

## The Affordable Care Act and Competition Policy: Antidote or Placebo?

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**I**n the run-up to its enactment, the Patient Protection and Affordable Care Act (ACA)<sup>1</sup> elicited howls of protest from opponents who claimed the federal government was taking over the American

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<sup>1</sup> Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

healthcare system, micromanaging medicine, and generally exposing the nation to the *bête noire* of socialized medicine.<sup>2</sup> Hyperbole, misrepresentation, and chauvinism aside,<sup>3</sup> these sound bites suffer from a deeper flaw: they mischaracterize the fundamental thrust of the new law. Though the ACA establishes significant new regulatory authority, this is not a new development (indeed it can be faulted for preserving pre-existing regulatory regimes), nor does it impair market competition. To the contrary, much of the law aims at improving conditions conducive to effective competition. With numerous programs designed to correct perverse incentives in the payment system, to mitigate market imperfections, and to make the delivery system responsive to market signals, the ACA might well be rechristened as the “Accommodation of Competition Act.”

That said, it is far from clear that market competition will work out as scripted by theorists and proponents of the new law. Myriad market imperfections still complicate market interactions, and regulations need to be carefully tailored to assure effective implementation and to minimize unintended consequences. Of even greater concern are the problematic market structures that pervade provider and payer markets. Concentration, embedded practices, and professional norms may cause markets to operate suboptimally even

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<sup>2</sup> See, e.g., Jim Meyers, *Kit Bond: Obamacare's Financial Cost to States Will Be 'Horrific,'* NEWSMAX.COM (Mar. 22, 2010), <http://www.newsmax.com/Headline/bond-healthcare-states-mandates/2010/03/22/id/353529> (quoting Republican Senator Kit Bond stating that passage of the health care reform bill sets the stage for turning the United States into a socialist country); SenJimDeMint, *DeMint Speech Against Socialized Medicine*, YOUTUBE (Sept. 28, 2007), <http://www.youtube.com/watch?v=9RPOwGTv6uQ> (“[W]e’re turning this country into a socialistic style of government taking away peoples’ freedom. . . . This is a decision to become more like socialized Europe to sell out our freedoms to give government control of our health care.”). Such claims are not new. Speaking against an early version of the Medicare legislation in 1962, Ronald Reagan warned, “One of the traditional methods of imposing statism or socialism on a people has been by way of medicine. It’s very easy to disguise a medical program as a humanitarian project.” Wyattmcintyre, *Ronald Reagan Speaks Out Against Socialized Medicine*, YOUTUBE (Aug. 1, 2007), <http://www.youtube.com/watch?v=fRdLpem-AA&playnext=1&list=PL52AA90A05E7AE899>.

<sup>3</sup> Leading in the hyperbole department was Rush Limbaugh. See Pharmacist, *Rush Limbaugh Quotes on Obamacare*, HUBPAGES, <http://hubpages.com/hub/Rush-Limbaugh-Quotes-on-Obamacare> (last visited Mar. 24, 2011) (“America is hanging by a thread,” and “[President Obama’s] desire is to have as many people on federal dependency as possible.”). Less than temperate assessments could be heard on the floor of the Senate as well, such as Senator Tom Coburn’s statement, “[to] our seniors . . . I have a message for you: [if the health care bill passes] you’re gonna die sooner.” MediaMattersAction, *Sen. Coburn’s Message to Seniors: “You’re Going to Die Sooner,”* YOUTUBE (Dec. 1, 2009), [http://www.youtube.com/watch?v=B\\_U1mQF9ZCw](http://www.youtube.com/watch?v=B_U1mQF9ZCw).

if reform is implemented smoothly. Finally, the ACA's effectiveness in achieving its goals depends on the executive branch's maintaining a steady hand in countless regulatory determinations. This Article surveys some of the misconceptions about health reform and the challenges proponents confront in realizing their goals.

## I

### HEALTH CARE: REGULATION, DEREGULATION, AND REREGULATION

Regulation in one form or another has long guided the development of health care markets in the United States. In certain respects, government regulation and private self-regulation have worked hand in hand. For many years, a "professional paradigm" prevailed, under which physicians effectively controlled payment systems, health care institutions, and conditions of entry.<sup>4</sup> Physician norms, ethical codes, and rules governing behavior in payment and delivery settings effectively established a system of self-regulation. These institutional and social structures found support in legal regimes that reinforced their authority. For example, laws exempting hospitals from federal and state taxation provided physicians access to free capital and enabled them to exercise control over the operations of those organizations.<sup>5</sup> Licensure, accreditation, and certificate of need (CON) laws reduced supply, limited rivalry, and set terms governing the conditions of competition in the professions and among hospitals.<sup>6</sup> Numerous other laws and conditions of payment have

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<sup>4</sup> The seminal work on professional dominance is PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982). See also CARL F. AMERINGER, *THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION* (2008) (tracing evolution in law and norms leading to market-based health policy).

<sup>5</sup> See Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?* 93 HARV. L. REV. 1416 (1980).

<sup>6</sup> See ROBERT I. FIELD, *HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE* 19–40 (2007) (describing the scope and history of regulation of professionals); *id.* at 41–73 (discussing regulation of hospitals and other institutions); see also James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1470 (1994) (concluding that the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (now called the Joint Commission)—which are given deemed status for hospital certification under Medicare—"institutionalize physician autonomy within hospitals by requiring that the medical staff have an independent organization and structure").

served to cement professional judgments and limit consumers' abilities to make desired trade-offs between costs and benefits.<sup>7</sup>

To be sure, legal doctrine has also directly shaped the development of health care organizations and reimbursement. The rapid expansion of hospitals following World War II is in part attributable to the Hill Burton Act, which provided \$3.7 billion in funding between 1947 and 1971 for hospital construction and imposed important and long-lasting obligations to provide charity care on grant recipients.<sup>8</sup> Perhaps most significantly, in setting the conditions for reimbursement under Medicare and Medicaid, the federal government has exerted significant control over the structure of provider organizations, their internal operations, and the nature and volume of services that are provided.<sup>9</sup> States have wide authority to regulate hospitals under the police power, and they exercise that authority through licensure, which imposes specific operational, clinical, and administrative requirements on practitioners. The era of regulation reached its zenith in 1974 with the National Health Resources Planning and Development Act, which sought to develop standards for controlling the supply, distribution, and organization of health resources, especially acute care hospitals.<sup>10</sup> That law created incentives for states to establish state health planning and development agencies to adopt health-planning strategies and to enact CON laws to assure an appropriate distribution of resources pursuant to the state plan.<sup>11</sup> Although the federal planning law was repealed in 1986, thirty-six states continue to operate CON regulatory schemes that require prior approval for various undertakings, such as new hospital construction or expansion and significant capital investments.<sup>12</sup> During this era, over thirty states also engaged in

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<sup>7</sup> See Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, 69 LAW & CONTEMP. PROBS., Autumn 2006, at 1.

<sup>8</sup> See FIELD, *supra* note 6, at 56–57.

<sup>9</sup> See *id.* at 58–60 (describing the “profound effect” on hospitals of Medicare’s change to prospective payment); *id.* at 34 (oversight authority of Centers for Medicare and Medicaid Services “effectively makes Medicare another arbiter of physician quality”).

<sup>10</sup> National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (repealed 1987).

<sup>11</sup> 1 BARRY R. FURROW ET AL., HEALTH LAW 32–36 (2d ed. 2000). Prior approval by a state agency empowered to issue a CON was required for all new institutional health services (e.g., hospitals, nursing homes, and ambulatory surgery centers) and for all capital expenditures in excess of \$150,000. *Id.*

<sup>12</sup> *Certificate of Need: State Health Laws and Programs*, NAT’L CONFERENCE OF STATE LEGISLATURES (Jan. 28, 2010), <http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx>.

direct regulation of hospital rates, many using prospective payment methodologies to assert control over explosive growth in costs attributable to fee-for-service payments.<sup>13</sup>

Regulation of private insurance has long been the province of the states, which typically exercise control over capitalization, solvency, mandated services and providers, marketing, and claims processing, but states generally do not engage in direct rate regulation.<sup>14</sup> However, federal authority over private insurance has also been exercised on numerous occasions. The Health Maintenance Organization (HMO) Act of 1973 required employers offering health insurance to include an HMO in the options offered to employees, and it provided subsidies for HMOs that met detailed standards regarding coverage, physician networks, and patient appeals.<sup>15</sup> Over the last twenty years, the federal government has expanded its role, requiring insurers to offer coverage in certain circumstances<sup>16</sup> and placing specific requirements on their handling of information and new technology.<sup>17</sup> Significant legal regimes, including fraud and abuse laws, false claims laws, and the Stark law, emerged as necessary to police abuse arising from the perverse incentives of fee-for-service medicine.<sup>18</sup> Likewise, the prevalence of tax-exempt institutions delivering health care services gave rise to a large body of federal and state law that governs the charitable practices of those institutions and restricts diversion of their assets to private interests. In the 1990s, states responded to perceived abuses and consumer dissatisfaction with managed care by unleashing a new wave of regulations that

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<sup>13</sup> See John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF. 142, 142 (1997).

<sup>14</sup> See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 654 (6th ed. 2008).

<sup>15</sup> 42 U.S.C. § 300e-9 (2006).

<sup>16</sup> Omnibus Budget and Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, 100 Stat. 1874. Congress required temporary continuation of group health coverage for employees who lose coverage through termination of employment. See FURROW ET AL., *supra* note 14, at 751–52.

<sup>17</sup> The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936, established minimum federal standards and requirements concerning guaranteed issue and renewability of health coverage, prohibited discrimination based on health factors, and limited disclosure of personal information. With the OBRA of 1986, Congress required continuation of group health coverage under certain circumstances. See FURROW ET AL., *supra* note 14.

<sup>18</sup> These laws share a common purpose of curbing incentives for providers to bill, refer, and practice medicine in a manner that serves their own interests to the detriment of consumer welfare. See generally FURROW ET AL., *supra* note 14, at 1023–94.

provided patients rights of appeal and other processes, that mandated coverage of specific services and inclusion of certain providers, and that regulated many other aspects of managed care.<sup>19</sup> The federal-state regulatory borders have frequently been a source of conflict. Significantly, federal law preempts much state regulation that would apply to self-insured employers, essentially creating a dual regulatory system in which state regulation imposes stringent limitations on some plans while others enjoy what has come to be known as a regulatory “vacuum.”<sup>20</sup>

Thus, regulation of health care providers and payers historically has been something of a roller coaster ride. The era of self-regulation (supported by government deference and facilitating law) lasted until the 1970s when direct intervention became more common. State and federal governments stepped up their efforts to control costs and restrict the supply of health resources, but they never fully supplanted private markets. As dissatisfaction with “command-and-control” regulation grew in the 1980s, what came to be known as the “competitive revolution” began, and antitrust laws helped depose private regulatory regimes while CON statutes and other laws were repealed or fell into disuse.<sup>21</sup> Again, however, this “revolution” never amounted to a coup d’état. Government supervision of providers under Medicare and Medicaid payment policies intensified, and laws necessary to encourage managed care as envisioned by its principal theorists<sup>22</sup> never were adopted. A counterrevolution ensued as public dissatisfaction with managed care and the defeat of the Clinton administration health reforms (which ironically fell victim to perceptions of being overly regulatory but in fact relied heavily on managed care theory) signaled to politicians and insurers that it was time to back off managing care. Numerous laws and judicial interpretations restricted managed care, as a “managed care backlash”

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<sup>19</sup> See Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL’Y & L. 427 (2005); Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003).

<sup>20</sup> See Andrew L. Oringer, *A Regulatory Vacuum Leaves Gaping Wounds—Can Common Sense Offer a Better Way to Address the Pain of ERISA Preemption?*, 26 HOFSTRA LAB. & EMP. L.J. 409 (2008).

<sup>21</sup> See Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 55.

<sup>22</sup> E.g., Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, 28 HEALTH AFF. WEB EXCLUSIVE w3-237, available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.237v1/DC1>.

imposed regulatory obstacles that impeded the market-based approach to health care.

What messages might be gleaned from the ebb and flow of regulatory activity? The nation has been ambivalent about the role of competition in health care but, at the same time, has resisted command-and-control regulation, at least to the extent that such regulation was apparent to it. While policy makers have broadly endorsed market-based approaches, they have been reluctant to provide the legal infrastructure necessary for effective competition and have cluttered the landscape with a maze of complex and conflicting laws and regulations.

## II

### THE CASE FOR COMPETITION-FOSTERING REGULATION

Justification for regulation to promote competition can be found in virtually every economic analysis of health care. Markets for providing and financing health care are beset with myriad market imperfections: inadequate information, agency, moral hazard, monopoly, and selection in insurance markets that greatly distort markets. Add to that governmental failures—for example, payment systems that reward intensity and volume but not accountability for resources or outcomes, restrictions on referrals that impede efficient cooperation among providers, and entry impediments in the form of licensure and CON—and toss in a strain of professional norms that are highly resistant to marketplace incentives, and you have the root causes of our broken system.

#### *A. Economic Theory: Coping with Market Failure in Health Care*

Since Kenneth Arrow's seminal 1963 essay,<sup>23</sup> economic analyses have properly focused on the significant market failures that beset health care markets. Arrow's principal culprits, "uncertainty in the incidence of disease and in the efficacy of treatment," information asymmetries between patient and physician, and the "nonmarketability of the bearing of suitable risks" still collude to prevent optimal resource allocation.<sup>24</sup> Though differing to some

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<sup>23</sup> Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

<sup>24</sup> *Id.* at 947 ("The failure of one or more of the competitive preconditions has as its most immediate and obvious consequence a reduction in welfare below that obtainable

extent in the severity to which they attach individual failures and the extent to which social institutions may rectify problems, health economists uniformly stress that information, agency, and insurance vastly complicate applying microeconomic principles to analyze the welfare effects of transactions or policy changes.<sup>25</sup> While the causes of market failure may be defined in several ways,<sup>26</sup> four factors appear to have the greatest impact: information deficits, product differentiation, agency relationships, and insurance market imperfections.

First, asymmetries in information and uncertainty as to diagnosis, treatment, and outcome are critical to understanding the health care marketplace. A variety of circumstances undermine the neoclassical assumption that buyers and sellers possess adequate information to assess the quality and costs of the services provided. Because of the technical nature of medical information and the complexity of diagnoses and treatment alternatives, patients and third-party payers find it difficult to evaluate the cost and quality of health services. Indeed, the considerable uncertainty that attends medical treatment makes judgments on causation (and hence costs and benefits of the treatment) difficult. In addition, information is asymmetrically distributed among providers, patients, and payers. This characteristic may permit physicians to induce demand for their services, and at a minimum, it makes information costly for buyers to acquire.<sup>27</sup>

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from existing resources and technology, in the sense of a failure to reach an optimal state in the sense of Pareto.”).

<sup>25</sup> A leading text summarizes market failure in health care as follows:

Health markets fail to satisfy the substantial list of requirements that must be met to be classified as perfectly competitive: large numbers of consumers and firms, free entry and exit, marketability of all goods and services including risk, symmetric information with zero search costs, and no increasing returns, externalities, or collusion. While health markets satisfy none of these requirements fully, they fail the requirements of symmetric information, zero search costs, and the marketability of all products most dramatically.

David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in 1 HANDBOOK OF HEALTH AND ECONOMICS 1093, 1095 (A.J. Culyer & J.P. Newhouse eds., 2000).

<sup>26</sup> *Id.*; see also THE CONCISE ENCYCLOPEDIA OF ECONOMICS 235, 235–41 (David R. Henderson ed., 2008); PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 468–74 (5th ed. 1999).

<sup>27</sup> Although the phenomenon of demand inducement has generated considerable debate over its extent and definition, economists broadly concur that physicians exert their power to supply services beyond the level that would be demanded by fully informed consumers. See Henry J. Aaron, *To Find the Answer, One Must Know the Question: Health Economics and Public Policy*, in INCENTIVES AND CHOICE IN HEALTH CARE 21, 30 (Frank A. Sloan

Second, product differentiation among physicians and hospitals along a number of dimensions is widely recognized.<sup>28</sup> Hospitals vary widely based on quality, reputation, geographic location, amenities, and other features. Likewise, physicians are differentiated by their training, reputations, locations, hospital affiliation, and many other aspects. On the demand side, the heterogeneous preferences of consumers are manifest, with varying preferences or “tastes” for travel, amenities, reputation, and “caring” service. These preferences interact with heterogeneous product characteristics in health services to contribute to reducing substitutability among providers of essentially the same services.<sup>29</sup> The quality of services sold by health care providers also may vary considerably, depending upon the professionals’ talents, training, attention to interpersonal relationships, communication skills, and other factors. Product differentiation that grows out of the heterogeneity of consumer preferences is a source of market power in health services markets.<sup>30</sup> Finally, sellers of health services are subject to impediments to mobility, both in the form of regulatory entry barriers imposed by governmental licensure and private certification and practice requirements and in the form of switching costs, such as those resulting from steep learning curves and changing technology.

Third, agency relationships, which pervade health markets, are highly influential in health care transactions.<sup>31</sup> A large majority of consumers (patients) purchase health care through multiple agents—

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& Hirschel Kasper eds., 2008) (“[I]f physicians are willing to do more of certain things when paid well to do them, it is hard to see why the idea that physicians might induce demand was ever controversial.”).

<sup>28</sup> See Martin Gaynor & William B. Vogt, *Antitrust and Competition in Health Care Markets*, in 1 HANDBOOK OF HEALTH ECONOMICS, *supra* note 25, at 1405, 1410–12. See generally Seth Sacher & Louis Silvia, *Antitrust Issues in Defining the Product Market for Hospital Services*, 5 INT’L J. ECON. BUS. 181 (1998).

<sup>29</sup> See Gaynor & Vogt, *supra* note 28, at 1411.

<sup>30</sup> See *id.*

It is th[e] combination of a heterogeneous product with heterogeneous preferences which is key. . . . [T]his bestows the seller with market power. Patients choose sellers who produce the type of services and have characteristics which best match their preferences. The fact that patients choose sellers who give them the highest utility gives sellers market power, since switching to another seller will reduce a patient’s utility.

*Id.*; see also Mark A. Satterthwaite, *Consumer Information, Equilibrium Industry Price and the Number of Sellers*, 10 BELL J. ECON. 483 (1979).

<sup>31</sup> Lawrence Casalino, *Managing Uncertainty: Intermediate Organizations as Triple Agents*, 26 J. HEALTH POL. POL’Y & L. 1055, 1055–57 (2001).

their employers, the plans or insurers chosen by their employers, and the physicians who guide patient choice through referrals and the selection of treatment modalities. For most consumers, choice is limited to a small number of plans; most small employers offer only one plan, and large employers rarely offer more than three.<sup>32</sup> The number of plans and benefits offered by each employer is strongly affected by the possibility of risk selection and the employer's transaction costs in administering health plan coverage. Thus, to some extent, the employer acts as an agent for its employees in purchasing health insurance by choosing plans that afford the mix of quality, price, and geographic coverage that best suits most of its employees. This multiplicity of agents greatly complicates antitrust analyses of consumer behavior and is a principal source of market failure in health care.<sup>33</sup>

Health insurance markets also exhibit conditions that give rise to market failures. Moral hazard, for example, refers to the overuse of medical care resulting from the fact that insurance lowers the cost of each purchase for insureds. Overuse causes inefficiency, as insured individuals purchase more services than they would if they had to bear the entire cost; hence, true marginal costs exceed marginal benefits.<sup>34</sup> Risk selection also may undermine health insurance markets. That is, insurers have strong incentives to seek a favorable, or low-risk, pool of insureds. Acting on that incentive can cause an unraveling of risk spreading as the sick and the healthy become divided into different market segments.<sup>35</sup> By the same token, adverse selection may occur as patients switch plans and adjust coverage according to anticipated needs.

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<sup>32</sup> See Alain Enthoven, *Managed Competition of Delivery Systems*, 13 J. HEALTH POL. POL'Y & L. 305 (1988).

<sup>33</sup> See Casalino, *supra* note 31, at 1061–62. Gaynor and Vogt summarize the multiple agent relationship: “In practice hospital choice is a complex combination of the consumer's choice of health plan, the health plan's choice of providers to contract with, the consumer's choice of physician, and the consumer-physician-health plan choice of whether and where to admit the consumer.” Gaynor & Vogt, *supra* note 28, at 1431.

<sup>34</sup> Seminal contributions on moral hazard are by Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968), and Mark V. Pauly, *Overinsurance and Public Provision of Insurance: The Roles of Moral Hazard and Adverse Selection*, 88 Q.J. ECON. 44 (1974). Analysts question the extent and welfare effects of moral hazard in health care. See, e.g., John A. Nyman, *The Economics of Moral Hazard Revisited*, 18 J. HEALTH ECON. 811 (1999); see also Malcom Gladwell, *The Moral-Hazard Myth*, NEW YORKER, Aug. 29, 2005, at 44.

<sup>35</sup> See David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-off Between Competition and Adverse Selection*, 113 Q.J. ECON. 433, 434 (1998).

### B. Structure and Performance

Turning to the structure and performance of health care markets, one finds additional evidence that conditions precedent for effective competition are lacking and that markets have fallen short of advancing consumer welfare. In short, as I have suggested elsewhere, provider markets evidence the worst of both worlds—hospital and physician markets that are *both* concentrated *and* fragmented.<sup>36</sup> Owing in part to several misguided court decisions and the enforcers' seven-year hiatus on challenging hospital mergers, hospital markets have become highly concentrated around the country. By one estimate, ninety-three percent of the nation's 2006 population lived in concentrated hospital markets.<sup>37</sup> Further, abundant evidence shows that consumers have borne the brunt of hospitals' exercise of market power. The Synthesis Project's summary of empirical studies of the effects of hospital consolidation in the 1990s indicates that anticompetitive horizontal mergers raised overall inpatient prices by at least five percent and by forty percent or more when merging hospitals were closely located.<sup>38</sup>

The causal connection between provider concentration and increasing health care costs finds further support in an important study by the Attorney General of Massachusetts. The report, which closely examined private insurance prices, offers a number of significant conclusions.<sup>39</sup> First, it found that prices paid to hospitals and physicians vary significantly and that higher prices are not associated with quality, complexity, proportion of government patients, or academic status.<sup>40</sup> Second, provider prices in Massachusetts are correlated to market leverage.<sup>41</sup> Hospitals and physician groups with bargaining power extracted higher prices that are not explained by the factors mentioned above. Third, more

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<sup>36</sup> Thomas (Tim) Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 231–35 (2009).

<sup>37</sup> CLAUDIA H. WILLIAMS ET AL., ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE 2 (2006), available at <http://www.rwjf.org/files/research/no9policybrief.pdf>.

<sup>38</sup> *Id.*

<sup>39</sup> OFFICE OF THE ATT'Y GEN. MARTHA COAKLEY OF MASS., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (2010), available at [http://www.mass.gov/Cago/docs/healthcare/final\\_report\\_w\\_cover\\_appendices\\_glossary.pdf](http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf).

<sup>40</sup> *Id.* at 3.

<sup>41</sup> *Id.* at 7–9.

expensive providers appear to gain market share at the expense of less expensive providers.<sup>42</sup> Fourth, the report concluded that a variety of contractual devices, such as payment parity agreements and product participation provisions, have reinforced and perpetuated pricing disparities.<sup>43</sup>

Another study, drawing on site visits by the Center for Studying Health System Change to six California markets in 2008, found that provider leverage has had a “major impact on California premium trends.”<sup>44</sup> Interviews in these markets revealed that the bargaining power of hospitals has been enhanced by extensive horizontal consolidation. Consolidation and other factors, such as system bargaining on an all-or-nothing basis, led to a sharp increase in the number of “must have” facilities in the state.<sup>45</sup> In addition, large, multispecialty group practices and independent practice associations also exercise market power by virtue of a lack of price competition for their services. In a remarkable twist, the study found some situations in which the market power of large groups outweighed the advantages for health plans of entering into capitation for insurers.<sup>46</sup>

Other, subtler results have also flowed from the wave of consolidations and the marginalization of managed care. Besides price increases owing to enhanced bargaining power, growth in hospital costs appear to have been driven by strategic decisions that take advantage of market imperfections and the absence of effective monitoring by payers. By some accounts, the “medical arms race” has resurfaced.<sup>47</sup> That is, hospitals have undertaken significant expansions in high-margin services and have accelerated technology acquisitions, a phenomenon attributable in part to providers’ capacity to induce demand.

Concentrated private-provider markets also impact government payers. Examining the effect of hospital concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to

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<sup>42</sup> *Id.* at 38–40.

<sup>43</sup> *Id.* at 40–43.

<sup>44</sup> Robert Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 704 (2010).

<sup>45</sup> *Id.* at 702.

<sup>46</sup> *Id.* at 703–04.

<sup>47</sup> See Robert A. Berenson et al., *Hospital-Physician Relations: Cooperation, Competition, or Separation?*, 26 HEALTH AFF. WEB EXCLUSIVE w31 (2006), available at <http://content.healthaffairs.org/content/26/1/w31.full.pdf>.

induce more construction and higher hospital costs and that, “when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise.”<sup>48</sup> These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.<sup>49</sup>

While provider concentration is pervasive, health delivery is also highly fragmented. Primary care practices remain small and isolated with little integration or coordination with specialty physician practices or between physicians and hospitals.<sup>50</sup> Even more damning is the fact that vertical integration is also lacking, or as David Hyman characterized it, “[h]ospitals and physicians occupy separate organizational universes.”<sup>51</sup> The case for integrating care across physician specialties and institutions rests on evidence of higher quality of care, opportunities for deployment of evidence-based medicine at the clinical level, and enhanced means of controlling costs by locating responsibility with an organization or team of accountable providers.<sup>52</sup>

The payer side has become more concentrated, at least in the individual and small group market, where, according to some data, two firms have greater than fifty percent of the market in twenty-two states, and one firm has more than fifty percent in seventeen states.<sup>53</sup> The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private

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<sup>48</sup> MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM xiv (2009) available at [http://www.medpac.gov/documents/mar09\\_entirereport.pdf](http://www.medpac.gov/documents/mar09_entirereport.pdf).

<sup>49</sup> *Id.*

<sup>50</sup> See Thomas Bodenheimer, *Coordinating Care—A Perilous Journey Through the Health Care System*, 358 NEW ENG. J. MED. 1064 (2008); Randal Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Health Care System*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 55–57 (Einer R. Elhauge ed., 2010).

<sup>51</sup> David A. Hyman, *Health Care Fragmentation: We Get What We Pay for*, in THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 23.

<sup>52</sup> See Alain C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency*, 24 HEALTH AFF. WEB EXCLUSIVE w5-420 (2005), available at <http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420.full.pdf>.

<sup>53</sup> Karen Davenport & Sonia Sekhar, *Interactive Map: Insurance Market Concentration Creates Fewer Choices*, CTR. FOR AM. PROGRESS (Nov. 5, 2009), [http://www.americanprogress.org/issues/2009/11/insurance\\_market.html](http://www.americanprogress.org/issues/2009/11/insurance_market.html).

insurance revenue increased even faster than medical costs, economists John Holahan and Linda Blumberg of the Urban Institute concluded that “the market power of insurers meant that they were not only able to pass on health care costs to purchasers but to increase profitability at the same time.”<sup>54</sup> While some other studies conclude that dominant insurers extract monopoly rents,<sup>55</sup> the extent of their exercise of market power has been questioned.<sup>56</sup> Finally, experience suggests that entry into concentrated insurance markets is far from easy and may be unlikely to occur in markets with few insurers. A recent study by the Antitrust Division of the Department of Justice found that entry in such insurance markets was impeded by the difficulty of securing provider contracts.<sup>57</sup>

The existence of oligopolies or monopolies in both the provider and insurance sectors creates opportunities for anticompetitive mischief. As mentioned earlier, dominant hospital systems and dominant single-specialty physician groups have been able to charge higher prices, which in turn result in higher insurance premiums (and, as some studies show, increased disparities in access to care). But

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<sup>54</sup> JOHN HOLAHAN & LINDA BLUMBERG, URBAN INST., HEALTH POLICY CTR., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH CARE REFORM? 3 (2008), available at [http://www.urban.org/health\\_policy/url.cfm?ID=411762](http://www.urban.org/health_policy/url.cfm?ID=411762).

<sup>55</sup> Leemore S. Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010) (finding that health insurers charge higher premiums to more profitable firms, suggesting that they possess and exercise market power).

<sup>56</sup> E.g., Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation, and Competition in Health Care Markets*, 13 J. ECON. PERSP. 141 (1999); Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 507 (2006) (asserting “that it is not at all clear that private health insurers systematically possess monopsony power”). The government antitrust enforcement agencies have on occasion opined that health insurance markets are generally competitive. See FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004). But see Christine A. Varney, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust and Healthcare Conference (May 24, 2009), available at <http://www.justice.gov/atr/public/speeches/258898.pdf> (promising “measured enforcement” of the antitrust laws involving the health insurance industry).

<sup>57</sup> The Department of Justice's study concluded:

[T]he biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.

Varney, *supra* note 56, at 9.

what happens when dominant insurers face dominant providers—what economists call bilateral monopoly? The outcome depends on the strategic interactions of the parties. For example, in the now notorious episode involving Partners Health Care and Blue Cross of Massachusetts, the parties reached a mutually beneficial understanding (a “market covenant”) to maintain high premiums and high hospital charges. More generally, it appears the dynamics of bargaining may often result in higher prices for consumers. As Holahan and Blumberg summarized industry tendencies: “Dominant insurers do not seem to use their market power to drive hard bargains with providers,” but “small insurers do not aggressively compete over price.”<sup>58</sup> Holahan and Blumberg noted that “rising premiums and increased profitability of nondominant firms provide indirect evidence of shadow pricing by smaller insurers; that is, smaller insurers do not seem to compete on premiums to gain market share but rather seem to follow the pricing of the dominant insurer.”<sup>59</sup>

In sum, it is hard to ignore the claim that markets as we have known them have not performed well. Whether measured by cost, outcomes, or customer satisfaction, the health care industry’s record is one that merits intervention.<sup>60</sup> The following section assays the ACA’s prospects for making improvements by introducing regulations that may improve market competitiveness.

### III

#### THE AFFORDABLE CARE ACT: AN ANTIDOTE TO MARKET IMPERFECTIONS

The ACA’s focus on improving competition is illustrated by the steps it takes to establish new markets that facilitate shopping for insurance and to mitigate market imperfections. Though perhaps counterintuitive to those who dichotomize between competition and regulation, law can sometimes foster competition by imposing rules and standards, by mandating purchasing, or by creating competition-fostering institutions. As I have argued since the early days of the

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<sup>58</sup> HOLAHAN & BLUMBERG, *supra* note 54, at 3.

<sup>59</sup> *Id.* (footnote omitted).

<sup>60</sup> See Len M. Nichols, Director, Health Policy Program, New Am. Found., Statement Before the Senate Committee on Commerce, Science, and Transportation, Competition in the Health Care Marketplace 3 (July 16, 2009), available at [http://www.newamerica.net/files/NICHOLS\\_Commerce.pdf](http://www.newamerica.net/files/NICHOLS_Commerce.pdf) (summarizing the costs of noncompetitive pricing, poor quality, and inefficiency in health care and concluding “[i]t is not unreasonable to argue that we pay roughly 2.4 times more than we should for health care”).

“competitive revolution” in health care, such regulation is a condition precedent for effective markets.<sup>61</sup>

### A. *Payment and Insurance Reforms*

Health insurance exchanges, which serve as the centerpiece of the ACA’s attempt to move toward universal coverage, are at bottom markets for offering and purchasing health insurance. Like countless other forums for exchange, such as farmers’ markets, stock markets, or online travel services, health insurance exchanges will afford individual consumers and small businesses the opportunity to examine and compare alternative insurance options and to purchase those that best suit their needs. The idea is hardly novel. Its ancestry can be traced to the concept of managed competition, as developed by economist Alain Enthoven and others,<sup>62</sup> and to numerous purchasing cooperatives, health alliances, and connectors—among states and private entities.<sup>63</sup> Past efforts to promote exchanges have floundered, however, primarily because of problems of adverse selection and a resulting inability to attract sufficiently large pools of customers to effectively spread risk.<sup>64</sup> The ACA requires that states establish individual and small group exchanges in each state,<sup>65</sup> and it mandates the purchase of insurance by individuals and encourages employers to purchase insurance for their employees. In doing so, lawmakers

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<sup>61</sup> See Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179 (1988) (predicting that competition in health care would not succeed if regulation and infrastructure do not support it).

<sup>62</sup> See Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 NEW ENG. J. MED. 29 (1989).

<sup>63</sup> See TIMOTHY STOLTZFUS JOST, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES (2010), available at [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426\\_Jost\\_hlt\\_insurance\\_exchanges\\_ACA.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf).

<sup>64</sup> *Id.* at 3 (explaining that unsuccessful exchanges failed to succeed because they “attempted to offer better coverage, or more affordable coverage, to too many individuals or groups with unfavorable risk profiles and were unable to attract enough healthy enrollees”); see also LINDA J. BLUMBERG & KAREN POLLITZ, URBAN INST., ROBERT WOOD JOHNSON FOUND., HEALTH INSURANCE EXCHANGES: ORGANIZING HEALTH INSURANCE MARKETPLACES TO PROMOTE HEALTH REFORM GOALS (2009), available at [http://www.urban.org/UploadedPDF/411875\\_health\\_insurance\\_marketplaces.pdf](http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf).

<sup>65</sup> While mandating that each state establish an exchange for individual purchasers (“American Health Benefit Exchange”) and small groups (“SHOP” exchange), the law permits states to establish multiple regional exchanges or interstate exchanges. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1311, 124 Stat. 119, 173–82 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)).

hoped to create sizeable and stable risk pools that will reduce the risks of adverse selection, that will lower marketing and administrative costs, and that will enable consumers to have sufficient clout bargaining collectively with insurers. In structuring exchanges, the ACA's drafters were fully cognizant of the need to address market imperfections. For example, the law requires that exchanges establish risk-adjustment mechanisms,<sup>66</sup> and it bans discrimination based on age, disability, or expected length of life.<sup>67</sup> Those provisions also serve to lessen the risks of favorable selection problems and to potentially broaden the size of group and non-group insurance pools. In addition, these exchanges can serve to widen choice, improve transparency, and reduce search costs for individuals and employers, thereby enhancing the efficiency of the market.

The ACA also addresses insurance market imperfections through several prohibitions on specific industry practices.<sup>68</sup> For example, it sets rules that govern the terms of insurance policies by prohibiting much medical underwriting and premium pricing based on health status in the small group and non-group markets.<sup>69</sup> These changes are designed to counter the proclivity of insurers to seek out healthy individuals and to mitigate the risk selection phenomenon that impairs insurance market efficiency. In addition, the ACA deals with information deficits in several ways. First, it seeks to increase the amount and accessibility of information by requiring exchanges to perform a variety of functions, such as establishing a toll-free hotline<sup>70</sup> and maintaining a Web site that provides standardized comparative information on health plans<sup>71</sup> and rating plans<sup>72</sup> and that develops enrollee satisfaction surveys.<sup>73</sup> These changes counter well-documented difficulties encountered in the consumer market

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<sup>66</sup> *Id.* §§ 1341–43, 124 Stat. at 208–12 (codified at 42 U.S.C.A. §§ 18061–63 (West 2010)).

<sup>67</sup> *Id.* § 2704, 124 Stat. at 323 (codified as note to 42 U.S.C.A. § 1396a (West 2010)).

<sup>68</sup> For summaries and analyses of the ACA, see BARRY R. FURROW ET AL., *HEALTH REFORM SUPPLEMENT TO HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (2010).

<sup>69</sup> ACA § 2701, 124 Stat. at 317–18 (codified at 42 U.S.C.A. § 1320b-9b (West 2010)).

<sup>70</sup> *Id.* § 1311(d)(4)(B), 124 Stat. at 176 (codified at 42 U.S.C.A. § 18031(d)(4)(B) (West 2010)).

<sup>71</sup> *Id.* § 1311(d)(4)(C), 124 Stat. at 176 (codified at 42 U.S.C.A. § 18031(d)(4)(B) (West 2010)).

<sup>72</sup> *Id.* § 1311(c)(3), 124 Stat. at 175 (codified at 42 U.S.C.A. § 18031(c)(3) (West 2010)).

<sup>73</sup> *Id.* § 1311(c)(4), 124 Stat. at 175 (codified at 42 U.S.C.A. § 18031(c)(4) (West 2010)).

regarding the content and quality of health insurance plans.<sup>74</sup> Second, the ACA sets minimum standards for insurance policies in the individual and non-group market by requiring that they cover the “essential benefits package” (to be defined by the Secretary of the Department of Health and Human Services (HHS)) and that they standardize packages of insurance levels of coverage (“precious metal” plans).<sup>75</sup> In addition, the law imposes a number of limitations on the net amount that cost-sharing plans may require,<sup>76</sup> and it mandates that insurers provide annual rebates to their enrollees if their medical loss ratios (the ratio of amounts incurred for claims and paid for activities to improve health care quality to total premiums) are less than eighty-five percent in the large group market or eighty percent in the small group or individual market.<sup>77</sup>

These and other measures find support in the necessity of dealing with severe information, agency, and behavioral issues described earlier. In insurance markets, not only are policies complicated and highly heterogeneous, thus making informed comparisons difficult, but also they cause people to rely on unreliable decision aids. As Russell Korobkin has explained,<sup>78</sup> evidence drawn from behavioral psychology demonstrates that consumers have cognitive limitations that can cause them to make decisions in only a “boundedly rational” manner, and they use highly imperfect heuristics and other shortcuts in their decision making. As a consequence, they are likely to fail to

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<sup>74</sup> See Karen Pollitz, Research Professor, Georgetown Univ. Health Policy Inst., Addressing Insurance Market Reform in National Health Reform (Mar. 24, 2009).

<sup>75</sup> ACA § 1302, 124 Stat. at 163 (codified at 42 U.S.C.A. § 18022 (West 2010)). Health plans offered in the individual and small group markets must cover specific percentages of actuarial value and are arrayed in “precious metal” categories: bronze plans must cover sixty percent of actuarial value, silver plans must cover seventy percent of actuarial value, gold plans must cover eighty percent of actuarial value, and platinum plans must cover ninety percent of actuarial value. Insurers may also offer a catastrophic plan to subscribers under thirty years of age (for a while the plan was referred to as the “young invincibles” plan because it is aimed at attracting younger subscribers inclined to doubt they need health insurance). *Id.* The actuarial value of services is essentially the net coverage offered by a plan taking into account cost-sharing responsibilities and determined on the basis of the average cost of providing the essential benefits to a standard population, not the actual population of the plan. *Id.*

<sup>76</sup> *Id.* § 1402, 124 Stat. at 220–24 (codified at 42 U.S.C.A. § 18071 (West 2010)).

<sup>77</sup> *Id.* § 2718(b)(1)(A), 124 Stat. at 886 (codified at 42 U.S.C.A. § 300gg-18(b)(1)(A) (West 2010)).

<sup>78</sup> See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999); see also Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 169.

make individual health insurance purchasing decisions in a way that promotes efficiency.<sup>79</sup> Given intractable difficulties of dealing with certain issues by contract and the absence of other institutional arrangements to assist consumers, legislation mandating coverage may be justified in some circumstances.

For some commentators, the prime culprit distorting markets is the moral hazard associated with health insurance.<sup>80</sup> Moral hazard operates not only in the economic dimension—encouraging overconsumption of services—but also in the regulatory area. Clark Havighurst has persuasively argued that consumers/voters in America are blinded to implications of costly regulations that inhibit insurers from managing care effectively:

[I]gnorance of the *cost* of care . . . ensures that neither the choices [consumers] make in the marketplace nor the opinions they express in the political process reveal their true preferences. . . .  
 . . . Even though moral hazard operates with particular vengeance in health insurance, it can be managed to some extent . . .  
 . Inefficiency occurs, however, as soon as government or the legal system barges in to preclude financing intermediaries from effectively managing care—that is, from taking administrative and other actions to limit the impact of moral hazard—or requires them to honor costly entitlements prescribed by law or professional standards rather than set forth in freely negotiated contracts.<sup>81</sup>

The ACA attempts to mitigate the moral hazard problem in several ways. First, the so-called “Cadillac Tax”<sup>82</sup> operates to reduce

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<sup>79</sup> These deficiencies have been applied to consumer decision making at the point of service in health care. Richard G. Frank, *Behavioral Economics and Health Economics*, in *BEHAVIORAL ECONOMICS AND ITS APPLICATIONS* 195, 195 (Peter Diamond & Hannu Vartiainen eds., 2007). In addition, there is considerable evidence that behavioral factors impair physician decision making. See Thomas L. Greaney, *Economic Regulation of Physicians: A Behavioral Economics Perspective*, 53 *ST. LOUIS U. L.J.* 1189 (2009).

<sup>80</sup> See Havighurst, *supra* note 21, at 78–82.

[I]t should be obvious that the market failure most responsible for economic inefficiency in the health care sector is not consumers’ ignorance about the quality of care, but their ignorance of the *cost* of care, which ensures that neither the choices they make in the marketplace nor the opinions they express in the political process reveal their true preferences.

*Id.* at 78.

<sup>81</sup> *Id.* at 78–79.

<sup>82</sup> The ACA imposes a forty percent excise tax on employment-related health coverage that costs more than \$10,200 for individual coverage or \$27,500 for family coverage beginning in 2018 subject to various adjustments and exceptions. Although the tax is levied on insurers, it will be passed on to employers and then to employees, and it is thereby likely to result in reduction in the generosity of insurance coverage for plans that exceed the thresholds. See FURROW ET AL., *supra* note 14.

incentives of employers to provide excessively generous insurance, incentivizes employers to shop more aggressively for plans that are cost-effective, and encourages employees to choose those plans. Indeed the “tax” is really a device to remove a costly and market-distorting tax benefit.<sup>83</sup> The ACA can be seen as combating moral hazard in other ways as well. Plans offered through exchanges will be structured in a manner that reflects the cost-saving incentives of co-payments and deductibles. Thus, plans in the “precious metal” categories with relatively generous coverage (i.e., lower co-pays and deductibles) will have higher premiums. In addition, although the ACA limits the level of out-of-pocket payments in plans, it sets those limits at the very high levels that current law sets for high-deductible plans under health savings accounts. As a result, high-deductible plans may prove to be popular under the ACA’s rules requiring the purchase of health insurance. An individual needs only to select a bronze level plan to avoid the individual mandate penalty and may purchase a catastrophic policy either if under age thirty or if no other plan is available for under eight percent of the individual’s household income.<sup>84</sup>

The ACA takes some steps to address the political aspect of moral hazard identified by Professor Havighurst. For example, the law discourages state mandates of benefits for plans participating in the exchange by requiring that any states that require benefits beyond the essential benefits package required by federal law must pay the additional cost of those benefits for individuals and families receiving federal subsidies.<sup>85</sup> Although such mandates will still apply to plans marketed outside the exchange, this provision is likely to sharply

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<sup>83</sup> See Jonathan Gruber, ‘Cadillac’ Tax Isn’t as Tax—It’s a Plan to Finance Real Health Reform, WASH. POST, Dec. 28, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/12/27/AR2009122701714.html> (estimating the total cost to the Treasury of exclusion of employer contributions for health care to be \$250 billion per year or twice the cost of providing universal care). Critics of this provision argue that high-cost plans generally insure sicker employees and those in risky occupations or in regions with high medical costs. Moreover critics assert that the money employers save by reducing health insurance coverage is unlikely to be passed on to employees for medically necessary as well as unnecessary services. See TIMOTHY S. JOST & JOSEPH WHITE, CUTTING HEALTH CARE SPENDING: WHAT IS THE COST OF AN EXCISE TAX THAT KEEPS PEOPLE FROM GOING TO THE DOCTOR? (2010), available at [http://www.ourfuture.org/files/Jost-White\\_Excise\\_Tax.pdf](http://www.ourfuture.org/files/Jost-White_Excise_Tax.pdf).

<sup>84</sup> See FURROW ET AL., *supra* note 68, at 120.

<sup>85</sup> Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1311(d)(3)(B)(ii), 124 Stat. 119, 176 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)); *id.* § 1334(c)(4), 124 Stat. at 904 (codified at 42 U.S.C.A. § 18054 (West 2010)).

curtail state benefit mandates, as states will likely be unwilling to impose costly mandates that may result in adverse selection and higher costs that will drive consumers away from choosing non-exchange participating plans.

As noted above, government policies, particularly payment methodologies, contribute significantly to the inefficiencies and distortions in the health care system. The ACA undertakes prodigious efforts to redirect federal payment away from fee-for-service payment. With many Medicare beneficiaries having complex health conditions and multiple co-morbidities, most observers agree that this system has significant cost and quality implications; the system provides no incentives for coordination of care, and it tolerates duplicative and costly provision of services.<sup>86</sup> These payment policies have played an important role in encouraging and ossifying a fragmented delivery system.<sup>87</sup> Thus, the ACA requires the Secretary of the HHS to establish, test, and evaluate a five-year pilot program “for integrated care during an episode of care . . . around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.”<sup>88</sup> Other reforms, many in the form of pilot programs or demonstrations, similarly attempt to rationalize government reimbursement so as to at least reduce the perverse incentives that have long plagued health care payment and delivery.<sup>89</sup>

Finally, the ACA deals with a very significant public goods market failure—the underproduction of research and the inadequate dissemination of information concerning the effectiveness and quality of health care services and procedures. The Act does so by subsidizing research and creating new entities to support such research<sup>90</sup> and to disseminate information about outcomes and

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<sup>86</sup> See Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Comm’n, Reforming the Health Care Delivery (Mar. 10, 2009), available at [http://www.medpac.gov/documents/20090310\\_EandC\\_Testimony\\_DeliveryReform.pdf](http://www.medpac.gov/documents/20090310_EandC_Testimony_DeliveryReform.pdf).

<sup>87</sup> See HYMAN, *supra* note 51, at 21–22.

<sup>88</sup> ACA § 3023, 124 Stat. at 399 (codified at 42 U.S.C.A. § 1395cc-4 (West 2010)).

<sup>89</sup> See, e.g., *id.* § 3022, 124 Stat. at 395 (codified at 42 U.S.C.A. § 1395jjj (West 2010)) (establishing a shared saving program, which creates reimbursement incentives for groups of providers establishing accountable care organizations); *id.* § 3025, 124 Stat. at 408 (codified at 42 U.S.C.A. § 1395ww (West 2010)) (creating a system that reduces payments to hospitals for excessive readmissions); *id.* § 3502, 124 Stat. at 513 (codified at 42 U.S.C.A. § 256a-1 (West 2010)) (establishing a program to provide grants to community health teams to support medical homes aimed at coordinating care for patients with chronic illnesses and reimbursement through bundled payments).

<sup>90</sup> E.g., *id.* § 3013, 124 Stat. at 381–84 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (establishing a Center for Quality Improvement and Patient Safety charged

medically effective treatments.<sup>91</sup> Numerous other provisions attempt to correct flaws in Medicare and Medicaid reimbursement methodologies, including those offering incentives to improve quality and induce reliance on “evidence-based medicine.”<sup>92</sup>

### B. *Delivery System Reform*

Considerable scholarship has identified fragmentation in health care delivery as a major source of inefficiency in the health care system.<sup>93</sup> The harms flowing from fragmentation can be observed at the clinical level (inadequate care attributable to lack of provider coordination)<sup>94</sup> and at the administrative level (high administrative and overall costs).<sup>95</sup> The causes of fragmentation are multifaceted and intertwined but aptly summarized by Einer Elhauge:

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with identifying effective quality measures and best practices for treatment outcomes); *id.* § 6301, 124 Stat. at 727–47 (codified in scattered sections of 26 and 42 U.S.C.A. (West 2010)) (establishing a Patient-Centered Outcomes Research Institute “to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments [and] services”); *id.* § 10303, 124 Stat. at 937–38 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (instructing the Secretary of the HHS to develop outcome measures for hospital physicians and to promote “best practices” in health care delivery); *id.* § 1204, 124 Stat. at 518 (codified at 42 U.S.C.A. § 300d-6 (West 2010)) (providing grants for research in emergency medical care systems to create “innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems”); *id.* § 3501, 124 Stat. at 507–13 (codified at 42 U.S.C.A. §§ 299b-33 to -34 (West 2010)) (providing grants for research into improving health care delivery systems).

<sup>91</sup> *See, e.g., id.* § 3501, 124 Stat. at 508–11 (codified as amended at 42 U.S.C.A. § 299b-33 (West 2010)); *id.* § 6301, 124 Stat. at 738–39 (codified as amended at 42 U.S.C.A. § 299b-37 (West 2010)).

<sup>92</sup> *E.g., id.* §§ 3001–08, 124 Stat. at 353–79 (codified in scattered sections of 42 U.S.C.A. (West 2010)) (establishing a value-based payment system for Medicare and Medicaid reimbursement).

<sup>93</sup> *See generally* THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50 (discussing analyses by fourteen contributors of causes, effects, and remedies to excessive fragmentation in American health system).

<sup>94</sup> Cebul et al., *supra* note 50, at 38–43.

<sup>95</sup> *Id.* at 44–45 (citing administrative costs of thirty-one percent of total health care expenditures); Alain Enthoven, *Curing Fragmentation with Integrated Delivery Systems: What They Do, What Has Blocked Them, Why We Need Them, and How to Get There from Here*, in THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 65–68 (citing evidence of lower costs in prepaid multispecialty group practices).

The dominant cause of fragmentation . . . appears to be the law, which dictates many of the fragmented features [of the health system] . . . and thus precludes alternative organizational structures. The law is the culprit even though the payment system is also an important cause of health care fragmentation<sup>96</sup> . . . . The reason is that . . . the law dictates that payment system.

The ACA heeds Elhauge's message by instituting new Medicare programs designed to reward integrated delivery of care. Prominent among these programs is the Medicare "Shared Savings Program," which will make groups of providers who voluntarily meet certain quality criteria eligible to share in the cost savings they achieve for the Medicare program.<sup>97</sup> To qualify, these "accountable care organizations" (ACOs) must agree to be accountable for the overall care of a defined group of Medicare beneficiaries, to have sufficient participation of primary care physicians, to have processes that promote evidence-based medicine, to report on quality and costs, and to be capable of coordinating care. Additionally, an ACO must be a group of providers and suppliers that has an established mechanism for joint decision making and may include practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements, networks of practices, and partnerships or joint venture arrangements between hospitals and practitioners. The Medicare program will pay the ACOs a global payment for all services needed or, alternatively, share savings based on comparing the ACOs' cost to benchmark payments under traditional Medicare.

The idea, which carries the endorsement of MedPAC and the influential health service researchers at Dartmouth,<sup>98</sup> is not entirely novel. Indeed, if this sounds a lot like the HMO managed care model,

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<sup>96</sup> Einer Elhauge, *Why We Should Care About Fragmentation?*, in THE FRAGMENTATION OF U.S. HEALTH CARE, *supra* note 50, at 11.

<sup>97</sup> ACA § 3022, 124 Stat. at 395–99 (codified at 42 U.S.C.A. § 1395jjj (West 2010)).

<sup>98</sup> MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 48, at 40–58; Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward in Medicare*, 28 HEALTH AFF. WEB EXCLUSIVE w219 (2009), available at <http://tdi.dartmouth.edu/documents/publications/HA%20Fisher-McClellan%20art.pdf>. In addition, a number of experiments involving bundled payments to the ACOs and to other innovative organizations (as in Medicare's Physician Group Practice demonstration) have been underway for some time. See, e.g., JIM HESTER ET AL., THE COMMONWEALTH FUND, THE VERMONT ACCOUNTABLE CARE ORGANIZATION PILOT: A COMMUNITY HEALTH SYSTEM TO CONTROL TOTAL MEDICAL COSTS AND IMPROVE POPULATION HEALTH (2010).

that's because it is.<sup>99</sup> In many respects the ACO is the latest in a long line of efforts to develop integrated delivery systems that bear financial responsibility for treatment decisions. Benefiting from the nation's experience with managed care, there are plausible, market-based reasons for going in this direction. Making entities accountable for care via capitation or global payments mitigates agency and information problems to some extent as providers are given economic incentives to economize care.<sup>100</sup> Further, there is at least modest evidence from the managed care experience that these steps work to moderate cost while continuing to maintain quality of care.<sup>101</sup> But to get there, the new law leaves much detail to the discretion of the Secretary of the HHS, who is presumably informed by experience and learning as the program progresses. For example, the legislation delegates the development of standards for quality, use of evidence-based medicine, and "patient-centeredness" to the HHS.<sup>102</sup>

The ACA also seeks to spur competition by adjusting regulatory agency oversight in several areas. For example, the ACA institutes changes to the mechanics of bidding for Medicare Advantage contracts that attempt to move the benchmark bidding process closer to a competitive model. The ACA also expands competitive bidding for medical devices.<sup>103</sup> Further, the ACA created an abbreviated approval pathway for biologic drugs that were "biosimilar," or

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<sup>99</sup> See KELLY DEVERS & ROBERT BERENSON, URBAN INST., ROBERT WOOD JOHNSON FOUND., CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? 5 (2009), available at [http://www.urban.org/uploadedpdf/411975\\_acountable\\_care\\_orgs.pdf](http://www.urban.org/uploadedpdf/411975_acountable_care_orgs.pdf) (referring to the ACOs as "HMOs in drag").

<sup>100</sup> See DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE: FROM MARCUS WELBY TO MANAGED CARE 9–15 (2000).

<sup>101</sup> See David M. Cutler et al., *How Does Managed Care Do It?*, 31 RAND J. ECON. 526, 526 (2000) (finding the HMOs have thirty percent to forty percent lower expenditures than traditional plans with little difference in outcomes).

<sup>102</sup> ACA § 3022, 124 Stat. at 395 (codified at 42 U.S.C.A. § 1395jjj (West 2010)); see also 1 FURROW ET. AL., *supra* note 11, at 141–43, 154–57; Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED. e1 (2011), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404>.

<sup>103</sup> ACA § 6410, 124 Stat. at 773 (codified at 42 U.S.C.A. §§ 1395m, 1395w-3 (West 2010)) (expanding the Medicare competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies); see also Mike Lillis, *Battle Continues over Medicare Competitive Bidding Program*, HILL (July 2, 2010), <http://thehill.com/blogs/healthwatch/medicare/107001-battle-continues-over-medicare-competitive-bidding-program> (citing thirty-two percent cuts in purchases of durable medical equipment resulting from competitive bidding programs in nine cities and estimating that over 250 members of the House of Representatives support repeal of the program).

interchangeable with previously approved biologics (“follow on” biologics). Although the law was a precompetitive innovation, the law was subject to criticism from the Federal Trade Commission and others that it was unnecessarily protective of intellectual property rights by providing twelve years of market exclusivity to innovator biologics.<sup>104</sup>

Finally, a number of proposals designed to foster competition were not enacted. Noticeably absent is the creation of a “public option” insurance plan, a hotly debated reform, which proponents argued would introduce much-needed competition into concentrated insurance markets.<sup>105</sup> However, the ACA gives states various options to create their own new insurance plans and mandates that the Office of Personnel Management contract with insurance carriers to assure that at least two “multistate plans” are offered in every health insurance exchange in each state.<sup>106</sup> Another much-discussed reform, the partial repeal of the McCarran-Ferguson insurance exemption, garnered significant support but was nevertheless excluded in the ACA.<sup>107</sup>

In sum, those painting health reform legislation as abandoning market-based values in health policy are mistaken. The ACA undertakes enumerable steps designed to eliminate perverse incentives in government payment policies, to encourage development of a scientific and technological infrastructure

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<sup>104</sup> A Federal Trade Commission report supported legislation that allows follow-on or biosimilar versions of biologic drugs, but it contended that the patent system would provide brand-name products all the protection they need without a period of exclusivity and that allowing for a period of patent exclusivity would be unnecessarily anticompetitive. MICHAEL S. WROBLEWSKI, FED. TRADE COMM’N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (2009).

<sup>105</sup> See Davenport and Sekhar, *supra* note 53 (discussing the public option plan debate).

<sup>106</sup> See *infra* note 136 and accompanying text.

<sup>107</sup> On February 24, 2010, the House of Representatives passed by a margin of 406–18 the Health Insurance Industry Fair Competition Act, repealing in part the McCarran-Ferguson Act’s applicability to health insurers by providing that (1) nothing in the act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance, and (2) Federal Trade Commission Act prohibitions against using unfair methods of competition shall apply to the business of health insurance without regard to whether such business is carried on for profit. Health Insurance Industry Fair Competition Act, H.R. 4626, 111th Cong. (2010). A number of observers have argued that, notwithstanding the advisability of repealing the McCarran-Ferguson exemption, it has had little application in health care matters and its importance should not be overstated. See, e.g., Chris Sagers, *Much Ado About Probably Pretty Little: McCarran-Ferguson Repeal in the Pending Health Reform Effort*, 28 YALE L. & POL’Y REV. 325 (2010).

conducive to comparison shopping, and to spur development of delivery systems that can be accountable for cost and quality decisions. So what could possibly go wrong?

#### IV

#### OBSTACLES TO INDUCING IMPROVED COMPETITIVENESS IN HEALTH CARE MARKETS

##### *A. Regulation: Not Too Much but Not Too Little?*

The ACA's capacity to unleash competitive forces to control cost and improve quality of care is contingent on a number of factors. First, much depends on regulations to be promulgated by the HHS and other agencies and the implementation of those regulations by the federal government and the states. Administrative agencies will make a host of determinations crucial to the law's scheme to improve the competitiveness of markets. For example, the Secretary of the HHS is charged with establishing the criteria governing entry into exchange insurance markets. Thus she will set standards for "qualified health plans," ensuring that they adopt appropriate marketing practices, offer a sufficient choice of providers, afford access to essential community providers, and meet numerous other requirements.<sup>108</sup> The Secretary is also required to enhance consumers' opportunity for shopping for plans by developing a rating system that would rate qualified health plans offered through an exchange in each benefits level on the basis of the relative quality and price,<sup>109</sup> and standardizing plans by identifying "essential benefits" that must be offered by each plan.<sup>110</sup> States are expected to undertake significant regulation, subject in many cases to regulatory standards set by the HHS. For example, states are responsible for the complex and critical task of developing risk-adjustment programs.<sup>111</sup> Significantly, the ACA gives the Secretary of the HHS considerable latitude to exercise her discretion as to the substance, timing, and extent of most of these regulations.<sup>112</sup>

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<sup>108</sup> ACA § 1311, 124 Stat. at 173–82 (codified at 42 U.S.C.A. § 18031 (West 2010)).

<sup>109</sup> *Id.* § 1311(d), 124 Stat. at 176–78 (codified at 42 U.S.C.A. § 18031(d) (West 2010)).

<sup>110</sup> *Id.* § 1311, 124 Stat. 119, 173–82 (2010) (codified at 42 U.S.C.A. § 18031 (West 2010)).

<sup>111</sup> *Id.* § 1343, 124 Stat. at 212–13 (codified at 42 U.S.C.A. § 18063 (West 2010)).

<sup>112</sup> See CURTIS W. COPELAND, CONG. RESEARCH SERV., R41180, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148) 3 (2010) (describing twenty-six provisions of the ACA mandating "federal agencies to issue regulations that define certain terms, establish substantive requirements, create certain programs, and determine the timing of particular events"; eleven provisions that permit

Most of the key regulatory determinations will be made over a period extending to 2014 and beyond and are likely to be the subject of intense political controversy and debate. The inevitably shifting political winds over this extended period of time<sup>113</sup> are likely to influence regulators and legislators as they implement the ACA.<sup>114</sup> Political turbulence might well cause regulators to dilute some of the features of the reform bill that are critical to maintaining competitive markets. For example, eliminating or weakening the individual mandate would likely cause severe disruptions in the insurance markets as a result of adverse selection. Inadequate risk-adjustment mechanisms would likely also permit insurance markets to unravel. In addition, indifferent attention to buyers' needs for standardization of choices and useable qualitative information will undermine the efficiency of comparative shopping.

States are also expected to assume significant responsibilities in implementing health reform.<sup>115</sup> For example, state legislative and regulatory actions are needed for setting up the local apparatus for new insurance markets, for implementing Medicaid expansion,<sup>116</sup> and for enforcing the ACA's requirements.<sup>117</sup> Whether the law will

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such actions; and seven provisions that "appear to contemplate" such actions); *see also* Henry J. Aaron & Robert D. Reischauer, *The War Isn't Over*, 362 NEW ENG. J. MED. 1259 (2010), available at <http://healthcarereform.nejm.org/?p=3223&query=home>.

<sup>113</sup> The period from 2010 through the end of 2014 includes three congressional elections, a presidential contest, and cycles of state legislative and gubernatorial contests in every state.

<sup>114</sup> *See* Aaron & Reischauer, *supra* note 112 (predicting controversy over provisions that do not take effect until 2014, such as the insurance mandates, insurance subsidies for qualified families, Medicaid expansion, and the establishment of state health insurance exchanges).

<sup>115</sup> *See* Alan Weil & Raymond Scheppach, *New Roles for States in Health Reform Implementation*, 29 HEALTH AFF. 1178 (2010); *see also* RACHEL MORGAN, NAT'L CONFERENCE OF STATE LEGISLATURES, STATE LEGISLATORS' CHECK LIST FOR HEALTH REFORM IMPLEMENTATION FY2010 (2010), available at <http://www.ncsl.org/documents/health/2010CLHlthRef.pdf> (listing dozens of provisions that require state legislative or administrative action or that merit state planning or consideration in fiscal year 2010). *See generally* 2010 State Actions to Implement Federal Health Reform, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/default.aspx?tabid=20231> (last updated Jan. 5, 2011) (listing state legislation and executive orders implementing the ACA).

<sup>116</sup> Sara Rosenbaum, A "Customary and Necessary" Program—Medicaid and Health Care Reform, 362 NEW ENG. J. MED. 1952 (2010).

<sup>117</sup> Professor Elizabeth Weeks Leonard aptly summarized the allocation of responsibility: "the Exchanges impose massive financial, administrative, and enforcement burdens on states to operate the new individual and small-group health insurance marketplace and coordinate with other specific ACA components." Elizabeth Weeks

succeed in inducing “cooperative federalism”—partnership between federal and state governments to implement the new law—is a matter of serious question.<sup>118</sup> Given the strength of the “health reform nullification movement,”<sup>119</sup> and efforts to get courts to overturn vital provisions of the new law,<sup>120</sup> there is a real possibility that some states may undertake half-hearted implementation efforts, provide limited funding, and make only lackadaisical enforcement efforts.

On the other side of the coin is the real risk that reform will produce what Professor Havighurst has called in another context “hyper-regulation” of health insurance markets.<sup>121</sup> That is, the far-reaching regulatory provisions of the ACA might result in a regulatory regime that distorts markets through “excessive” consumer safeguards or that undermines the ability of payers and providers to offer alternatives that appeal to different consumer groups.<sup>122</sup> For example, regulating network adequacy, specifying conditions of programs (e.g., “patient-centeredness”<sup>123</sup>), and dictating other terms

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Leonard, *Rhetorical Federalism: The Role of State Resistance in Health Care Decision-Making*, 39 J.L. MED. & ETHICS 73 (2011).

<sup>118</sup> See Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256 (2009). The ACA contains numerous “cooperative federalism arrangements” for implementing reform, such as conditional funding, conditional preemption, block grants, and contractual arrangements between states and the federal government. See Leonard, *supra* note 117, at 74.

<sup>119</sup> Leonard, *supra* note 117, at 3–9. Five states have enacted resolutions stating that their citizens would not be required to comply with the ACA’s individual mandate, Missouri has passed a ballot measure prohibiting governments from mandating insurance, and lawmakers in over forty states have introduced bills asserting their States’ rights to opt out of implementation of the ACA or otherwise nullify some or all of its provisions. *Id.*; see also Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010-2011*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/default.aspx?tabid=18906> (last updated Mar. 22, 2011).

<sup>120</sup> As of this writing, twenty states have filed federal suits challenging the constitutionality of the ACA. See Kevin Sack, *Suit on Health Care Bill Appears Likely to Advance*, N.Y. TIMES, Sept. 15, 2010, at A20.

<sup>121</sup> See Havighurst, *supra* note 21, at 90.

<sup>122</sup> See *id.* at 84 (arguing that “the dynamics of the political market for consumer-protection regulation provide strong reasons to believe not only that standard-setting, command-and-control regulation systematically generates more social costs than benefits, but also that those costs are most likely to fall disproportionately on persons with lower incomes”).

<sup>123</sup> Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 3021, 124 Stat. at 389–95 (2010) (codified in scattered sections of 42 U.S.C.A. (West 2010)) (patient-centeredness as one standard for evaluating models under new innovation center in the Centers for Medicare and Medicaid Services); *id.* § 3022, 124 Stat. at 395–99 (codified at 42 U.S.C.A. § 1395jjj (West 2010)) (ACOs must meet patient-centeredness criteria to be established by the Secretary).

of private insurance may unduly limit choice, unfairly burdening low-income groups with expenditures they may not otherwise choose to make. As some have argued, preserving choice within limits along the dimensions of quality, convenience, and cost provides the *raison d'être* for maintaining a private system of health care financing.<sup>124</sup>

Finally, one can safely predict that the ACA will give rise to unintended consequences (though identifying them is not so easy).<sup>125</sup> A key challenge for regulators will be to refrain from overprotective denials and to respond quickly to make necessary changes. However, when legislation is needed,<sup>126</sup> politics may intrude, and opponents may prefer to allow the statute's flawed provisions to remain in effect rather than fix what they regard as a wholly wrongheaded and unconstitutional enterprise.

### B. Concentrated Markets and Entry Barriers

The high levels of concentration in hospital, specialty physician, and payer markets pose a serious problem for implementing reforms that rely on competition. As described above, the ACA relies on two important innovations to promote competition. First, it creates exchanges that will afford opportunities for comparative shopping by consumers and competition among health plans. Second, it supports development of new delivery systems, such as ACOs and medical homes, that can integrate care and take responsibility for managing care under budgetary constraints. Uncompetitive provider and payer markets may imperil both initiatives.

Achieving cost savings from competition among payers requires provider market competition. The effects of provider leverage on

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<sup>124</sup> See Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM (Robert B. Helms ed., 1993).

<sup>125</sup> Academics and bloggers are lining up to predict such eventualities. See, e.g., David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a "Game Changer?"* (Univ. of Ill., Law and Econ. Research Paper No. LE10-010, 2010), available at <http://ssrn.com/abstract=1624311> (recognizing the risk that employers will drop health insurance when the ACA reforms are implemented in 2014); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125 (2011) (asserting that the ACA may induce employers to redesign their health plans to encourage employees who are likely to require extensive medical services to opt out of employer-provided coverage and instead acquire coverage from the individual market).

<sup>126</sup> See, e.g., Monahan & Schwarcz, *supra* note 125, at 194–95 (describing the limitations of regulatory actions designed to correct the problem of employers dumping certain employees).

health costs are well documented,<sup>127</sup> and there is little in the reform legislation designed to change things. While returning insurers to the role of managing care can help mitigate the myriad market imperfections that complicate health care markets, it remains to be seen how effective regulations improving transparency, promoting evidence-based medicine, and curtailing insurance industry practices will be. Further, enforcement of antitrust law offers no panacea for the problems sketched above. Antitrust does not break up legally acquired monopolies or oligopolies, nor does it counter their exercise of market power through monopoly pricing, output restrictions, or quality degradation. Thus, to a considerable extent, the horse is out of the barn as far as consolidation in physician, hospital, and insurance markets that has already occurred.

To some commentators, embedded provider market concentration is an intractable problem that can be cured only by rate regulation.<sup>128</sup> An alternative approach recommends blending reliance on markets with steps to improve competition when possible and falling back on rate regulation when possible. For example, Len Nichols has framed this approach as follows:

When prices are stuck far from the efficient cost level, policy makers have three basic tools at their disposal:

- (1) Change rules related to market entry and structure to engender more market competition (e.g., antitrust)
- (2) Use countervailing market buying power (monopsony) to counter local provider market power and resistance to change
- (3) Impose direct<sup>129</sup> regulation of prices or specific behaviors of competitors.

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<sup>127</sup> See *supra* notes 38–46 and accompanying text.

<sup>128</sup> See, e.g., Berenson et al., *supra* note 47.

Unless market mechanisms can be found to discipline providers' use of their growing market power, it seems inevitable that policy makers will need to turn to regulatory approaches, such as putting price caps on negotiated private-sector rates and adopting all-payer rate setting. Indeed, some purchasers who believe strongly in the long-term merits of increased integration of care delivery believe that price regulation may be a prerequisite for payment reforms that encourage integration.

*Id.* at 705; see also Bruce C. Vladeck & Thomas Rice, *Market Failure and the Failure of Discourse: Facing Up to the Power of Sellers*, 28 HEALTH AFF. 1305, 1306 (2009) (arguing that high prices in American health care are the result of a "fundamental imbalance in power between buyers and sellers").

<sup>129</sup> Nichols, *supra* note 60, at 5.

Nichols's proposal merits consideration. However, given the difficulties associated with parts (1) and (2) of his concept, much of the burden may fall on item (3), rate regulation. Regulators and enforcers can take steps to encourage new entry; however, their tools are limited. While collusion to inhibit entry is actionable under antitrust law,<sup>130</sup> CON laws, laws governing the scope of practice for allied health practitioners, and other regulatory limitations on provider competition are the product of state and federal law. The ACA made no efforts to alter these limitations, and it is doubtful there is political will to do so. Indeed, the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement.<sup>131</sup> Reliance on countervailing power is also open to question. As a matter of economic theory<sup>132</sup> and experience,<sup>133</sup> bilateral monopoly does not necessarily advance consumer welfare. Moreover, identifying the conditions in which bilateral monopoly should be encouraged (e.g., by countenancing otherwise anticompetitive mergers) is fraught with uncertainty.

The structure of insurance markets also poses an obstacle to reliance on competition. With one insurer controlling more than fifty

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<sup>130</sup> See, e.g., Press Release, U.S. Dep't of Justice, Justice Department Requires Two West Virginia Hospitals to End Illegal Market-Allocation Agreements (Mar. 21, 2005), available at [http://www.justice.gov/atr/public/press\\_releases/2005/208209.htm](http://www.justice.gov/atr/public/press_releases/2005/208209.htm). See generally 1 FURROW ET AL., *supra* note 11, at 206–07 (describing cases challenging concerted action to limit competition through abuse of the CON process).

<sup>131</sup> The ACA essentially bans future development of physician-owned hospitals that depend on Medicare reimbursement by eliminating the Stark Law exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010, and it sharply curtails the ability of existing facilities to expand. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (2010) (codified at 42 U.S.C.A. § 1395nn (West 2010)); see also 1 FURROW ET AL., *supra* note 11, at 172.

<sup>132</sup> ROGER D. BLAIR & JEFFREY HARRISON, *MONOPSONY IN LAW AND ECONOMICS* 124–67 (2010).

<sup>133</sup> A notorious example of cooperation between dominant firms involved the so-called “market covenant” between the CEOs of Partners Health Care, the dominant hospital system in Massachusetts, and the State’s largest insurer, Blue Cross Blue Shield (BCBS) of Massachusetts. As reported in *The Boston Globe*, BCBS agreed to a major payment increase for Partners, and in return, Partners “promised [it] would push for the same or bigger payment increases” from other insurers, thereby affording BCBS some insulation from competition from rival insurers. Scott Allen et al., *A Handshake That Made Healthcare History*, BOS. GLOBE, Dec. 28, 2008. See generally Robert Pitofsky, Chairman, Fed. Trade Comm’n, Thoughts on “Leveling the Playing Field” in Health Care Markets, Remarks Before the National Health Lawyers Association Twentieth Annual Program on Antitrust in the Health Care Field (Feb. 13, 1997).

percent of the market in seventeen states and at least twenty-two others states having two firms that dominate the market,<sup>134</sup> much attention during the reform debate focused on improving the competitiveness of insurance markets. Advocates claimed that offering a government-sponsored public plan option in each market would improve the dynamics of private plan competition in local and regional markets. The competition-based argument for the public option rested on the dynamics of rivalry in concentrated markets. When insurers were unable or unwilling to effectively bargain for discounts with hospitals,<sup>135</sup> the public plan would act as a “maverick” because it did not have incentives to go along with rivals that might be content to compete less vigorously.

While the foregoing arguments did not carry the day, Congress did adopt two proposals ostensibly designed to inject new competition into private insurance markets. The ACA authorizes the Office of Personnel Management (OPM) to enter into contracts with “multi-state insurance plans” to offer individual or small group coverage through the exchanges.<sup>136</sup> It requires the OPM to contract with at least two plans in each state, at least one of which must be a nonprofit.<sup>137</sup> Second, the ACA authorizes federal grants and loans to encourage the creation of nonprofit, member-owned consumer insurance cooperatives.<sup>138</sup> Cooperatives will be tax exempt, nongovernment entities, but they will be subject to a number of

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<sup>134</sup> See Davenport and Sekhar, *supra* note 53.

<sup>135</sup> John Holahan explained the dynamic of hospital-payer bargaining as follows:

In markets where there is little concentration among insurers but a concentrated hospital market, there is little ability to negotiate. Where there is a dominant insurer, it is possible to do better and obtain discounts from hospitals, but they still have little negotiating power with dominant hospital systems. In some markets, dominant insurers have no real incentive to be tough negotiators because they have no real competitors. Small insurers lack bargaining power with providers and thus cannot significantly compete with larger insurers on premiums. Finally, there is no real competition in many hospital markets because smaller hospitals have no ability to challenge the dominant system.

John Holahan, Dir., Health Policy Ctr., The Urban Inst., Statement at the Hearing on Health Reform in the 21st Century: Proposals to Reform the Health System (June 24, 2009).

<sup>136</sup> ACA § 10104, 124 Stat. at 902–06 (codified as amended at 42 U.S.C.A. § 18054 (West 2010)).

<sup>137</sup> The ACA empowers the Office of Personnel Management to negotiate with the plans concerning their medical loss ratio, profit margin, premium levels, and other terms and conditions as are in the interests of the enrollees. *Id.*

<sup>138</sup> *Id.* § 1332, 124 Stat. at 203–06 (codified at 42 U.S.C.A. § 18052 (West 2010)).

regulatory restrictions. The problem that both cooperative and multistate plans encounter is the obstacle that has stymied new entrants in the past: the entry barrier associated with obtaining provider discounts and assembling networks that will enable new plans to compete effectively with established incumbents.<sup>139</sup>

## V

### ACOs MAY BE THE ANSWER, BUT WHAT IS THE QUESTION?

ACOs have garnered much attention.<sup>140</sup> For many observers they hold out the prospect of rationalizing the delivery system by incentivizing providers to integrate their practices, make investments in technology and human capital, and ultimately change the way medicine is practiced. Under this Panglossian account, ACOs can provide a vehicle for lowering cost and improving quality, not only in Medicare but in the private sector as well. To meet the organizational and practical requirements of the ACA, providers will need to combine through merger or some other form of affiliation and make lasting commitments regarding their participation. There are already anecdotal reports of a pending merger and acquisition wave prompted by hospitals and physicians that want to position themselves to form ACOs,<sup>141</sup> even though, as of this writing, the HHS has yet to release rules or guidance.

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<sup>139</sup> See Varney, *supra* note 56; see also Timothy S. Jost, *Are Cooperatives a Reasonable Alternative to a Public Plan?*, HEALTH REFORM WATCH (June 15, 2009), <http://www.healthreformwatch.com/2009/06/15/jost-on-cooperatives> (questioning the viability of cooperatives but allowing that they could succeed with “concerted and probably long-lasting support from the federal government”).

<sup>140</sup> See, e.g., Atul Gawande, *Testing, Testing*, NEW YORKER, Dec. 14, 2009, [http://www.newyorker.com/reporting/2009/12/14/091214fa\\_fact\\_gawande](http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande); Reed Abelson, *A New Concept in Health Care*, N.Y. TIMES, July 8, 2010, <http://prescriptions.blogs.nytimes.com/2010/07/28/a-new-concept-in-health-care> (recognizing ACOs as “one of the hottest concepts to emerge from the discussions about how best to overhaul the nation’s health care system”). For less sanguine views, see Jeff Goldsmith, *The Accountable Care Organization: Not Ready for Prime Time*, HEALTH AFF. BLOG (Aug. 17, 2009), <http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time> (“The problem with this movie is that we’ve actually seen it before, and it was a colossal and expensive failure.”). See also Joe Carlson, *ACOs: A Mystery of Biblical Proportions*, MOD. HEALTHCARE (Aug. 9, 2010), <http://www.modernhealthcare.com/article/20100809/NEWS/308099959>.

<sup>141</sup> See Caralyn Davis, *Investors Expect Healthcare M&A Uptick Through 2Q 2011*, FIERCE HEALTHFINANCE (July 21, 2010, 11:05 AM), <http://www.fiercehealthfinance.com/story/investors-expect-healthcare-m-uptick-through-2q-2011/2010-07-21#ixzz0zZ6qZLVp> (predicting a sharp increase in consolidation among providers resulting from health reform).

From the perspective of the topic of this Article, a key issue is whether the movement to form ACOs will advance the competitive model or retard it. To a considerable extent, ACOs mirror the pro-competitive potential that HMOs brought to the table during the managed care era. That is, the ACO can serve as a locus of responsibility, accountable for maintaining quality and using evidence-based medicine and operating under financial incentives to control costs. As such, employers and insurers will be able to shop, compare, and bargain with ACOs to get the best deal for their insureds. Indeed, because they assume risk, ACOs can reduce the role of the insurer/middleman, offering presumed benefits to both providers and consumers who are suspicious of the insurance industry. But at the same time, the path of ACO development could prove profoundly anticompetitive. One concern flows from what might come to be called the “2010 Health Reform Merger Wave”—a rush to consolidation induced in part by hospitals and physicians wanting to be assured they will be in a strong bargaining position.<sup>142</sup> As hospitals buy up or otherwise affiliate with physician practices, as physician practices merge, and as hospitals merge with rivals, there may be little room for formation of competing ACOs in many markets. Whether the HHS will use its regulatory authority to discourage over-inclusive ACOs is still an open question.<sup>143</sup> Although the ACA contemplated that Medicare ACOs also serve the private insurance industry,<sup>144</sup> it gave no guidance as to whether the HHS should attempt to preserve conditions that are conducive to competition among ACOs. Thus, although ACOs are potentially the most potent mechanism for systemic change in the new law, Congress neglected to specifically charge the HHS with the responsibility for assuring that the Shared Savings Program does not enhance or entrench provider market power.

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<sup>142</sup> See Robert Pear, *As Health Law Spurs Mergers, Risks Are Seen*, N.Y. TIMES, Nov. 21, 2010, at A1.

<sup>143</sup> Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED. e1 (2011), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404>; Robert F. Leibenluft, *ACOs and the Enforcement of Fraud, Abuse, and Antitrust Laws*, 364 NEW ENG. J. MED. 99 (2011), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1011464>.

<sup>144</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10307, 124 Stat. 119, 941 (2010) (codified at 42 U.S.C.A. § 1315a (West 2010)) (stating that the Secretary of the HHS “may give preference to the ACOs who are participating in similar arrangements with other payers”).

## CONCLUSION

The interplay between competition and regulation has a long history in American healthcare. This Article has argued that, although the ACA takes important steps toward improving the prospects for competition, political and practical obstacles stand in the way of realizing that end. As we approach the forty-fifth anniversary of the passage of the last major health care reform in America, the adoption of Medicare and Medicaid, can one now say which side—competition or regulation—has prevailed? As Zhou En-lai answered when asked about the effect of the French Revolution, the answer seems to be “it’s too soon to tell.”<sup>145</sup>

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<sup>145</sup> SIMON SCHAMA, *CITIZENS: A CHRONICLE OF THE FRENCH REVOLUTION*, at xiii (1989).

