Introduction

Encouraging Competition and Cooperation: The Affordable Care Act's Contradiction?

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Abstract This introductory essay to *JHPPL*'s special issue on accountable care organizations (ACOs) presents the broader themes addressed in the issue, including (1) a central tension between *cooperation* versus *competition* in health care markets with regard to how to bring about improved quality, lower costs, and better access; (2) US regulatory policy—whether it will be able to achieve the appropriate balance in health care markets under which ACOs could realize expected outcomes; and (3) ACO realities—whether ACOs will be able to overcome or further embed existing inequities in US health care markets.

Keywords Affordable Care Act (ACA), accountable care organizations (ACOs), antitrust, cooperation, competition

A central theme in US health policy is contradiction. For so long, we juxtaposed paying very high prices for medical care (that many but not all Americans had access to) with failing to be any healthier as a population (relative to equally economically advanced countries). To pay so much for so little comparative value in return has become part of the rallying cry against the US health care system (Berwick, Nolan, and Whittington 2008). This problem of high US health care costs without commensurate health gains is not, of course, a new problem. While our measures of health outcomes have changed over the years—lots of uninsured left largely outside the system, relatively high infant mortality rates, high levels of chronic disease, high rates of medical errors—the contradiction between high health care costs alongside strikingly bad outcomes, especially in poor minority neighborhoods, has long been evident.

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Moreover, the solutions offered to solve this dual problem are themselves beset with contradictions. Major health reforms in the United States are often (perhaps always?) a strange stew of incongruous policy goals. The most common and persistent contradiction is that which promotes competition, on the one hand, and collaboration, on the other. This contradiction started, one could argue, when the Sherman Antitrust Act was passed in 1890. Written into the act, by necessity, is ambiguity around the notion of what types of agreements or collaborations act to "unreasonably restrain trade" (Remis 1996: 117; see 15 U.S.C. § 1 (1994)). The state action doctrine was instituted in 1943, in which the Supreme Court clarified that the Sherman Act does not supersede the regulatory power of the state or the ability of state legislatures to pass "anticompetitive" laws, such as rate-setting laws passed in several states. There was also ambiguity for a long time regarding whether antitrust laws apply to the health care industry, until the Supreme Court rejected exemption and, in 1975, ruled affirmatively that antitrust laws do apply. Yet, at the same time, the court noted that "special accommodations may be necessary" (Remis 1996: 119; see Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 n.17 (1975)). Thus, at least the latter half of the twentieth century has coexisted with the notion, codified into legal doctrine, that health care in the United States should strike a harmonious balance between competition and cooperation. From the start, however, this harmony has been difficult to find and subject to multiple interpretations, some seeing dissonance and others more balance.

The development of accountable care organizations (ACOs) under the Affordable Care Act (ACA) is the latest in a long line of antitrust concerns about whether the benefits of particular delivery model reforms outweigh the costs (due to higher prices) of reduced competition (Saponaro 1999; Baicker and Levy 2013). This is the simplified antitrust equation, and one can clearly see the values that lie behind both sides of the equation. Those who see great hope in cooperation among providers to improve (1) continuity of care and (2) integration across traditionally separate lines of service provision, and often ownership (in order to create more holistic care plans that start with prevention and combine social, medical, and behavioral health needs), tend to view competition's ability to bring about improved quality with skepticism (Madison 1996; Morone 1992, 2000; Marmor and Plowden 1991). And, those who view the evidence for competition as convincing are more skeptical of integrated delivery model reforms, especially if a reduction in competitive behavior results, as Roger Feldman (2015) discusses in this issue.

These different values and weights accorded to the benefits of cooperation and integration, versus competition, are on full display in the articles that follow. These pages are symbolic of the larger amalgamation of tensions—public versus private, competition versus cooperation—that exist within the US health care system. While there are important voices on both sides of this tension, those grappling with how best to work within a mixed system (perhaps accepting the inevitability of a completely merged public-private system) are represented here.

The issue opens with "Accountable Care Organizations: Integrated Care Meets Market Power," an introductory overview from Richard Scheffler (2015), coeditor of this special issue, wherein he uses the lens of transaction cost economics to provide an economic rationale for why we might expect ACOs to be more efficient and increase quality of care. He reviews how the papers in this issue fit into a larger argument.

The ACO articles are organized into three parts. Part 1 provides an introduction to the current landscape of ACOs across the United States and, more specifically, California, where ACOs have spread most quickly. Because Scheffler reviews the articles in parts 1 and 3 in more depth in his introductory article, I focus primarily on the articles in part 2.

Part 2 dives more deeply into questions around ACO benefits. In particular, the articles in this section consider whether ACOs will reduce overall health expenditures (especially if high prices for medical services remain), increase quality, integrate care, and improve population health. All the articles in this section provide important critiques suggesting that, given the current incentive structures, it is unlikely that ACOs will be able to deliver on these dimensions. In "Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust," Robert Berenson (2015) explicitly considers whether antitrust policy can do anything to substantially challenge the ability of providers to demand high prices. Feldman (2015) concurs, albeit for different underlying reasons, that ACOs will not adequately address the problem of high prices. In "The Economics of Provider Payment Reform: Are Accountable Care Organizations the Answer?" he argues that the most efficient way for Medicare to address this issue is to set a lower reimbursement rate. Eric Kessell and his colleagues contribute "Review of Medicare, Medicaid, and Commercial Quality of Care Measures: Considerations for Assessing Accountable Care Organizations," an examination of why ACOs are expected to improve the quality of care provided to enrollees. Their article also asks this important question: How would we know if ACOs did improve value? They lay out a useful plan for what outcomes can be measured and should be collected (Kessell et al.

2015). From Thomas D'Aunno et al. (2015), we have "Integration of Substance Abuse Treatment Organizations into Accountable Care Organizations: Results from a National Survey." This article looks at data from outpatient substance abuse treatment providers to determine the extent of their involvement in ACOs to date. The authors find very low rates of involvement and raise important questions about the extent to which ACOs will move toward integrated systems of care, which includes behavioral health services. Finally, in "Accountable Care Organizations and Population Health Organizations," Lawrence Casalino et al. (2015) examine the ubiquitous use of the term *population health* to consider what ACOs can actually achieve—perhaps improving health for their enrollees—in relation to the true meaning of population health: improving the health of communities.

Miriam Laugesen's (2015) commentary, "Payment Policy Disruption and Policy Drift," closes part 2, asking us to consider a key question: Will ACOs disrupt the status quo to help reshape the US health care system? Because all the articles in this section engage this question, their sum forces us to consider whether ACOs may not just leave promises unfulfilled but may also further entrench existing problems. For example, if the ability of certain hospitals and providers to command high prices is further solidified, and competition under the current system allows extremely large price differentials, the development of ACOs—even with strongly enforced antitrust policy—will likely do little to change these variations in price. Moreover, if price differentials are related to health disparities, then the contracting structure of ACOs may undermine other ACA reform efforts to reduce inequities.

Finally, part 3 returns to the crucial question of how cooperation and competition can—or should—coexist. In "Antitrust and Provider Collaborations: Where We've Been and What Should Be Done Now," Robert Leibenluft (2015) reviews past antitrust policy regarding provider collaborations and provides recommendations for how antitrust could be structured around this important question in light of the implementation of ACA reforms. Next, we hear directly from those working in antitrust enforcement. In "Accountable Care Organizations and Antitrust Enforcement: Promoting Competition and Innovation," by Deborah Feinstein, Patrick Kuhlmann, and Peter Mucchetti (2015), and in "A Few Thoughts about ACO Antitrust Issues from a Local Enforcement Perspective," by Kathleen Foote and Emilio Varanini (2015), we receive an insider perspective on important enforcement approaches to coexistence. Finally, Thomas Greaney (2015) and Daniel Fox (2015) provide separate commentary on the regulatory aspects of ACOs. Greaney's article, "Competition Policy after

Health Care Reform: Mending Holes in Antitrust Law's Protective Net," facilitates further inquiry into this question: How should collaboration exist under antitrust law? What would be markers of "fair" collaborative behavior that would not also be anti-competitive? In "Patients' Rights Matter in Regulating Accountable Care Organizations," Fox probes the important consideration of what regulatory policies should be in place to ensure adequate patient rights under ACOs.

Ultimately, what lies behind these multiple interpretations of whether ACOs will be able to truly disrupt the current dysfunction in the US health care system are the different weights we all assign to the many variables at play: cost control; improved quality; integrated care; population health; reduced health disparities; and, perhaps just as importantly, different interpretations of the evidence—and therefore beliefs in—the power of competition to bring about these values.

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