

Commentary

Accountable Care Organizations and Narrow Network Insurance Plans

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Rapid medical care cost growth is one of the primary economic and fiscal challenges that policy makers wrestle with in the United States. Nationwide, medical expenses have grown at a rate approximately double the rate of inflation over the past two decades, in part due to price increases, in part due to quantity increases, and in part due to the introduction of new medical technologies. Medical care expenses have risen to approximately 20 percent of gross domestic product as of 2012, and it is projected that these expenses will cripple the state and federal budgets and slow economic growth in other sectors in the years to come.

Accountable Care Organizations (ACOs) and insurer formation of narrow provider networks are two oft-discussed policies to reduce costs, with both having been implemented to some degree in practice. Participation in ACOs allows medical providers to work around the Stark laws and collaborate across the vertical chain of care, from primary care to specialty care to hospital care, and then allows these providers to collectively share savings if the population they treat is healthier and/or less expensive than some baseline level. Thus ACOs permit some level of integration between different medical providers, ostensibly to facilitate efficiencies arising from (a) care coordination, (b) technology adoption, and (c) population health management that might be hard to realize in the absence of some degree of integration. These greater efficiencies could lead to lower medical expenses (or lower growth in these expenses) at equal or higher care quality levels. However, while ACOs have some promise for providing more efficient care, they also have the possible downside of increased

market concentration and, consequently, increased prices for health care services. As H. E. Frech III et al. (2014) and Christopher Whaley, Frech, and Richard M. Scheffler (2014) note, increased market power arising from ACO formation is a central concern for antitrust authorities, and organizations exercising this market power could lower, eliminate, or reverse the potential efficiency gains from ACOs.

Narrow provider networks, in comparison, emerge when insurers reduce consumer access to medical providers in a given region, to secure low enough prices for those providers that do provide services. As described, for example, by Jonathan Gruber and Robin McKnight (2014), formation of narrow networks is a core insurer strategy, especially in the state-by-state exchanges set up in the Affordable Care Act (ACA), to realize efficiencies in medical care and lead to either (a) lower prices from providers or (b) exclusion of more expensive providers.

While policy makers often discuss ACOs and narrow networks as separate policies, the level of regulation and enforcement relevant to each of these two reforms has important implications for the other. Consider the case of a large vertically integrated ACO with some market power across the range of services provided in a given region. If state and federal regulations on how narrow provider networks can be are quite restrictive, then this complements and enhances the ability of the ACO to extract higher prices. Regulations that restrict insurers' abilities to form narrow networks include (a) those that require certain types of "essential" providers to be covered and (b) those that require some providers of a given type to be available within a certain distance radius for all consumers enrolled in an insurance plan. As these regulations become more restrictive, ACOs can exercise more market power conditional on their level of concentration, via greater bargaining power. As a result, policies that restrict formation of narrow networks make it harder to realize the potential efficiencies from ACOs by making them a greater target for antitrust enforcement.

Conversely, if state and federal regulations regarding insurer network formation are lax, and insurers can credibly threaten to exclude many kinds of providers to negotiate large discounts, then provider integration via ACO formation is less threatening to antitrust authorities, because it is more likely that insurers can discipline their market power by excluding the entire ACO from the network.

Foundations: ACO Market Power

While it is clear that regulations restricting market power in ACOs (resulting from either horizontal or vertical integration) interact with

policies on how restrictive insurer networks can be, it is important to understand the foundations for ACO market power concerns in order to understand the full space of feasible policies to deal with market power while allowing for these organizations to realize efficiencies in medical care provision.

First, it is important to address whether ACOs can form to realize efficiencies but be required to negotiate separately with insurers, thereby removing ACO market power concerns in private insurance markets. While implementing such a policy is likely feasible, it also works counter to the notion that we want ACOs to realize greater efficiencies. If some ACO members are in network for a given private insurer and others are out of network, then it will be hard to realize the envisioned efficiencies for care coordination for patients because the ACO will not be able to refer patients within its organizational structure and within the insurer's network. Thus, even if providers *could* negotiate separately, it doesn't make sense to allow them to do so because the whole purpose of ACOs is to have integrated care delivery.

Second, it is useful to establish why antitrust authorities might have more concern about ACOs than about vertically integrated HMOs such as Kaiser. Since ACOs typically do not have insurer stakes, they essentially function as integrated provider organizations with greater ability to bargain with insurers. A vertically integrated HMO typically (a) bargains with integrated providers to lower cost, (b) reviews utilization, (c) uses efficient technology, and (d) offers physician payment incentives to control costs. Essentially, an HMO aligns incentives for both narrow network formation and efficient medical care provision within one organization; in practice, ACOs intend to have an impact on utilization reviews and efficient technology use but do not have the same incentives as the vertically integrated HMO to control costs. In the typical ACO-insurer relationship in the private market, the insurer has to negotiate both low prices and efficient payment incentive schemes with providers; if providers have substantial market power as an organization, they will extract more of the rents in this scheme because they are not worried about competing with other insurers and reducing costs.

Third, it is worth understanding why the vertical relations in an ACO are likely to lead to antitrust concerns. A key reason is that each link in the vertical chain of care provision (e.g., primary care, hospitals) is crucial for an insurer to have within network. As a result, an ACO with substantial market power in one part of the vertical chain (e.g., certain specialties or hospitals) can use market power in that one area to secure higher rates across the range of services. Again, this could be mitigated by requiring

some ACO members to negotiate separately with insurers, but doing so on a case-by-case basis is hard, and doing it broadly is unattractive because the whole purpose of ACO formation is to deliver integrated care throughout the organization (so the whole organization should, generally speaking, be in network for the insurer). This suggests that antitrust officials will be concerned about maximum market power, or maximum Herfindahl-Hirschman Index (HHI), for any horizontal part of the vertical chain.

Policies: ACO Market Power and Narrow Networks

If an ACO is viewed as an integrated organization with differential market concentration for different parts in the vertical chain (and we care about the maximum concentration across that vertical chain), then it is clear that ACO antitrust enforcement should be considered in the context of state and federal narrow network regulations. In a “thick” urban market, an ACO with generally low market concentration in different horizontal markets, but high concentration in one market, is less of a concern because there are still likely many providers the insurer can include in the network (outside the ACO) in the area with high horizontal concentration within the ACO. This means that the insurer can form a viable network, still at low bargained rates through the vertical chain. In this case, *as long as network adequacy regulations are lax*, insurers have enough flexibility in network formation to get around the bottleneck in concentration in one horizontal market and create a credible alternative network excluding the ACO. This could in turn lead them to contract with that ACO at lower rates. With restrictive network adequacy regulations, the insurer would be more likely to be *required* to contract with providers in the concentrated part of the ACO, and, in turn, the ACO could exercise its market power from that throughout the vertical chain of care.

It is important to point out that a thick provider market is necessary for lax network adequacy regulations to reasonably alleviate antitrust concerns from vertically integrated ACOs. Consider a case where an ACO has high market concentration in one area, for example, primary care, but the market is thin. Then in a rural area with four primary care providers, having three of those providers in an ACO would not allow for the insurer to bargain among primary care providers outside of the ACO (and in turn the rates from those providers would still be quite high). Consequently, even with lax network adequacy regulations in rural markets, it is unlikely that an insurer could form a low-cost network alternative to the ACO when the ACO has market power in one or more horizontal markets.

Of course, network adequacy regulations have some merit and foundation from a consumer protection standpoint. If consumers lack information about provider networks when choosing insurance plans in an ACA exchange or other private market, then allowing for lax network adequacy regulations could cause insurers to overreach and make networks too restrictive. Consumers would still choose these networks (lacking information on how limited they truly are) and suffer *ex post* upon medical event realizations. In this case, there is a key link between (a) consumer choice adequacy in insurance markets, (b) network adequacy regulation, and (c) ACO antitrust enforcement. If consumers are well informed and make sound insurance choices for themselves, network regulations can be more lax, and, in turn, ACO antitrust enforcement can be more relaxed. However, if consumers have substantial information frictions (see, e.g., Handel and Kolstad 2014), then there is a real concern with allowing insurers to form very narrow networks and, in turn, likely a need for tighter ACO antitrust enforcement.

Wrap Up

This comment focuses on ACO formation for private markets; regulation of ACOs in Medicare is less concerning because Medicare sets prices administratively and wields substantial bargaining power. However, it is clear that, as Robert Berenson (2015 [this issue]) discusses, formation of Medicare ACOs under the Shared Savings Program (SSP) could facilitate formation of ACOs for the private market, where insurers don't have the same inherently strong bargaining position. Additionally, it is worth pointing out that realizing efficiencies in ACOs requires payers to appropriately set incentives for the ACO to control costs. This occurs via the SSP for Medicare ACOs, but private insurers should be able to provide stronger incentives to ACOs and, ultimately, realize greater efficiencies as a result.

Overall, it is clear that formation of ACOs by providers has the potential to lead to more efficient provision of medical care. Whether or not this potential is realized depends crucially on how creative and effective payers (public and private) can be in unlocking these efficiencies and on how ACOs exercise newfound market power. Particularly, if there is an appropriate balance between consumer information in insurance choices, the ability of insurers to form narrow networks, and antitrust enforcement of ACOs, then ACOs may be able to be an important part of the solution to the national problem of rapidly increasing health care costs.

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