

The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*

ERIN C. FUSE BROWN AND JAIME S. KING†

The average family of four in the United States spends \$25,826 per year on health care. American health care costs so much because we both overuse and overpay for health care goods and services. The Affordable Care Act's cost control policies focus on curbing overutilization by encouraging health care providers to integrate to promote efficiency and eliminate waste, but the cost control policies largely ignore prices. This article examines this overlooked half of health care cost control policy: rising prices and the policy levers held by the states to address them. We challenge the conventional wisdom that reducing overutilization through health care integration will effectively reduce health spending. We argue that vertical integration—bringing together disparate providers from hospitals to physicians—is a double-edged sword, with not only the potential to reduce wasteful and unnecessary use of services but also downside risks of increasing market consolidation and health care prices. Due to already highly concentrated health care markets and the limits of federal antitrust enforcement of vertical health care integration, states have both an opportunity and an obligation to supplement federal antitrust efforts to control rising health care prices stemming from health care integration. The way to manage the double-edged sword of health care integration is to require price and quality oversight to avoid harm to competition. We offer a menu of six policy initiatives for states to choose from, ranging from data collection to rate regulation. If we are to control our personal and national health care spending, states have a critical role to play in overseeing health care integration and private health care price increases.

INTRODUCTION.....	56
I. THE RISE OF HEALTH CARE INTEGRATION.....	61
A. THEORETICAL BENEFITS OF VERTICAL INTEGRATION.....	61
B. POLICY INCENTIVES FOR VERTICAL INTEGRATION.....	63
II. THE DOUBLE-EDGED SWORD OF VERTICAL HEALTH CARE INTEGRATION.....	68
A. INCREASED MARKET POWER	68
B. INCREASES IN REFERRALS AND REIMBURSEMENT.....	72
C. AGENCY PROBLEMS AND CONSUMER CHOICE	74

* Copyright © 2016 Erin C. Fuse Brown and Jaime S. King.

† Erin C. Fuse Brown is an Assistant Professor of Law, Georgia State University College of Law; Faculty Member, Georgia State University Center of Law, Health & Society. Jaime S. King is a Professor of Law, UC Hastings College of Law; Co-Director, UCSF/UC Hastings Consortium on Law, Science & Health Policy; Executive Editor, The Source on HealthCare Price & Competition. The authors would like to thank Robert Berenson, I. Glenn Cohen, John Cogan, Abbe Gluck, Thomas Greaney, Henry Greely, Mark Hall, Barak Richman, Rachel Sachs, and David Studdert for their insightful and helpful comments, and E. Hardin Patrick and Michael Montgomery for their excellent research assistance. We also thank the numerous commenters from presentations of this paper at Harvard Law School's Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics, Yale Law School's Solomon Center for Health Policy and Law, Stanford Law School's Center for Law and the Biosciences, and the National Academy for State Health Policy.

III. THE CENTRAL ROLE OF STATES	76
IV. STATE OPTIONS TO ADDRESS THE DOUBLE-EDGED SWORD.....	78
A. ALL-PAYER CLAIMS DATABASES	79
B. ANTITRUST ENFORCEMENT AND IMMUNITY.....	82
1. ANTITRUST ENFORCEMENT	83
2. STATE ACTION IMMUNITY AND CERTIFICATES OF PUBLIC ADVANTAGE.....	91
C. ACO CERTIFICATION	94
D. RATE OVERSIGHT AUTHORITY.....	96
1. RATE OVERSIGHT COMMISSION	97
2. INSURANCE RATE REVIEW	98
E. PRIVATE RATE CAPS	102
F. PROVIDER RATE REGULATION.....	104
1. ALL-PAYER RATE SETTING	104
2. PRIVATE RATE REGULATION.....	106
3. GLOBAL BUDGETS.....	107
CONCLUSION.....	111

INTRODUCTION

It is no secret that U.S. health care costs are out of control. The United States has experienced a more than 400% increase in total annual health care expenditures since 1990,¹ exceeding \$3 trillion and representing 17.5% of gross domestic product (GDP) in 2014 alone.² The average family of four spends \$25,826 on health care per year, an amount that could buy the family a new Toyota Prius or Tacoma every year.³ Yet while we pay more per capita than any other nation for health care, the health of American citizens does not reflect this additional spending.

In the lead-up to the passage of the Affordable Care Act (ACA), Atul Gawande laid out what has become the dominant narrative of U.S. health care cost containment

1. See CTRS. FOR DISEASE CONTROL & PREVENTION, GROSS DOMESTIC PRODUCT, NATIONAL HEALTH EXPENDITURES, PER CAPITA AMOUNTS, PERCENT DISTRIBUTION, AND AVERAGE ANNUAL PERCENT CHANGE: UNITED STATES, SELECTED YEARS 1960–2013, tbl.102 (2014), <http://www.cdc.gov/nchs/data/hus/2014/102.pdf> [<https://perma.cc/G4T8-UR67>].

2. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2014 HIGHLIGHTS, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf> [<https://perma.cc/V2NC-X226>].

3. CHRIS GIROD, SUE HART & SCOTT WELTZ, 2016 MILLIMAN MEDICAL INDEX 3 (May 2016), <http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/2016-milliman-medical-index.pdf> [<https://perma.cc/7XYA-S834>] (“[O]f the typical family of four’s \$25,826 in total [health care] spending, . . . the employer pays 57% of costs, or \$14,793, while the employee pays the other 43%: \$6,717 in employee contributions through payroll deduction and \$4,316 in the form of out-of-pocket expenses incurred at time of service.”); see TOYOTA, <http://www.toyota.com/#!/hybrids-ev> [<https://perma.cc/8RX2-6D5N>] (listing the starting price for a 2016 Prius as \$19,560) TOYOTA, <http://www.toyota.com/#!/trucks> [<https://perma.cc/KL37-YC59>] (listing the starting price for a 2017 Tacoma as \$24,120).

in his highly influential *New Yorker* article, *The Cost Conundrum*.⁴ The narrative was this: Medicare health care expenditures vary widely throughout the country in ways that cannot be explained by the sickness of the patient population, the quality of care provided, or even the cost of producing the health care. The most expensive regions in the country have higher health care utilization, and for that extra utilization, they produce neither better quality care nor better patient health outcomes. In fact, leading researchers estimate that the federal government could eliminate nearly 30% of Medicare spending without sacrificing quality or outcomes if higher-spending regions mirrored the utilization patterns of lower-spending regions.⁵ Following this logic, Dr. Gawande and several leading health economists argued that to bend the cost curve, the U.S. health care system needed to realign its payment and delivery systems to disincentivize and reduce overutilization, and to instead reward coordination, quality, and efficiency.⁶ Gawande's account was so compelling that it became required reading in President Obama's White House and Capitol Hill in the months leading up to the passage of the ACA, heavily influencing the translation of cost control policies into law.⁷

As a result, the cost containment mechanisms of the ACA and other recent health care reform efforts focus heavily on reducing overutilization.⁸ To do so, federal policy incentivizes vertical integration among providers at different phases of health care delivery to improve care coordination, eliminate wasteful or repetitive services, encourage shared resources, and reduce overhead expenses.⁹ Vertical integration in health care commonly occurs when a hospital purchases a physician practice, making

4. Atul Gawande, *The Cost Conundrum*, NEW YORKER (June 1, 2009), <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum> [https://perma.cc/5JHY-4WV4].

5. *Id.*; see also John E. Wennberg, Elliot S. Fisher & Jonathan S. Skinner, *Geography and the Debate over Medicare Reform*, HEALTH AFF. W96, W104 (Feb. 13, 2002), <http://content.healthaffairs.org/content/early/2002/02/13/hlthaff.w2.96.short> [https://perma.cc/V5G6-DW2X].

6. See, e.g., Public Meeting of the Medicare Payment Advisory Commission 309, 380–400 (Nov. 8, 2006), *transcript available at* <http://www.medpac.gov/docs/default-source/meeting-materials/november-2006-meeting-transcript.pdf?sfvrsn=0> [https://perma.cc/BB5N-G57L] (describing the ACO model variously as “extended hospital medical staff” and “accountable organization”); David Cutler, *How Health Care Reform Must Bend the Cost Curve*, 29 HEALTH AFF. 1131 (2010); Elliot S. Fisher, Douglas O. Staiger, Julie P.W. Bynum & Daniel J. Gottlieb, *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44 (2007).

7. See Bob Kocher & Farzad Mostashari, Opinion, *A Health Care Success Story*, N.Y. TIMES (Sept. 23, 2014), <http://www.nytimes.com/2014/09/24/opinion/a-health-care-success-story.html> [https://perma.cc/4CC4-4PLB]; Robert Pear, *Health Care Spending Disparities Stir a Fight*, N.Y. TIMES (June 8, 2009), <http://www.nytimes.com/2009/06/09/us/politics/09health.html> [https://perma.cc/BF7A-R6L7].

8. Examples include the Medicare Shared Savings Program, 42 U.S.C. § 1395jjj (2012); the Hospital Value-Based Purchasing Program, 42 U.S.C.A. § 1395ww(o) (West 2015); and the National Pilot Program on Payment Bundling, 42 U.S.C. § 1395cc-4 (2012).

9. See KAISER FAMILY FOUND., SUMMARY OF THE AFFORDABLE CARE ACT (2013), <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act> [https://perma.cc/9UMJ-CUK2].

the resulting entity responsible for both inpatient and outpatient care. Unfortunately, in this effort to control utilization, we have overlooked the other half of the cost control equation: prices.¹⁰

Health care cost containment efforts must consist of two parts: reducing overutilization and constraining health care prices.¹¹ Just like going to the grocery store, the amount of your bill depends on how many items you buy as well as the price of each item. The United States will not bend the cost curve without addressing private health care prices.¹² High prices are the main reason the United States spends so much more on health care than other wealthy, developed countries.¹³ Moreover, similar to the overutilization problem, the higher prices we pay do not result in more or better quality care nor do they lead to better health outcomes.¹⁴ While it may be true that nearly a third of Medicare spending is waste,¹⁵ when looking at our total public and private health care spending, price increases explain most of the rise in U.S. health care costs,¹⁶ eclipsing the effects of increasing utilization, the aging or sickness of the population, the supply of health care services, malpractice litigation, and defensive medicine.¹⁷

10. See Kevin Quealy & Margot Sanger-Katz, *The Experts Were Wrong About the Best Places for Better and Cheaper Health Care*, N.Y. TIMES: THE UPSHOT (Dec. 15, 2015), <http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html> [<https://perma.cc/9XNR-CJRB>] (quoting Robert Berenson, fellow at the Urban Institute, as saying “[p]rice has been ignored in public policy”).

11. Erin C. Fuse Brown, *The Blind Spot in the Patient Protection and Affordable Care Act’s Cost-Control Policies*, 163 ANNALS INTERNAL MED. 871 (2015).

12. See Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured 2–3* (Dec. 2015) (unpublished manuscript), http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf [<https://perma.cc/3V7T-LL2X>].

13. Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhi Petrosyan, *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 103 (2003); Bruce C. Vladeck & Thomas Rice, *Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers*, 28 HEALTH AFF. 1305, 1305–06 (2009).

14. See Vladeck & Rice, *supra* note 13, at 1306.

15. See Wennberg et al., *supra* note 5, at W104.

16. Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner & Hugh R. Waters, *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 904 (2005); Hamilton Moses III, David H. M. Matheson, E. Ray Dorsey, Benjamin P. George, David Sadoff & Satoshi Yoshimura, *The Anatomy of Health Care in the United States*, 310 JAMA 1947, 1949 (2013).

17. Anderson et al., *supra* note 16, at 904; Moses III et al., *supra* note 16, at 1949 (“Between 2000 and 2011, increase in price (particularly of drugs, medical devices, and hospital care), not intensity of service or demographic change, produced most of the increase in health’s share of GDP.”); OFFICE OF ATT’Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 3–4, 16–27, 35 (2010), <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf> [<https://perma.cc/928G-3242>] (“Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.”).

In the United States, the health care pricing problem is largely a provider market power problem.¹⁸ Within the same geographic area, there can be a 60% difference between the highest- and lowest-priced hospitals for the same inpatient service, and a twofold difference in prices for outpatient services.¹⁹ A substantial body of research demonstrates that market power drives these unwarranted variations in price between providers, not differences in quality, payer mix, demographics, or health of the patient population.²⁰ In other words, when we pay more at a high-price provider, we rarely receive more or better care; we simply pay more for its market leverage.²¹

Unfortunately, the vertical integration used to target overutilization may also increase provider market leverage.²² The primary vehicle for achieving vertical integration in the ACA is the Accountable Care Organization (ACO), a group of affiliated doctors, hospitals, and other health care providers that cooperate to provide high-quality, coordinated care to a specific patient population.²³ To form an ACO, provider organizations can integrate clinically, structurally, and/or financially. However, obtaining the desired clinical and financial integration can also open the door for health care provider organizations to vertically integrate in ways that further consolidate health care markets, increase provider market leverage, and raise prices.

18. See, e.g., PAUL B. GINSBURG, CTR. FOR STUDYING HEALTH SYS. CHANGE, RESEARCH BRIEF NO. 16, WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER 6 (2010), <http://www.hschange.org/CONTENT/1162/1162.pdf> [<https://perma.cc/U2XN-HGAH>]; CHAPIN WHITE, AMELIA M. BOND & JAMES D. RESCHOVSKY, CTR. FOR STUDYING HEALTH SYS. CHANGE, RESEARCH BRIEF NO. 27, HIGH AND VARYING PRICES FOR PRIVATELY INSURED PATIENTS UNDERSCORE HOSPITAL MARKET POWER 2 (2013), <http://www.hschange.com/CONTENT/1375/1375.pdf> [<https://perma.cc/987U-AVYX>]; Robert A. Berenson, Paul G. Ginsburg, Jon B. Christianson & Tracy Yee, *The Growing Power of Some Providers To Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012); Robert Berenson, *Acknowledging the Elephant: Moving Market Power and Prices to the Center of Health Policy*, HEALTH AFF. BLOG (June 3, 2014), <http://healthaffairs.org/blog/2014/06/03/acknowledging-the-elephant-moving-market-power-and-prices-to-the-center-of-health-policy/> [<https://perma.cc/CC5X-4M9R>].

19. WHITE ET AL., *supra* note 18, at 2–4.

20. OFFICE OF ATT’Y GEN. MARTHA COAKLEY, *supra* note 17, at 2–4; Joseph P. Newhouse & Alan M. Garber, *Geographic Variation in Health Care Spending in the United States: Insights from an Institute of Medicine Report*, 310 JAMA 1227, 1227–28 (2013) (“[P]rice variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons. Variation in wage levels and variation in the quantity of services delivered are almost equally responsible for the remaining estimated 30% of spending variation.”); Cooper et al., *supra* note 12, at 3 (concluding that hospital market structure, that is, the degree of competition in the market, is strongly associated with hospital prices); GINSBURG, *supra* note 18, at 7.

21. OFFICE OF ATT’Y GEN. MARTHA COAKLEY, *supra* note 17, at 3–4; see GINSBURG, *supra* note 18, at 6.

22. Katherine Baicker & Helen Levy, *Coordination Versus Competition in Health Care Reform*, 369 NEW ENG. J. MED. 789, 789–91 (2013).

23. *Accountable Care Organizations (ACO)*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 6, 2015, 2:58 PM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/> [<https://perma.cc/2JH4-FX2D>].

Despite all the hoped-for benefits from health care integration, there is no empirical evidence showing that the wave of integration is generating efficiencies or widespread savings. On the contrary, all the emerging literature on vertical integration between hospitals and physicians points in the same troubling direction: vertical integration is associated with increased prices and reduced consumer welfare.²⁴

This article examines the overlooked half of the narrative on health care cost control: rising prices and the policy levers held by the states to address them. Specifically, we challenge the conventional wisdom that policies directed at health care integration and utilization controls alone can meaningfully reduce health spending, and we consider the potentially harmful effects from increasing vertical integration between hospitals and provider organizations.²⁵ We argue that unregulated vertical integration is a double-edged sword that poses significant risks to consumer welfare from increased health care prices. Due to already highly concentrated health care markets and the limits of federal antitrust enforcement of vertical health care integration, states have both an opportunity and an obligation to supplement federal antitrust efforts to control rising health care prices stemming from health care integration.

The way to address the double-edged sword of vertical health care integration is to allow beneficial integration with a *quid pro quo* that the integrating entities must submit to oversight regarding price, quality, and competition. We offer six policy initiatives available to states in order of least to greatest amount of intervention into the state's health care market: all-payer claims databases (APCDs); state antitrust enforcement or immunity; ACO certification programs; rate oversight authority; provider price caps; and rate regulation.²⁶

Given the range of initiatives, legislators should vary their policy prescription based upon the particular market and political dynamics in the state. Three key ingredients, however, emerge as critical for effective state oversight of vertical integration and private price increases: (1) Information—states must have a means to collect and analyze price, quality, utilization, and market data, such as an all-payer claims database, in order to match their policy approach to their market and to evaluate their success; (2) Independence—state oversight bodies must be insulated from

24. A discussion of this literature is set forth *infra* Part II.

25. In this article, we focus specifically on vertical integration because antitrust authorities have generally treated its use as procompetitive. As a result of this treatment, antitrust analysis and guidance for vertical integration efforts are much less robust than for horizontal consolidation among direct substitutes or competitors, such as mergers among hospitals.

26. States may also increase health care competition by implementing policies to eliminate certificate-of-need laws that pose barriers to entry for new health facilities, loosening of scope-of-practice laws to allow different types of mid-level providers to compete with or augment the supply of physician services, or regulating provider-plan contracting practices to restrict anticompetitive use of most-favored-nation or anti-tiering clauses. We do not discuss these policies here because they mostly address threats to horizontal competition rather than describing ways states can oversee vertically integrated entities. For a good discussion of these options, see NAT'L ACAD. SOC. INS., ADDRESSING PRICING POWER IN HEALTH CARE MARKETS: PRINCIPLES AND POLICY OPTIONS TO STRENGTHEN AND SHAPE MARKETS 29–37 (2015) [hereinafter NASI PANEL ON PRICING POWER], https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf [<https://perma.cc/7ASE-W8YG>].

the powerful providers they oversee; and (3) Regulatory Authority—state oversight bodies must have the authority to enforce or impose limits on providers’ prices when they become too high.

This Article explores the states’ critical role in addressing the double-edged sword of health care integration. Part I documents the rise of vertical health care integration driven by its theoretical benefits, as well as the legal incentives to integrate. Part II describes the emerging evidence that vertical integration in health care may also pose a threat to competition and lead to increased prices. Part III explains that states have a key role to play in managing this threat because of the limits of federal antitrust enforcement, federal oversight, and market-based solutions. Part IV posits that the way to manage the double-edged sword of vertical health care integration is to permit beneficial integration to proceed in exchange for price and quality oversight by states. Part IV goes on to examine an array of policy tools that all build upon robust all-payer claims data gathering to inform future health policy decisions.

I. THE RISE OF HEALTH CARE INTEGRATION

Health care in the United States is notoriously fragmented and inefficient.²⁷ A popular policy view posits that increased vertical integration and collaboration in health care can reduce waste, increase efficiency, and improve quality by altering the financial incentives to overuse care and permitting physicians and other providers to more easily coordinate care.²⁸ Accordingly, recent health care reforms have created powerful incentives for providers and even health plans to form vertically integrated systems, whether to operate an ACO or better manage the shift away from fee-for-service to new payment models based on value.²⁹ But little is known about what conditions are required for health care integration to achieve these efficiencies or whether the benefits of integration outweigh the risks to competition and concentration of market power. Part I explores the theoretical promise of vertical health care integration and the incentives for integration contained in various legal reforms, including the ACA.

A. Theoretical Benefits of Vertical Integration

Unlike horizontal consolidation,³⁰ vertical integration is theoretically ambiguous—it may achieve increased efficiencies, but it may also serve to enhance market

27. See, e.g., THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge ed., 2010).

28. See Cutler, *supra* note 6, at 1133–34.

29. Similar incentives exist for horizontal consolidations between hospitals or between health insurers. Indeed, the pace of horizontal mergers in health care has also increased following the passage of the ACA. See Leemore Dafny, *Hospital Industry Consolidation—Still More To Come?*, 370 NEW ENG. J. MED. 198, 198 (2014).

30. The literature on the anticompetitive potential of horizontal consolidation among hospitals is clearer than for vertical integration. See, e.g., MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 [https://

power.³¹ In microeconomics, vertical integration refers to the common ownership of two different stages of production of a product, such as manufacturing and distribution.³² In health care, vertical integration refers to the integration of suppliers of different components of health care services, such as hospitals and physicians, as well as integration of health systems and health plans, which collectively supply different elements of the health care product to the ultimate consumer.³³

According to neoclassical economic models, vertical integration enhances efficiency by reducing transaction costs and arm's-length contracting across separate organizations.³⁴ In health care, vertical integration has similarly been thought to improve efficiency through improved care coordination and reduction of fragmentation among providers and payers.³⁵ Common ownership of hospitals and physician inputs in the health care "supply chain" can align financial incentives between hospitals and referring physicians, reduce duplicative or unnecessary care, provide centralized administrative services, and reduce transaction costs by allowing joint contracting with third-party payers.³⁶ Vertical mergers of hospitals and physicians or health plans into integrated delivery systems may reduce the costs of complex negotiations between providers and payers. Between hospitals and physicians, arm's-length contracts are costly to establish, whether due to health care fraud and abuse laws that limit hospital-physician contracts or payment systems that separate hospital and physician payments.³⁷ As a result, vertical integration in health care has the potential to create significant efficiencies.

perma.cc/JK6R-397T]. Our analysis, therefore, focuses on the "harder case" of vertical health care integration. See Thomas L. Greaney, *Competition Policy After Health Care Reform: Mending Holes in Antitrust Law's Protective Net*, 40 J. HEALTH POL. POL'Y & L. 897, 897–98 (2015).

31. Martin Gaynor & Robert J. Town, *Competition in Health Care Markets*, in 2 HANDBOOK OF HEALTH ECONOMICS 499, 620 (Mark V. Pauly, Thomas G. McGuire & Pedro Pita Barros eds., 2012).

32. See Austin B. Frakt, Steven D. Pizer & Roger Feldman, *Plan-Provider Integration, Premiums, and Quality in the Medicare Advantage Market*, 48 HEALTH SERVS. RES. 1996, 1999 (2013).

33. Christopher Afendulis & Daniel Kessler, *Vertical Integration and Optimal Reimbursement Policy* 5 (Nat'l Bureau of Econ. Research, Working Paper No. 17316, 2011).

34. Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 33 HEALTH AFFAIRS 756, 756–57 (2014); Gaynor & Town, *supra* note 31, at 619–20.

35. See, e.g., Baker et al., *supra* note 34, at 756–57; Lawton Robert Burns, Jeff C. Goldsmith & Aditi Sen, *Horizontal and Vertical Integration of Physicians: A Tale of Two Tails*, 15 ADVANCES HEALTH CARE MGMT. 39, 66–70 (2013); Stephen L. Walston, John R. Kimberly & Lawton R. Burns, *Owned Vertical Integration and Health Care: Promise and Performance*, 21 HEALTH CARE MGMT. REV. 83, 84–85 (1996).

36. Afendulis & Kessler, *supra* note 33, at 5.

37. Baker et al., *supra* note 34, at 757; William M. Sage, *Getting the Product Right: How Competition Policy Can Improve Health Care Markets*, 33 HEALTH AFF. 1076, 1078 (2014).

B. Policy Incentives for Vertical Integration

Based on these economic assumptions and the utilization-centered narrative of health care cost containment,³⁸ the ACA offers numerous incentives to promote vertical integration in health care. The primary example is the Medicare Shared Savings Program, which encourages providers to form ACOs for Medicare beneficiaries, with the intent that private payers would adopt the model as well.³⁹ ACOs are groups of providers organized into a formal legal entity that agrees to be collectively accountable for the cost and quality of the health care for a defined population of individuals.⁴⁰ The ACO structure rewards groups of providers for improving quality and care coordination while reducing unnecessary utilization by paying them a share of the amount they save for the payer.⁴¹ To the extent that an ACO assumes insurance risk, the providers within the ACO have an incentive to reduce the overall volume of services and reduce waste.⁴² Shared savings payments for ACOs further encourage hospitals and physicians to integrate to increase efficiency and reduce costs. Vertically integrated entities can more easily share data, eliminate redundancy, invest in interoperable health information technology, and implement clinical protocols that cross care settings. Further, vertical integration can make it easier to reduce “internal agency problems and take advantage of economies of scope.”⁴³

Other Medicare programs, such as bundled payments or value-based purchasing, also create incentives for fragmented providers to work together, coordinate care,

38. *See supra* text accompanying notes 4–7. Federal cost control policy also tends to focus on Medicare, and because the government sets the prices in Medicare, the opportunities to control Medicare spending focus on ways to reduce overutilization. However, these assumptions do not apply to private health care spending. *See* Cooper et al., *supra* note 12, at 1–3 (“[V]ariation in providers’ transaction prices across HRRs [Hospital Referral Regions] is the primary driver of spending variation for the privately insured, whereas variation in the quantity of care provided across HRRs is the primary driver of Medicare spending variation.”); Newhouse & Garber, *supra* note 20, at 1227–28 (“Whereas price variation explains almost none of the overall variation in Medicare expenditures (after adjusting for wage variation), price variation is responsible for an estimated 70% of the total geographic variation in spending among privately insured persons.”).

39. *See* 42 U.S.C. § 1395jjj (2012); 42 C.F.R. § 425 (2015); *see also* Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 16–17 (2014).

40. Gary E. Bacher, Michael E. Chernew, Daniel P. Kessler & Stephen M. Weiner, *Regulatory Neutrality Is Essential to Establishing a Level Playing Field for Accountable Care Organizations*, 32 HEALTH AFF. 1426, 1426 (2013).

41. *See* Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis & Jonathan S. Skinner, *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. W219, w222 (2009), <http://content.healthaffairs.org/content/28/2/w219.full.pdf> [<https://perma.cc/N882-U8NK>].

42. JEFF GOLDSMITH, LAWTON R. BURNS, ADITI SEN & TREVOR GOLDSMITH, NAT’L ACAD. SOC. INS., *INTEGRATED DELIVERY NETWORKS: IN SEARCH OF BENEFITS AND MARKET EFFECTS* 1–2 (2015).

43. Alison Evans Cuellar & Paul J. Gertler, *Strategic Integration of Hospitals and Physicians*, 25 J. HEALTH ECON. 1, 4 (2006).

and collectively internalize the costs of disparate aspects of an entire care episode. The payment bundling program pays providers a single lump-sum payment to cover all inpatient, physician, outpatient, and post-acute services involved in the episode of care.⁴⁴ The ACA also implements significant payment cuts to hospitals according to measures of quality and value. These payment changes include Medicare rate cuts for excessive readmissions⁴⁵ and hospital-acquired conditions,⁴⁶ and calculating Medicare bonuses or penalties based on measures of value.⁴⁷ The upshot of all these Medicare payment reforms for providers is that they are assuming more financial risk and experiencing major changes to their business and revenue models, built on the old fee-for-service and diagnosis-based reimbursement methods.

Providers may look to consolidation to maximize their ability to assume financial risk. Bigger systems have more enrollees, and ACOs need to be sufficiently large to be able to absorb financial risk and make the financial investments needed to achieve economies of scope necessary to generate cost savings on which ACO payments depend.⁴⁸ Furthermore, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have largely focused their antitrust policy guidance and review on horizontal provider consolidation, further encouraging providers to integrate vertically.⁴⁹

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which, among other things, repealed the formula that ties Medicare physician payments to a “sustainable growth rate” (SGR).⁵⁰ MACRA adds to the momentum of provider consolidation by shifting more physicians to value-based and

44. 42 U.S.C. § 1395cc-4 (2012); *see also* CHAPIN WHITE, JAMES D. RESCHOVSKY & AMELIA M. BOND, NAT’L INST. FOR HEALTH CARE REFORM, RESEARCH BRIEF NO. 14, INPATIENT HOSPITAL PRICES DRIVE SPENDING VARIATION FOR EPISODES OF CARE FOR PRIVATELY INSURED PATIENTS 2 (2014).

45. 42 U.S.C. § 300gg-17(a)(1)(B) (2012); *see, e.g.*, Jordan Rau, *Half of Nation’s Hospitals Fail Again To Escape Medicare’s Readmission Penalties*, KAISER HEALTH NEWS (Aug. 3, 2015), <http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicare-readmission-penalties/> [<https://perma.cc/4SMD-AST6>].

46. 42 U.S.C.A. § 1395ww(p) (West 2015).

47. 42 U.S.C.A. § 1395ww(o).

48. Stephen M. Shortell, Carrie H. Colla, Valerie A. Lewis, Elliot Fisher, Eric Kessel & Patricia Ramsay, *Accountable Care Organizations: The National Landscape*, 40 J. HEALTH POL. POL’Y & L. 645, 659–60 (2015) (estimating that ACOs need approximately 25,000–50,000 enrollees to make investments needed for success).

49. *See* Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011); U.S. DEP’T OF JUSTICE & FED. COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996); FED. TRADE COMM’N & U.S. DEP’T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 3 (2000); U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (2010); *see also* Deborah L. Feinstein, Director, Bureau of Competition, Fed. Trade Comm’n, Address at Fifth National Accountable Care Organization Summit—Washington DC: Antitrust Enforcement in Health Care: Proscription, Not Prescription (June 19, 2014).

50. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. No. 114-10, § 101(a)(1), 129 Stat. 87, 89 (2015).

alternative payment models. Also known as the “doc fix,” MACRA replaced the widely unpopular SGR-based formula with a plan to implement Medicare physician fee bonuses based on participation in alternative payment models, such as ACOs.⁵¹ For physicians who do not participate in alternative payment models, MACRA adjusts their fee-for-service rates according to a merit-based incentive program that takes into account the physician’s quality measures, resource use, and adoption of electronic health records.⁵²

On top of the incentives already in the ACA, MACRA pushes more physicians to join ACOs. Even for physicians who stick with fee-for-service, the incentive-based adjustments to their fees nudge physicians toward integration with larger systems due to the administrative burden and expense of implementing quality reporting, electronic health records, and resource use analysis. Together, the payment reforms of the ACA and MACRA are driving an upsurge of vertical health care integration.

The ACA’s incentives extend beyond payment changes. The regulatory environment also favors clinical and financial integration among hospitals, physicians, and other types of providers (such as post-acute providers) by providing valuable waivers for onerous regulatory regimes like the Stark Law, Anti-Kickback Statute, and limited antitrust scrutiny to providers who implement a Medicare ACO or bundled payment pilot program.⁵³ Provider liability under the Stark Law, compounded with the False Claims Act’s treble damages, create an environment of extreme financial risk for hospitals, physicians, and other providers who seek to more closely align financial incentives and clinical processes. The greatest regulatory flexibility comes with forming a Medicare-approved ACO because then the ACO participants, and the payments made between them, are largely exempted from having to comply with the Stark Law and the Anti-Kickback Statute.⁵⁴

In addition, the antitrust review process for ACOs only applies to independent entities collaborating to form an ACO, which may also create an incentive for vertically situated health care entities to merge into a unified delivery system prior to applying to participate in the Medicare Shared Savings Program, to ease the approval process. While the prior merger would be subject to FTC oversight and review, the

51. *Id.* § 101(a)(2).

52. *Id.* § 101(b); Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Under the Physician Fee Schedule, 81 Fed. Reg. 77,008 (Nov. 4, 2016) (to be codified at 42 C.F.R. pt. 414) (setting forth CMS’s final rule for physician payment under MACRA); *see, e.g., Frequently Asked Questions on MACRA and Medicare Payment Reform*, AM. ACAD. FAM. PHYSICIANS, <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html> [<https://perma.cc/8K5Y-ZB9M>].

53. *See* 42 U.S.C. § 1899jjj(f) (2012) (granting Secretary of Health and Human Services the authority to waive requirements of the Stark Law, Anti-Kickback Statute, and Civil Monetary Penalties Statute as needed to carry out the Medicare Shared Savings Program); Medicare Program; Final Waivers in Connection with the Shared Savings Program, 76 Fed. Reg. 67992, 67999–68001 (Nov. 2, 2011); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011); I.R.S. Notice 2011-20, 2011-16 I.R.B. 652.

54. Medicare Program; Final Waivers in Connection with the Shared Savings Program, *supra* note 53, at 67999–68001.

FTC has challenged very few vertical mergers, and none among health care entities.⁵⁵ Thus, if a hospital or physician group is contemplating forming a relationship to coordinate care, share referrals, and assume responsibility for the health and spending of a population of patients, there are strong regulatory incentives to merge or form a fully integrated ACO rather than adopting looser, contractual forms of alignment. These regulatory incentives are further enhanced by increases in market power and leverage that could arise from a merger or integration.

Many of the desired benefits of clinical and financial integration, however, do not require health care entities to merge or formally integrate. Vertical integration can occur on several levels. The loosest form of vertical integration, the *open contract* form, would be a nonexclusive contractual relationship between a hospital and a group of physicians, such as the hospital's medical staff or an independent practice association (IPA), in which the hospital provides some administrative support for health plan contracting and may engage in nominal care-coordination activities.⁵⁶ An intermediate form of vertical integration, the *closed contract* form, would involve an exclusive contractual relationship between the hospital and a select group of physicians, in which the hospital provides higher levels of administrative and management services (e.g., electronic health records, billing, utilization and quality review, etc.), private health plan contracting, and care coordination.⁵⁷ The tightest form of vertical integration is when the hospital owns the physician practices or directly employs the physicians.⁵⁸ ACOs themselves can be organized along a spectrum from loose to tight integration between hospitals and physician-participants. While entities in these looser models can still engage in significant clinical and financial integration (such as shared electronic medical records systems, payment incentives, and quality-of-care reporting mechanisms), tighter forms of integration may be encouraged by financial and regulatory incentives.

Because of the promise of accountable care and the payment incentives through reform efforts, the pace of all types of vertical health care integration has increased. From 2004 to 2011, hospital ownership of physician practices, the tightest form of hospital-physician integration, increased from 24% to 49%.⁵⁹ The Government Accountability Office reports that the number of vertically integrated physicians nearly doubled from 95,000 to 182,000 between 2007 and 2013.⁶⁰ Although not all ACOs necessarily involve vertical integration of hospitals and physicians, most do.⁶¹

55. See Feinstein, *supra* note 49, at 8; see, e.g., *St. Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015), *aff'g* Nos. 1:12-CV-00560-BLW, 1:13-CV-00116-BLW, 2014 WL 272339 (D. Idaho Jan. 24, 2014).

56. Baker et al., *supra* note 34, at 759.

57. *Id.*

58. *Id.*

59. *Id.*; David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964, 1966 (2013).

60. U.S. GOV'T ACCOUNTABILITY OFFICE, *MEDICARE: INCREASING HOSPITAL-PHYSICIAN CONSOLIDATION HIGHLIGHTS NEED FOR PAYMENT REFORM 9* (2015).

61. Stephen M. Shortell, Frances M. Wu, Valerie A. Lewis, Carrie H. Colla & Elliott S. Fisher, *A Taxonomy of Accountable Care Organizations for Policy and Practice*, 49 HEALTH SERVS. RES. 1883, 1889 (2014).

Following the passage of the ACA, the growth of ACOs has been rapid, with more than 700 ACOs established nationwide by 2015, about evenly split between Medicare and commercial ACOs.⁶² ACOs cover approximately 23.5 million individuals, and only about a third of this total (7.8 million) are Medicare enrollees.⁶³ It is projected that a majority of Americans will receive their care from an ACO by 2018.⁶⁴

Some of the same trends driving health care provider integration are also contributing to an increase in plan-provider integrations. New payment models, like global payments, require provider organizations to assume more financial risk, which entails being responsible for the cost of care for an entire population of patients. Up to a point, the larger an organization is, the better it is able to assume population risk and invest in systems to meet quality targets. However, as it does, the provider network must assume more of the functions and capacity of health insurers. An ACO or a health system that is part of an ACO will be more likely to meet quality and cost-savings goals if it has the capacity to manage clinical, quality, and cost data and to take on financial risk, and one of the easiest ways for providers to acquire this capacity is to merge with a health plan.⁶⁵

From the payers' perspective, health insurers are increasingly regulated under the ACA even while insurance market dynamics are changing. Many plans are either shifting more of the insurance/financial risk to providers (through ACOs and alternative payment systems) or leaving insurance risk with self-insured employers. Health plans are marketing their capacities for financial risk management, data gathering and analysis, and care management to providers via management services contracts or consolidation into common entities.⁶⁶ The ACA's requirements, including medical-loss ratios,⁶⁷ limits on underwriting activities,⁶⁸ guaranteed issue,⁶⁹ and the Cadillac Tax on costly employer-sponsored health plans⁷⁰ are altering the business models of health plans and putting limits on the amount of profits the plans can earn from their premium revenue. As a result, health plans are looking for ways to increase their market share and shift their function to more of an administrative role, such as processing claims and gathering data on quality and cost. These trends are pushing more health plans to consider combinations with providers.

Consequently, vertical integration between providers and health plans is rising. In one report from 2012, approximately 20% of hospital networks offered an integrated

62. Shortell et al., *supra* note 48, at 646.

63. David Muhlestein, *Growth and Dispersion of Accountable Care Organizations in 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/> [<https://perma.cc/45TD-A42D>].

64. *Id.*

65. See Frakt et al., *supra* note 32, at 1997.

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

67. 42 U.S.C. § 1395w-27 (2010).

68. 42 U.S.C. § 300gg-3 (2011).

69. 26 U.S.C. § 35 (2012).

70. 26 U.S.C. § 4980I (2010).

insurance plan, with another 20% contemplating doing so.⁷¹ Within the Medicare Advantage market, in which Medicare beneficiaries receive Medicare services through private managed care plans, about 17% of Medicare Advantage plans were integrated with providers in 2013.⁷² A 2015 poll of fifty-eight chief executive officers of health care providers and plans found that 88% predicted more plan-provider collaboration in the next three to five years.⁷³ For instance, several hospital systems in California, other than Kaiser Permanente,⁷⁴ have begun offering insurance through Covered California (California's health care marketplace under the ACA).⁷⁵

Whether between hospitals and physicians or plans and providers, vertical integration in health care is on the rise. Providers are rapidly consolidating before we have a clear sense of what effect this integration will have on health care markets and prices. The early evidence is ominous.

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

Despite its many anticipated benefits, vertical health care integration presents a double-edged sword. The effort to promote beneficial integration has opened the door to health care consolidation across the country. Emerging empirical data reveals that vertical integration carries significant downside risks to competition and consumer welfare through increases in market power, increases in referrals and reimbursement rates, and reductions in consumer choice. Moreover, these studies have not found any evidence supporting the assumptions that vertical health care integration generates efficiencies or reduces costs.

A. Increased Market Power

Theoretical models suggest that vertical integration between hospitals and physicians can harm competition by conferring greater market power on the merged entity. First, if at least one of the parties (either the hospital or physician group) has market power pre-merger, then a merger of the two can increase the aggregate market power of the merged entity vis-à-vis health plans.⁷⁶ In 1999, Ester Gal-Or argued that the

71. Roni C. Rabin, *Some Hospital Networks Also Become Insurers*, WASH. POST (Aug. 25, 2012), http://www.washingtonpost.com/business/some-hospital-networks-also-become-insurers/2012/08/25/53e90a72-eb1d-11e1-b811-09036bcb182b_story.html.

72. See Frakt et al., *supra* note 32, at 1997.

73. Joseph Conn, *Closer Provider-Insurer Ties Bring New Challenges*, MODERN HEALTHCARE (Aug. 15, 2015), <http://www.modernhealthcare.com/article/20150815/MAGAZINE/308159969> [<https://perma.cc/74G7-AQSW>].

74. Kaiser Permanente is the dominant integrated delivery system in California, which has offered fully integrated care since the 1940s. *Fast Facts About Kaiser Permanente*, KAISER PERMANENTE, <http://share.kaiserpermanente.org/article/fast-facts-about-kaiser-permanente> [<https://perma.cc/3RTE-XMU3>].

75. Kathleen E. Foote & Emilio E. Varanini, *A Few Thoughts About ACO Antitrust Issues from a Local Enforcement Perspective*, 40 J. HEALTH POL. POL'Y & L. 887, 890 (2015).

76. Esther Gal-Or, *The Profitability of Vertical Mergers Between Hospitals and Physician Practices*, 18 J. HEALTH ECON. 623, 625 (1999); Martin Gaynor, *Is Vertical Integration*

profitability of vertical hospital-physician mergers depended on the relative competitiveness between the hospital and physician markets.⁷⁷ She reasoned that when the merging hospital and physician markets share similar levels of competitiveness, the merged entity can negotiate higher rates due to increased market power.⁷⁸ The market power increase is strongest when both merging entities are in highly concentrated markets. By contrast, when the relative level of competitiveness differs significantly between the two markets, vertical mergers between physicians and hospitals may be unprofitable unless the merger includes a vertical restraint requiring exclusivity between the parties.⁷⁹

One way vertical integration increases the market share of the merged entity is through tying hospital and physician services together. Hospitals that acquire physician groups can effectively lock up the referral pool of physicians and bundle hospital and physician services together when negotiating with payers.⁸⁰ This type of tying increases bargaining power of the merged provider-entity because in order for an insurer to include one provider in its network, it must also include other tied providers or services, often at elevated rates.⁸¹ In highly concentrated health-care and health-insurance markets with significant barriers to entry, tying and refusal to supply can lead to rival exclusion.⁸² In its most extreme form, a vertically integrated entity will require “all or nothing” dealing, in which an insurer must either include all affiliated providers in its network or none at all.⁸³ One way of achieving an “all or nothing” bargaining position is to enter into exclusive agreements between hospitals and physician groups, where the parties are unable to bargain with health plans outside of the tied entity.⁸⁴ “All or nothing” dealing can lead to supracompetitive reimbursement rates across a wide range of providers in a particular provider organization.

Another way vertical mergers can increase the merged entities’ market power is through foreclosure.⁸⁵ Foreclosure occurs when “actual and potential competitors are disadvantaged due to restricted access to one of the most favorable providers,”

Anticompetitive? Definitely Maybe (but That’s Not Final), 25 J. HEALTH ECON. 175, 180–81 (2006); Afendulis & Kessler, *supra* note 33, at 5.

77. Gal-Or, *supra* note 76, at 625.

78. *Id.* at 624. This was true even in the absence of exclusivity requirements.

79. *Id.* at 625.

80. Baker et al., *supra* note 34, at 757.

81. BARAK D. RICHMAN, AM. ENTER. INST., CONCENTRATION IN HEALTH CARE MARKETS: CHRONIC PROBLEMS AND BETTER SOLUTIONS 13 (Thomas P. Miller ed., 2012), http://www.aei.org/wp-content/uploads/2012/06/-concentration-in-health-care-markets-chronic-problems-and-better-solutions_171350288300.pdf [<https://perma.cc/NWJ4-XQBD>].

82. Robert F. Leibenluft, *Antitrust and Provider Collaborations: Where We’ve Been and What Should Be Done Now*, 40 J. HEALTH POL. POL’Y & L. 847, 850 (2015).

83. NASI PANEL ON PRICING POWER, *supra* note 26, at 17 (describing “all-or-none” bargaining by large, multihospital systems).

84. See Gal-Or, *supra* note 76, at 625.

85. Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation Under the Clayton Act*, 91 WASH. L. REV. 199 (2016).

making their costs higher for equivalent services and quality.⁸⁶ The merger of a hospital with a physician group can foreclose rival hospitals from accessing the services of the integrated physicians, thereby increasing market power.⁸⁷ In particular, competitors may lose patient volume needed to support their facilities because they cannot access the integrated physicians' referrals.⁸⁸

Empirical evidence supporting theoretical hypotheses that vertical health care mergers can be used to increase market power and prices has begun to emerge.⁸⁹ In an earlier study, Alison Evans Cuellar and Paul Gertler similarly found that tighter forms of hospital-physician integration in the 1990s showed significantly higher prices and volume than stand-alone, unintegrated providers, supporting the theory that such vertical integrations are done to increase market power.⁹⁰ But Federico Ciliberto and David Dranove found that vertical integration during the 1990s did not affect hospital prices.⁹¹ The opposite results in these two contemporaneous studies were seen as consistent with the theory that vertical integration can be both efficiency-enhancing and anticompetitive.⁹² There are differences between the market conditions of the 1990s and today; one significant difference is that the hospital

86. See Frakt et al., *supra* note 32, at 2000.

87. Gaynor, *supra* note 76, at 177.

88. Greaney & Ross, *supra* note 85, at 221. Although courts have not applied the foreclosure theory to a challenged merger, in the *St. Luke's* case involving the merger of St. Luke's health system and the Saltzer group of physicians, the private plaintiffs in the case, rival hospital St. Alphonsus and surgery center Treasure Valley Hospital, asserted an argument for competitive harms based on a foreclosure model. *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015), *aff'g* 2014 WL 272339 (D. Idaho Jan. 24, 2014). These private plaintiffs posited that St. Luke's would gain a monopoly share of the Nampa, Idaho, market for adult primary care "foreclosing virtually all competition for the hospital admissions of the physician practices it acquires." Complaint for Preliminary and Permanent Injunction and Damages at 2–3, *St. Luke's*, 778 F.3d 775 (No. 1:12 Civ. 00560), 2012 WL 5882652. The complaint went on to assert that the merger would harm the plaintiffs by causing the loss of admissions, referrals, and services performed by Saltzer physicians. *Id.* Ultimately, the Ninth Circuit struck down the merger based on horizontal grounds (the merger of physician groups) and thus did not examine the anticompetitive impact of the vertical integration due to foreclosure. *St. Luke's*, 778 F.3d at 791.

89. See Baker et al., *supra* note 34; Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 Health Aff. 699 (2010); Alison Evans Cuellar & Paul J. Gertler, *Strategic Integration of Hospitals and Physicians*, 25 J. HEALTH ECON. 1 (2006); Cory Capps, David Dranove & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* (Inst. for Policy Research, Northwestern Univ., Working Paper No. WP-15-02, 2015). But see Federico Ciliberto & David Dranove, *The Effect of Physician-Hospital Affiliations on Hospital Prices in California*, 25 J. HEALTH ECON. 29 (2006) (finding no increase in costs due to physician-hospital affiliations in California).

90. See Cuellar & Gertler, *supra* note 89, at 16–17, 26.

91. See Ciliberto & Dranove, *supra* note 89, at 37.

92. See Gaynor, *supra* note 76, at 177.

market is substantially more concentrated today, which may amplify the anti-competitive effects of vertical integration between hospitals and physicians.⁹³

Indeed, more recent studies are starting to show that current forms of vertical integration can lead to higher prices. Laurence Baker, M. Kate Bundorf, and David Kessler examined vertical integration between 2001 and 2007 and found that the tightest form of vertical integration—hospital ownership of physician practices—was associated with higher hospital prices, increased spending, and only modestly reduced utilization in the form of hospital admissions.⁹⁴ To evaluate integration's effects on physician prices, Cory Capps, David Dranove, and Christopher Ody looked at vertical mergers between 2007 and 2013 and found that physician prices increased nearly 14% following integration with hospitals.⁹⁵ The price increase was not due to an increase in physician market power through horizontal mergers between physicians. Rather, the price increase corresponded to the hospital's market share prior to integration—the larger the market share, the greater the price increase—which could be due to the hospital's ability to charge facility fees for services previously provided on an outpatient basis or patients' willingness to pay a premium for a plan with both a desired hospital and a preferred physician group.⁹⁶

James Robinson and Kelly Miller examined vertically integrated organizations in California between 2009 and 2012 and found that hospital ownership of physician organizations led to significantly higher total expenditures per patient compared to physician-owned organizations.⁹⁷ The expenditures were 10.3% higher for physician organizations owned by a local hospital, and 19.8% higher when the physician organization was owned by a multihospital system.⁹⁸ The larger the market share of the vertically integrated hospital owner, the greater the expenditures. Notably, the study showed little or no evidence that vertical consolidation of hospitals and physicians resulted in increased efficiency.⁹⁹

Another study by Hannah Neprash, Michael Chernew, Andrew Hicks, Teresa Gibson, and Michael McWilliams found that markets with greater increases in hospital-physician integration between 2008 and 2012 experienced significantly greater increases in outpatient spending and prices.¹⁰⁰ Because commercial price differences were greater than differences in Medicare prices, the authors concluded that the price increases associated with the hospital-physician integration resulted from enhanced market power of integrated providers, not just the site-of-service

93. See James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, 312 JAMA 1663 (2014).

94. Baker et al., *supra* note 34, at 760.

95. Capps et al., *supra* note 89, at 3.

96. *Id.* at 3, 5–7, 36 (suggesting that only 25% of the price increases result from facility fees).

97. Robinson & Miller, *supra* note 93, at 1668. In this study, expenditures were measured as the amounts insurers paid health care providers on a per-patient basis, excluding high-cost patients (incurring >\$100,000 in health care expenses annually). *Id.* at 1665.

98. *Id.* at 1668.

99. See *id.*

100. Hannah T. Neprash, Michael E. Chernew, Andrew L. Hicks, Teresa Gibson & Michael McWilliams, *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices*, 175 JAMA INTERNAL MED. 1932, 1937 (2015).

differential allowing higher prices for integrated physicians, discussed below.¹⁰¹ Like Robinson and Miller's, the study by Neprash et al. found that hospital-physician integration was not associated with reduced utilization or improved efficiency from care coordination.¹⁰²

Empirical data on the effect of vertical integration between health plans and providers is even more limited than hospital-physician integration. In 2013, Austin Frakt, Steven Pizer, and Roger Feldman examined the impact of plan-provider integration on health care premiums and quality in the Medicare Advantage market.¹⁰³ The study revealed that plan-provider integration was associated with higher monthly premiums and also higher quality ratings than nonintegrated plans.¹⁰⁴ However, only 30% of the premium increase associated with integration was attributable to improvements in quality.¹⁰⁵ Although some of the increased premiums could have been due to benefit enhancements, the authors did not observe a statistically significant increase in benefit generosity following integration for several benefits examined.¹⁰⁶ The authors hypothesized that the increase in premiums also could have resulted from an increase in market power conferred on the plan from the integrated provider organization.¹⁰⁷ While the Frakt et al. study has several limitations related to its generalizability and conclusions,¹⁰⁸ it raises significant concerns regarding the ability of plans and providers to use vertical integration as a means to increase market power and leverage, warranting significantly more attention from health services researchers and antitrust enforcers.

Overall, the emerging research on vertical integration has found that hospital ownership of physician organizations correlates with higher hospital prices, physician prices, prices for outpatient procedures, and per-patient expenditures. Furthermore, the only study on plan-provider integration also found an association between integration and higher premiums. These studies, and the dearth of any findings illustrating significant efficiencies or cost savings, lend support to the view that vertical integration in health care can be used to increase market power and prices.

B. Increases in Referrals and Reimbursement

Another anticompetitive effect of vertical integration is that acquisition of physician groups by hospitals may increase health spending from greater utilization and patient volume by allowing the hospital to pay for referrals within the bounds of health care self-referral laws.¹⁰⁹ The federal Anti-Kickback Statute and the Stark Law both provide greater flexibility for hospitals to compensate employed, as opposed to

101. *Id.* For discussion of the site-of-service differential, *see infra* Part II.B.

102. Neprash et al., *supra* note 100, at 1938.

103. *See* Frakt et al., *supra* note 32, at 1996.

104. *Id.* at 2008.

105. *Id.* at 2008–09.

106. *Id.* at 2009.

107. *Id.*

108. *Id.* at 2009–10.

109. Afendulis & Kessler, *supra* note 33, at 6–7; Capps et al., *supra* note 89, at 1.

contracted, physicians. For example, hospitals can pay employed physicians productivity bonuses for services personally performed by the physician, which would not be permitted for nonemployed physicians (i.e., independent contractors).¹¹⁰ Hospitals also can more readily require their employed physicians to refer patients to the hospital or to other integrated providers than they can require of independent physicians.¹¹¹ Moreover, when the integrated entities share fixed assets, it is easier for them to financially benefit from referrals within the integrated entity within the strictures of anti-referral and anti-kickback laws.¹¹² Hospitals, for example, are willing to acquire primary care physicians even if it is a money-losing proposition for the hospital because it allows the hospital to capture (and thus pay for) the primary-care physicians' referrals for hospital services.¹¹³ When explaining why hospital ownership of physician organizations led to higher total expenditures per patient, Robinson and Miller reasoned that higher expenditures could be driven by increased use of higher-priced services, but it could also be due to higher volume of services, or both.¹¹⁴

A merger between hospitals and physicians may also allow the merged entity to charge higher prices for certain outpatient services by exploiting the fact that hospital-based services are typically reimbursed at higher rates than identical services provided in physician-based locations.¹¹⁵ This pricing practice is called the *site-of-service differential* and is cited as one of the financial incentives driving hospital-physician integration.¹¹⁶ The site-of-service differential exists in Medicare

110. The Stark Law exception for bona fide employment relationships provides that entities (including hospitals) may pay employed physicians productivity bonuses for services personally performed by the physician. The exceptions for independently contracted physicians, including the exceptions for fair market value and personal services arrangements exceptions, do not permit productivity bonuses. 42 C.F.R. § 411.357(c) (2008) (bona fide employment relationships); 42 C.F.R. § 411.257(d) (personal services arrangements); 42 C.F.R. § 411.357(l) (fair market value compensation). The Anti-Kickback Statute safe harbor for employees permits "any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs." 42 C.F.R. § 1001.952(i).

111. See 42 C.F.R. § 411.354(d)(4) (2008) (setting forth the requirements for conditioning a physician's compensation on referring to certain providers). Although hospitals may also require independent physicians to refer to the hospital in a personal services contract, the scope of the required referrals is limited to those services covered by the employment or personal services contract. 69 Fed. Reg. 16054, 16069–70 (Mar. 26, 2004). Because of the limited nature of personal services agreements (e.g., call-coverage agreements, medical director agreements), the scope of services subject to required referrals is thus much broader for employed physicians than under most personal services agreements.

112. See Afendulis & Kessler, *supra* note 33, at 17.

113. ANN S. O'MALLEY, AMELIA M. BOND & ROBERT A. BERENSON., CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 136, RISING HOSPITAL EMPLOYMENT OF PHYSICIANS: BETTER QUALITY, HIGHER COSTS? 2 (2011).

114. Robinson & Miller, *supra* note 93, at 1664, 1668.

115. O'MALLEY ET AL., *supra* note 113, at 3; Capps et al., *supra* note 89, at 6.

116. See Neprash et al., *supra* note 100, at 1933–34.

reimbursement policy and is replicated in the commercial market.¹¹⁷ In Capps, Dranove, and Ody's research finding that vertical integration between hospitals and physicians increased physician prices, they estimate that about a quarter of the 14% price increase resulted from exploitation of reimbursement methodologies that allow hospitals to charge facility fees for employed physicians.¹¹⁸ In the study by Neprash et al., the site-of-service differential explained part of the increase in prices for outpatient services experienced by those areas experiencing the highest increase in hospital-physician integration.¹¹⁹

C. Agency Problems and Consumer Choice

Hospital ownership of physician practices may exacerbate agency problems between physicians and patients. Agency problems arise between patients (the principals) and physicians (their agents) when physicians' medical decisions on behalf of their patients are influenced by the physicians' financial incentives and practice norms that may be at odds with the patients' interests in obtaining the highest quality care at the lowest price.¹²⁰ In the context of hospital services, the physician both orders and performs the hospital service, thus driving demand not only for the type of service but also for the particular facility at which the service will be performed.¹²¹

Theoretically, it is unclear what effect vertical integration of hospitals and physicians may have on agency problems between physicians and patients. On the one hand, common ownership could align the financial incentives between hospitals and physicians, and thus improve care coordination and patient welfare.¹²² However, hospital ownership of physicians could also create financial and other incentives for the physician to refer to the owner-hospital or to increase the volume or intensity of

117. See MEDICARE PAYMENT ADVISORY COMM'N., REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM. 27 (2013), http://www.medpac.gov/docs/default-source/reports/jun13_entirereport.pdf?sfvrsn=0 [<https://perma.cc/WV78-5KDD>] (describing the site-of-service differential in Medicare payment policy); JAMES D. RESCHOVSKY & CHAPIN WHITE, NAT'L INST. HEALTH CARE REFORM, RES. BRIEF NO. 16, LOCATION, LOCATION, LOCATION: HOSPITAL OUTPATIENT PRICES MUCH HIGHER THAN COMMUNITY SETTINGS FOR IDENTICAL SERVICES 1 (2014), http://nihcr.org/wp-content/uploads/2016/07/Research_Brief_No_16.pdf [<https://perma.cc/HE33-KAYK>] (describing the site-of-service differential for private payers).

118. See Capps et al., *supra* note 89, at 4.

119. Neprash et al., *supra* note 100, at 1937 (concluding that the increase in outpatient prices was driven by both an increase in the integrated entity's bargaining power and the higher prices driven by the site-of-service differential).

120. Thomas L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective*, 53 ST. LOUIS U. L.J. 1189, 1199–2000 (2009); Paul A. Pautler & Michael G. Vita, *Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?*, 10 J. CONTEMP. HEALTH L. & POL'Y 117, 120 (1994).

121. See Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849, 864–65 (2000).

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

services ordered, rather than to choose the most cost-effective option for the patient.¹²³

In a study that examined the impact of hospital-physician integration on the patient's choice of hospital, Laurence Baker, M. Kate Bundorf, and Daniel Kessler found empirical evidence that hospital ownership of physicians worsens the agency problem between physicians and patients.¹²⁴ They found that "a hospital's ownership of an admitting physician dramatically increases the probability that the physician's patients will choose the owning hospital. . . . [P]atients are more likely to choose a high-cost, low-quality hospital when their admitting physician's practice is owned by that hospital."¹²⁵ Although they were unable to determine whether, on net, the harms of vertical integration to patient welfare outweigh the potential benefits, the authors concluded that "hospital/physician integration affects patients' hospital choices in a way that is inconsistent with their best interests."¹²⁶

Even when providers have the right motives for integrating, when large conglomerates gain market power, they tend to use it to command higher prices. Taken together, the empirical picture of vertical integration in health care suggests some emerging themes: first, tighter forms of integration (e.g., acquisition versus contractual affiliation) are associated with greater increases in prices; second, the greater the market share of the hospital entity prior to consolidation, the more likely the merger will have anticompetitive effects; and third, the harms to consumer welfare go beyond higher prices and include incentives to refer patients to lower-value facilities or higher-cost settings. In addition, there is a noted absence of empirical data illustrating that vertically integrated health care systems improve quality¹²⁷ or reliably generate cost savings through reduced utilization or improved efficiency.¹²⁸ Although there may be limits on the generalizability of any one of the studies, it is notable that all the data point in the same direction: that vertical health care integration is associated with increased prices and higher per patient health care spending.

123. O'MALLEY ET AL., *supra* note 113, at 3.

124. Baker et al., *supra* note 122, at 18.

125. *Id.* at 17.

126. *Id.* at 18–19.

127. J. Michael McWilliams, Michael E. Chernew, Alan M. Zaslavsky, Pasha Hamed & Bruce E. Landon, *Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries*, 173 JAMA 1447, 1451–52 (2013) ("[S]pending was higher and quality of care not better for [Medicare] beneficiaries assigned to larger hospital-based groups than for those assigned to smaller physician groups, consistent with other studies of physician-hospital consolidation. Although integration between physicians and hospitals theoretically could support continuity during care transitions, readmission rates were highest for hospital-based groups.")

128. Neprash et al., *supra* note 100, at 1937 (finding that "[c]onsistent with prior research, physician-hospital integration was not associated with lower utilization, suggesting that this form of provider consolidation has not led to gains in health care efficiency in recent years through improved care coordination or management").

III. THE CENTRAL ROLE OF STATES

Due to significant inefficiencies in the health care markets and the limits of federal antitrust enforcement, states have an important role to play to complement and support federal efforts to address the competitive threats of health care integration. When market power abuses lead to higher prices and reductions in quality and consumer choice, the primary remedy has been federal antitrust enforcement. But while federal antitrust enforcement has a key role to play, it cannot be the only weapon in the arsenal. First, given the rapid rate of collaboration and consolidation in health care, the Federal Trade Commission and the Department of Justice (the Antitrust Agencies) simply do not have the resources or capacity to police all of the consolidation efforts under way throughout the country.¹²⁹ Second, federal antitrust enforcement offers a powerful means of preventing anticompetitive mergers and collaborations but has proven less successful at balancing the pro- and anticompetitive effects of a proposed merger or correcting anticompetitive conduct following consolidation.¹³⁰ At a time when state and federal governments are incentivizing vertical integration, and in which the majority of health care markets in the United States are already highly concentrated,¹³¹ policy makers need more nuanced tools that they can deploy throughout the country.

States are in a unique position to assist in this effort. First, state governments oversee most of the regulation of insurance and health care within the state, which will enable them to design new policies that complement existing regulatory structures. For instance, states could require payers to report all of their claims to a state all-payer claims database (APCD)¹³² to promote a better understanding of the drivers of health care prices and provide federal antitrust agencies with valuable information on markets throughout the state. Second, state actors may have existing relationships with market stakeholders and a better understanding of market dynamics in local health care markets, which can improve policy selection. Third, state attorneys general have broader mandates than federal antitrust enforcement agencies, which enable them to analyze the actions of health care providers and insurer organizations through a consumer-protection or community-benefits lens, broadening both the range of harms that are evaluated and potential enforcement tools. Fourth, allowing states to monitor the impact of vertical integration in a wide variety of market settings

129. See Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088, 1090 (2014); Greaney, *supra* note 39, at 27; Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 871 (2011).

130. See Feinstein, *supra* note 49, at 15 (“Conduct remedies do not restore the competitive status quo and raise several concerns.”); see also Greaney, *supra* note 39, at 12 (“A common misapprehension among legislators and policymakers is that antitrust law provides a reliable counterforce to monopoly.”).

131. See Cutler & Scott Morton, *supra* note 59, at 1966.

132. Note, however, that in *Gobeille v. Liberty Mutual Ins. Co.*, the Supreme Court held that ERISA preempts state requirements for self-insured employer health plans to report to APCDs. 136 S. Ct. 936 (2016). For further discussion, see *infra* notes 152–59 and accompanying text.

and try different regulatory approaches will speed understanding of whether and under what circumstances the benefits of engaging in vertical integration outweigh the risks. Finally, states can learn and exchange best practices for developing APCDs and other regulatory models, easing the transition for states with less experience.¹³³ Enhancing state and federal collaboration will expand both the information and policy tools available to regulators aiming to control health care costs, as well as allow available resources to be targeted to the most appropriate entities and markets.

Increasing state involvement does create some risks. Most importantly, the existence of relationships between market stakeholders and government officials also risks agency capture and undue political influence over legislation and regulation.¹³⁴ Many states have had well-intentioned policy initiatives, such as certificate-of-need laws and licensure programs, co-opted by political and financial interests.¹³⁵ In states with powerful health provider or insurance entities, maintaining the independence of the APCD and oversight entities will be essential. For example, the Massachusetts legislature created the Massachusetts Health Policy Commission (HPC) as an independent state agency that resides in, but is not under the control of, the Executive Office of Administration and Finance. HPC is “not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth.”¹³⁶ Instead, an eleven-member Board of Commissioners with guidance from a broadly representative advisory council govern the agency.¹³⁷ HPC is funded solely by assessments taken from industry participants rather than from state general revenue.¹³⁸ Given the wealth and political power of many insurance companies and health care systems, state legislatures should carefully insulate any oversight entities in terms of both governance and funding.

Further, state regulation without the requisite expertise and resources to engage in continued oversight and enforcement risks exacerbating existing problems. Recently, several states have offered immunity from state and federal antitrust laws to

133. For instance, much of the legal, technical, and organizational infrastructure necessary to implement an APCD could be transferrable across states.

134. *Regulatory or agency capture* refers to “the phenomenon whereby regulated entities wield their superior organizational capacities to secure favorable agency outcomes at the expense of the diffuse public.” Nicholas Bagley, *Agency Hygiene*, 89 TEX. L. REV. 1, 2 (2010). Others have defined *agency capture* as “the control of agency policy decision making by a sub-population of individuals or organizations outside the agency.” Susan Webb Yackee, *Reconsidering Agency Capture During Regulatory Policymaking*, in PREVENTING REGULATORY CAPTURE: SPECIAL INTEREST INFLUENCE AND HOW TO LIMIT IT 292, 296 (Daniel Carpenter & David Moss eds., 2013).

135. See, e.g., Frances H. Miller, *Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 GEO. L.J. 873 (1979–1980).

136. See MASS. GEN. LAWS ANN. ch. 6D, § 2(a) (West 2016). For a detailed discussion of Certificate of Need statutes and regulations in health care, see ROBERT J. CIMASI, THE U.S. HEALTHCARE CERTIFICATE OF NEED SOURCEBOOK (2005).

137. Ch. 6D, § 2-4

138. See *id.* § 2 (setting forth the structure of the Massachusetts Health Policy Commission).

vertically integrating health care entities, which drew criticism from federal officials who argued the practice potentially immunizes anticompetitive behavior and results in consumer harm if the states fail to appropriately oversee and regulate the entities.¹³⁹ As successful oversight and enforcement measures often require substantial financial, personnel, and knowledge-based resources, states must carefully assess which policy options are best suited to their particular circumstances. In addition, federal and state government officials should collaborate and coordinate their efforts as much as possible to promote efficient oversight and regulation of health care integration.

Vertical integration in health care continues to be encouraged by state and federal government entities as a means to control overutilization and promote quality. To maintain control over the amount of consolidation in the health care market and guide entities in how to structure their integrations in ways that promote competition, regulators need improved information on how integration may lead to abuses of market power, greater guidance on the appropriate balance between pro- and anticompetitive effects, and more nuanced oversight and regulatory tools. With the limits of federal antitrust tools to address vertical integration in health care, states are uniquely situated to manage the price and quality effects of the emerging forms of health care combinations, but they must be cognizant of the political risks, resources, and competencies necessary to take on such a role. As set forth in Part IV, this federalized, “laboratory of the states” model allows jurisdictions to tailor policies to the specifics of the state’s own health care markets.

IV. STATE OPTIONS TO ADDRESS THE DOUBLE-EDGED SWORD

Because of the limits of federal antitrust enforcement and of market forces to discipline private health care prices, states have the opportunity to complement and supplement federal efforts to address the potential harm to competition from increased health care consolidation. The double-edged sword of health care integration requires states to grapple with ways to balance the potential efficiency benefits while controlling the price effects of consolidation. To do so, states can encourage clinical integration, but with a quid pro quo that the integrating entities must submit to price and quality oversight.

Part IV explores a range of policy options states can use to further these ends. The strategies include: (A) all-payer claims databases; (B) antitrust enforcement and immunity; (C) ACO certification; (D) rate-oversight authorities; (E) private rate caps; and (F) provider rate regulation.

These policy options for state oversight of health care integration are explored in order of least to most regulatory intervention in the market, which also generally correlates to political difficulty. Although the best combination of these tools will depend on the specific market and political dynamics in each particular state, as a general matter, the more consolidated and concentrated a state’s health care market, the more the state may have to rely on the stronger regulatory devices to curb rising health care prices.

139. Edith Ramirez, *Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2246 (2014).

While states may pick and choose from this menu of policy options, three key ingredients emerge for effective state oversight of vertical integration and private price increases: (1) Information—oversight bodies must have access to detailed and timely price, quality, and utilization claim data; (2) Independence—state oversight bodies must be insulated from the powerful providers they oversee; (3) Regulatory Authority—state oversight bodies must have the authority to enforce or impose limits on providers’ prices when they become too high.

A. All-Payer Claims Databases

To evaluate the impact of integration on health care costs and quality, states must first gain access to reliable data about their health care prices, quality of care, and market dynamics. This information will inform the analysis of the role that market leverage, as opposed to value, plays in setting negotiated health care prices.

Obtaining negotiated health care prices will not be an easy task. Private health care prices are notoriously opaque and difficult to ascertain.¹⁴⁰ Different plans pay the same provider different prices for the same service. Providers’ charges vary wildly from each other for the same service in the same geographic areas.¹⁴¹ Furthermore, nondisclosure agreements, trade secrets claims, and highly complex billing mechanisms shroud health care prices in a veil of secrecy.¹⁴² But states can get around many of these barriers by requiring disclosure of the information to a state entity.¹⁴³

About a third of all states currently require disclosure of health care claims to an all-payer claims database (APCD).¹⁴⁴ APCDs are large-scale, state-run databases that

140. Morgan A. Muir, Stephanie A. Alessi & Jaime S. King., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL’Y REV. 319 (2013).

141. See Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F.L. Lucas & Étoile L. Pinder, *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273, 273 (2003) [hereinafter *Regional Variations in Medicare Spending Part 1*]; Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F.L. Lucas & Étoile L. Pinder, *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288 (2003) [hereinafter *Regional Variations in Medicare Spending Part 2*].

142. Muir et al., *supra* note 140, at 326.

143. See *id.* But see *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) (finding Vermont’s APCD reporting requirements for self-insured employers were preempted by ERISA).

144. *Interactive State Report Map*, APCD COUNCIL, <https://www.apcdouncil.org/state/map> [https://perma.cc/P5Z4-S5DT] (showing eighteen states with APCDs). As of October 15, 2015, the eighteen states that have enacted legislation to establish an APCD are Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Tennessee, Vermont, Virginia, Washington, West Virginia. *Id.* The twenty states that are seriously considering an APCD are Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana,

collect health care claims data and provider data from all payers in the state, including private insurers, Medicaid, the Children's Health Insurance Program (CHIP), self-insured employers, dental insurers, prescription drug plans, state employee health plans, and others. Furthermore, several APCDs pair price and quality data for providers.¹⁴⁵ States generally use APCDs to collect data on patient demographics, diagnoses, services rendered, charges, payments, and procedure codes.¹⁴⁶ According to the APCD Council, a nonprofit entity that monitors APCD creation, eighteen states have enacted legislation to create an APCD, with another twenty states demonstrating a strong interest in doing so.¹⁴⁷

APCDs are often thought of as tools for promoting consumer price transparency,¹⁴⁸ but their functions go far beyond providing pricing information to consumers. For example, by marrying claims data with quality assessments, APCDs can allow policy makers to monitor the impact of vertical integration on price and quality under various market conditions. Given the experimental nature of ACOs, access to data is essential to evaluating whether they can achieve their procompetitive goals of promoting quality improvement and cost-saving efficiency, or whether their potential anticompetitive effects outweigh any consumer benefit. For instance, policy makers will need to know whether vertical integration in their market changes provider referral patterns in ways that harm quality of care or patient outcomes. With all the changes set in motion by the ACA, it is essential to be able to learn from experience and adapt regulations quickly in response to shifting market dynamics.¹⁴⁹

The collection of APCD data both underlies and informs all of the subsequent policy options discussed below and should be a precursor to the selection of an approach to manage the double-edged sword of health care integration and consolidation. Policy makers could use APCD data to implement policy incentives targeting consumers, purchasers, providers, and payers. For instance, if a dominant provider engaged in anticompetitive conduct to drive up prices to supracompetitive levels, the

Michigan, Montana, Nebraska, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, and Wyoming. *Id.*

145. *The Basics of All-Payer Claims Databases: A Primer for States*, THE ROBERT WOOD JOHNSON FOUNDATION (2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988 [<https://perma.cc/7XSU-HJG9>].

146. Massachusetts also requires certain provider organizations to register with the state and submit information on provider costs, charges, and services. The Center for Health Information and Analysis collects and maintains large databases of provider and payer information that policy makers and researchers can use to analyze market dynamics in the state. *Hospital and Other Provider Data*, CENTER FOR HEALTH INFORMATION AND ANALYSIS, <http://www.chiamass.gov/data-index/> [<https://perma.cc/JQ9T-7V97>].

147. *Interactive State Report Map*, *supra* note 144.

148. For examples of consumer facing tools available in Colorado, Maine, and New Hampshire, see CO MEDICAL PRICE COMPARE, <https://www.comedprice.org/#/home> [<https://web.archive.org/web/20161014052429/https://www.comedprice.org/#/home>] (CO Medical Price Compare is limited to information on childbirth, knee replacement, and hip replacement services); COMPAREMAINE: HEALTH COSTS & QUALITY, <http://www.comparemaine.org/> [<https://perma.cc/9GQ8-SG3F>]; *Health Costs for Consumer*, N.H. HEALTHCOST, <http://nhhealthcost.nh.gov/health-costs-consumers> [<https://perma.cc/5USX-9WA8>].

149. See Cutler, *How Health Care Reform Must Bend the Cost Curve*, *supra* note 6, at 1131–35.

state could consider bringing an antitrust enforcement action, implementing some form of rate regulation, or finding ways to incentivize market entry.

While the creation of an APCD presents numerous opportunities and benefits, doing so also raises significant challenges. Without question, the creation and maintenance of any statewide database will require substantial financial support and resources. However, with APCDs, obtaining a usable, standardized, and complete set of data from various payers and providers poses the biggest challenge. For example, all quality, price, and patient data must be converted to standardized metrics and all patient data must be de-identified. Given the confidential nature of the database, the state will also need to impose significant data-security measures. States may also face additional challenges from providers and insurers claiming that the pricing data constitutes a trade secret or is subject to a nondisclosure agreement.¹⁵⁰ State legislatures can address many of these concerns directly by requiring payers and providers to submit health care claims data in standardized formats to the state APCD and including a provision that exempts APCD reporting requirements from nondisclosure agreements and trade secrets claims.¹⁵¹

Unfortunately, the Supreme Court recently dealt a significant blow to state APCDs in *Gobeille v. Liberty Mutual Insurance Co.*¹⁵² The 6-2 opinion held that the Employee Retirement Income Security Act (ERISA) preempts state APCD reporting requirements for self-funded employee health plans, depriving states of essential information on health care utilization, pricing, and quality.¹⁵³ Nationally, 61% of workers with employer-based health insurance are in self-funded plans, which represents a significant portion of the population state health policy makers aim to target with healthcare reforms.¹⁵⁴ Moreover, individuals with employer-based health insurance tend to be healthier than those covered by public payers, so removing claims data for a majority of individuals with employer-based coverage from the database can skew the data and undermine the accuracy of any policy analysis performed using the data.¹⁵⁵

States seeking to obtain claims data for employees with self-insured employers have three options after *Gobeille*.¹⁵⁶ First, states could gather and analyze the more limited set of health care claims data by continuing to require APCD data from all

150. Muir et al., *supra* note 140, at 326.

151. Such requirements could be imposed via legislation, state agency regulation, or, in the case of trade secrets, through a judicial opinion.

152. 136 S. Ct. 936 (2016).

153. *Id.* at 946–47. For a good discussion of the case and what is at stake for APCDs, see Nicholas Bagley & Christopher Koller, *Transparency and the Supreme Court—Can Employers Refuse To Disclose How Much They Pay for Health Care?*, 373 *NEW ENG. J. MED.* 1 (2015).

154. THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *EMPLOYER HEALTH BENEFITS ANNUAL SURVEY 2016*, § 10 (2016).

155. Amicus Brief to the Second Circuit on Behalf of Harvard Law School Center for Health Law & Policy at 20, *Gobeille*, 136 S. Ct. 936 (No. 14-181).

156. Erin Fuse Brown and Jaime King, *The Consequences of Gobeille v. Liberty Mutual Ins. Co. for Health Care Cost Containment*, *HEALTH AFF. BLOG* (Mar. 10 2016), <http://healthaffairs.org/blog/2016/03/10/the-consequences-of-gobeille-v-liberty-mutual-for-health-care-cost-control/> [https://perma.cc/B7P7-HMUB].

other types of payers, including fully insured employee-benefit plans, public payers, and individual and small-group plans within and outside the exchanges, and by encouraging self-insured employee health plans to submit information on a voluntary basis.¹⁵⁷ Second, despite being less efficient and more expensive than obtaining the data from payers, states could require health care providers to submit the missing data from self-insured employees.¹⁵⁸ Finally, states could request that the federal government, via the Departments of Labor and Health and Human Services, mandate collection of relevant claims data from ERISA plans.¹⁵⁹ A federal requirement could standardize data for inclusion in all state APCDs, which could facilitate data analysis and comparison between states.

A final challenge is that creation of an APCD requires significant thought regarding the amount and scope of data disclosure. Several antitrust enforcers and academics have expressed concerns that, depending on the market dynamics, widespread disclosure of all health care price and quality data could lead to increased prices or collusion.¹⁶⁰ Determining which data to disclose, to whom, and in which market, will require substantial analysis and oversight, which again requires resources.

Despite these numerous challenges, states need comprehensive health care price, utilization, and quality data to inform their health care cost-containment policies. Thus, states must strive to collect and access this data notwithstanding these challenges. Information forms the basis of any effective state action to address to the competitive risks of health care integration and consolidation.

B. Antitrust Enforcement and Immunity

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

157. Voluntary data submission has some precedent. Virginia has implemented an entirely voluntary APCD, and four other states use voluntary data collection into databases similar to APCDs. *See* VA. CODE ANN. § 32.1-276.7:1 (Supp. 2016); *see also* APCD Council, *supra* note 144.

158. *See* Nicholas Bagley, *The Supreme Court's Wrongheaded Decision in Gobeille*, INCIDENTALECONOMIST (Mar. 3, 2016, 11:50 AM), <http://theincidentaleconomist.com/wordpress/the-supreme-courts-wrongheaded-decision-in-gobeille/> [<https://perma.cc/Q87P-5G4X>].

159. The majority in *Gobeille*, and Justice Breyer in his concurrence, suggested federally mandated data collection as solution to replace the lost APCD data from ERISA self-funded plans. *Gobeille*, 136 S. Ct. 936, 949–50 (2016) (Breyer, J., concurring). For an example of a state-based proposal for a federal requirement for the submission of health care claims data by ERISA plans, see National Academy for State Health Policy, Comment on Department of Labor Notice of Proposed Rulemaking (Sept. 20, 2016), <https://www.regulations.gov/contentStreamer?documentId=EBSA-2016-0010-0033&attachmentNumber=1&disposition=attachment&contentType=pdf> [<https://perma.cc/VF3U-HL5X>].

160. *See, e.g.*, Foote & Varanini, *supra* note 75, at 891; Muir et al., *supra* note 140, at 354.

Alternatively, states can encourage integration by granting state action immunity from state and federal antitrust laws to integrated health care entities via legislation or Certificates of Public Advantage (COPAs).¹⁶¹ Regardless of a state's chosen path, vigorous oversight and significant data monitoring will be essential to controlling costs and preserving quality in the face of increased concentration.

1. Antitrust Enforcement

States can challenge anticompetitive conduct by enforcement of the federal or its own state antitrust laws. At the federal level, the Sherman Act and the Clayton Act prohibit anticompetitive mergers, collaborations, and conduct.¹⁶² In addition, forty-nine states have their own antitrust laws that promote and protect competition.¹⁶³ Given the market-specific information required to bring an antitrust enforcement challenge, state officials are well positioned to identify integration proposals that threaten to harm competition. State attorneys general can challenge mergers and collaborations and bring enforcement actions both independently and in conjunction with a federal action. Joining with the federal antitrust agencies to bring an action can be an especially effective means for states to leverage both the expertise and resources of the federal agencies as well as their own knowledge of existing market dynamics.¹⁶⁴

State attorneys general, like the federal antitrust agencies, generally have the opportunity to review a proposed integration, which could be a formal merger or a looser collaboration, both at the time of its creation and on an ongoing basis. While the antitrust analysis typically differs between horizontal mergers, vertical mergers, and collaborations, the FTC generally considers similar factors when addressing health care provider integrations.¹⁶⁵ At the time of a proposed integration, antitrust enforcers initially consider whether a proposed merger or collaboration is per se illegal.¹⁶⁶ Initial concerns for enforcers include (1) whether the integration could create potential efficiencies such as cost savings, quality improvement, and transactional efficiencies; (2) whether the proposed integration is a legitimate attempt to achieve those efficiencies or a means to enhance market power; and (3) whether the

161. See ROBERT A. BERENSON & RANDALL R. BOVBJERG, URBAN INST., *CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER?* 4 (2015), <http://www.urban.org/research/publication/certificates-public-advantage> [<https://perma.cc/V68Q-J7RM>].

162. 15 U.S.C. §§ 1–7, 12–18 (2012).

163. Pennsylvania, which is the only state without a separate antitrust law, enforces competition under its Unfair and Deceptive Practices statute. 73 PA. STAT. AND CONS. STAT. ANN. § 201-1 (West Supp. 2016).

164. See, e.g., *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015).

165. See Feinstein, *supra* note 49, at 3–5 (explaining the FTC's approach to enforcement in health care markets); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating the Medicare Shared Savings Program, *supra* note 49; FTC ET AL., *HORIZONTAL MERGER GUIDELINES*, *supra* note 49; FTC ET AL., *ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS*, *supra* note 49, at 3.

166. See Feinstein, *supra* note 49, at 4.

efficiency goals could be obtained through a means that poses less of a threat to competition.¹⁶⁷ For an existing entity, enforcers consider whether the current conduct of the entity is on balance harming competition. If on initial review the state finds that its antitrust concerns are not satisfied, it can engage in further investigation.

Given the potential benefits of vertical integration in health care, the majority of proposed integrations should survive initial review and not be challenged as per se illegal. Once a bona fide integration is established, antitrust enforcers will review the integration under a “rule of reason” standard.¹⁶⁸ As the Director of the FTC’s Bureau of Competition Deborah Feinstein pointed out at the Fifth National Accountable Care Organization Summit in June 2014, “the rule of reason analysis applied to provider collaborations generally follows the same framework contained in the *Horizontal Merger Guidelines*.”¹⁶⁹ The rule of reason analysis compares the state of competition with and without the proposed integration and requires the parties to define the relevant product and geographic markets, identify the market participants, calculate market shares and concentration, consider the likelihood of market expansion, and determine whether any efficiencies are likely to result.¹⁷⁰ Antitrust enforcers will further examine whether the proposed integration will likely harm competition by increasing “the ability or incentive profitably to raise price above or reduce output, quality, service, or innovation below what likely would prevail” in its absence.¹⁷¹ Rule of reason analysis is flexible and market specific in its inquiry, and no one factor is dispositive.¹⁷²

The most challenging question facing antitrust enforcers in the case of vertical integration is whether the purported procompetitive effects of the integration will outweigh any anticompetitive effects. Before antitrust enforcers will credit any procompetitive efficiencies, the health care entities must demonstrate that the claimed efficiencies are sufficiently cognizable, explicit, and require the proposed level of integration (merger, joint venture, or affiliation) to produce the procompetitive effects.¹⁷³ Doing so has proven extremely difficult.¹⁷⁴ For instance, the Ninth Circuit

167. See Ramirez, *supra* note 139, at 2246. Although, alliances and other collaborations have not yet been challenged on antitrust grounds; the FTC has expressed concerns that such collaborations could also harm competition. See also Feinstein, *supra* note 49.

168. See FTC ET AL., HORIZONTAL MERGER GUIDELINES, *supra* note 49, at 15–17; see also FTC ET AL., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS, *supra* note 49, at 3–6.

169. Feinstein, *supra* note 49, at 4.

170. *Id.*; see also FTC ET AL., HORIZONTAL MERGER GUIDELINES, *supra* note 49, at 15–19; FTC ET AL., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS, *supra* note 49, at 17–21.

171. FTC, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS, *supra* note 49, at 4.

172. See *id.* at 4.

173. See Feinstein, *supra* note 49, at 9 (stating that the claimed efficiencies must be merger specific, explicit, and cognizable).

174. See Tasneem Chipty & Asta Sendonaris, *Economists’ Perspective on the Efficiency Defense in Provider Consolidations: What Works, What Doesn’t Work, and What We Still Don’t Know*, 19 AHLA CONNECTIONS 16, 17 (2015) (stating “no provider has convinced an

Court of Appeals found in *Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System* that the quality benefits obtained from sharing electronic medical records, standardizing treatment protocols, and integrating physicians across practices did not require a formal merger; that is, they were not “merger specific.”¹⁷⁵ Although the Ninth Circuit decided *St. Luke's* based purely on the anticompetitive potential of the proposed horizontal merger of primary care physician practices in Nampa, Idaho, the principle that a merger was not necessary to achieve the purported efficiencies would also apply in the analysis of a vertical merger.

The complexity of vertical health care integrations will significantly complicate antitrust analysis.¹⁷⁶ Vertical integrations can harm competition in upstream and downstream markets, as well as in entirely different markets.¹⁷⁷ For example, Health First, an integrated delivery system in Brevard, Florida, owns and operates health plans, hospitals, physician groups, urgent care centers, outpatient centers, rehabilitation facilities, diagnostic and treatment centers, and a network of fitness and wellness services.¹⁷⁸ In these cases, it will not be sufficient to analyze only the impact of the integration in each market in isolation, but instead antitrust enforcers and courts should analyze the more global impact of the integration on the particular health care market. This makes conducting the competitive effects analysis significantly more complex.¹⁷⁹ Further, state enforcers may have to consider how to balance pro-competitive effects in one market, such as primary care, with anticompetitive effects in an altogether different market, such as surgical procedures, or whether quality improvements for certain services outweigh across the board price increases.¹⁸⁰ All of this will require extensive amounts of time, resources, data, and analysis to accomplish in any meaningful way.

However, once a state has decided that a proposed or existing integration is anticompetitive, it must decide upon a remedy. The goal of any antitrust enforcement action is to restore the opportunity for the market to function without the illegal restraints on competition.¹⁸¹ Antitrust enforcers generally have two kinds of equitable remedies to choose from: structural and conduct remedies. Depending on the timing

antitrust enforcer that the claimed efficiencies are cognizable and sufficient to offset” the potential harms to competition).

175. 778 F.3d 775, 791 (9th Cir. 2015).

176. See STEVEN C. SALOP & DANIEL P. CULLEY, POTENTIAL COMPETITIVE EFFECTS OF VERTICAL MERGERS: A HOW-TO GUIDE FOR PRACTITIONERS 5–6 (2014).

177. *Id.*

178. See Lisa Schenker, *Competitor Sues Florida System Health First*, MODERN HEALTH CARE (Sept. 2, 2015), http://www.modernhealthcare.com/article/20150902/NEWS/150909986?utm_source=modernhealthcare&utm_medium=email&utm_content=externalURL&utm_campaign=am [<https://perma.cc/5XUK-TB8L>].

179. See SALOP & CULLEY, *supra* note 176, at 6.

180. While historically the courts have not permitted benefits in one market to excuse harms in another, the Horizontal Merger Guidelines do provide some indication that the Antitrust Agencies may balance cross-market effects when deciding whether to prosecute a merger. See, e.g., *Philadelphia Nat'l Bank v. United States*, 374 U.S. 321, 370 (1963); FTC ET AL., HORIZONTAL MERGER GUIDELINES, *supra* note 49, at 30 n.14.

181. See Feinstein, *supra* note 49, at 14.

of the action and the market conditions, states can use structural and conduct remedies alone or in combination to address anticompetitive concerns arising from greater consolidation in health care.

a. Structural Remedies

Antitrust enforcers use structural remedies to prevent a proposed merger, to undo a recent merger, or to require divestiture or other structural change in order to restore competition.¹⁸² In the instance that a vertically integrated entity has not yet or only recently formed, structural remedies offer a relatively straightforward means of restoring competition by dissolving the integration. Given the level of concentration in both the health care insurance and provider markets, antitrust enforcers have expressed a strong preference for structural remedies,¹⁸³ as preventing anticompetitive harms prior to consolidation has proven more successful than attempting to address them after the entities have fully integrated.¹⁸⁴

While structural remedies are frequently used to prevent horizontal mergers, their use in vertical mergers has rarely occurred because antitrust enforcers generally view vertical integration as procompetitive.¹⁸⁵ However, given the evidence that vertical health care integration can increase provider market leverage and prices, antitrust enforcers should consider structural remedies, both when evaluating proposed vertical integrations and when an existing consolidated entity continues to amass or abuse its market power.¹⁸⁶

In the case of proposed vertical integrations, antitrust enforcers should consider structural remedies in three instances. First, they should be especially wary of proposed integrations that appear overinclusive in the number of hospitals and/or physicians participating in the integration, as this may signal an attempt to gain market power in ways that are unnecessary to the efficiency goals of vertical integration.¹⁸⁷ Second, in instances where the integration would involve a significant number of providers in a particular area, questions arise regarding whether those providers are eligible to see patients independently from the entity or subject to exclusivity requirements and whether the integration will substantially limit consumer choice. Third, vertical integrations that consolidate market power across several different provider markets can create significant leverage in negotiating reimbursements, such that the

182. *Id.* at 14–16.

183. *Id.* at 14.

184. See Stephen Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction* 23 (Fed. Trade Comm'n, Working Paper No. 293, 2008).

185. Edith Ramirez, Comm'r, Fed. Trade. Comm'n, Presentation to Am. Bar Ass'n at the Antitrust Fall Forum: FTC Behavioral Remedies (Nov. 17, 2011), http://www.americanbar.org/content/dam/aba/publications/antitrust_law/at311550_fall_forum_panel_5.authcheckdam.pdf [<https://perma.cc/D5VF-CNXL>].

186. See, e.g., ANN HOLLINGSHEAD, JAIME KING, BRENT D. FULTON, JOSHUA RUSHAKOFF, & RICHARD M. SCHEFFLER, STATE ACTIONS TO PROMOTE AND RESTRAIN COMMERCIAL ACCOUNTABLE CARE ORGANIZATIONS 17 (2015).

187. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating the Medicare Shared Savings Program, *supra* note 49.

entity becomes a “must have” and threatens the ability of other organizations to compete.¹⁸⁸

Despite the oft-repeated reminder that mergers, once consummated, are difficult, if not impossible, to unwind, the highly concentrated nature of U.S. health care markets suggests antitrust enforcers should seriously consider using structural remedies to break down some of the market leverage some providers have amassed over the last several decades.¹⁸⁹ Over the last several decades, health care entities have come to rely on the fact that mergers, once consummated, will not be undone. As a result, health care entities have strong incentives to consolidate, even in the face of increased monitoring or limitations via conduct remedies, because the limitations are only temporary, but the gain in market power is permanent. In many markets, health care provider organizations have systematically accumulated market power and abused it in ways that have significantly increased costs and eliminated competitors. Such abuses of power could result in anticompetitive conduct claims under Section 1 of the Sherman Act or monopolization and attempted monopolization claims under Section 2 of the Sherman Act.¹⁹⁰ Antitrust enforcers have the authority to break this market power down in two ways: division of a larger entity into several smaller entities¹⁹¹ or required divestitures in certain geographic regions.¹⁹² The most prominent example of division of an existing entity into smaller ones occurred in 1983 when the Department of Justice successfully litigated its case against AT&T, resulting in the divestiture of several “Baby Bells.”¹⁹³ Assistant Attorney General William Baxter created the “Bell Doctrine” to prevent local telephone service providers from leveraging their legally acquired monopolies in local markets to monopolize the national long distance market.¹⁹⁴ While the Bell Doctrine was designed for regulated

188. For a more theoretical description of how amassing market power across a range of markets will increase leverage in negotiations with a single purchaser, see generally Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253 (2013); Thibaud Vergé, *Portfolio Effects and Merger Control: Full-Line Forcing as an Entry-Deterrence Strategy* (Ctr. Mkt. Pub. Org., CMPO Working Paper Series No. 02/046, 2003).

189. Antitrust enforcers have rarely won monopolization or attempted monopolization claims under the Sherman Act; a major victory of this kind could substantially quell anti-competitive behavior for some time.

190. Sherman Act, 15 U.S.C. §§ 1–2 (2012).

191. See generally, Paul L. Joskow & Roger G. Noll, *The Bell Doctrine: Applications in Telecommunications, Electricity, and Other Network Industries*, 51 STAN. L. REV. 1249 (1999).

192. See Press Release, *FTC Requires Community Health Systems, Inc. To Divest Two Hospitals as a Condition of Acquiring Rival Hospital Operator*, FED. TRADE COMM’N, (Jan. 22, 2014), <https://www.ftc.gov/news-events/press-releases/2014/01/ftc-requires-community-health-systems-inc-divest-two-hospitals> [<https://perma.cc/DPN5-XG8N>]; Virgil Dickson, *Community Health Systems to Spin Off 38 Hospitals, Shift Focus to Larger Markets*, MODERN HEALTHCARE (Aug. 3, 2015), <http://www.modernhealthcare.com/article/20150803/NEWS/150809993> [<https://perma.cc/QV6Q-4PU4>].

193. *United States v. Western Electric Co.*, 569 F. Supp. 990 (D.D.C. 1983) (modifying the final judgment in that case, and terminating *United States v. AT&T*).

194. William F. Baxter, *Conditions Creating Antitrust Concerns, with Vertical Integration by Regulated Industries—“For Whom the Bell Doctrine Tolls,”* 52 ANTITRUST L.J. 243, 243–47 (1983).

monopolies, many of its principles can be analogized to dominant health care organizations.¹⁹⁵ A successful state or federal antitrust challenge resulting in divestitures, or other structural remedies dividing the entity into smaller parts, would serve as a strong deterrent to other entities.

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

b. Conduct Remedies

The majority of vertical integrations, however, are unlikely to require structural remedies, as they will present substantial procompetitive effects that are not so clearly outweighed by potential harm to competition. In these instances, conduct remedies are more frequently used to curb anticompetitive behaviors. State and federal antitrust enforcers have typically used conduct remedies to address anticompetitive concerns arising from vertical mergers and joint ventures; the agencies believed that conduct remedies would enable an entity to gain the procompetitive benefits of the vertical integration while still restricting any potential anticompetitive conduct.¹⁹⁶

Conduct remedies can be used in two ways to regulate the anticompetitive harms that may arise from vertical integration. First, conduct remedies provide a means to limit anticompetitive behavior in a health care entity that has obtained a significant amount of market power without requiring it to divest portions of its business in ways that may compromise patient care.¹⁹⁷ Second, for entities that are integrating to create an ACO or other form of integrated delivery system, conduct remedies offer a tool to protect competition in ways that are tailored to the concerns of a particular market, while still enabling providers the opportunity to achieve the desired procompetitive effects of clinical integration.

195. A full explication of how this theory could apply to health care entities is beyond this scope of this paper, but we feel that antitrust enforcers should begin to consider whether a structural remedy could be useful in particular instances.

196. DEP'T OF JUSTICE, ANTITRUST DIV., POLICY GUIDE TO MERGER REMEDIES 12–13 (2011). Some common behavioral remedies in vertical mergers include firewalls, non-discrimination and fair dealing restrictions. *See* Ramirez, *supra* note 185.

197. *See* Opinion of the Comm'n on Remedy, *In re* Evanston Northwestern Healthcare Corp., No. 9315 (Apr. 28, 2008), <https://www.ftc.gov/sites/default/files/documents/cases/2008/04/080428commopiniononremedy.pdf> [<https://perma.cc/4UD6-N4A9>]. Instead of requiring divestiture, the FTC allowed the merged hospitals to establish separate contracting teams to negotiate with health plans and gave health plans the option to negotiate with the hospitals separately or jointly. At the time, the FTC's reasoning behind this conduct remedy was the "unique circumstances of the case," including that the hospitals had consummated their merger seven years earlier, significant integration had already occurred, and that divestiture could risk patient safety at Highland Park. *See* Opinion of the Comm'n at 89–91, *In re* Evanston Northwestern Healthcare Corp., No. 9315 (Aug. 6, 2007), <https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf> [<https://perma.cc/4ACG-ZEFF>]. To qualify this, however, the FTC has since rejected these sort of conduct remedies and now uses structural remedies.

The use of vertical integration and ACOs to control costs and improve quality in health care is still largely experimental. Like any experiment, the model will require iterative refinement and oversight to improve its results. Conduct remedies permit this iterative process to continue to maximize the benefits of integration, while minimizing the harm to competition. For example, depending on the concerns in a particular market, antitrust enforcers could impose direct price caps, limits on total health care expenditures, limits on contract provisions,¹⁹⁸ requirements to preserve existing services, prohibitions on employment restrictions, and limits on further acquisitions on health care providers.

But using conduct remedies effectively is challenging. Historically, the antitrust agencies have not favored the use of conduct remedies to control the anticompetitive effects of proposed horizontal mergers or collaborations.¹⁹⁹ Their logic is relevant to vertical integration as well. First, unlike structural remedies, conduct remedies do not restore the status quo with respect to competition.²⁰⁰ Instead, they provide restrictions and oversight over the newly integrated entity, which are often inferior substitutes for competition between independent providers.²⁰¹ For instance, direct price caps have been used to control cost increases following a merger, but it is not clear if the price caps are higher than what a competitive market would permit.²⁰² Further, conduct remedies often focus on price, but they are unable to take account of other impacts of competition like quality improvement and innovation.²⁰³ Second, conduct remedies are often difficult to enforce and have high administrative costs.²⁰⁴ Enforcing conduct remedies requires the enforcement agency to either oversee enforcement itself or hire a third party to monitor the entity, both of which require substantial resources. In some instances, enforcement can be so expensive and burdensome that the remedy can be self-defeating. Finally, conduct remedies are generally time-limited, which begs the question of what happens when the consent decree ends. Health care entities may find it financially rewarding to consolidate and accept the conduct remedies and oversight in the short term to obtain greater market leverage in the future.

In comparison to their federal counterparts, state attorneys general may be better positioned and more willing to use conduct remedies. State officials will be more familiar with local stakeholders and market dynamics, and they may be more willing to engage in conduct oversight than to litigate a merger challenge. For instance, the Pennsylvania Attorney General has successfully negotiated three consent decrees since 2011 with Geisinger Health System.²⁰⁵ The most recent decree, involving

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

199. See Feinstein, *supra* note 49, at 14–15.

200. *Id.* at 15.

201. *See id.*

202. *See id.*

203. *See id.*

204. *See id.*

205. Ober Kaler, *Recent State Attorney General Merger Enforcement: Charting a Different Path from the Feds – or Not?*, LEXOLOGY (Oct. 29, 2014), <http://www.lexology.com/library/detail.aspx?g=a2b2048f-475b-468f-9224-96d6e5dcef32> [<https://perma.cc/NFG9-W76A>].

Geisinger's acquisition of Lewiston Health Care Foundation, required caps on price increases and prohibited most-favored-nation and anti-tiering provisions.²⁰⁶

In Massachusetts, the then-Attorney General, Martha Coakley, negotiated an extensive consent decree with Partners Healthcare conditioning its acquisition of South Shore Hospital and two Hallmark hospitals on several factors including (1) caps on price increases and total health care expenditures; (2) component contracting, which permits health plans to contract with all or some of Partners's four major components; (3) limitations on Partners's ability to contract with payers on behalf of affiliated providers; (4) preservation of existing services; and (5) Attorney General approval for any further acquisitions.²⁰⁷ The Partners consent decree was ultimately rejected after substantial opposition from the Massachusetts Health Policy Commission (HPC),²⁰⁸ which estimated that the merger would result in approximately forty million dollars in increased health care expenditures per year and Partners having more discharges than the next four largest competitors in the state combined.²⁰⁹ HPC's impact on the outcome of the Partners merger demonstrates the importance of states having readily available access to price, quality, and utilization data for analysis. If the financial impact of the proposed Partners acquisition had not been so significant, HPC would have been well-suited to oversee the merger and the conditions of the consent decree. Few states have an agency that has the data, analytical tools, authority, and resources that HPC does to monitor an actor's health care system and its costs. Although it has only been in existence for three years, HPC has already played a large role in shaping the future of health care in Massachusetts, and its role in antitrust enforcement will continue to develop. Other states interested in regulating health care costs should follow HPC's lead, using its progress and setbacks as guidance for policy design.

Overall, antitrust enforcement is an essential tool for states to curb increases in health care costs driven by abuses of provider and payer market power. But it can be too blunt or unwieldy an instrument to strike the delicate balance needed to promote beneficial integration in health care while preventing providers and payers from acquiring too much market power. In some instances, legislation may be preferable to

206. *Pennsylvania v. Geisinger Health Sys. Found.*, No. 1:13-CV-02647-YK (M.D. Pa. Oct. 28, 2013).

207. Memorandum of the Commonwealth of Mass. in Support of Entry of Final Judgment, *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCV2014-2033BLS (Mass. Super. Ct. June 24, 2014), <http://www.mass.gov/ago/docs/press/2014/memo-in-support.pdf> [<https://perma.cc/4G64-37U5>].

208. The Massachusetts Health Policy Commission (HPC) is an independent state agency created to monitor health care costs; develop policies to reduce overall health care costs and maintain quality; and provide objective, data-driven analyses of specific provider transactions. *See* MASS. GEN. LAWS ANN. ch. 6D, § 2 (West 2016). For further discussion of the Massachusetts HPC, see *infra* Parts IV.C–IV.D.

209. Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent at 27, *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2 (Mass. Super. Ct. Jan. 29, 2015), <http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf> [<https://perma.cc/HT86-849H>] (estimating that total medical spending would increase by more than \$38.5 million to \$49 million per year).

conduct remedies for behavior that states wish to curb across all actors, like all-or-nothing provisions or most-favored-nation clauses. If enforcers fear eliminating pro-competitive efficiencies, they may opt to delay enforcement in ways that can cause lasting harm to competition. Likewise, if used too aggressively, the threat of antitrust enforcement could chill integration efforts.

2. State Action Immunity and Certificates of Public Advantage

In some instances, state and federal governments may wish to alleviate that chilling effect of antitrust law by signaling to health care entities that they favor promoting integration over protecting competition. The courts have granted states the ability to regulate the market in ways that promote other policy goals even if those ways may harm competition.²¹⁰ In *Parker v. Brown*, the Supreme Court granted states the ability to offer *state action immunity*, which would displace the antitrust laws in favor of public supervision, so long as their actions did not unduly burden interstate commerce or violate the Constitution.²¹¹ States seeking to exempt nonsovereign private actors from state and federal antitrust enforcement must demonstrate that the exemption arises from a “clearly articulated and affirmatively expressed . . . state policy” and that the policy is “actively supervised by the State.”²¹² States can grant non-sovereign entities immunity through a range of actions including direct legislation, agency action, or by granting a certificate of public advantage (COPA). Currently, thirteen states have statutes authorizing the state to grant a COPA or state action immunity.²¹³

It is unclear whether state action immunity has successfully promoted beneficial integration while protecting competition. In recent years, use of state action immunity has come under significant scrutiny, especially in health care, as several states had granted immunity without proper articulation of state purpose or

210. See Phillip Areeda, *Antitrust Immunity for “State Action” After Lafayette*, 95 HARV. L. REV. 435, 436 (1981).

211. *Parker v. Brown*, 317 U.S. 341 (1943); see also Areeda, *supra* note 210, at 436 n.5.

212. *N.C. Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1110 (2015). For a more in-depth discussion of *North Carolina Board of Dental Examiners v. FTC*, see Marie Forney, Note, *North Carolina State Board of Dental Examiners v. FTC: Aligning Antitrust Law with Commerce Clause Jurisprudence Through a Natural Shift of State-Federal Balance of Power*, 92 IND. L.J. 365 (2016).

213. State statutes authorizing COPAs include the Idaho Health Planning Act, IDAHO CODE ANN. § 39-4903 (2011); the Kansas Health Care Provider Cooperation Act, KAN. STAT. ANN. §§ 65-6801 to -6809 (2002); the Maine Hospital Cooperation Act, ME. REV. STAT. ANN. tit. 22, § 1844 (Supp. 2015); MISS. CODE ANN. § 41-9-307 (West 2007); the Montana Health & Safety Code, MONT. CODE ANN. § 50-4-603 (2015); the Nebraska Health Care Facility-Provider Act, NEB. REV. STAT. ANN. §§ 71-7701 to -7711 (LexisNexis 2014); the New York Public Health Law, N.Y. COMP. CODES R. & REGS. tit. 10, § 83-2 (2014); the North Carolina Hospital Cooperation Act, N.C. GEN. STAT. ANN. § 131E-192.4 (West 2010); the South Carolina Health Care Cooperation Act, S.C. CODE ANN. § 44-7-530 (2002); TENN. CODE ANN. § 68-11-1303 (2013); TEX. HEALTH & SAFETY CODE ANN. § 314.002 (West 2016); VA. CODE ANN. § 15.2-5384.1 (2012); and WIS. STAT. ANN. § 150.85 (West 2016).

supervision.²¹⁴ Robert Berenson and Randall Bovbjerg performed an extensive case study of a COPA granted in North Carolina that enabled Mission Health System (“Mission”) in Asheville to acquire its major rival, St. Joseph’s Health System.²¹⁵ North Carolina granted Mission a COPA in exchange for an agreement to a “quasi-regulatory” regime that controlled Mission’s overall profit margins, its average inpatient and outpatient costs, and the share of primary physicians it could employ.²¹⁶ After analyzing years of data, the researchers were unable to conclude that the COPA effectively counteracted the loss of competition in the area, but they did find that the model had some successes and with modifications “a COPA-like approach could provide a useful complement to antitrust enforcement in addressing market power.”²¹⁷

If carefully limited and executed properly, a COPA may offer a state several benefits over antitrust enforcement alone. First, it could give states the ability to experiment with vertical integration in health care in ways that attempt to balance the benefits of clinical integration with the risks to competition. Second, protection from antitrust prosecution offers health care entities further incentive to submit to data reporting and monitoring that can provide essential information on the impact of vertical integration in different market conditions. Such data would also enable states to monitor the impact of various forms of antitrust immunity on price or utilization as a result of a merger over time. Finally, properly executed state action immunity could offer the opportunity to closely monitor and regulate far more health care entities than federal enforcement agencies could cover alone and for longer periods of time than conduct remedies.

But the state must have a clearly defined regulatory body assigned to monitor and regulate the entities, as well as the financial and personnel resources to do so. A COPA that grants antitrust immunity without appropriate oversight risks significant harm to consumers. In fact, federal antitrust enforcement officials have recently raised significant concerns about whether state action immunity may do more harm than good.²¹⁸ Edith Ramirez, Chairwoman of the FTC, expressed concerns that in some states the grant of antitrust immunity in an effort to promote collaboration and integration “betrays a misunderstanding of the crucial role that competition plays in the healthcare sector.”²¹⁹ She reiterated the careful balancing that federal antitrust enforcement agencies conduct when reviewing a proposed merger or collaboration,

214. See, e.g., *N.C. Bd. of Dental Exam’rs*, 135 S. Ct. at 1115 (finding North Carolina did not sufficiently supervise the Board of Dental Examiners); *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2013).

215. See BERENSON & BOVBJERG, *supra* note 161, at 8.

216. See *id.* at 1.

217. *Id.* at 16, 25.

218. See Ramirez, *supra* note 139, at 2245; Staff Comment, Fed. Trade Comm’n, Letter to Ctr. for Health Care Pol’y and Res. Dev. re: Certificate of Pub. Advantage Applications Filed Pursuant to N.Y. Pub. Health L., N.Y. COMP. CODES R. & REGS. tit. 10, § 83-2 (2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf [<https://perma.cc/X8YQ-R3TA>].

219. Ramirez, *supra* note 139, at 2246.

including a weighing of the procompetitive and anticompetitive effects of a proposed integration.²²⁰ Without careful supervision and narrowly defined limits on the scope of antitrust immunity, COPAs and grants of state action immunity risk exacerbating antitrust concerns rather than ameliorating them.

The FTC further demonstrated its skepticism of COPAs and state action immunity recently with respect to New York's COPA for health care collaboratives.²²¹ In reviewing an application for a COPA, New York considers (1) the potential benefits of the health care provider collaborative activities, including preservation of needed health care services, improvement in quality and access to services, lower costs, and improvements in payment methodologies; (2) the health care provider landscape; (3) the potential disadvantages of the collaborative activities; (4) the availability of alternatives that would be less harmful to competition; and (5) the extent to which active supervision will mitigate the risks associated with the collaboration.²²² Despite its review process, New York's COPA immunity raised substantial concerns at the FTC that such immunity would promote anticompetitive behavior arising from healthcare integration.²²³ On April 22, 2015, the FTC sent a letter to the Center for Health Care Policy and Resource Development in New York, claiming that the FTC fully recognized the potential procompetitive benefits that can arise from health care collaborations but that the COPA exemptions "are based on inaccurate premises about the antitrust laws and the value of collaboration among health care providers."²²⁴ The FTC found that a COPA was unnecessary to enable providers to engage in procompetitive collaborative activities, but it threatened to "immunize conduct that would *not* generate efficiencies and therefore *not* pass muster under the antitrust laws."²²⁵ The FTC went on to argue that the COPA risked increasing health care costs and decreasing access to consumers in New York. States considering offering state action immunity through legislation or a COPA program must be aware of FTC's concerns and carefully condition the immunity on significant data reporting requirements, regulatory oversight, and explicit boundaries of antitrust exemption.²²⁶

In general, while we favor incentivizing health insurers and providers to provide price and quality data, we remain skeptical that offering immunity to state and federal antitrust laws is an advisable means of doing so. States with no other options should consider creating clear price, quality, and concentration thresholds that would trigger revocation of the immunity.

States must determine how to best employ their antitrust laws to promote

220. *See id.*

221. *See* Fed. Trade Comm'n, Letter to Ctr. for Health Care Pol'y and Res. Dev., *supra* note 218.

222. N.Y. COMP. CODES R. & REGS. tit. 10, § 1003.14 (2015).

223. *See* Fed. Trade Comm'n, Letter to Ctr. for Health Care Pol'y and Res. Dev., *supra* note 218. The entities applying for the COPA at issue were part of the Delivery System Reform Incentive Program for Medicaid recipients; however, the COPA program applies to all health care provider collaborations, including ACOs.

224. *Id.* at 1.

225. *Id.* (emphasis in original).

226. *See* Fed. Trade Comm'n, Letter to Ctr. for Health Care Pol'y and Res. Dev., *supra* note 218.

competition and efficiency in the health care markets. Data collection and analysis of health care prices, insurance premiums, utilization rates, and quality of care will be essential to this effort. Such data would enable state officials to identify anticompetitive collaborations as early as possible, and seek to revoke immunity or engage in some form of antitrust enforcement if entities violated the terms of the immunity. While states have a significant role to play in antitrust enforcement, as Robert Berenson previously noted, antitrust enforcement “can only be one—and not the primary—approach to addressing provider pricing power.”²²⁷

C. ACO Certification

To monitor the impact of vertical integration on price, quality, and competition, state certification programs can offer a more comprehensive and preferable alternative to COPAs and state action immunity. Unlike the regulatory approval and reporting requirements for Medicare ACOs, there is no regime of oversight for commercial ACOs. States can take a more active role overseeing health care integration, particularly commercial ACOs, by creating Certificate of Authority programs. States can tailor the Certificate of Authority requirements to enable them to achieve their particular policy goals. Key considerations include determining which state entity will oversee the certification, whether certification will be mandatory or voluntary, whether to require antitrust and solvency reviews, what price and quality disclosures to require, and whether to incentivize integration by granting antitrust immunity and exemptions to other state laws.²²⁸ Certification programs also allow states to review these features of any particular ACO both prior to certification and on an ongoing basis. Gathering historical and ongoing price and quality data will enable states to monitor market dynamics, inform future decisions regarding integration, and support antitrust enforcement actions.

To date, three states have established Certificate of Authority programs for commercial ACOs—Texas, Massachusetts, and New York.²²⁹ The features of the three different programs reflect each state’s goals and concerns. Certification presents essentially a quid pro quo, where the state offers a range of benefits to the integrating entity—typically an ACO—in exchange for a more in-depth review up front and continued oversight.²³⁰ Massachusetts has a voluntary ACO Certification Program

227. Robert Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL. POL’Y & L. 711, 714 (2015).

228. HOLLINGSHEAD ET AL., *supra* note 186, at 14–16.

229. These programs are Massachusetts Health Policy Commission (HPC), MASS. GEN. LAWS ANN. ch. 6D, § 2 (West 2016); New York Certificates of Authority, N.Y. COMP. CODES R. & REGS. tit. 10, § 1003.6 (2015); and Texas Health Care Collaboratives (HCC), TEX. INS. CODE ANN. § 848 (West 2009).

230. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 6D, § 2 (West 2016) (setting forth duty of HPCs to monitor health care delivery and payment); N.Y. COMP. CODES R. & REGS. tit. 10, § 1003.1 (2015) (setting forth data reporting requirements for ACOs); TEX. INS. CODE ANN. § 848.106 (Supp. 2016) (setting forth quality and cost monitoring requirements for HCCs). New York only certifies non-risk-bearing ACOs. Organizations that bear insurance risk or manage care,

governed by the Massachusetts Health Policy Commission. ACOs seeking certification must satisfy several minimum standards, including the use of alternative payment methodologies, providing medical and behavioral health services across the continuum, and allowing for health care price transparency in exchange for an HPC “seal of approval” and the opportunity for preferential contracting with state-funded insurance contracts.²³¹ As to data gathering, HPC already requires all provider organizations of a certain size and scope to register and submit data on costs and charges to the Center for Health Information and Analysis, but any ACO applying for certification must also register as a provider and disclose such information regardless of size or scope.²³² While the ACO certification process and its requirements are still under development, HPC has yet to require a solvency review or offer further potential incentives for ACO formation, such as immunity or a safe harbor from state and federal antitrust laws, exemption from state self-referral, or other consumer protection laws.²³³ According to staff members at HPC, a seal of approval from the state “is a meaningful distinction in a competitive marketplace, such as Massachusetts,”²³⁴ which may provide sufficient incentive for ACO certification, negating the need for the state to grant such legal exemptions.

In Texas, the Department of Insurance governs the certification of Health Care Collaboratives (HCCs), Texas’s version of ACOs.²³⁵ Certification is mandatory for the HCC to take on certain levels of financial risk, and the program focuses mostly on the antitrust implications of HCCs.²³⁶ To obtain certification, an HCC must demonstrate the willingness and ability to increase collaboration and integration among health care providers; promote improvements in care quality and outcomes; reduce preventable medical errors; contain costs without jeopardizing quality; and gather, analyze, and report statistics on health care costs, quality, access, and utilization.²³⁷ In addition, the HCC must fund and engage in an in-depth antitrust review that provides evidence that the proposed collaboration is not likely to harm competition and that the procompetitive effects of the collaboration outweigh any anti-competitive effects of increased market power.²³⁸ Having the applicants fund the reviews saves state resources, but may also discourage health care entities from

as defined under New York insurance law, must receive an appropriate license. N.Y. COMP. CODES R. & REGS. tit. 10, § 1003.1.

231. See MASS. GEN. LAWS ANN. ch. 6D, § 15 (West 2016) (setting forth standards for certification as an ACO in Massachusetts); HOLLINGSHEAD ET AL., *supra* note 186, at 14.

232. MASS. GEN. LAWS ANN. ch. 6D, § 15.

233. *Id.*; HOLLINGSHEAD ET AL., *supra* note 186, at 17.

234. HOLLINGSHEAD ET AL., *supra* note 186, at 14 (quoting from interviews conducted by the authors with key officials at HPC).

235. See, e.g., TEX. INS. CODE ANN. §§ 848.056–57 (West 2009) (providing requirements for application for certification of authority and approval of that application); *id.* § 848.201 (establishing basis for state enforcement actions against an HCC).

236. HOLLINGSHEAD ET AL., *supra* note 186, at 15.

237. TEX. INS. CODE ANN. § 848.057; see also HOLLINGSHEAD ET AL., *supra* note 186, at 15 (stating that depending on complexity and extent, review costs could range from \$25,000 to \$250,000 for the initial review and up to \$10,000 per annual renewal).

238. TEX. INS. CODE ANN. § 848.057(a)(5)–(6).

forming HCCs. To date, no health care provider organization has applied for certification as an HCC in Texas, and so whether this type of certification serves to protect competition or discourage integration remains uncertain.

In contrast to Massachusetts and Texas, New York's voluntary certificate of authority for commercial ACOs both demands more of and offers more to applying ACOs. New York encourages clinical and financial integration by offering to exempt qualifying ACOs from prosecution under the corporate practice of medicine doctrine, state and federal antitrust laws, and prohibitions on fee splitting and self-referrals.²³⁹ In exchange, the ACO must agree to "[p]rovide, manage and coordinate health care . . . for a defined population . . . ; [b]e accountable for quality, cost, and delivery of health care to ACO patients; [n]egotiate, receive and distribute any shared savings or losses; and [e]stablish, report and ensure provider compliance with health care criteria including quality performance standards."²⁴⁰ In addition to the materials requested for initial certification application, ACOs applying for a COPA must submit any additional information requested by the state during the COPA review process described above.²⁴¹

State certification of ACOs offers a means of incentivizing beneficial integration in health care while offering states the opportunity to gather valuable cost and quality data to determine the impact of such integration on the dynamics in the health care markets. States considering certification should monitor the success of Massachusetts, Texas, and New York to determine which elements of their programs to emulate. The design of an ACO certification program entails policy tradeoffs. For instance, mandatory certification enables states to guarantee oversight and access to essential cost and quality data, but it may create substantial barriers to ACO formation, which states may still want to encourage. By contrast, the promise of state action immunity via a COPA may encourage ACO formation, but it may also unduly protect entities that engage in anticompetitive behavior and abuse market power. Finally, voluntary certification programs that do not offer significant benefits may not enroll many ACOs, which would significantly hinder the state's ability to monitor and regulate the activities of integrating health care entities.

D. Rate Oversight Authority

A step beyond ACO certification models that only apply to certain forms of integration is to vest more widespread rate oversight authority in a rate oversight body. There are two models of oversight authority: (1) an independent rate commission that reviews and oversees *provider* rates; or (2) expanding the *insurance* rate review authority of the state department of insurance. Authorities under both models can be vested with a spectrum of authority ranging from weaker reporting or recommendation power to stronger rate approval and enforcement power. To be effective, however, the rate oversight body should be insulated from capture by the providers or insurers it regulates and possess regulatory and enforcement authority to limit rate increases.

239. See HOLLINGSHEAD ET AL., *supra* note 186, at 14–15.

240. N.Y. COMP. CODES R. & REGS. tit. 10 § 1003.6(b) (2015).

241. See *supra* notes 221–25 and accompanying text.

1. Rate Oversight Commission

States can establish an independent rate oversight commission to oversee providers' health care prices and transactions in their state. A rate oversight commission's charge typically includes authority to study and make recommendations on proposed health care mergers and to monitor prices and quality data postmerger. But a more powerful oversight model vests the oversight commission with regulatory authority to enforce and limit excessive provider prices.

In states that have established an APCD, a commission could have authority to analyze statewide claims data from the APCD to evaluate the pricing power, efficiency, utilization, and quality of the existing provider landscape. Based on its findings, the commission then makes recommendations and supplies data to both the state's attorney general regarding proposed mergers or anticompetitive provider behavior and policy-making bodies regarding the need for regulatory intervention.²⁴² For example, if the commission observes that powerful providers are using anti-tiering provisions in contracts with health plans to limit the ability of those health plans to steer members to lower cost or higher value providers, the commission could recommend enforcement action by the state attorney general, or legislation prohibiting anti-tiering clauses in provider-plan contracts. A rate oversight commission also could be given more direct regulatory authority beyond simply monitoring and making recommendations. For example, it might be granted the ability to implement price caps if prices rise beyond certain supracompetitive thresholds.

To date, five states have established a rate-oversight commission: Delaware, Maryland, Massachusetts, New York, and Pennsylvania.²⁴³ Perhaps the most prominent example of such a body is the Massachusetts Health Policy Commission. In terms of rate oversight, HPC has some regulatory authority, with the ability to require providers that exceed cost growth benchmarks to implement performance improvement plans and fine them if the provider fails to comply.²⁴⁴ Along with HPC, rate oversight commissions in Delaware, New York, and Pennsylvania have authority to analyze price and cost data and make recommendations.²⁴⁵ The commission in Maryland, by contrast, has additional authority to approve and set inpatient and

242. An example is Pennsylvania's Health Care Cost Containment Council, which has the authority to collect, analyze, and make recommendations on health care price data. *See* 35 PA. STAT. AND CONS. STAT. ANN. § 449.17b (West Supp. 2016); NASI PANEL ON PRICING POWER, *supra* note 26, at 42.

243. *See* DEL. CODE ANN. tit. 16, § 9902 (West 2003) (establishing the Delaware Health Commission); MD. CODE ANN., HEALTH-GEN. § 19-720 (LexisNexis 2015) (establishing the state Health Services Cost Review Commission); MASS. GEN. LAWS ANN. ch. 6D, § 2 (West 2016) (establishing the Massachusetts Health Policy Commission); N.Y. INS. LAW § 213 (McKinney 2015) (establishing the New York State Health Care Quality and Cost Containment Commission); 35 PA. CONS. STAT. AND CONS. STAT. ANN. § 449.17b (West Supp. 2016) (establishing the Health Care Cost Containment Council).

244. MASS. GEN. LAWS ANN. ch. 6D, § 3; *see also* NASI PANEL ON PRICING POWER, *supra* note 26, at 42.

245. *See supra* note 242.

outpatient rates and limit hospitals' total revenues.²⁴⁶ In addition, in 2015 Colorado established a health care cost-containment commission with a three-year mandate to study the drivers of health care cost growth, analyze the state's APCD and insurance rate review data, and make recommendations to the legislature.²⁴⁷

A significant challenge to the effectiveness of an independent rate oversight commission is protecting the body from regulatory capture.²⁴⁸ In particular, it is important to insulate the commission from undue influence from health care providers and powerful health systems who will resist oversight efforts and commission recommendations that scrutinize or threaten their market power and pricing practices. The Massachusetts HPC, for example, was structured to avoid capture by requiring diverse representation, including those with experience as a health administrator, a health economist, a physician, and a representative from a variety of perspectives including consumer advocates, health insurance, health care workforce, and labor unions, among others.²⁴⁹ In addition, the members of the HPC may not be employed as a state executive branch official and may not be employed by, affiliated with, serve as a board member, or have a financial stake in any health care provider.²⁵⁰

Another challenge is making sure the rate oversight commission coordinates with other existing government agencies and does not just add another regulatory body to the mix.²⁵¹ To be effective, a commission must closely communicate with the APCD authority, the state attorney general, the department of insurance, certificate-of-need authorities, and others. Although it can be extremely valuable for a state to have an expert, independent commission to analyze APCD data and make policy or enforcement recommendations, the most effective model of rate oversight commission must be vested with meaningful regulatory and enforcement authority—whether it is the power to approve provider budgets, impose limits on excessive prices or price increases, or engage in rate regulation.

2. Insurance Rate Review

States could also increase the insurance rate review authority of the department of insurance. The ACA requires states to review proposed insurance rates for non-grandfathered health plans and determine the reasonableness of any proposed rate

246. MD. CODE ANN., HEALTH-GEN. §§ 19-219 to 19-221 (LexisNexis 2015) (providing authority for the Maryland's Health Services Cost Review Commission (HSCRC) to review and set hospital rates); MD. CODE ANN., INS. § 15-604 (LexisNexis 2015) (requiring all payers to reimburse Maryland hospitals based on the rates established by the HSCRC). For a further discussion of Maryland's all-payer rate setting program, see *infra* Part IV.F.

247. See COLO. REV. STAT. ANN. § 25-46-101 to 105 (West Supp. 2015) (establishing the Colorado Commission on Affordable Health Care).

248. See generally Rachel E. Barkow, *Insulating Agencies: Avoiding Capture Through Institutional Design*, 89 TEX. L. REV. 15 (2010).

249. MASS. GEN. LAWS ANN. ch. 6D, § 15.

250. *Id.* § 2.

251. See 35 PA. STAT. AND CONS. STAT. ANN. § 449.17b (West Supp. 2016) (creating an oversight commission with members who are appointed by the Governor and members of the legislature); NASI PANEL ON PRICING POWER, *supra* note 26, at 42.

increase of more than 10%, but it does not require states to give prior-approval (or disapproval) authority over such rate hikes to the department of insurance.²⁵² Pursuant to these requirements, many states strengthened their insurance rate review functions. States with prior-approval authority require health insurers to submit their rates to the department of insurance for prior approval, and the insurance commissioner has the authority to reject or reduce proposed rate increases.²⁵³ Other states give the insurance commissioner weaker “file-and-use” authority, where rates go into effect once they have been filed and the department has no ability to reject the rate increase.²⁵⁴ States also vary in terms of which types of health insurance products (e.g.,

252. 42 U.S.C. § 300gg-94(c) (2012); 45 C.F.R. § 154.200 (2015). If the state does not establish an effective rate review authority, the Department of Health and Human Services shall determine the reasonableness of the proposed rate increase above 10%, but it does not have the authority to disapprove the rate. For more on the ACA’s insurance rate review requirements and state rate review activities, see generally John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 *TEMPLE L. REV.* 411 (2016).

253. “Prior approval” authority generally means that the state insurance commissioner can approve, reject, or reduce proposed rate increases from insurers. If a rate is not disapproved or reduced by a deadline, it goes into effect. *COMMUNITY CATALYST, RATE REVIEW: WHAT IS IT AND WHY DOES IT MATTER?* 2 (2013), <http://www.communitycatalyst.org/resources/publications/body/Rate-review-fact-sheet-FINAL.pdf> [<https://perma.cc/7E8G-CE4G>]. The following states vest the insurance commissioner with prior approval authority: Alabama, ALA. CODE § 27-2-17 (LexisNexis 2014); Alaska, ALASKA STAT. § 21.51.405 (2014); Arkansas, ARK. CODE ANN. § 23-79-109 (Supp. 2015); Colorado, COLO. REV. STAT. ANN. § 10-16-107 (West Supp. 2015); Delaware, DEL. CODE ANN. tit. 16, §§ 9902-9903 (Supp. 2014); Hawaii, HAW. REV. STAT. ANN. § 431:14G-105 (West Supp. 2016); Indiana, IND. CODE § 27-8-4-7 (2012); Iowa, IOWA CODE ANN. § 514A.13 (West 2015); Kansas, KAN. STAT. ANN. § 40-2215 (Supp. 2015); Kentucky, KY. REV. STAT. ANN. § 304.17-380 (LexisNexis 2011); Maryland, MD. CODE ANN. HEALTH-GEN. § 19-108 (LexisNexis 2015); Massachusetts, MASS GEN. LAWS ch. 6D § 2 (West 2016); Michigan, MICH. COMP. LAWS ANN. § 550.1607 (West Supp. 2016); Minnesota, MINN. STAT. ANN. § 62A.02 (West Supp. 2016); Mississippi, MISS. CODE ANN. § 83-9-3 (West Supp. 2015); Nebraska, NEB. REV. STAT. ANN. § 44-710 (LexisNexis Supp. 2015); Nevada, NEV. REV. STAT. ANN. § 686B.070 (LexisNexis 2014); New Hampshire, N.H. REV. STAT. ANN. § 415:1 (2015); New Mexico, N.M. STAT. ANN. § 59A-18-13.2 (West Supp. 2015); New York, N.Y. INS. LAW § 213 (McKinney 2015); North Carolina, N.C. GEN. STAT. ANN. § 58-51-95 (West Supp. 2015); North Dakota, N.D. CENT. CODE § 26.1-17-26 (2010); Ohio, OHIO REV. CODE ANN. § 3923.021 (LexisNexis 2010); Oklahoma, OKL. STAT. ANN. tit. 36 § 2606 (West 2011); Oregon, OR. REV. STAT. § 743.018 (2015); Tennessee, TENN. CODE ANN. § 56-26-102 (Supp. 2015); Vermont, VT. STAT. ANN. tit. 8 § 4062 (2015); and West Virginia, W. VA. CODE ANN. § 16-29B-1 (LexisNexis Supp. 2016).

254. “File-and-use” authority generally means that the insurance companies must file their proposed rates with the department of insurance, but the rates may go into effect without department approval. The department may have the ability to go back and disapprove a rate increase that was later deemed unreasonable, usually triggered by a consumer complaint process. *COMMUNITY CATALYST, supra* note 253, at 2. The following states vest the insurance commissioner with file-and-use authority: Arizona, ARIZ. REV. STAT. ANN. § 20-1342.02 (2010); Illinois, 235 ILL. COMP. STAT ANN. 93/25 (West 2008); Louisiana, LA. STAT. ANN. § 22:972 (2009); Missouri, MO. ANN. STAT. § 354.152 (West 2015); Montana, MONT. CODE

individual, group, HMOs, PPOs) are subject to their rate-review requirements.²⁵⁵ Recent research suggests states with stronger forms of rate review authority, such as prior-approval authority and loss-ratio requirements, experienced lower premium increases in the individual market than states without rate review authority or with only file-and-use authority.²⁵⁶

Although insurance rate review focuses on premium rate increases rather than on provider prices, limiting the ability of insurance companies to raise premiums puts pressure on providers negotiating with the health plans.²⁵⁷ When health plans are limited in their ability to raise premiums, they cannot simply pass high provider prices on to the policy holders. But most state insurance rate review systems, even as augmented by ACA requirements, are generally inadequate to offset some insurers' lack of bargaining power relative to powerful providers.

To really get at provider pricing power, insurance rate review must be further strengthened by giving the insurance commissioner authority to condition approval of insurance rates on mandatory limits on provider price increases. For instance, Rhode Island has expanded its insurance department's authority to limit annual price increases for inpatient and outpatient services.²⁵⁸ The state caps the amount of price increases to which insurers can contractually agree to the Consumer Price Index-Urban plus 1%.²⁵⁹ Rhode Island's cap on the rate increases insurance plans may accept from providers is a form of indirect provider rate caps via health insurance rate review.

The advantages of strengthening insurance rate review authority are that stronger forms of insurance rate review may be effective at constraining premium growth,

ANN. § 33-22-156 (2015); New Jersey, N.J. STAT. ANN. § 17B:18-5 (West 2013); South Carolina, S.C. CODE ANN. § 38-71-310 (2015); Texas, TEX. INS. CODE ANN. § 1507.008 (West 2009); Utah, UTAH CODE ANN. § 31A-22-602 (LexisNexis 2014); and Virginia, VA. CODE ANN. § 38.2-316.1 (2015).

255. The following states vest prior approval authority in the insurance commissioner only for subsets of the insurance market: Connecticut, CONN. GEN. STAT. ANN. § 19a-638 (West 2011); Florida, FLA. STAT. ANN. § 627.410 (West 2016); Georgia, GA. CODE ANN. § 33-21-13 (2014); Idaho, IDAHO CODE § 41-5206 (2010); Maine, ME. REV. STAT. ANN. tit. 24-A, § 2736 (2015); Pennsylvania, 35 PA. STAT. AND CONS. STAT. ANN. § 449.17b (West Supp. 2016); Rhode Island, 4D R.I. GEN. LAWS § 27-18-54 (2008); South Dakota, S.D. CODIFIED LAWS § 58-17-4.1 (2004); Washington, WASH. REV. CODE ANN. § 48.44.020 (West 2014); Wisconsin, WIS. STAT. ANN. § 625.11 (West 2006); and Wyoming, WYO. STAT. ANN. § 26-18-135 (2015).

256. Pinar Karaca-Mandic, Brent D. Fulton, Ann Hollingshead & Richard M. Schaffer, *States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market*, 34 HEALTH AFF. 1358, 1360 (2015).

257. See NASI PANEL ON PRICING POWER, *supra* note 26, at 44.

258. 6C R.I. GEN. LAWS § 42-14.5-3 (Supp. 2015); CODE R.I. REG. 4424 (2012).

259. See R.I. Office of the Health Ins. Comm., Reg. 17, Sec. 7.e (setting affordability standards that include limits on hospital rate increases as a condition of health insurance rate approval), <http://www.ohic.ri.gov/documents/Regulation-17-Filing-of-Forms-and-Rates.pdf> [<https://perma.cc/29UW-RUBH>]. The rules limit hospital price increases to the CPI-Urban less Food and Energy for the Northeast Region (CPI-U) plus 1%, decreasing to CPI-U plus 0% by 2018. See Cogan, *supra* note 252, at 463 n.297.

which may be especially important as the insurance market becomes more concentrated.²⁶⁰ A significant advantage is that insurance rate review builds on a state's existing institutions and infrastructure. In addition, even in states without an APCD, the insurance commissioner has extensive authority to gather private price and claims data from payers in the state. To be effective, however, most states would have to augment the authority of the insurance commissioner, as Rhode Island did, to explicitly place limits on provider price increases as part of its insurance rate review authority.²⁶¹

Without the authority to impose limits on provider prices, a major limitation of most states' insurance rate review system is that the standards for reviewing rate increases are not calibrated to address providers' pricing power but rather get at antiquated property-casualty insurance market problems, such as financial solvency.²⁶² Another challenge of insurance rate review is the scope of most states' laws and the ACA are too limited and may not apply to all health insurance products by excluding, for example, for-profit, employer-based, or large-group plans.²⁶³ In addition, it is unclear how existing rate review authority will apply to provider-risk-bearing organizations, such as ACOs or conglomerates consisting of health systems with a health plan. Another risk is that stronger limits on insurers' premium revenue without addressing provider pricing power may drive insurers to fold or exit the market. Finally, to the extent insurance rate caps or targets are based on averages, they may widen the gap between the "must-have" and "have-not" providers.²⁶⁴ Must-have health systems may still command monopoly prices, but to get under the cap, the insurers may force less powerful providers to lower prices below sustainable levels or exit the market.

In sum, the existing rate review authority in most states will not likely provide sufficient levers to oversee and contain the pricing power of integrated providers. However, states can follow Rhode Island's example and build on the existing

260. Karaca-Mandic et al., *supra* note 256, at 1365; *Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 114th Cong. (2015), https://judiciary.house.gov/wp-content/uploads/2016/02/114-47_96274.pdf [<https://perma.cc/ASS3-W8AW>] (written statement of Jaime S. King, Professor of Law at the University of California, Hastings College of Law).

261. *See supra* notes 258–59 and accompanying text.

262. John Cogan delves extensively into the post-ACA insurance rate review system and concludes:

Since the states, and now the federal government, apply to health insurance a rate review standard designed to address a set of market failures that existed a hundred years ago for a different insurance product, the health insurance rate review process is simply incapable of controlling the fundamental problems that plague *today's* health insurance market—the market failures leading to excessive provider prices. As such, rate review can do little to control the medical cost component of health insurance rates. Simply put, there is a mismatch: health insurance rate review uses the wrong tools for the job at hand.

Cogan, *supra* note 252, at 415 (emphasis in original).

263. *See id.* at 469.

264. *See* NASI PANEL ON PRICING POWER, *supra* note 26, at 44.

infrastructure and expertise of the insurance department to provide insurance commissioners regulatory authority over private provider rate increases.

E. Private Rate Caps

As an intermediate step before full-fledged rate regulation and in conjunction with the establishment of a rate oversight authority, a state could cap providers' private health care prices. The cap would apply to all private payers, including out-of-network payments and self-pay patients.²⁶⁵ In many proposals, price caps are set as a percentage of Medicare rates. For example, health economics and policy experts from Dartmouth suggested a private price cap of 125% of Medicare rates;²⁶⁶ Robert Murray, former executive director of Maryland's rate setting agency, suggested a cap of 150–175% of Medicare rates.²⁶⁷ Recent analysis demonstrating that private inpatient payments are, on average, 175% of Medicare payments may suggest that maximum price cap levels may need to be even higher.²⁶⁸ Alternatively, price caps could be defined not by reference to Medicare rates but in terms of average or percentages of private prices. Such a price cap would require access to private price data from an APCD or other database.²⁶⁹

265. Mark Hall & Carl Schneider, *Price-Gouging by Doctors and Hospitals*, HEALTH REFORM WATCH (July 19, 2009), <https://web.archive.org/web/20091211202230/http://www.healthreformwatch.com/2009/07/19/price-gouging-by-doctors-and-hospitals/> [<https://perma.cc/N2HR-B6HE>] (suggesting a price cap of 150% of Medicare prices for self-pay patients).

266. Jonathan Skinner, Elliot Fisher & James Weinstein, *The 125 Percent Solution: Fixing Variations in Health Care Prices*, HEALTH AFF. BLOG (Aug. 26, 2014), <http://healthaffairs.org/blog/2014/08/26/the-125-percent-solution-fixing-variations-in-health-care-prices/> [<https://perma.cc/6ZU5-9433>] (“If every patient and every insurance company always had the option of paying 125 percent of the Medicare price for any service, we would effectively cap the worst of the price spikes. No longer would the tourist checked out at the ER for heat stroke be clobbered with a sky-high bill. Nor would the uninsured single mother be charged 10 times the best price for her child’s asthma care. This is not just another government regulation, but instead a protection plan that shields consumers from excessive market power.”).

267. See Robert Murray, *The Case for a Coordinated System of Provider Payments in the United States*, 37 J. HEALTH POL. POL’Y & L. 679, 689 (2012) [hereinafter Murray, *The Case for a Coordinated System of Provider Payments*]; Robert Murray, Health Servs. Cost Review Comm’n, *The Cost of Hospital Care: Experience from Maryland’s All-Payer Rate Setting System*, NAT’L HEALTH POL’Y F., at slide 21 (Oct. 8, 2010), http://www.hsrc.state.md.us/documents/pdr/Presentations/TheCostofHospitalCareNHPFR_Murray2010-10-08.pdf [<https://perma.cc/U25A-RRJ2>].

268. Thomas M. Selden, Zeynal Karaca, Patricia Keenan, Chapin White & Richard Kronick, *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, 34 HEALTH AFF. 2147, 2148–49 (2015) (finding that the differential between average private rates have grown to 75% higher than Medicare rates in 2012, up from about 10% higher than Medicare in the period 1996–2001).

269. See, e.g., Robin Gelburd, *The Need for a Comprehensive, Current, and Market-Representative Health Care Cost Benchmark*, HEALTH AFF. BLOG (Oct. 7, 2014), <http://healthaffairs.org/blog/2014/10/07/the-need-for-a-comprehensive-current-and-market>

Rate caps offer several advantages. First, they can limit outlier prices at the top end of the scale, while still allowing for some competition below the cap.²⁷⁰ Rate caps preserve the ability of providers to charge different prices from each other, which allows providers to compete within this range on the basis of price or quality, but the caps limit the extent of price variation by imposing a ceiling on prices.²⁷¹ Second, a broad cap on private payer rates would improve payers' bargaining position to resist price increases by powerful providers or at least put a regulatory backstop on the degree to which such providers can charge monopoly prices. Third, rate caps are simpler from a regulatory perspective than rate setting, where the administrative body has to set prices for each service, because rate caps piggyback on the prices set in the Medicare system.²⁷²

On the other hand, to the extent that rate caps piggyback on Medicare rates, they incorporate all the flaws of the Medicare pricing system as well as its strengths.²⁷³ Rate caps also do not eliminate inefficiencies and administrative costs of price discrimination by providers, the practice of charging different rates to different payers for the same service.²⁷⁴ Rate caps should only be considered for noncompetitive markets, because any rate-cap level, even if supported by substantial expertise and data, will not precisely replicate the maximum prices that would result in a competitive market in equilibrium. Some have criticized rate caps and other forms of rate regulation as potentially stifling financial incentives for innovation.²⁷⁵ Rate caps are

-representative-health-care-cost-benchmark/ [https://perma.cc/2PR6-AVNB] (proposing to set a provider's "usual, customary, and reasonable" (UCR) rates, used in fee disputes for out-of-network and self-pay patients, to 80% of average charges drawn from a geographically representative dataset of private prices, here, FairHealth.org); David Seltz, David Auerbach, Kate Mills, Marian Wrobel & Aaron Pervin, *Addressing Price Variation in Massachusetts*, HEALTH AFF. BLOG (May 12, 2016), <http://healthaffairs.org/blog/2016/05/12/addressing-price-variation>

-in-massachusetts/ [https://perma.cc/QKG9-ZQ6J].

270. NASI PANEL ON PRICING POWER, *supra* note 26, at 46.

271. Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 133 (2015).

272. Robert A. Berenson, Jonathan H. Sunshine, David Helms & Emily Lawton, *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFF. 1289, 1295 (2015) ("Placing an upper limit on what a hospital or physician can charge as a percentage above Medicare prices might provide a regulatory alternative to actually setting the commercial rates themselves, likely a less intrusive and less resource-intensive endeavor, especially if the out-of-network ceilings were set initially to affect only a small number of especially high-price hospitals.")

273. Gelburd, *supra* note 269 (critiquing a system of price caps based on Medicare prices because Medicare may not be representative of costs or particular dynamics in certain markets, such as for lower-volume providers).

274. Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFF. 2125, 2128–29 (2011).

275. See, e.g., Michael A. Morrissey, Frank A. Sloan & Samuel A. Mitchell, *State Rate Setting: An Analysis of Some Unresolved Issues*, 2 HEALTH AFF. 36, 36 (1983) (noting that detractors of state rate setting say that rate setting stifles innovation).

politically challenging as well; they are likely to be opposed by the most powerful providers whose pricing power will be limited by the caps. Caps may be supported, however, by health plans, employers, and other purchasers of health care because they could constrain the cost of including must-have providers in health plan networks.

To date, no state has implemented price caps, although Rhode Island's insurance rate caps²⁷⁶ and West Virginia's now-defunct hospital rate review program²⁷⁷ resemble the price caps described here.²⁷⁸

Price caps are often viewed as an intermediate, less intrusive alternative to rate-setting to limit unwarranted price variation especially among dominant providers. Nevertheless, some administrative infrastructure must be established to determine whether to implement a price cap or how to set the cap. States will require data from an APCD and perhaps a rate oversight commission with expertise to come up with the price cap levels and methodology.

F. Provider Rate Regulation

In highly concentrated provider markets where provider conglomerates are exercising unchecked market power, states can address provider pricing power through direct regulation of provider prices. Different versions of rate regulation are discussed below: all-payer rate setting exemplified by Maryland's system; private rate regulation as illustrated by West Virginia's now-defunct rate-review authority; and the move to incorporate rate setting into global budget initiatives.

1. All-Payer Rate Setting

The prototypical system of provider rate regulation is all-payer rate setting, which would set the rate for all payers, whether private insurers, government programs, or self-pay patients. To include Medicare in the all-payer model, the state must obtain a waiver from the Centers for Medicare and Medicaid Services.²⁷⁹ Under an all-payer system, either a rate setting commission or a representative body of payers negotiates

276. See *supra* text accompanying notes 258–59.

277. See *supra* text accompanying note 290–92.

278. In an effort to address persistent provider price variation in Massachusetts, a SEIU-led ballot initiative in 2015–2016 proposed to limit providers' private rates to a corridor 20% above or 10% below the average price paid to all providers by that health plan for that service. Massachusetts Fair Health Care Pricing Act, No. 15-19 (2015–2016 Mass. Ballot Initiatives), <http://www.mass.gov/ago/docs/government/2015-petitions/15-19.pdf> [<https://perma.cc/3CZ6-8D3Q>]. The SEIU agreed to drop the ballot measure when the Massachusetts legislature passed a compromise to create a fund to redistribute funds from higher- to lower-priced hospitals and with the promise of more union jobs at the largest hospital system. Priyanka Dayal McCluskey & Jim O'Sullivan, *Deal Reached To Avert Ballot Question on Hospitals*, BOS. GLOBE (May 25, 2016), <https://www.bostonglobe.com/business/2016/05/25/deal-reached-avert-ballot-question-hospitals/xDPLHx13YRUq89Qz8FMCXK/story.html> [<https://perma.cc/TZ8C-TG7K>].

279. See Robert Murray, *Setting Hospital Rates To Control Costs and Boost Quality: The Maryland Experience*, 28 HEALTH AFF. 1395, 1395–96 (2009).

a uniform set of provider reimbursement rates.²⁸⁰ Although traditionally applied to hospital services, in its broadest form, rate setting could apply to all provider services (whether hospital, physician, post-acute, lab, diagnostic, etc.).

Under the rate setting commission approach, the commission collects detailed information about costs, patient volumes, hospital finances, and services for each provider for use in rate setting.²⁸¹ The best-known and only example of this public utility model of rate setting is Maryland's all-payer rate setting system, where an administrative body sets hospital rates.²⁸² Maryland's system has controlled hospital costs-per-case, but it must be paired with global budgets or ACO-type mechanisms to limit incentives to increase patient volume. In the 1970s, several states adopted rate setting systems only to abandon them during the deregulatory era of the 1980s–90s when managed care seemed to be constraining health care costs.²⁸³

For the second model of rate setting through collective negotiation, there are no examples from the United States, but Japan, Germany, France, Switzerland, and other OECD countries use this model.²⁸⁴ This model combines the bargaining leverage of all payers together in an oligopsony.²⁸⁵ To counteract provider pricing power, insurers combine their bargaining power and collectively negotiate with each provider separately or with a consortium representing all providers.²⁸⁶ For those concerned about concentration among health insurers, allowing payers to come together to bargain collectively with providers is not the same as increasing concentration in the insurance market. The individual health plans would still have to compete for their own customers on the basis of premiums, provider networks, consumer experience, and other benefits.²⁸⁷

Although rate setting eliminates price discrimination by a single provider against

280. See Vladeck & Rice, *supra* note 13, at 1312–13.

281. Murray, *The Case for a Coordinated System of Provider Payments*, *supra* note 267, at 686–88. The data collection and analysis is similar to that performed through an APCD and could also be used for rate setting.

282. MD. CODE ANN., HEALTH-GEN. § 19-201 to 19-203 (LexisNexis 2015) (establishing the Maryland Health Services Cost Review Commission (HSCRC)); §§ 19-219 to 19-221 (providing for the HSCRC's authority to review and set hospital rates); MD. CODE ANN., INS. § 15-604 (requiring all payers to reimburse Maryland hospitals based on the rates established by the HSCRC); MD. CODE REGS. 10.37.01–.37.12 (2016) (setting forth administrative rules for hospital rate review and rate setting in Maryland); see also Murray, *The Case for a Coordinated System of Provider Payments*, *supra* note 267, at 686.

283. John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 145 (1997).

284. See Uwe E. Reinhardt, *A Modest Proposal on Payment Reform*, HEALTH AFF. BLOG (July 24, 2009), <http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/> [<https://perma.cc/YK3S-DXJV>]; Reinhardt, *supra* note 274, at 2129; Vladeck & Rice, *supra* note 13, at 1313.

285. Vladeck & Rice, *supra* note 13, at 1313.

286. See Austin Frakt, *All-Payer Rate Setting and Health Reform's Underpants Gnomes Strategy*, WASH. POST: WONKBLOG (June 2, 2011), http://www.washingtonpost.com/blogs/wonkblog/post/all-payer-rate-setting-and-health-reforms-underpants-gnomes-strategy/2011/06/02/AG3SfHHH_blog.html#pagebreak [<https://perma.cc/FP6X-2KD3>].

287. See *id.*

its various payers, rate setting generally allows providers to charge different prices from each other, which preserves some degree of competition. Competition can be amplified by reporting providers' percentage markup above the standard rate and quality ratings to allow price and quality comparisons with other providers.²⁸⁸ Somewhat like Medicare, this approach allows for price differences to reflect differences in costs if, for example, the facility is a teaching hospital.²⁸⁹ To the extent it encourages price and quality transparency, rate setting could also encourage competition among providers on the basis of value, while still limiting the pricing power of dominant providers.

2. Private Rate Regulation

Until recently, West Virginia provided a different model of provider rate regulation through review of providers' private prices.²⁹⁰ West Virginia established its Health Care Authority in 1983 to gather information on health care costs and run the state's rate regulation and certificate of need programs to control health care costs and capital expenditures.²⁹¹ In 2016, West Virginia abolished the agency's hospital rate review authority,²⁹² but we describe its system here as an example of a state program to regulate private prices.

Under the prior system, West Virginia hospitals would submit a rate application to the Authority with their proposed private rates and their cost information, and the Health Care Authority could approve, disapprove, or seek modification of the hospital's rates for private payers.²⁹³ West Virginia's hospital rate review system excluded Medicare rates (which would require a Centers for Medicare and Medicaid Services (CMS) waiver) as well Medicaid and public employees' insurance rates.²⁹⁴ A hospital could accept a guaranteed or pre-approved rate increase by tying its proposed increase to a benchmarking methodology, based on peer hospitals' costs and charges,

288. See Murray, *The Case for a Coordinated System of Provider Payments*, *supra* note 267, at 683–84; Reinhardt, *supra* note 284; Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind the Veil of Secrecy*, 25 HEALTH AFF. 57, 65–66 (2006); Austin Frakt, *Simply Put: All-Payer Rate Setting*, INCIDENTAL ECONOMIST BLOG (Apr. 8, 2011), <http://theincidentaleconomist.com/wordpress/simply-put-all-payer-rate-setting/> [https://perma.cc/7CAW-X5EQ].

289. See Frakt, *supra* note 288; Reinhardt, *supra* note 284.

290. West Virginia's was not an all-payer system, because it did not include Medicare and Medicaid in its rate-setting authority.

291. W. VA. CODE ANN. § 16-29b-1 to -29 (West 1997 & Supp. 2016) (§ 16-29b-19 to -21a repealed 2016); W. VA. CODE R. § 65-5-1 to -28 (1992).

292. S.B. 68, 2016 Leg., Reg. Sess. (W. Va. 2016) (enacted) (amending the powers granted to the Health Care Authority in West Virginia).

293. W.VA. CODE ANN. § 16-29b-19 (repealed 2016).

294. ROBERT MURRAY & ROBERT A. BERENSON, HOSPITAL RATE SETTING REVISITED: DUMB PRICE FIXING OR A SMART SOLUTION TO PROVIDER PRICING POWER AND DELIVERY REFORM? 31 (2015), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000516-Hospital-Rate-Setting-Revisited.pdf> [https://perma.cc/9YEEY-AM8K].

or it could apply for a greater rate increase subject to more in-depth review.²⁹⁵ Rather than setting rates precisely for each hospital, West Virginia's system effectively created a rate corridor with the authority-approved charge limit serving as the ceiling on its privately negotiated prices and the hospital's costs serving as the floor.²⁹⁶ Under this system, hospitals could negotiate different prices and payment methodologies with different payers, preserving a degree of price variation and discrimination.

Under its private rate review system, West Virginia's costs-per-case grew slower than the national average, suggesting that it was somewhat effective at controlling health care price growth.²⁹⁷ However, West Virginia's inpatient and outpatient utilization rates were much higher than the national average, which drove the state's relatively high per capita hospital spending.²⁹⁸ In any event, without rate review authority and with new laws shielding hospital mergers and conduct from state and federal antitrust liability,²⁹⁹ West Virginia has moved rapidly to remove oversight of hospital pricing or competition.

3. Global Budgets

Newer rate setting approaches are moving to incorporate global budgets to simultaneously regulate prices and utilization for providers by imposing total revenue limits on health systems.³⁰⁰ States can prospectively set a global budget for an integrated

295. See ANNA S. SOMMERS, CHAPIN WHITE & PAUL B. GINSBURG, ADDRESSING HOSPITAL PRICING LEVERAGE THROUGH REGULATION: STATE RATE SETTING 7 & 9 n.24 (2012), http://nihcr.org/wp-content/uploads/2016/07/Policy_Analysis_No._9.pdf [<https://perma.cc/VN8A-QB38>].

296. MURRAY & BERENSON, *supra* note 294, at 32 (“This corridor-based approach stands in contrast to most other mandatory rate setting systems, such as Maryland, in which the approved rate largely acts as both a ceiling and a floor for a hospital and the hospital must adjust its charges to be in compliance with that approved rate.”).

297. GRAHAM ATKINSON, COMMONWEALTH FUND, PUB. 1332, STATE HOSPITAL RATE-SETTING REVISITED 11 (2009) (“From 1985 to 2007, costs per [inpatient admission] in West Virginia increased by 192 percent, compared with a nationwide increase of 213 percent.”); MURRAY & BERENSON, *supra* note 294, at 38–39 (noting that in 2011, West Virginia had the 16th lowest hospital markups at 151% above costs, versus a national average markup of 220% above costs, and that in 2012, West Virginia's median gross price per inpatient discharge was 26% lower than the U.S. median).

298. See MURRAY & BERENSON, *supra* note 294, at 39.

299. See S.B. 68, 2016 Leg., Reg. Sess. (W. Va. 2016) (enacted) (amending the powers granted to the Health Care Authority in West Virginia); John Kennedy, *W. Va. Gov. Signs Bill with Antitrust Exemptions for Hospitals*, LAW360 (Mar. 21, 2016), <http://www.law360.com/articles/774171/w-va-gov-signs-bill-with-antitrust-exemptions-for-hospitals> [<https://perma.cc/6UYR-NA6P>].

300. Rachel Block, *State Models for Health Care Cost Measurement: A Policy and Operational Framework*, MILBANK MEMORIAL FUND, at 7 (2015). Global budgets can also be implemented by private payers, often called “Alternative Quality Contracts” or ACOs with two-sided risk, or “Total Cost of Care Contracts.” See, e.g., Ann Robinow, *The Potential of Global Payment: Insights from the Field*, COMMONWEALTH FUND, at 3 (2010); Zirui Song, Dana Gelb Safran, Bruce E. Landon, Mary Beth Landrum, Yulei He, Robert E. Mechanic,

health system to cover the total expected health care costs of a defined population for a given time period.³⁰¹ A health system that exceeds its global budget must make up for the excess spending in the following year's budget, but if its expenditures come in under budget, the health system keeps the surplus.

CMS has modified Maryland's rate setting waiver to require implementation of global budgets.³⁰² Other states could similarly establish regulatory limits on hospital budgets without first implementing stand-alone rate setting. Controlling a provider's total revenues simultaneously constrains both prices and utilization because the provider's revenues are the result of a combination of its prices, utilization, and operating costs. A global budget approach tied to population health spending may be more efficient than stand-alone hospital rate setting because providers cannot simply increase utilization to make up for constrained prices, increase prices to compensate for constrained utilization, or cost shift between inpatient and outpatient settings.

Vermont passed legislation in 2012 to constrain total health care spending through administrative review of hospital budgets.³⁰³ Hospitals are required to submit their proposed annual budget to the state's Green Mountain Care Board for review and approval.³⁰⁴ The Board may require a hospital to adjust its budget with changes to its rates or net revenues,³⁰⁵ and hospital compliance with the budget is enforceable through court-ordered injunction or civil administrative penalties.³⁰⁶ Vermont is moving toward a global budget system, which would allow the Board to set payments rates and total revenues for hospitals from all payers to manage all of the health care for a given population.³⁰⁷ Under the global budget system, the Board would set a uniform rate increase for each hospital applicable to all payers, eliminating the

Matthew P. Day & Matthew E. Chernew, *The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality*, 31 HEALTH AFF. 1885, 1885–86 (2012).

301. See Song et al., *supra* note 300, at 1885.

302. Maryland All-Payer Model Agreement, CMS–Md., Feb. 11, 2014, http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/chcf_all_payer_model_agreement.pdf [<https://perma.cc/UJ6D-B9US>] (setting forth CMS's 2014 Medicare innovation waiver for Maryland's all-payer model, including limits on total hospital revenues); see generally, *Maryland All-Payer Model*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 6, 2015), <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/> [<https://perma.cc/325V-LKZC>].

303. VT. STAT. ANN. tit. 18, § 9456 (West 2012 & Supp. 2015); 4-7 VT. CODE R. §§ 3:3.100–3:3.500; see generally Green Mountain Care Bd., *The Green Mountain Guide to Hospital Budget Review* (2012), <http://gmcbboard.vermont.gov/sites/gmcb/files/files/hospital-budget/GMcb-Hospital-Budget-Review-Guide.pdf> [<https://perma.cc/T4WR-MUYQ>].

304. VT. STAT. ANN. tit. 18, § 9456(a)–(d) (West 2012 & Supp. 2015); 4-7 VT. CODE R. § 3:3.300.

305. 4-7 VT. CODE R. § 3:3.400.

306. VT. STAT. ANN. tit. 18, § 9456(h) (West 2012 & Supp. 2015).

307. Zack Budryk, *VT Hospitals Eye "Global Budget" Payment Model*, FIERCE HEALTHCARE (Apr. 15, 2014), <http://www.fiercehealthfinance.com/story/vt-hospitals-eye-global-budget-payment-model/2014-04-15> [<https://perma.cc/3XUS-7L8L>]; Morgan True, *Vermont To Launch Global Budget Pilot for Hospitals*, VT DIGGER (Apr. 14, 2014), <http://vtdigger.org/2014/04/14/vermont-launch-global-budget-pilot-hospitals/>.

hospital's separate rate negotiation with each commercial payer.³⁰⁸ In late 2016, CMS and Vermont agreed to implement an all-payer model, which aligns payment rates for Medicare, Medicaid, and commercial payers under an all-payer accountable care organization.³⁰⁹ Under the all-payer model, which not only applies to hospital services but also includes physician and other ancillary providers, Vermont will limit statewide per-capita health spending growth to 3.5% annually and move away from a fee-for-service payment model to payments that are adjusted for population health outcomes and quality of care targets.³¹⁰

Initial results from Maryland and Vermont's efforts at hospital budget oversight are promising. During the first year with global budgets, Maryland limited per capita hospital cost growth to 1.47%—well under the target of 3.58% annual growth—and saved Medicare \$116 million.³¹¹ Vermont's hospitals have been limited to modest budget increases, but they simultaneously increased their profitability.³¹² Global budget models are promising because they go beyond rate setting models that focus only on prices to incorporate mechanisms to oversee all the components of total health care spending: prices, utilization, and hospital operating costs.

The primary advantage of all forms of provider rate regulation is that these approaches directly counteract providers' pricing power in noncompetitive markets. Rate regulation does this either through administrative rate setting as is done by

308. Richard Slusky, Spenser Wepler & Robert Murray, Green Mountain Care Bd., Proposed Pilot Payment Reform Projects: Consideration of Hospital Global Budget Pilot, VT. GEN. ASSEMBLY, at slide 8 (Apr. 3, 2014), <http://legislature.vermont.gov/assets/Documents/2014/WorkGroups/House%20Ways%20and%20Means/Health%20Care/W~Robert%20Murray%20and%20Richard%20Slusky~Proposed%20Pilot%20Payment%20Reform%20Projects%20Consideration%20of%20Hospital%20Global%20Budget%20Pilot-4-3-2014.pdf> [https://perma.cc/F45Q-5QVE].

309. Vermont All-Payer Accountable Care Organization Model Agreement, CMS-Vt., Oct. 27, 2016, <http://gmcbboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf> [https://perma.cc/D6MR-JRHV]; see also, Green Mountain Care Board of Vermont, In re: Vermont All-Payer Accountable Care Organization Model Agreement (Oct. 31, 2016), <http://gmcbboard.vermont.gov/sites/gmcb/files/documents/APM-FINAL-Justification.pdf> [https://perma.cc/WZH9-5F3Z] (describing the Board's justification for entering into the all-payer-model agreement with CMS).

310. See *Vermont All-Payer ACO Model*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 26, 2016), <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/> [https://perma.cc/3MDQ-XFQE].

311. Ankit Patel, Rahul Rajkumar, John M. Colmers, Donna Kinzer, Patrick H. Conway & Joshua M. Sharfstein, *Maryland's Global Hospital Budgets—Preliminary Results from an All-Payer Model*, 373 N. ENG. J. MED. 1899, 1899 (2015).

312. See Nancy Remsen, *Hospitals in Vermont Anticipate Modest Budget Increases Next Year*, SEVEN DAYS (July 23, 2015), <http://www.sevendaysvt.com/OffMessage/archives/2015/07/23/hospitals-in-vermont-anticipate-modest-budget-increases-next-year> [https://perma.cc/5RBM-CYR6] (reporting that the Chair of the Green Mountain Care Board, Al Gobeille, noted that the average rate increase Vermont hospitals requested from insurers was only 4.3%, the lowest rate increase in fifteen years); see also Erin Mansfield, *Special Report: Despite Regulation, Hospital Profits Up*, VT DIGGER (July 17, 2016) <http://vtdigger.org/2016/07/17/special-report-despite-regulation-hospital-profits-up/> [https://perma.cc/9A76-JUJH].

public utilities and in the Medicare program or by combining the bargaining power of all purchasers and payers. Rate regulation also has the potential to dramatically reduce administrative costs for providers. By eliminating price discrimination among payers, providers could reduce the administrative costs of negotiating different rates and maintaining separate billing procedures for each payer. These administrative costs are significant drivers of health care costs as the United States' fragmented payer landscape explains much of why providers' administrative costs are so much higher in the United States than in other countries with similarly developed health systems.³¹³ To maximize transparency and administrative ease, the rate schedule could be based on Medicare rates, and to the extent that Medicare is not included in the payment system, the rate setting entity could express private rates as a simple multiplier of Medicare rate.

Rate setting could allow prices to vary between providers, but the variation in price would reflect differences in quality rather than market power as it does now.³¹⁴ Thus, under a rate-setting regime, you could still have an element of competition between providers on the basis of value and quality or services offered.

One of the biggest challenges of rate setting is political. The major hospital systems whose prices would be constrained the most are often extremely powerful entities, the engines of local economies and jobs. A lesson from the many states that implemented and later abandoned rate setting in the 1980s is that the rate-setting agency must be structured to avoid regulatory failure from bureaucratic complexity and regulatory capture.³¹⁵ Regulatory complexity and inflexibility can be avoided by using standard payment formulas rather than individual budget review.³¹⁶ A global budget approach may also get regulators out of the difficult business of setting specific rates for each item and service and instead let them focus on total hospital budgets, which may be more flexible and less complex. Ensuring the independence of the rate setting authority from excessive industry or political influence is essential to avoiding regulatory capture. Agency independence can be protected by prohibiting commissioners from having affiliations with regulated providers³¹⁷ and

313. David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet & Steffie Woolhandler, *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All by Far*, 33 HEALTH AFF. 1586, 1589, 1592 (2014) (explaining that U.S. hospitals spend more than 25% of all costs on administration, driven by the complexity of the reimbursement system and the mode of capital funding).

314. COMMONWEALTH OF MASS. HEALTH POLICY COMM'N, 2015 COST TRENDS REPORT: PROVIDER PRICE VARIATION 14–15 (2015), <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf> [<https://perma.cc/ZCH7-3L8Q>] (noting that price variation under Maryland's value-based factors is substantially less than the variation in Massachusetts, which is driven largely by provider market power); MURRAY & BERENSON, *supra* note 294, at 10–11.

315. MURRAY & BERENSON, *supra* note 294, at 72–73.

316. *Id.*

317. West Virginia's Health Care Authority, for example, is an autonomous body within the state's Department of Health and Human Resources, and it is made up of three full-time

implementing accountability measures, such as federal oversight under a Medicare waiver, to counteract local political pressure to loosen standards or make special exceptions.³¹⁸

Another significant challenge with rate setting is that it only addresses the price half of the cost-control equation.³¹⁹ Rate regulation must be paired with global budgets, volume adjustments, or other population-based payments to control the tendency to increase utilization. Both Maryland and West Virginia demonstrated that rate setting can control costs-per-case quite effectively, but not volume. Maryland's 2014 Medicare waiver adds global budgets to its rate-setting program, which is no easy feat, but it is a necessary adjustment to control both the price and utilization components of health care spending. Vermont's all-payer model builds on an ACO design, in which the ACO will receive a population-based payment for every person attributed to it, whether a Medicare beneficiary or privately insured patient.³²⁰

In sum, in states where competition is no longer functioning to keep provider prices in check, rate regulation may be the preferred strategy, or the last best hope for counteracting the price effects of health care integration. To set rates or global budgets, provider rate regulation must be built on a foundation of information from an APCD or similarly comprehensive and detailed claim data. The ingredient of independence is necessary to avoid regulatory failure from capture by powerful providers.

CONCLUSION

Bending the health care cost curve requires constraining both utilization and price. Reducing fragmentation in health care can help reduce overutilization by offering incentives to promote collaboration and integration. But increased health care integration is a double-edged sword. Efforts to integrate health care to achieve benefits in terms of quality and reduced utilization can also lead to increased market power and prices, which could potentially defeat much or all of the cost savings from reduced utilization.

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

The way to manage the double-edged sword of health care integration is to encourage beneficial integration but pair it with oversight on price and quality. States

board members who cannot have financial or employment relationships with any hospital or health care organization. *Id.* at 31.

318. *Id.* at 73–74.

319. See Mark Pauly & Robert Town, *Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency*, 37 J. HEALTH POL. POL'Y & L. 697, 699 (2012); Kevin Outterson, *All-Payer Rate Setting in JAMA: A "Maryland Miracle"?*, INCIDENTAL ECONOMIST (Sept. 14, 2011), <http://theincidentaleconomist.com/wordpress/all-payer-rate-setting-in-jama-a-maryland-miracle/#comments> [<https://perma.cc/GH5D-HS7G>].

320. See Green Mountain Care Bd., *supra* note 303, at 5–6.

have a menu of policy options, and the particular policy recipe will vary by state, but three ingredients are necessary for effective oversight: (1) Information—states must have a means to collect and analyze price, quality, utilization, and market data, such as an all-payer claims database, in order to determine which policy choices to select and to evaluate their success; (2) Independence—state oversight bodies must be insulated from the powerful providers they oversee; and (3) Regulatory Authority—state oversight bodies must have the authority to enforce or impose limits on providers' prices when they become too high. If we are to control our personal and national health care spending, states have a critical role to play in overseeing health care integration and private health care price increases.