⁶

38. *Cal. Dental Ass’n v. FTC*, 526 U.S. 765, 770 (1999).

39. *AREEDA & HOVENKAMP*, *supra* note 17, at § 1911.

40. *Id.*

41. *Cal. Dental Ass’n*, 526 U.S. 765, 770 (1999).

42. *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447, 459 (1986); *see also Cal. Dental Ass’n v. FTC*, 526 U.S. 765, 780 (1999) (A quick look can be applied in the “twinkling of an eye”).

43. *AREEDA & HOVENKAMP*, *supra* note 17, at § 1911. (“The inquiry can be severely truncated when the restraint is sufficiently threatening to place it in the presumptively per se class”).

44. *Id.* (“With power and highly likely anticompetitive effects established, the burden would better have been placed on the defendant to justify its restraint.”).

45. *Id.*

46. *Id.*

C. Federal Guidelines

Statutes and caselaw have the final say in whether an activity is anticompetitive, but the regulators have made their enforcement practices known to the public. The Department of Justice and the Federal Trade Commission have published “Guidelines” which describes the enforcement measures taken by the federal regulators.⁴⁷ These Guidelines have not gone through any federal rulemaking process so they are not binding on any party, even the agency that wrote them.⁴⁸ However, they are highly persuasive on courts and offer information to regulated industries to ensure that they are not violating antitrust law. For our purposes, there are three Guidelines which will be important to understand.

The first is the Horizontal Merger Guidelines which describe the agencies’ position on mergers and acquisitions of businesses in all industries.⁴⁹ This Guidance describes how the Federal Trade Commission will treat *horizontal* integration, i.e. one company purchasing another in the same market.⁵⁰ These guidelines are not perfect; however, they serve an important role in helping regulated industries remain compliant with antitrust law. One pro-consumer criticism is that the guidelines do not address small-market or “roll-up” mergers, but recent policy changes show that the Agencies are focusing more of their attention on these issues.⁵¹ However, the merger Guidelines have been successful at helping industry participants remain compliant with one another.⁵²

The second are the Healthcare Guidelines.⁵³ Although recent critics have called it into question, the traditional thinking was that healthcare was a unique market, not subject to traditional economic principles.⁵⁴ This is reflected in antitrust, and as such regulators believed Healthcare deserved its own antitrust guidance.⁵⁵ The statement itself does not differ in many ways from the general

47. See generally REPEALED ACO GUIDELINES, *supra* note 9, at 2; see also *Federal Trade Commission Withdraws Health Care Enforcement Policy Statements*, *supra* note 10 (for another FTC Guideline).

48. *FTC Publishes Final Guides Governing Endorsements, Testimonials*, FED. TRADE COMM’N (Oct. 5, 2009), <https://www.ftc.gov/news-events/news/press-releases/2009/10/ftc-publishes-final-guides-governing-endorsements-testimonials> [<https://perma.cc/CUT2-XX2L>].

49. U.S. DEPT. OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES 1 (Aug. 19, 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819_hmg.pdf [<https://perma.cc/6GAH-R23U>].

50. AREEDA & HOVENKAMP, *supra* note 17, at § 900 (contrast this with a vertical merger where a company purchases the business which provide the services necessary for the business).

51. FED. TRADE COMM’N, File No. P110014, STATEMENT OF COMMISSIONER ROHIT CHOPRA REGARDING PRIVATE EQUITY ROLL-UPS AND THE HART-SCOTT RODINO ANNUAL REPORT TO CONGRESS (2023), https://www.ftc.gov/system/files/documents/public_statements/1577783/p110014hrsannualreportchoprastatement.pdf [<https://perma.cc/A83A-49YY>].

52. *Id.*

53. *Repealed Healthcare Guidelines*, *supra* note 9, at 1.

54. Amitabh Chandra et al., *Healthcare Exceptionalism? Performance and Allocation in the U.S. Healthcare Sector*, 106 AM. ECON. REV. 2110, 2110 (2015).

55. *Repealed Healthcare Guidelines*, *supra* note 9, at 1.

horizontal and vertical guidelines. However, the general guidance is lacking for the healthcare market in a few key areas. Healthcare systems typically place competitors in situations where collaboration is highly incentivized, if not mandatory, so the horizontal guidelines prohibition on information sharing or pricing may not be applicable. What the Healthcare Guidelines did is carve out specific “zones of safety” for healthcare entities.⁵⁶ Specific examples include language on competitor collaboration in joint ventures, information sharing, and mergers in specific markets.⁵⁷ Again, these markets are not perfect and leave a lot of wiggle room for anticompetitive behavior, but they serve a crucial role in setting the black and white rules for what activities will and will not be condoned by the regulating agencies.

The third is the ACO Guidelines which will be described in length later in this Section.⁵⁸ These Guidelines provide ACO participants with easy-to-follow instructions on remaining compliant with the antitrust law.⁵⁹

Both the ACO Guidelines and the Healthcare Guidelines were repealed by the DOJ and the FTC in July of 2023. The FTC cited to the fact that the Guidelines were “outdated.” Instead of “rely[ing] on outdated guidance, the Commission will rely on general principles of antitrust enforcement.”⁶⁰ The “General principles” which the Federal Trade Commission refers to here are likely their guidance for horizontal mergers, as well as interpretations from the courts regarding the Sherman, Clayton, and Federal Trade Commission Acts. Although repealed, the guidance is still crucial to understand because it gives an indication for how the agencies thought about the healthcare marketplace.

Prior to their repeal the healthcare market was a unique marketplace necessitating its own regulations. Now, the agencies seem to be taking an approach which de-prioritizes the healthcare market’s unique characteristics. Now, the agencies are treating the markets for hospitals the same as markets for hotels. At least in the case of ACOs, this could prove to be incredibly troubling.

All guidelines are not binding on the states or on private rights of action.⁶¹ Even if the guidelines allow an anticompetitive behavior individuals or state governments are not bound by the guidelines. In practice claims from individuals which conflict with the guidelines are not rare and serve as an effective tool for enforcement of antitrust principles. In fact, the Supreme Court has held that the antitrust laws are formed to allow people to serve as their own “attorneys general” to enforce the law.⁶²

56. *Id.* at 5.

57. *Id.*

58. *Repealed Healthcare Guidelines*, *supra* note 9, at 5.

59. *Id.* at 8, 13-14.

60. *Federal Trade Commission Withdraws Health Care Enforcement Policy Statements*, *supra* note 10.

61. FEDERAL TRADE COMM’N & DEPT. OF JUSTICE, *supra* note 11, at 1 (Guidance is not binding on the federal regulators since it did not go through notice and comment. However, it is relevant to courts.)

62. *Hawaii v. Stand. Oil Co. of Cal.*, 405 U.S. 251, 262 (1972).

D. Healthcare Antitrust

Competition in the healthcare industry is difficult to address succinctly. Scholars and regulators agree that competition is necessary in the healthcare market because it leads to lower price and higher quality.⁶³ But difficulty in defining the healthcare marketplace is what leads to debate among antitrust and healthcare scholars. Is choice really a factor in determining where someone gets their care? What about in an emergency, does the patient really have any choice of what hospital to go to? These questions go beyond the topic of this note and have been addressed previously by the courts and scholarship,⁶⁴ but they are constantly in the background when discussing a healthcare antitrust issue. A few key concepts will help guide our analysis of the ACO mergers.

First, non-profit hospitals are just as subject to antitrust law as for-profit hospitals.⁶⁵ although a healthcare entity is more likely than not a non-profit institution, they are still subject to antitrust laws.⁶⁶ There had been some debate as to whether the two antitrust acts were applicable to non-profit hospitals since non-profits do not have stock.⁶⁷ This lack of ownership of a nonprofit gave some hospitals the impression that they could avoid antitrust laws.⁶⁸ In *United States v. Rockford Memorial Corporation*, the 7th Circuit Court of Appeals rejected that argument.⁶⁹ The court reasoned that there was nothing about the non-profit structure which made it more likely to compete “vigorously” than a for-profit business.⁷⁰ The argument that the non-profit hospitals have no stock was also not persuasive, since the Sherman Act puts a blanket restriction on business behavior which is in restraint of trade.⁷¹ Thus, antitrust laws are just as applicable to nonprofit hospitals as their for-profit counterparts.⁷² Just because the organizations are subject to the non-distribution principle, and thus assets cannot be held in stock, is not an excuse to avoid application of the antitrust laws.⁷³

63. *Competition in the Health Care Market*, FED. TRADE COMM’N., <https://www.ftc.gov/advice-guidance/competition-guidance/industry-guidance/competition-health-care-marketplace> [<https://perma.cc/7ULA-9SZ4>] (last visited Nov. 19, 2022) (however, the argument that a consolidation in the healthcare marketplace is good is certainly common).

64. Karyn Schwartz et al., *What We Know About Provider Consolidation*, KFF (Sept. 2, 2020), <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/> [<https://perma.cc/YD5W-PPHY>] (addressing Health Care Market Consolidation and High Prices); see also Emily Gee & Ethan Gurwit, *Provider Consolidation Drives Up HealthCare Costs*, CAP20 (Dec. 5, 2018), <https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs> [<https://perma.cc/R47Y-276M>].

65. See *U.S. v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

Second, a competitive healthcare market is one with multiple diverse players, that promote high quality care, and keep the costs down to attract new clientele.⁷⁴ Thus, an effective and competitive healthcare market will satisfy the so-called triple-aim of healthcare. This triple aim is “(1) improving the individual experience of care; (2) improving the health of populations; and (3) reducing the per capita costs of care for populations.”⁷⁵ A noncompetitive healthcare market will not achieve these gains since a noncompetitive market results in higher costs and worse quality of care.⁷⁶ This theory has been proven true in multiple studies with many demonstrating that the triple aim of healthcare is seriously impaired by consolidation and other anticompetitive behavior.⁷⁷

Third, the history of implementation of antitrust law in the healthcare marketplace is vast and we will only touch on a small but crucial moment in it: the prohibition on clinician managed care. In the 1950s healthcare providers were beginning to get frustrated with the relatively new system of health insurance payors.⁷⁸ To the providers, it seemed like the health insurance system took care out of the hands of providers and into the hands of the insurance companies. The insurers could determine where someone went to receive treatment and how much the procedure would cost.

Some providers took action on their belief that they should be making billing decisions instead of an actuary who had never practiced medicine.⁷⁹ They formed Foundations for Medical Care (FMCs) which would negotiate price ceilings among all providers in a geographic area.⁸⁰ In consideration of paying their premiums, member-patients of these Foundations would be provided healthcare services for no additional cost and the provider would be paid a flat fee described in their plan.⁸¹ At first this model was successful at containing costs for patients, many patients received treatment at lower prices than they would pay if they were part of a “traditional” insurance plan.⁸² However, once some FMCs grew too large and began increasing premiums simply to increase the payment to the provider, regulators got involved.⁸³

The regulators argued that these horizontal price-fixing schemes were *per se* violations of the Clayton and Sherman Acts.⁸⁴ In the eyes of regulators, an

74. *Competition in the Health Care Marketplace*, *supra* note 58; *see also* discussion of the triple aim of healthcare, *infra* Section IV.

75. Berwick et. al. *The Triple Aim: Care, Health, & Cost*, 27 HEALTH AFF. 1, 1 (May/June 2008).

76. *Competition in the Health Care Marketplace*, *supra* note 58.

77. *Id.*

78. Donald C. Harington, *Foundations for Medical Care*, 170 J. Am. Med. Ass’n 969, 969-70 (1959) (discussing the creation of Foundations for Medical Care).

79. *See Ariz. v. Maricopa County Medical Soc.*, 457 U.S. 332, 351 (1982).

80. *Id.* at 337.

81. *Id.* at 341.

82. *Id.*

83. *Id.*

84. *Id.*

FMC was a restraint on commerce.⁸⁵ *Arizona v. Maricopa County Medical Society* was a pivotal decision for FMCs and eventually ACOs.⁸⁶ In that case, the Supreme Court found that FMCs were a *per se* violation of the antitrust acts and must be barred by law.⁸⁷

Although the foundations set price ceilings, the Court still saw them as an unfair restraint on commerce.⁸⁸ In a 4-3 majority opinion, Justice Stevens refused to interpret the business structure under the rule-of-reason.⁸⁹ Instead, the court opted for a *per se* approach which invalidated the FMC model.⁹⁰ Further, the Court gave little credence to the argument that since FMCs were pro-competitive, holding that the FMCs had failed to demonstrate their procompetitive benefits sufficiently to overcome a *pro se* analysis.⁹¹

This case demonstrated that the court does not interpret a horizontal price ceiling any different than horizontal price floors.⁹² Had the Court applied the Rule of Reason in *Maricopa*, it would have been required to prove that the price ceiling was not reasonably necessary to keep costs down.⁹³ The FMC argued that the organization could not have existed without the price-ceiling.⁹⁴ Thus the harsh result of the *Maricopa* decision calls into question the use of *per se* analysis in a healthcare antitrust action.

Putting the correctness of the *Maricopa* decision aside the reality today is that a program like an FMC is an illegal restraint on trade.⁹⁵ Yet, if we compare an ACO to the FMC in *Maricopa*, the structures are almost identical. Both are a group of providers, sharing information, setting prices, and negotiating with payors as an organization. This begs the question: how are Accountable Care Organizations allowed to exist when the Supreme Court explicitly banned that structure in the 1970s? The short answer: the government has agreed to look the other way in exchange for cost-savings.⁹⁶

85. *Id.*

86. *Id.* at 332.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. See generally REPEALED ACO GUIDELINES, *supra* note 9, at 2, 6; see also Andrew A. Kasper, Comment, *Antitrust Review of Accountable Care Organizations: An Assessment of FTC and DOJ's Relaxed Approach to regulating Physician-Hospital Networks*, 90 N.C. L. Rev. 203, 203 (2011).

E. ACO History

In the 2000s CMS was exploring new methods to respond to the never-ending public backlash to managed care.⁹⁷ Unsure of what would work, CMS turned to experimenting with “demonstrations” in small markets across the country. These demonstrations included new and untested techniques for controlling healthcare cost.⁹⁸ In 2006 CMS hypothesized the basis for the ACO program; if financial risk for patient outcomes was placed on providers, then providers would help keep costs down and deliver higher quality care.⁹⁹

To test their hypothesis, CMS formed the Medicare Physician’s Group Practice (PGP) Demonstration Project to pilot a program of rewarding physicians for taking on risk.¹⁰⁰ Providers would be paid bonuses if they were able to make efficiency gains and improve quality in any of the thirty-two predetermined care measures.¹⁰¹ The PGP Demonstration ended in 2010 and was generally successful at accomplishing its cost and quality goals.¹⁰² The lessons learned from the PGP Demonstration would be incorporated into the Affordable Care Act.¹⁰³

The ACA included a provision to allow CMS to create a system of reimbursement for ACOs.¹⁰⁴ The statute permitted providers to form contractual obligations with one another and to share information regarding patient care and risk.¹⁰⁵ The ACO model would, in theory, take the benefits of a consolidated healthcare system while avoiding the results of anticompetitive mergers and acquisitions.¹⁰⁶ The ACA created two types of Accountable Care Organizations: public and commercial.¹⁰⁷

Public Accountable Care Organizations are those which participate in the Medicare Shared Savings Program (MSSP).¹⁰⁸ The MSSP is a carrot and stick approach to ensure cost efficient care and quality outcomes. If an Accountable Care Organization can reach the benchmarks, then they will be rewarded with a payment which is distributed to participants.¹⁰⁹ However, if the ACO falls short of their goal then the participants are penalized and must pay CMS back for their

97. TU ET AL., *supra* note 6, at 2.

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.* (this is known as “benchmarking” the ACOs).

102. *Id.*

103. *Id.*

104. Patient Protection & Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 395 (2010).

105. *Id.*

106. REPEALED ACO GUIDELINES, *supra* note 9, at 2-3.

107. *Id.*

108. *Id.*

109. 42 C.F.R. § 425.20 (2011) (“Shared losses means a portion of the ACO’s performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it must repay to CMS.”).

failure.¹¹⁰

F. How the Government Preemptively Addressed the Antitrust Concerns with ACOs.

Scholars were concerned that two features of ACOs would encourage anticompetitive behavior, particularly price-fixing.¹¹¹ First, the ACO participants can share information with one another regarding price.¹¹² Second, the participants can negotiate collectively for reimbursement.¹¹³

The ACO scheme is almost identical to that in *Maricopa*.¹¹⁴ They both include physician-managed pricing and information sharing.¹¹⁵ The reason why an ACO is permitted to exist while an FMC cannot is simple, the FTC and DOJ have ruled—preemptively—that the sharing agreements are reasonably required to accomplish the goals of the ACO.¹¹⁶ So, the issue has never actually reached the courts to decide if an ACO is an illegal restraint on trade.¹¹⁷ Instead, the preemptive permission has resulted in the government not enforcing the antitrust law against ACOs.¹¹⁸

To instill confidence in the Accountable Care model, the CMS partnered with the FTC and the DOJ to craft policy which would require the three agencies to work together to keep a close eye on Accountable Care Organizations.¹¹⁹ The agreement between the agencies required that CMS craft policy which will ensure that the ACOs will stay competitive and not devolve into price-fixing schemes.¹²⁰

110. *Id.* at § 425.112(a)(3)(i). *See also* CMS, *Shared Savings and Losses and Assignment Methodology* (2022). The program increases reimbursement to providers who agree to take on more financial risk. *Id.* at 52. Providers who take on no risk can still benefit from the MSSP but at a significantly reduced rate. *Id.* at 56. (Level A & Level B (One-Sided Model)).

111. Kasper, *supra* note 97, at 226.

112. TU ET AL., *supra* note 6, at 2.

113. *Id.*

114. Compare Patricia M. Bruns, Note, *Accountable Care Organizations: 2012 Symposium Comments: An Antitrust Analysis of Accountable Care Organizations: Potential Abuses From*

Allowing Reduced Scrutiny Under the Affordable Care Act, 28 J. CONTEMP. HEALTH L. & POL'Y. 268, 269 (2012) (“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.”) with *Ariz. v. Maricopa County Medical Soc.*, 457 U.S. 332, 335-336 (1982) (“Agreements among competing physicians setting, by majority vote, the maximum fees that they may claim in full payment for health services provided to policyholders of specified insurance plans.”).

115. REPEALED ACO GUIDELINES, *supra* note 9, at 2-3; *see also* TU ET AL., *supra* note 6, at 2.

116. REPEALED ACO GUIDELINES, *supra* note 9, at 2-3

117. *But see* *Sidibe v. Health*, 4 F. Supp. 3d 1160, 1177-78 (N.D. Cal. 2013) (dismissing a case against an Accountable Care Organization in part because the court applied the rule of reason instead of *per se* analysis).

118. REPEALED ACO GUIDELINES, *supra* note 9, at 2-3.

119. Kasper, *supra* note 97, at 207.

120. *Id.*

Striking this balance between the Antitrust agencies' desire to protect competition and the CMS' desire to reduce healthcare costs was contentious.¹²¹ However, the respective agencies eventually found a happy medium. In the end, the antitrust agencies preemptively applied the rule of reason to the Accountable Care Organizations.¹²² This more forgiving standard of review was necessary because their structure would be a *per se* violation of the two antitrust acts.

Despite using a more relaxed standard for review, the agencies put limits on the ACOs in the "Zone of Safety." Notably, exclusive ACOs cannot become a dominant market participant, meaning that no one participant of an ACO can control more than 50% of their relevant market and be exclusive to the ACO.¹²³ Additionally, the participants cannot share "competitively sensitive information" with one another.¹²⁴

Unpacking those two exceptions is important. Relevant market share is defined as the geographic area in which a customer, in this case a patient, may access services.¹²⁵ For instance, if the geographic area was defined as "Marion County, Indiana" and there were two providers, say dentists, then each dentist would control 50% of the relevant market. If there were three providers, then they would each control 33% of the market. If one of the dentists in this example were to have purchased one of the other two dentists in Marion County and then join an ACO, they would be deemed to be preemptively in violation of Federal Antitrust law because they control more than 50% of the relevant market.

Clinicians in the same market who practice in the same medical specialty are competitors. For instance, Dermatologist A in the same market as Dermatologist B are competitors. An ACO, operating within the guidelines, can have both Dermatologist A and B in the same organization. This collaboration means that participants are at risk for anticompetitive behavior in their relevant market. Thus, the guidance would not allow any single ACO participant from controlling more than 50% of a relevant market.¹²⁶

Similarly, the ACOs were allowed to share information with each other subject to limitation.¹²⁷ If information could lead to opportunities for collusion on issues of price or output, it is "competitively sensitive."¹²⁸ This would seem to be a strict standard to place on ACOs since the sharing of any patient or pricing information would seem to lead to the opportunity for collusion. However, the Guidance recognized this and only limits the sharing of

121. Bruns, *supra* note 109, at 269.

122. REPEALED ACO GUIDELINES, *supra* note 9 at 4.

123. *Id.*

124. *Id.*

125. *Competition and Monopoly: Single-Firm Conduct Under Section 2 of the Sherman Act: Chapter 2*, U.S. DEP'T OF JUST. (Mar. 18, 2022), <https://www.justice.gov/archives/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-2> [<https://perma.cc/7T2Q-Y7XA>].

126. REPEALED ACO GUIDELINES, *supra* note 9, at 9.

127. *Id.* at 10.

128. *Id.* at 63.

competitively sensitive information if it is related to business “outside the ACO.”¹²⁹ So, if the information is not related to the ACO, then the competitively sensitive information cannot be shared.¹³⁰

By way of example, if one dermatologist ACO participant were to send information regarding the number of Medicare patients that he or she was seeing this month, and what the prices he or she was paying for supplies to serve those patients to the ACO members, it would not violate the Guidance. However, if the dermatologist sent the ACO members information regarding all (i.e. non-Medicare beneficiaries) of his or her patients seen at the clinic and the costs to serve those patients, then it would have violated the Guidance.¹³¹

The reasoning behind the ban on sharing competitively sensitive information regarding outside-ACO business is that the regulators are concerned with competitors knowing each other’s pricing and output information.¹³² Since the ACO model requires reporting of pricing and cost, the agencies acquiesced to the CMS and allowed the sharing of competitively sensitive information only when it involves ACO patients.¹³³ If all competitively sensitive information was banned from being shared, then the ACO would never be able to report to the CMS the amount of money they saved or how many patients they saw.

Neither the 2010 nor the 2023 Horizontal Merger Guidelines are express regarding the sharing of Competitively Sensitive Information. It does speak to the danger of sharing this information with a competitor when merging and will likely interpret the share of competitively sensitive information under a rule of reason approach. However, the FTC has prosecuted cases against merging firms for sharing Competitively Sensitive Information under §1 of the Sherman Act. So, how harshly the FTC will enforce this issue on ACO participants will need to be seen, due to the lack of current guidance.

G. Criticism at the Following ACO Implementation

After the introduction of ACOs, the program was subject to a dearth of literature and scholarship, both legal and otherwise. Skeptics anticipated that the federal government would struggle to define and implement regulations which would actually keep costs down and quality up.¹³⁴ Proponents anticipated that they would be the future of healthcare. Further, they predicted that the Guidance passed by the regulatory agencies would be insufficient at ensuring that the anticompetitive qualities inherent in the Accountable Care model would not

129. *Id.* at 167.

130. *Id.* at 99-100.

131. *Id.*

132. E. John Steren, *Antitrust Compliance and Exchanges of Competitively Sensitive Information Three Situations in Which Access Can Lead to Antitrust Concerns and Possible Safeguards for Each*, 21 J. HEALTH CARE COMPLIANCE 61, 61 (2019).

133. See generally Tu, *supra* note 6.

134. See Bruns, *supra* note 109.

raise their ugly head and destroy any good qualities.¹³⁵

The concerns echoed those of the Supreme Court in the *Maricopa County* decision.¹³⁶ Many worried that the ACOs would be encouraged to set price ceilings with one another since they negotiate together and share price information. Specifically, there was concern that the government had not adequately defined the limitations of the ACO, and that anticompetitive behavior by ACO participants would be the result.¹³⁷

H. The Future of ACOs: The REACH Model

In August of 2022, the Centers for Medicare and Medicaid Services published a proposed rule change to the MSSP which introduced the ACO Realizing Equity, Access, and Community Health (ACO REACH) plan.¹³⁸ The proposal would increase payments to ACOs participating in the MSSP, increase ACO participation of mental health professionals, and increase ACO participation in underserved communities.¹³⁹ The agencies were encouraged to do this because of demonstrations by different ACO groups and claims that ACOs were not equitably available to all Medicare enrollees.¹⁴⁰ Also, the CMS saw that retaining ACO participants would only be possible if the agency increased the shared savings payments.¹⁴¹

So, by increasing ACO payments, CMS is hoping that they will encourage more providers to join the ACO model.¹⁴² While the increase in payments will reduce the net cost savings from MSSP participants, the increase in quality care across the nation will hopefully result in fewer visits to providers and better outcomes for Medicare enrollees.¹⁴³

135. *Id.*

136. *See Generally* Tu, *supra* note 6. *See also* Bruns, *supra* note 109.

137. *See Generally* Julia Kapchinskiy, *The Duality of Provider and Payer in the Current Healthcare Landscape and Related Antitrust Implications*, 55 *SAN DIEGO L. REV.* 617, 652 (2018). *See also* Shaun E. Werbelow, *Rule of Reason Without a Rhyme: Using “Big Data” to Better Analyze Accountable Care Organizations Under the Medicare Shared Savings Program*, 90 *NYU L. REV.* 361, 364 (2015).

138. Medicare and Medicaid Programs; Payment Policies Under the Physician Fee Schedule, 87 *Fed. Reg.* 45860 (July 29, 2022).

139. *Id.* at 46098.

140. *Id.* at 46040.

141. *Id.* at 46163.

142. *Id.* at 46094.

143. *Id.* at 46082.

III. ANALYSIS

A. Have ACOs Achieved Their Goals?

For the Accountable Care Organizations to maintain their rule of reason status, they must prove that their behavior is reasonably necessary to achieve their Triple Aim goals.¹⁴⁴ The goals of the Triple Aim are to reduce healthcare costs, provide a better individual experience, and improve population health.¹⁴⁵ The anticompetitive behavior must be reasonably necessary to achieve these goals. So, it is necessary to analyze how ACOs performed in each of the Triple Aim categories.

In terms of savings, the data is pretty clear. ACOs save the CMS money and since the CMS is funded through tax dollars it eventually saves the taxpayer money.¹⁴⁶ In the first five years after the adoption of the ACO program, the Medicare Shared Savings Program participating ACOs only had modest annual net savings.¹⁴⁷ The reason for the slow start to ACO savings was difficulty in adoption and formation of ACOs.¹⁴⁸ Many organizations could not take advantage of the MSSP reimbursements because they had difficulties meeting the benchmarks or justifying taking on more patient risk.¹⁴⁹

Eventually, in 2019 annual savings nearly doubled to \$1.4 billion and signaled that the ACO savings that CMS had promised had finally been delivered.¹⁵⁰ Most scholars agree that an overhaul in how the program penalizes providers for not meeting cost and quality benchmarks is the lead driver in the cost savings.¹⁵¹ In 2020 it is estimated that the program saved Medicare about \$4 billion while in 2021 it saved a more modest \$1.6 billion.¹⁵²

144. J. Michael McWilliams & Alice J. Chen, *Understanding The Latest ACO “Savings”:* *Curb Your Enthusiasm And Sharpen Your Pencils—Part 1*, HEALTH AFF. FOREFRONT (Nov. 12, 2020), <https://www.healthaffairs.org/content/forefront/understanding-latest-aco-savings-curb-your-enthusiasm-and-sharpen-your-pencils-part-1><https://www.healthaffairs.org/doi/10.1377/forefront.20201106.719550/>. [perma: <https://perma.cc/Q65V-Z58W>].

145. Donald M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFF. FOREFRONT 759, 760 (May/June 2008), <https://doi.org/10.1377/hlthaff.27.3.759> [https://perma.cc/C9F8-NLA9].

146. CMS *supra* note 16.

147. Allen Dobson et al., *Estimates of Savings by Medicare Shared Savings Program ACOs*, NAACOS, <https://www.naacos.com/full-report-for-mssp-savings-2012-2015> [https://perma.cc/L6KV-VNT9] (last visited Nov. 19, 2022).

148. McWilliams & Chen, *supra* note 139.

149. *Id.*

150. *Id.*

151. Jonathan Gonzalez-Smith et al., *The Medicare Shared Savings Program in 2019: Positive Results During Major Transitions And On the Eve Of A Pandemic*, HEALTH AFF. FOREFRONT (Oct. 20, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201016.884678/> [https://perma.cc/BNP4-WVDE].

152. Thomas Sullivan, *ACOs Saved Medicare More than \$4 Billion in 2020*, ACCOUNTABLE CARE ORGANIZATIONS (Dec. 5, 2021) <https://www.policymed.com/2021/12/acos-saved-medicare-more-than-4-billion-in-2020.html> [https://perma.cc/XY92-LV3K].

As for individual experience, the quality requirements of the MSSP have led to better patient outcomes. At its heart, the ACO and the MSSP are quality improvement organizations. Unless the participating provider meets the quality benchmark, they will not get paid by the MSSP.¹⁵³ Thus, the MSSP has been effective at policing provider outcomes. In 2021, the MSSP reported that nearly all providers met quality benchmarks to be reimbursed as part of the MSSP reimbursement program while having average performance and quality measures higher than those of non-participating physicians' groups.¹⁵⁴

Finally, how did ACOs do at improving population health? Accountable Care Organizations were first marketed as an alternative to "normal" managed care.¹⁵⁵ When the program first started the number of participating groups in MSSP ACOs was rapidly accelerating.¹⁵⁶ However, in the past five-or-so years the number of clinicians participating in the program has begun to stagnate.¹⁵⁷ This has not translated into a decrease in the number of enrollees covered in the program.¹⁵⁸ Currently, about 11 million Medicare enrollees are served by about 525,000 ACO participant clinicians.¹⁵⁹ This is a significant population who benefits from the care provided by ACOs.

ACOs certainly have been successful at achieving their goals.¹⁶⁰ The inability of other payer models to do what ACOs have done demonstrates that the anticompetitive behavior that the FTC and DOJ permitted for ACOs was reasonably necessary for their success. The FTC and DOJ's plan to put the oversight in the hands of CMS was pragmatic. The strict quality and cost requirements from CMS proved to be a good measure of anticompetitive behavior.¹⁶¹ If any ACO participant began to practice anticompetitively then they would fall out the program and be penalized for providing low quality care.¹⁶² In reverse, if the participant was acting in a way to drive up costs, then

153. Tu, *supra* note 6.

154. Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Saves Medicare more Than 1.6 Billion In 2021 And Continues to Deliver High-Quality Care*, NEWSROOM (Aug. 30, 2022), <https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high> [https://perma.cc/KG9Q-2GBR].

155. *How Do ACOs and MCOs Compare and Contrast*, GEORGE WASHINGTON UNIVERSITY (May 13, 2019), <https://healthcaremba.gwu.edu/blog/how-do-acos-and-mcos-compare-and-contrast> [https://perma.cc/P5QZ-RG4J].

156. STATISTA, Number of Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program in the United States from 2012/2013 to 2022, STATISTA (last visited Nov. 19, 2022), <https://www-statista-com.proxy.ulib.uits.iu.edu/statistics/1278895/number-of-acos-in-medicare-shared-savings-program/> [https://perma.cc/DD34-UAA2].

157. *Id.*

158. *Id.* (The ACOs collectively care for around 10.9 million beneficiaries in 2023, which is roughly one in six Medicare enrollees." *Id.*

159. *Id.*

160. *Id.*

161. Sullivan, *supra* note 147.

162. See generally CMS, *supra* note 4. See also, REPEALED ACO GUIDELINES *supra* note 9, at 4.

their savings would not be paid out.¹⁶³

The self-regulating system designed by CMS has been successful. Does this disprove the worries of ACO critics? Not at all, instead it shows that there were aspects of ACOs which the critics and regulators could not yet anticipate.¹⁶⁴ Specifically, the ACO system leads to anticompetitive mergers and acquisitions between ACO participants which directly impacts the Triple Aim of healthcare.¹⁶⁵

B. Anticompetitive Merger of ACO Participants.

Most criticism of ACOs was directed to worries about horizontal price fixing,¹⁶⁶ instead ACO skepticism should have been focused on “soft consolidation” turning into actual mergers and acquisitions.¹⁶⁷ The likelihood of an ACO participant to merge is significantly higher than other providers.¹⁶⁸ FTC Guidance explicitly indicates that a merger or acquisition of an ACO participant will not be governed by the ACO guidelines.¹⁶⁹ By focusing solely on price-fixing issues, the Federal Guidance failed to anticipate that there would be concerns regarding ACO consolidation.

In a 2020 study, counties with above average ACO participation were shown to have 5% higher rates of mergers and acquisitions than counties that did not have high levels of ACO participation.¹⁷⁰ This is attributed to the ACO members working closely together with one another and learning of the benefits that could be gained by integrating clinical systems.¹⁷¹ Because of the Agencies voluntary bliss. So, providers working together to provide low cost care in the ACO scheme are not likely to stay in that system.¹⁷² Which is especially unfortunate considering that Medicare enrollees and taxpayers are forced to pick up the costs associated with healthcare consolidation.¹⁷³ The Medicare enrollee will pay more because their copays and other fees will increase according to any increase in cost on the provider’s side.¹⁷⁴ While the taxpayer will be forced to pay more since Medicare and Medicaid are funded through taxes.¹⁷⁵ With the

163. *Id.*

164. Kanter, *supra* note 1.

165. *Id.* (The anticipation that ACO participants would merge at higher rates than other healthcare provider systems.) *Id.*

166. See generally Collin C. Groebe, Note, *The Evolution of Federal Courts’ Healthcare Antitrust Analysis: Does the PPACA Spell the End to Hospital Mergers?*, 92 WASH. U. L. REV. 1617, 1628 (2015).

167. Kanter et al. *supra* note 1.

168. *Id.*

169. REPEALED ACO GUIDELINES, *supra* note 9, at 3.

170. Kanter et al., *supra* note 1.

171. *Id.*

172. *Id.*

173. CMS, *supra* note 16.

174. *Id.*

175. *Id.*

federal and state governments already shelling out for healthcare at increasingly shocking amounts, any increase in costs deserves serious consideration.

It is unpersuasive to argue that mergers and acquisitions by ACO participants is reasonably necessary for the accomplishment of the triple aim. While merger or acquisitions can be procompetitive, that is not always the case.¹⁷⁶ If a merger is in restraint of trade and does not offer any “merger specific benefits,” then the merger is anticompetitive and must be struck by the courts.¹⁷⁷

There are no pro-competitive benefits available to an ACO participant which wishes to merge with another.¹⁷⁸ Every pro-competitive benefit possible through merger was already addressed by the ACO system. Specifically, proponents of merger and acquisition argue that the efficiency gains by information sharing and price sharing allow for reduced costs and improved continuity of care.¹⁷⁹ And to a certain extent, those advocating for consolidation in healthcare are correct. It is much more efficient to run a healthcare organization if it benefits from horizontal and vertical integration.¹⁸⁰ Streamlined continuity of care is much cheaper and more effective than disparate providers not coordinating with one another.¹⁸¹

However, all of those benefits are available to ACOs.¹⁸² They can share information with one another about patients, they coordinate care, and they get rewarded when the program keeps costs down and quality up.¹⁸³ ACOs can even share pricing information together and negotiate with payors as a collective.¹⁸⁴ It seems, the only benefit of a merger of ACO partners is to remove the profit incentive from keeping high quality outcomes.¹⁸⁵

The only potential benefit of merger and acquisition is in the form of profit to the ownership group which no longer needs to be concerned with meeting the ACO benchmarks to receive their bonus.¹⁸⁶ Once merger takes place, profit no

176. Dirk Hackbarth, *Can Horizontal Mergers Boost Competition?* PROMARKET (Aug. 14, 2018), <https://www.promarket.org/2018/08/14/can-horizontal-mergers-actually-boost-competition> [<https://perma.cc/9VVBG-HL5M>]; c.f. Tyler J. Kubik, *The efficiencies defense after anthem: asymmetric burdens and strict scrutiny of merger efficiencies*, 26 GEO. MASON L. REV. 1365, 1365 (2019). (Highlighting the strict scrutiny of merger specific benefits when analyzing mergers and acquisitions.)

177. *Id.*

178. Tu, *supra* note 6.

179. Monica Noether & Sean May, *Hospital Merger Benefits Views From Hospital Leaders and Econometric Analysis*, AM. HOSP. ASS'N, (Jan. 2017) <https://www.aha.org/guidesreports/2017-01-24-hospital-merger-benefits-views-hospital-leaders-and-econometric-analysis> [<https://perma.cc/5JEM-BGW2>].

180. *Id.* at 3.

181. *Id.*

182. Tu, *supra* note 6, at 8.

183. *Id.*

184. *Id.*

185. *Id.*

186. Fred Schulte, *Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties*, KFF HEALTH NEWS, (Nov. 14, 2022), <https://khn.org/news/>

longer flows from the accomplishment of the Triple Aim, instead it flows from the reduction in cost of services and an increase in the number of services provided.¹⁸⁷ Without any quality requirement, the newly merged ACO participants are encouraged to do the highest number of procedures for the highest price. In a consolidated system without the ACO quality protection a patient's care may decrease in quality and thus their outcomes suffer.¹⁸⁸ It has already been shown that an ACO leads to better outcomes for its patients than in a non-ACO provider, so it is expected that the quality and outcomes will be worse in a consolidated ACO.¹⁸⁹

Although removing the government's ability to oversee a business has not yet been recognized as a procompetitive benefit, it is a necessary aspect of the ACO system. Without the oversight, the FTC and DOJ would not have given their blessing to ACOs.¹⁹⁰

C. Necessary Changes to Federal Regulation

The now repealed DOJ and FTC Guidance is focused on ensuring that ACO participants who take part in the MSSP are protected from antitrust enforcement. Based on the context and the time when the Guidance was written, the agencies would not have been concerned with what ACO participants would eventually do when they decided to stop participating. Instead, the Guidance focuses on encouraging ACO participation, and instilling confidence that the ACO system would not be anticompetitive.¹⁹¹ Now, the agencies have the opportunity to implement regulations to prevent these mergers. If not, CMS will continue to be required to pay higher costs for Medicare enrollees and the enrollees themselves will pay higher out of pocket costs for lower quality care. Further, the Horizontal merger guidelines and "general principles of antitrust enforcement" will be inappropriately applied to ACOs, resulting in them losing critical protections from antitrust enforcement.

Specifically, the new guidelines need to include a provision which will require that any merger between ACO participants will not be analyzed under the rule-of-reason. Instead, the standard needs to be changed to a quick-look analysis. To someone with "even a rudimentary understanding of economics," the merger of a former ACO participant with another similarly situated clinician

article/private-equity-takeover-health-care-cities-specialties/ [permalink: <https://perma.cc/SYY7-2L99>].

187. *Id.*

188. *See generally id.* If the motive in private equity funded hospitals is only profit, then it is fair to impute that motive onto consolidated ACOs which no longer have their profit motive based on quality of care. *id.*

189. *Id.*

190. *Id.*

191. *Id.*

is clearly anticompetitive.¹⁹² It is a naked restraint on the healthcare market. It is abandoning a model which keeps costs down and quality up and moving to a system which has documented pattern of increasing costs and decreasing quality.¹⁹³ So, the agencies could prevail in court with a simple quick look analysis of the proposed merger.

Unfortunately, the Guidance on this issue is also lacking in that it is not as easily applied to small clinicians, who are more likely to be ACO participants.¹⁹⁴ Thus, the ACO participants who need this regulation the most are also the most likely to be overlooked. By incorporating the language into new ACO specific guidelines, the Agencies would be drawing a hard line in the sand. Pointing to ACO participants and declaring that mergers will be viewed under a quick-look model, is a much stronger carrot than saying “we will let the Horizontal Guidelines dictate this issue.” Additionally, the Guidelines for ACOs are only for ACOs. This negates any concern about quick look being applied too broadly to other industries.

On the other hand, the logistical concerns of monitoring ACO mergers and acquisitions are real. Specifically, the higher burden on the regulating agencies. Overextension of the FTC and DOJ antitrust enforcement is a real concern. It would be unwise to require them to analyze every merger and acquisition in every healthcare market. However, they are not going to be alone in implementing these new requirements. By effectively partnering with state Attorneys General, the federal government can shift some of its burden over to the states.

This is not an unprecedented idea and would not require any overhaul of agency procedure. The FTC, DOJ, and the states already work closely with one another to ensure that federal and state consumer law is enforced across the nation. The states serve a boots-on-the-ground purpose to the federal agencies.

Recent successes by state Attorneys General have grown support for state action to protect their residents. For instance, the opioid litigation has greatly increased the public’s confidence that AGs will act in the best interest of their citizens.¹⁹⁵ With this power, the AGs would have public support on their side to defeat these anticompetitive mergers before they get into court.

In *People v. Sutter Health*, a case from California eventually settled out of court, the Attorney General of California was able to negotiate a settlement for the anticompetitive behavior of one of the largest hospital networks in the

192. *Cal. Dental Ass’n*, 526 U.S. at 770. (Recall, this standard is required by *Cal. Dental Ass’n v. FTC*, or else an in-depth market analysis is required); *See also supra* text accompanying note 32.

193. Jacqueline LaPointe, *Healthcare Private Equity Down But Not Out*, REV CYCLE INTELLIGENCE, (Jan. 19, 2023), <https://revcycleintelligence.com/news/healthcare-private-equity-down-but-not-out-report-finds> (<https://perma.cc/LJN3-VQBF>).

194. Kanter, *supra* note 1.

195. *People v. Sutter Health*, 2018 Cal. Super. LEXIS 1948. (This action was brought by former California Attorney General Xavier Becerra, who is at the time of writing the Secretary of Health and Human Services.)

state.¹⁹⁶ The lawsuit was based entirely on state law causes of action.¹⁹⁷ This action could be replicated throughout the country. The participation between strong state AGs and the federal regulators is crucial for the success of regulating ACOs.

Some states have requirements in place to review healthcare mergers and acquisitions pre-consummation.¹⁹⁸ Even in these states, enforcement of purely state law antitrust rules is not common. *Sutter* demonstrates that this does not need to be the case and state law can prevail as the only ground on which to block a healthcare merger.¹⁹⁹

Also, state Attorneys General have shown that they can work together independent of the federal government to enforce antitrust policy.²⁰⁰ For instance, Attorneys General across the country have come together to enforce their state and federal laws regarding antitrust.²⁰¹ This shows that there is nothing stopping Attorneys General offices from blocking these mergers. Especially considering the hyper-local market analysis which might be necessary to enforce antitrust laws on ACO participants, the Attorneys General might be better positioned than the federal government to act against ACO consolidation.

What does limit the Attorneys General from achieving their goals is the cost associated with enforcement.²⁰² Many Attorneys General offices are limited in their resources and convincing them to act can be difficult.²⁰³ Also, many rely heavily on complaints from constituents. In many cases, complex cases like this cannot get off the ground because the patient's themselves do not know that they are the victim of anticompetitive practices.²⁰⁴ They will feel the increased costs in their pocketbook but have no knowledge of the complex organizational

196. *Id.*

197. *Id.*

198. Alexandra Montauge et. al, *State Action to Oversee Consolidation of Health Care Providers*, MILBANK MEMORIAL FUND (Aug. 5, 2021), <https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/> [https://perma.cc/6T3R-RJ5W].

199. California and Washington have seen great success in their courts bringing solely state antitrust claims. *See generally* CAL. OFFICE OF ATTY GEN., *Antitrust Enforcement in California: How You Can Help*. <https://www.oag.ca.gov/sites/all/files/agweb/pdfs/antitrust/antitrust.pdf> (last visited Feb. 29, 2024) [https://perma.cc/H57X-P9UE].

200. Diego Lasarte, *The ongoing big tech antitrust cases to watch in 2023*, QUARTZ (Jan. 24, 2023), <https://qz.com/antitrust-cases-big-tech-2023-guide-1849995493> [https://perma.cc/3QMK-54QZ].

201. *Id.*

202. *See generally* Clark Corbin, *after budget concerns, JFAC reduces raises for Idaho Attorney General's Office*, IDAHO CAPITAL SUN (Mar. 20, 2023, 4:38 PM), <https://idahocapitalsun.com/2023/03/20/after-budget-concerns-jfac-reduces-raises-for-idaho-attorney-generals-office/> [https://perma.cc/5W5Z-Y7LY] (Supporting the position that State AG offices are underfunded.).

203. *See generally Id.*

204. *The Challenge of Health Care Fraud*, NHCAA, <https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/> [https://perma.cc/U4V8-M5RZ] (last visited July 27, 2023).

structures which lead to these changes. Therefore, any attempt by state Attorneys General must be coupled with an increase in education to the public about their rights and some way to help fund these investigations by state Attorneys General.

A patient also has a private right of action under both state and federal antitrust law.²⁰⁵ This might be an additional tool to keep pressure off of the overworked regulators. If private plaintiffs' attorneys are willing to put in the work to complete market analysis and take a consolidated ACO into court, they can win sizable awards for their clients while benefiting the public.²⁰⁶ Also, since it is a private action, the plaintiff will be unbound from the federal Guidance on antitrust law.²⁰⁷ This would allow them to argue for the use of quick look analysis instead of rule of reason.

Unfortunately, the private attorney will run into the same cost and time roadblocks the federal regulators will if they have to overcome a rule of reason defense. So, it is crucial that the regulators set an example by waiving their own standard of review.

D. Criticism of The ACO REACH Program

The issue with this proposed ACO expansion is that it will permit private firms to get involved in the ACO model.²⁰⁸ Set up as a middleman in between the providers and Medicare, a new player representing private interests has been introduced to the MSSP ACO scheme: The Direct Contractor. The Direct Contractor is an independent entity who receives the payment from Medicare to the ACO participant and ensures that the quality standards are met before payment is dispersed. Policymakers and regulators are concerned with the attention the ACO Direct Contractor has received from private equity and other capital focused firms.²⁰⁹ While there is nothing necessarily anticompetitive about these firms getting involved in the ACO scheme, they carry a connotation which worries lawmakers.²¹⁰

Since their motive is purely to achieve profit, many regulators are concerned that the Direct Contractors will have perverse incentives and encourage anticompetitive behavior.²¹¹ After all, what makes the ACOs so beneficial is that they put the cost and financial risk of care in the hands of clinical providers, not

205. 15 U.S.C. § 15(a)

206. *Id.*

207. *Id.* (Private right of action is based entirely on §15(a) of the Clayton Act, not on federal regulatory framework).

208. Robert King, *House progressives push for CMS to end newly rebranded ACO REACH model*, FIERCE HEALTHCARE, (Mar. 17, 2022), <https://www.fiercehealthcare.com/payers/house-progressive-push-cms-end-newly-rebranded-aco-reach-model> [<https://perma.cc/9FTY-GRAH>] (the ACO REACH Model was proposed and lobbied for by ACO industry groups like the National Association for ACOs.).

209. *Id.*

210. *Id.*

211. *Id.*

third parties reviewing their decisions.

A private third party getting involved in the ACO process is not as clearly anticompetitive as a merger between two former ACO participants. The agencies will probably have to go a bit further than a quick look analysis in this case to prove that it would violate the statute. But nevertheless, if the effects of this new ACO REACH system are what politicians think they will be, then the regulators must remove REACH participants from the Zone of Safety. Even if rule-of-reason analysis is necessary, this should not be barring the agencies from bringing action against ACO REACH participants who act anticompetitively.

If not, then the triple aim will no longer be the purpose of the Accountable Care Organizations. Instead, the profitability and financial success of the ACO will become the Organization's priority. As the rest of the healthcare industry has seen, the introduction of private equity firms into the management and provision of healthcare has had terrible effects on cost, quality, and access.²¹² So, it seems unwise to encourage these firms to join ACOs. Especially when the purpose of the REACH program is to increase the equitable distribution of high-quality care. Not every government intervention needs a private-public partnership to justify its existence. Sometimes, a program can exist solely on its own merit, and ACOs have shown that they can be successful on their own.

E. Preventing ACO Participants from Merging.

Preventing this consolidation should be the primary focus of any new regulation. Thus, any regulatory changes must be able to prevent anticompetitive effects before the consolidation takes place. Conspiracy to place a restraint on trade is a violation of the Sherman Antitrust Act.²¹³ Conspiracy to restrain trade requires two or more people planning to restrain trade by producing anticompetitive effects which outweigh any procompetitive effects stemming from the agreement which affects interstate or foreign commerce.²¹⁴

Federal and state regulators, after revision of the federal ACO Guidance to include quick-look analysis, can use conspiracy to restrain trade to prevent potential consolidation of ACO participants.²¹⁵ A couple hurdles make this more difficult than a "normal antitrust" action. First, a conspiracy action requires proof that the restraint would outweigh any procompetitive effects.²¹⁶ Second, there must be some form of overt action that would clearly demonstrate anticompetitive action.²¹⁷ The requirement for an overt action poses an interesting problem in ACO antitrust. The organization members already are participating in overt anticompetitive action. Specifically, they share

212. Schulte, *supra* note 187.

213. 15 U.S.C. § 1 (1890).

214. *Id.*

215. AREEDA & HERBERT HOVENKAMP, *supra* note 17, at § 101.

216. *Id.*

217. *Id.* at § 1416

information and act in a concerted effort to set prices, contain spending, and coordinate care.²¹⁸ This type of behavior would be described as “tacit coordination,” or merely the coordination of competitors which is created by interdependence.²¹⁹ An overt action would be something like secretive meetings or communication, a contract to agree to merge, or something else that a regulator could point to and easily identify as anticompetitive.²²⁰

Further, the conspiracy litigation, if successful, would solidify that the ACOs require the federal regulation in order to remain valid under the antitrust statutes. This would put the third parties who profit from ACOs on notice that they cannot simply strip the profit out of the ACOs and walk away.

F. Unwinding Consummated Mergers

Simply put, the damage has already begun with ACO mergers.²²¹ The data is clear that ACO participants have already begun to consolidate at a high rate.²²² So, how can the state and federal regulators undo the mergers and acquisitions of ACO participants? This can be done through the use of post-consummation lawsuits brought by federal and state governments.

A post-consummation action mirrors the pre-consummation actions in that it requires that the plaintiff prove that the defendant acted in restraint of trade.²²³ However, a post-consummation merger requires proof that it had actual negative effects on the market.²²⁴ This means if a merger has already taken place, then the plaintiff must show that there were actually negative trade results.²²⁵

This is a difficult hurdle to meet and requires a standard of review higher than quick look or rule of reason. It requires essentially *per se* analysis of the proposed restraint on trade.²²⁶ Considering that there is sufficient evidence to show that there have been negative effects on price and quality by ACO participants merging, this standard should be achievable.

IV. CONCLUSION

Accountable Care Organizations work. They are effective tools to contain costs and improve quality. The data shows that the ACO system can lead to lower costs, higher quality, and greater access. ACOs have saved billions of dollars over the past decade. They contain anticompetitive qualities, but the procompetitive benefits have outweighed those aspects. The ACO gives the

218. *Id.*

219. *Id.*

220. *Id.*

221. Kanter et. al, *supra* note 1, at 1936.

222. *Id.* at 1941.

223. AREEDA & HERBERT HOVENKAMP, *supra* note 17, at § 315(b).

224. *Id.* And that the negative effects would not have occurred otherwise. *Id.*

225. *Id.*

226. *Id.*

benefits of a merger or consolidation without the risks of price hikes and reduced quality.

From a financial point of view, it seems that preserving the ACO model is crucial to keeping Medicare and Medicaid functional. To keep ACOs, the government must overcome the fundamental truth that Adam Smith wrote in *Wealth of Nations*, and that Justice Posner paraphrased in his *Rockford* opinion: “Most people do not like to compete and will seek ways of avoiding competition by agreement tacit or explicit, depending of course on the costs of agreeing.” So, how can the federal government maintain the ACO system but avoid their members from merging? By publishing new guidelines to include a quick look analysis of any proposed merger of healthcare entities who were previously members of the same ACO.

If the federal and state governments can come together to draft new guidance then the harm that has already been done can be reversed and further harm can be stopped.

By promulgating new guidance to include quick-look review of ACO participant mergers, the agency can prevent these mergers from taking place. Instead of asking whether the anticompetitive behavior is reasonably required to achieve the pro-competitive gains, the authors of the new guidance should ask whether the effects of an anticompetitive merger are so clear that even someone with a “rudimentary understanding of economics” could see the harm.

Since this requires a clear proof of anticompetitive harm, this standard might be a bit more difficult to achieve. However, when the harm is clear the standard is easier to achieve than rule of reason. In the case of ACO participants merging, the harm is clear.

Under this new standard of review the agencies will be able to bring conspiracy to restrain trade suits against potentially consolidating ACOs and bring post-consummation suits against those that already have merged. Further, it will allow the federal government, state agencies like their Attorney General, and private citizens to bring more meritorious claims against these consolidating ACOs. This has to happen now before any further changes to the ACO model can be implemented. The effects of private organizations entering the ACO scheme has politicians concerned. If plans like the REACH model are implemented before any change to the antitrust framework for ACOs can be implemented, then we will see consolidation trends increase drastically.

The ACO REACH has wonderful goals which should be applauded, increasing the access and equity of ACOs is something that everyone agrees is necessary. However, the method to do so will only further drive ACOs away from their original goal of keeping cost, quality, and access down. By including private third-party payors into the program, REACH will result in skyrocketing costs and undermine the integrity of the entire ACO program.

The future for ACOs does not look bright unless the regulators can come together to draft new pro-competitive Guidance. While it appears that the regulators are doing this now, it may not be soon enough.

Hopefully any new Guidance will reflect the reality that ACO participants do not want to compete and will do whatever they can to avoid being forced to compete.