

# Managed Care Marketplaces: Growing Drivers of Payer-Provider Vertical Integration

**Brian J. Miller and George L. Wolfe**

Recent health insurance marketplace changes have brought about innovative risk-sharing arrangements and vertical integration along the healthcare delivery supply chain. This integration is occurring through full-asset acquisitions—such as UnitedHealth’s acquisition of Surgical Care Affiliates to provide a comprehensive ambulatory care services platform—and through joint venture and contractual arrangements—such as Aetna’s partnering with Inova Health System to create Innovation Health Plans. These vertical arrangements have the potential to provide significant quality of care and cost saving efficiencies by increasing transparency and collaboration along the healthcare supply chain. At the same time, vertical alignment between health insurance providers (“payers”) and hospital-centric health systems raises unique antitrust questions that require courts to balance foreclosure issues against enhanced quality of care and network design efficiencies.

This article examines the recent *Omni Healthcare v. Health First* decision and ongoing healthcare marketplace changes to examine the role that efficiencies play in antitrust enforcement policy when analyzing vertical healthcare integration. Despite the complex market structure of healthcare insurance and delivery vehicles, there does not appear to be any empirical evidence supporting the view that vertical healthcare affiliations pose a risk of antitrust harm greater than standard vertical theories would predict. Network design vis-à-vis using tiers and exclusion are integral parts of offering affordable plan products that enable vertically integrated payer-providers to implement cost savings and improve quality of care.<sup>1</sup> These include providing tangible benefits to consumers by streamlining care delivery, providing a seamless care experience, integrating clinical operations, and potentially increasing medical quality. We note, however, that “low” levels of risk shifting like Accountable Care Organization (ACOs) may be insufficient to trigger changes in clinical operations or physician practice patterns that would result in significant gains for consumers.

## The Omni Healthcare Decision

In *Omni Healthcare Inc. v. Health First, Inc.*, Judge Roy B. Dalton Jr. of the Middle District of Florida concluded that alleged vertical foreclosure issues raised triable issues of fact.<sup>2</sup> Omni Healthcare and a consortium of medical providers (Omni) had sued Health First and its subsidiaries (Health First) for violating, *inter alia*, Sections 1 and 2 of the Sherman Act and Section 7 of the Clayton Act,

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<sup>1</sup> Network tiering allows insurers to grade providers and subsequently incentivize patients to use preferred providers by reducing their copayment and/or co-insurance responsibilities. Tiered networks provide insurers with more precise tools for network design than the classical in-network and out-of-network dichotomy.

<sup>2</sup> *Omni Healthcare Inc. v. Health First, Inc.*, No. 6:13-cv-1509, 2016 WL 4272164, at \*1 (M.D. Fla. Aug. 13, 2016).

due to its varying alleged anticompetitive conduct in Southern Brevard County (SBC). Omni alleged that Health First is a dominant regional hospital system due to its 86.8 percent market share for inpatient hospital services vis-à-vis its Holmes Regional Medical Center and three additional nearby hospitals.<sup>3</sup> Health First also offers multiple health insurance plans through its Health First Health Plans (HFHP) subsidiary, and operates its physician practices through its Health First Physicians (HFP) subsidiary.<sup>4</sup>

The crux of Omni's antitrust claims was that Health First, by engaging in various forms of exclusionary conduct, such as requiring its physicians and other in-network providers to only refer patients within the business group-owned hospital system, harmed competition in various health-care markets.<sup>5</sup> At the summary judgement phase, Judge Dalton concluded that the alleged exclusionary conduct, in conjunction with Health First's 86.8 percent market share in inpatient hospital services, created triable issues of fact for the jury.<sup>6</sup>

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For the payer-provider claim, Omni alleged that Health First attempted to monopolize the Medicare Advantage marketplace by refusing to contract for inpatient hospital services with other Medicare Advantage insurers. The court held that (1) Medicare Advantage is a relevant market, (2) Health First intended to monopolize Medicare Advantage based on its internal documents, (3) Health First terminated other Medicare Advantage contracts that were otherwise profitable, and (4) unilateral termination of an otherwise profitable arrangement "may be indicative of anticompetitive intent where it suggests a willingness to forsake short-term profits to achieve an anti-competitive end."<sup>7</sup> The court thus denied summary judgment because the exclusionary conduct created triable issues of fact.<sup>8</sup>

Omni also alleged that Health First's acquisition of Melbourne Internal Medicine Associations (MIMA) in 2013—the second largest physician group in SBC—was an impermissible merger in violation of Section 7 of the Clayton Act.<sup>9</sup> Interestingly, Omni pled its challenge as a vertical merger between the largest inpatient hospital services provider and the second largest physician group. The acquisition allegedly harmed competition in SBC, where MIMA was the largest independent physician group, due to Health First requiring the acquired physicians to (1) accept only Health First Medicare Advantage Plans, and (2) only refer patients to other Health First providers (with limited exceptions).<sup>10</sup>

In support of their allegation, Omni relied on three key pieces of evidence: (1) deposition testimony affirming that physicians employed by Health First were required to refer patients to other Health First facilities, i.e., exclusive steering, (2) an expert report concluding that the acquisition and referral requirement foreclosed "more than 25% of the physician services market," and (3) an

<sup>3</sup> *Id.* at \*2, \*14. Health First also owns Canaveral Hospital, Palm Bay Hospital, and Viera Hospital in Brevard. These three hospitals are not named as defendants in the action.

<sup>4</sup> *Id.* at \*2.

<sup>5</sup> *Id.* at \*18–19. The plaintiffs voluntarily withdrew their attempted monopolization of private health insurance claim. All other claims survived summary judgment.

<sup>6</sup> *Id.* at \*14.

<sup>7</sup> *Id.* (citing *Verizon Commc'ns, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 409 (2004)).

<sup>8</sup> *Id.* at \*19. Interestingly, the court noted that Health First was free to argue at trial that their recently declining Medicare Advantage market share from 100% to 50%–60% due to recent entry negated their market power.

<sup>9</sup> *Id.* at \*2.

<sup>10</sup> *Id.* at \*12.

acquisition business plan detailing the elimination of all non-HFHP Medicare Advantage plans in SBC.<sup>11</sup> Judge Dalton concluded that the evidence created a triable issue of fact for the allegations of harm raised by the vertical acquisition.

The *Omni* decision raises many interesting questions of law. For example, can a dominant hospital system's acquisition of a large physician practice violate Section 7 as a vertical transaction? Can that hospital system's unilateral expansion into Medicare Advantage violate Section 2 based on the hospital's refusal to contract with other Medicare Advantage plans? Can a joint venture between an insurer and a hospital violate Section 1 if it establishes exclusive dealings? Judge Dalton's summary judgment opinion answers "yes" to each of these questions as a matter of law.

Whether these allegations were supported as a matter of fact, however, is a different story. Health First, in its motion for summary judgment, alluded to being able to proffer evidence that its conduct was justified procompetitive behavior, and that any growth was a "consequence of a superior product, business acumen, or historic accident."<sup>12</sup> The case settled on the second day of trial before Health First was able to put on their defense. Settlement prevented the court from addressing the triable issues of fact on vertical integration. This begs the question of what are the procompetitive benefits from vertical mergers and other vertical payer-provider arrangements that can counterbalance such triable allegations.

### The Antitrust Analytical Framework

There has traditionally been very little vertical merger antitrust enforcement in the United States.<sup>13</sup> This is likely because courts, agencies, and economists generally view vertical arrangements as procompetitive, inasmuch as coordination along the supply chain is often necessary to innovate, lower costs, or achieve other beneficial goals.<sup>14</sup> Although vertical arrangements are also less likely to raise antitrust concerns, "vertical concerns can arise if a network's power in one market in which it operates enables it to limit competition in another market."<sup>15</sup> As the Federal Trade Commission stated in its recent *Norman PHO Advisory Opinion*, healthcare antitrust is concerned with "vertical arrangements that would enable [the system] to use any market power the network might possess in selling certain services to limit competition in the sales of any other services."<sup>16</sup>

Vertical healthcare integration attempts to coordinate providers operating at different levels of our healthcare delivery system by increasing alignment of clinical and financial risk. Such arrange-

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<sup>11</sup> *Id.* at \*13.

<sup>12</sup> See Defs.' Mot. for Summ. J. at 6–8, *Omni* (Jan. 29, 2016), ECF No. 209 (quoting *United States v. Grinnell Corp.*, 384 U.S. 563, 570–71 (1966)).

<sup>13</sup> For example, a study concluded that there were only 48 vertical merger enforcement actions during the 1994–2015 period (most were consent decrees). Steven C. Salop & Daniel P. Culley, *Vertical Merger Enforcement Actions: 1994–2015* (Oct. 30, 2015), <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2541&context=facpub>.

<sup>14</sup> See, e.g., *Leegin Creative Leather Prods., Inc. v. PSKS, Inc.*, 551 U.S. 877, 903 (2007) (recognizing the procompetitive justifications of vertical restraints and eliminating the per se prohibition against resale price maintenance); U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care 108* (1996) [hereinafter *Healthcare Guidelines*], [https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements\\_of\\_antitrust\\_enforcement\\_policy\\_in\\_health\\_care\\_august\\_1996.pdf](https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf) ("In some multiprovider networks, significant efficiencies may be achieved through agreement by the competing providers to share substantial financial risk for the services provided through the network.").

<sup>15</sup> *Healthcare Guidelines*, *supra* note 14, at 19.

<sup>16</sup> Letter from Markus H. Meier, Assistant Dir., Health Care Div., FTC Bureau of Competition, to Michael E. Joseph, Esq. 19 (Feb. 13, 2013) [hereinafter *Norman PHO Advisory Opinion*], [https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr\\_0.pdf](https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf).

ments may include products where one is an input for another, such as surgeons and operating rooms. It can also include complementary products that are typically consumed together.<sup>17</sup> We can exemplify this by adding an anesthesiologist to our preceding surgeon and operating room hypothetical; continuing to add complementary services to our hypothetical results in the package becoming akin to a hospital system. Our hypothetical hospital system can then offer its own insurance products to more fully integrate along the healthcare supply chain.

Vertical integration is generally viewed as procompetitive across the entire healthcare delivery system because it frequently eliminates costs, streamlines operations, promotes clinical integration, and facilitates innovation in care delivery design.<sup>18</sup> These potential quality improvements and cost savings are exactly what health systems companies seek to unlock through vertical integration. For instance, vertical integration facilitates the creation and execution of capitated insurance plans whereby integrated payer-providers can undertake coordinated management of clinical and financial risk. Creating supply chain efficiencies can enable a vertically integrated undertaking to better compete by lowering prices or expanding output.

Streamlining operations may result in targeted marketing or research and development efforts that spur innovation. Customers also are often better informed by vertically integrated product offerings that share a brand, for example, because they know that their health insurance will be accepted throughout the vertically integrated hospital system. Without that information, in seeking emergency services, consumers may unwittingly be treated by an out-of-network emergency room physician, incurring significant costs.<sup>19</sup> A vertically integrated payer-provider may help consumers avoid these risks.<sup>20</sup> These examples are just a few of the many ways that vertical integration can “benefit suppliers, distributors, and consumers alike.”<sup>21</sup>

In certain circumstances when a company has pre-existing market power, however, vertical integration “can create changed incentives and enhance the ability of the merged firm to impair the competitive process.”<sup>22</sup> Vertical integration can impact competition in either the upstream or downstream product market. Where both markets are impacted differently, vertical integration raises open questions of law and policy as to how to decide whether the benefits outweigh the harm.<sup>23</sup>

Vertical theories of anticompetitive harm typically focus on conduct that raises rivals’ costs through either input or customer foreclosure. Raising rivals’ costs through foreclosure may be accomplished through boycotts, tying, bundling products and services, contracts referencing

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<sup>17</sup> Steven C. Salop & Daniel P. Culley, *Revisiting the U.S. Vertical Merger Guidelines: Policy Issues and an Interim Guide for Practitioners*, 4 J. ANTITRUST ENFORCEMENT No.1, at 30 (2016).

<sup>18</sup> See AM. BAR ASS’N SECTION OF ANTITRUST LAW, *MERGERS AND ACQUISITIONS: UNDERSTANDING THE ANTITRUST ISSUES* 365–77 (4th ed. 2015).

<sup>19</sup> See generally Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise*, 375 N. ENG. J. MED. 1915 (2016).

<sup>20</sup> Another example is that of the surgeon-anesthesiologist pair: a consumer may see an in-network surgeon but be served by an out-of-network anesthesiologist, chosen by the surgeon.

<sup>21</sup> See Jon Sallet, Deputy Assistant Att’y Gen., Antitrust Div., U.S. Dep’t of Justice, *The Interesting Case of the Vertical Merger*, Remarks at the American Bar Association Fall Forum (Nov. 17, 2016), <https://www.justice.gov/opa/speech/deputy-assistant-attorney-general-jon-sallet-antitrust-division-delivers-remarks-american>.

<sup>22</sup> U.S. Dep’t of Justice, Antitrust Division Policy Guide to Merger Remedies 5 (2011), <https://www.justice.gov/atr/archived-antitrust-division-policy-guide-merger-remedies-october-2004>. Analyzing vertical integration typically raises similar concerns to vertical mergers.

<sup>23</sup> See Salop & Culley, *supra* note 17, at 10.

rivals (most-favored-nations clauses, etc.), refusals to deal, or other methods that inhibit rivals from competing. Vertical mergers may also change competitive dynamics within a product market by creating cost symmetry or enhancing information exchanges that impede competition in the post-merger world. For example, network tiering by vertically integrated payers that is specifically designed to eliminate downstream competition in a healthcare provider segment can serve to foreclose rival providers from serving the health plan's insureds.

Vertical integration can also reduce potential competition by raising barriers to entry. Entry becomes increasingly difficult under circumstances where a potential new provider would have to compete in two product segments to commercialize a successful product. In certain contexts market maturation obviates viewing the independent products as themselves comprising relevant markets. In other instances double-sided entry effectively impedes new competitors from entering the marketplace. Vertical integration may also increase a company's incentives to charge more for the downstream product due to upward pricing pressure from the potential recoupment of lost sales of the combined product through individual sales of the two products. This dual product recoupment strategy is similar to the unilateral effects theory discussed in the Department of Justice and FTC 2010 Horizontal Merger Guidelines.<sup>24</sup>

### Drivers Behind Vertical Healthcare Consolidation

The current vertical healthcare consolidation trend can be traced back to the initial shift towards managed care—the rise of Medicare Advantage and Medicaid Managed Care in the 1990s and early 2000s. The development of these specific product markets fundamentally changed healthcare by creating structured, transparent insurance marketplaces for health plan products for elderly (Medicare) and impoverished (Medicaid) Americans. The Patient Protection and Affordable Care Act (ACA), passed in 2010, similarly created public insurance exchanges for individuals and small business employees.<sup>25</sup> The creation of these marketplaces and their accompanying regulatory overhauls has spurred innovation in risk-sharing arrangements and insurance design, and has consequently served as an impetus for enhanced vertical integration in the healthcare industry.

For example, public insurance exchanges—federally facilitated or state-run—function as direct-to-consumer marketplaces that enable individuals to seamlessly compare multiple insurance products across federally defined terms and categories. Specifically, insurance products sold on public exchanges are required to display transparent pricing, network information, and be priced according to four standardized plan actuarial values (bronze, silver, gold, and platinum). These metrics enable consumers to easily compare plan premiums, network design, and additional important features across multiple insurance products offered by competing plans. The ACA

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<sup>24</sup> U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines 20–21 (2010), <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

<sup>25</sup> In addition to creating the marketplace, the ACA includes various initiatives to balance both sides of the market. On the consumer protection side, the ACA removes lifetime medical expense limits on plan products, guarantees policy issuance and renewability, and requires payers to offer insurance coverage irrespective of “pre-existing conditions.” To prevent adverse selection—the phenomena of having only patients that need insurance enroll—the ACA mandates that all U.S. citizens and legal residents have qualifying health coverage or face an annual tax penalty. This is in turn balanced by a tiered insurance plan premium subsidy program to assist indigent Americans with purchasing insurance. Families earning up to 300%–400% of the Federal Poverty Limit (FPL) are only exposed to premiums up to 9.5% of their annual income. For families with incomes up to 133% of the FPL, states have the option to expand Medicaid in order to serve this population.

also stabilizes insurer risk pools by, for example, limiting enrollment periods.<sup>26</sup> These features create market liquidity by establishing a centralized forum on which plans compete.

Healthcare companies are responding to managed-care marketplace changes by vertically integrating healthcare financing (i.e., insurance) and delivery (i.e., providers) in a variety of forms. Integrating financing and delivery weaves together clinical and financial risk. This dual-risk integration exists along two continua: (1) network construction, with the aim of increasing integration of clinical operations into the health plan; and (2) risk bearing or transfer, in order to distribute financial risk down the healthcare delivery supply chain.

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With respect to network construction, corporations choose a strategy along a continuum that runs from contract-based constructed networks to fully owned and operated networks. A parallel continuum exists for risk management, ranging from fee-for-service (payment per “piece”), to fully capitated risk (payment per member per month). Healthcare companies usually traverse these spectra in unison with increased network integration coupling with an increased degree of capitation.

Basic forms of risk shifting include one-sided risk schemes—e.g., “gain sharing” arrangements—that are frequently found in ACOs. ACOs are joint contracting vehicles for healthcare providers that were created by the Centers for Medicare & Medicaid Innovation Center (CMMI) to test new models of healthcare finance.<sup>27</sup> ACOs contract with Medicare, which sets an acceptable per beneficiary target based on historical data. If the delivery system exceeds target spending, Medicare pays nothing. If the delivery system exceeds target expectations, the provider shares savings with Medicare.<sup>28</sup>

These models serve to build core business operations for plans and providers and are often a precursor to more integrated risk-sharing models that are best exemplified by Medicare Advantage and Medicaid Managed Care programs. By their very design, these programs incentivize vertical integration between plans and providers. For example, Medicare Advantage plans have specific network and access requirements, rigorous quality rating review via the Centers for Medicare and Medicaid Services (CMS) “Stars” rating program and marketing oversight.<sup>29</sup>

<sup>26</sup> The ACA also further stabilizes the risk pool by establishing standard enrollment periods—November 1 to January 31 of each year—to ensure that individuals do not elect to purchase coverage only at the advent of illness. Individuals may only purchase insurance on the public exchanges outside of this enrollment period if they have a “qualifying event,” such as relocation to another state, marriage or divorce, change in family size, etc.

<sup>27</sup> CMMI is charged with designing, implementing, and evaluating insurance experiments for the Medicare and Medicaid programs. Endowed with statutory authority to waive traditional requirements of the Medicare program in its insurance experiments, CMMI has great freedom to innovate. This enables the CMS Chief Actuary to explore novel programs and certify programs that lower cost without reducing quality. These successful programs can then be scaled out to the entire Medicare program, which covers 55 million individuals. *See* ACA, Pub. L. No. 111-148, 124 Stat. 393 (2010) (“The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).”).

Medicare innovations that successfully reduce government spending often serve as a “test model” for private plan products in other markets. Such innovation can lead to structural changes that affect multiple levels of the healthcare supply chain by reallocating financial risk for care delivery, realigning incentives, and steering the marketplace towards increased integration in an effort to improve patient outcomes.

<sup>28</sup> These “risk lite” products serve as a precursor to risk corridors. Risk corridors have healthcare delivery systems take the financial risk for a defined patient population by providing baseline fee-for-service payments and, traditionally, a 5–10% risk corridor that is accompanied with a minimum gain/loss in order for the health system to “experience” the risk (i.e., be financially responsible to the insurer). Risk corridors effectively function as a limitation on losses for providers by having the plan issuer serve as a reinsurer for unforeseen expenditures and patient population variance outside of the predetermined risk corridor.

<sup>29</sup> U.S. Dep’t of Health & Human Servs., CMS, Medicare Marketing Guidelines (2016), <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf>.

In response to increased risk-shifting structures, providers have vertically integrated into the payer space for private Medicare and Medicaid plan products through a variety of mechanisms with increasing operational complexity. Some health systems, such as Iora Health (a primary care clinic chain), serve as an exclusive network for Humana's Medicare Advantage plans in many counties. Other hospital systems are partnering with traditional insurers to jointly launch both new health plans and products. For example, Inova partnered with Aetna to launch the Innovation Health Plans joint venture insurance company; Bassett Healthcare Network partnered with Excellus BlueCross BlueShield to offer an exclusive individual exchange product with Bassett as the only Tier 1 network provider.

Larger health systems are also repositioning their existing provider-sponsored health plans to enter additional regulated markets via new subsidiaries. For example, multi-hospital academic health systems like Johns Hopkins Medicine entered the Medicare Advantage marketplace through pre-existing payer subsidiaries, such as Johns Hopkins HealthCare LLC. Similarly, large community hospital chains like Geisinger Health System entered Medicare Advantage through Geisinger Health Plans. In other instances, health insurers partner with regional healthcare systems to create joint plans, acquire local healthcare systems outright, or exclusively contract with local providers.<sup>30</sup> We outline certain tenets to help illuminate how entry into the health insurance marketplace works:

- *De novo* entry into the payer marketplace is usually simpler with respect to more regulated insurance marketplaces, such as Medicare Advantage, than broader commercial segments.<sup>31</sup> This is because regulated marketplaces often contain more defined structures that require less geographically dispersed networks (such as Medicare Advantage plans being offered on a county basis). Large health systems have taken advantage of these simplified entry conditions by creating their own health plans and product offerings that utilize their healthcare delivery system as a pre-packaged insurance network.
- Expansion upstream into regulated insurance products may also encourage entry into private commercial insurance for local businesses because the health system may offer the commercial insurance products to its own employees in order to jumpstart its plan (or vice versa). For example, in 1996 Johns Hopkins Medicine vertically entered the insurance market by creating a new health plan subsidiary, Johns Hopkins HealthCare LLC, offering a self-insured plan product to Johns Hopkins Medicine employees and later expanding horizontally into adjacent, regulated insurance markets, such as Medicaid Managed Care (late 1990s) and Medicare Advantage (2015).
- Significant private Medicaid payers are also expanding into public exchanges with owned and operated vertically integrated models. For example, Molina Healthcare, a Medicaid Managed Care Organization with its own chain of clinics, has successfully entered and thrived in multiple public exchange markets.<sup>32</sup> This has occurred in parallel with the exit of "single level" (i.e., pure plan) health insurers, such as Aetna, who specialize in employer-group market models. This parallel entry/exit dance may suggest that public exchanges,

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<sup>30</sup> *Iora Health, Humana Offer 2 Additional Mesa Practices for Medicare Beneficiaries*, MY NEWS MESA (Oct. 13, 2016), <http://mynewsmesa.com/iora-health-humana-offer-2-additional-mesa-practices-medicare-beneficiaries/>.

<sup>31</sup> For example, Catholic Health—one of the U.S.' largest hospital operators—decided to abandon its entry into the commercial employer insurance market due to posting mounting losses, including \$109.6 million in its last fiscal year that ended in June 2016.

<sup>32</sup> Anna Wilde Mathews, *Molina Outperforms Rivals in ACA Marketplaces*, WALL ST. J., Oct. 6, 2016, <http://www.wsj.com/articles/molina-outperforms-bigger-rivals-in-aca-marketplaces-1475767657>.

which typically require broader networks than Medicare Advantage, paradoxically have low entry barriers when coupled with increased vertical integration. Alternatively, it is possible that these companies have a managed-care experience advantage due to their strength in managing indigent patient population pools through state Medicaid programs.<sup>33</sup>

### Achieving Cognizable Efficiencies

Vertical healthcare arrangements promise significant potential efficiencies for consumers, be they patients, clinicians, or employers' purchasing plan products. Consumers may benefit from a seamless care experience provided by integrating health plans and provider operations, for example, by providing single-source billing for consumers. Increased vertical alignment may also improve quality and safety through central planning and the design of safety and IT systems. Vertically integrated payer-providers can also eliminate insurance coverage disputes that occur in loosely integrated provider networks.

We discuss recent empirical healthcare literature to help ascertain how varying degrees of vertical integration—from shared-savings to outright merger—impact healthcare cost and patient care quality outcomes. Perhaps the best data set to analyze quality improvements is offered by the Medicare Advantage marketplace due to CMS tracking each insurer-sponsored plan's quality by its 2016 star ratings. Star ratings are an integrated quality measurement system used by CMS to assess Medicare Advantage plans. We can compare standalone insurance sponsored plans with hospital-sponsored plans to compare quality improvements. We rely on data available through the McKinsey Center for U.S. Health System Reform<sup>34</sup> for two findings.

First, the study indicates substantial quality rating improvement from vertical integration, concluding that vertically integrated delivery networks received a higher weighted average rating of 4.45 (out of five) than plans offered by private insurers (3.96) or by the Blues (3.86). For example, Kaiser Permanente, a traditionally vertically integrated healthcare system, stands out with a perfect star rating (5.00). The 2016 star ratings analysis is consistent with prior-year results since at least 2012. The difference in stars ratings may indicate that vertical integration provides significant procompetitive consumer benefits by improving healthcare quality through increased clinical and financial integration.

Another study found that “health plans integrated with provider systems may offer better enrollee experiences and higher quality of care than nonintegrated plans do.”<sup>35</sup> Vertically integrated Medicare Advantage plans were found to improve both quality of care performance—i.e., managing chronic conditions—and process quality, for example by timely administering screenings, tests and vaccines. The study concluded that vertically integrated payer-providers “ha[ve] significantly higher” quality performance.<sup>36</sup>

We expect to see the aforementioned quality improvements achieved from vertical integration due to increased organizational planning and integrated clinical and financial information. This is especially true in insurance marketplaces that reward enhanced quality of care coordination

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<sup>33</sup> Craig Garthwaite & John A. Graves, *Success and Failure in the Insurance Exchanges*, 376 N. ENG. J. MED. 907 (2017).

<sup>34</sup> The McKinsey Center analyzes star ratings trends for the 2016 Medicare Advantage enrollment period. McKinsey & Company, *Assessing the 2016 MA Star Ratings* (2015), [http://healthcare.mckinsey.com/sites/default/files/McKinsey%20Reform%20Center\\_Medicare%202016%20Stars%20Ratings\\_Oct%202015.pdf](http://healthcare.mckinsey.com/sites/default/files/McKinsey%20Reform%20Center_Medicare%202016%20Stars%20Ratings_Oct%202015.pdf).

<sup>35</sup> Garret Johnson, Zoe M. Lyon & Austin Frakt, *Provider-Offered Medicare Advantage Plans: Recent Growth and Care Quality*, 36 HEALTH AFF. 539 (2017).

<sup>36</sup> *Id.*



through bonus payments (such as Medicare Advantage). However, these sustained expected quality efficiencies were not observed in weakly vertically integrated networks, at least based on an ACO performance retrospective that yielded minimal to no benefits in traditional quality of care outcomes and process metrics.<sup>37</sup> This could be due to a variety of reasons, including: initial high performance could “top out” quality measures; plans may incorrectly attribute members to the wrong providers; or high variability in performance on quality metrics may mask meaningful quality improvements (i.e., high signal to noise ratio). These reasons might explain why quality gains in low levels of vertical integration may be occurring but are not detected.

Analyzing cost-savings produced by vertically integrated payer-provider companies is more difficult “given the opacity of present [payer-provider] disclosure of key operating information” and there being “very little empirical research on the performance of provider integration with insurance vehicles.”<sup>38</sup> Recent literature, however, indicates that health systems vertically integrating upward into health plan markets may be able to achieve insurance economies of scale benefits with narrower insurance product offerings than previously thought. As an example, one study finds that economies of scale for operating insurance plans “begin to converge above 100,000 lives” due to the greater organizational complexity required for having more lines of business across varying states.<sup>39</sup> This helps explain why health system-sponsored health plans are able to effectively compete with larger insurance competitors.

### Antitrust in Managed Competition Marketplaces

The rise of managed care marketplaces incentivized vertical integration through improving transparency, promoting risk-shifting, and fostering innovation to provide lower-cost and higher-quality healthcare. As we explored in the previous section, recent empirical evidence reveals that vertical integration improves performance on quality metrics, and having a single payer-provider creates cognizable efficiencies vis-à-vis consumer convenience and quality improvements. Healthcare systems can achieve these benefits through *de novo* entry into the insurance marketplace as the evidence supports health systems realizing meaningful economies of scale due to offering plan products in multiple markets (e.g., Medicaid Managed Care, Medicare Advantage, etc.), all built upon the same core insurance business operations and an owned and operated-network.

These health systems are able to field competitive products in the insurance segments that they enter *de novo* due to effective marketplace entry and maximizing desired cost savings and quality improvements by vertically integrating. Health systems that offer managed care insurance products also forgo many of the initial barriers to entry identified in *United States v. Aetna*, such as reputational barriers and network incipency constraints.<sup>40</sup> Compared to full integration through *de novo* entry or acquisition, “low” levels of integration have produced mixed results. Fully-vertically integrated arrangements may be necessary to fully achieve desired cost savings and quality improvements.

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<sup>37</sup> J. Michael McWilliams et al., *Early Performance of Accountable Care Organizations in Medicare*, 374 N. ENG. J. MED. 2357 (2016).

<sup>38</sup> J. GOLDSMITH ET AL., INTEGRATED DELIVERY NETWORKS: IN SEARCH OF BENEFITS AND MARKET EFFECTS, NAT’L ACAD. OF SOCIAL INSURANCE 10–13, 29 (2015), [https://www.nasi.org/sites/default/files/research/Integrated\\_Delivery\\_Networks\\_In\\_Search\\_of\\_Benefits\\_and\\_Market\\_Effects.pdf](https://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf).

<sup>39</sup> Shubham Singhal, *Bigger May Not Be Better: Does Scale Matter For Payors?*, HEALTH AFFAIRS: BLOG (Nov. 15, 2013), <http://healthaffairs.org/blog/2013/11/15/bigger-may-not-be-better-does-scale-matter-for-payors/>.

<sup>40</sup> *United States v. Aetna Inc.*, No. CV 16-1494 (JDB), 2017 WL 325189 (D.D.C. Jan. 23, 2017).

*Because of the significant potential procompetitive benefits for consumers we recommend thoughtful enforcement in the absence of direct evidence of anti-competitive intent.*

Our analysis supports the proposition that meaningful vertical integration is generally procompetitive and yields tangible quality benefits for consumers. There is “scant empirical evidence on the anti-competitive effects of vertical integration by hospitals,”<sup>41</sup> which further supports recommending a cautious approach in determining whether to assert antitrust challenges to vertically integrated healthcare systems. Because of the significant potential procompetitive benefits for consumers we recommend thoughtful enforcement in the absence of direct evidence of anti-competitive intent. This is especially true with network design, where network tiering is an integral part of affordably offering a plan product. A similar policy may make sense for network exclusion, in the absence of clear anticompetitive intent, because careful, integrated network construction can play a vital role in maximizing the benefits of vertical integration.

At the same time, vertical arrangements may raise antitrust concerns where a dominant health system leverages its downstream power to steer patients into its insurance products or to foreclose rivals from access to healthcare providers that are necessary to field a competitive product. This is likely what Judge Dalton was envisioning when the court denied Health First’s motion for summary judgment. We commend Judge Dalton for focusing on contemporaneous business plans depicting anticompetitive intent but wonder whether the case would have been ripe for a directed verdict if it had not settled on the second day of trial.

Omni’s vertical theories of harm were based on foreclosure—customer foreclosure through restrictive referral practices or input foreclosure through forgoing contracting with third-party Medicare Advantage plans. Based on our review of recent empirical studies, there may be procompetitive justifications for both forms of conduct. Medicare Advantage plans operated by a vertically integrated payer-provider perform better on customer ratings and provide a better customer care experience. Similarly, it appears that having closed provider networks enables the plan to exert more quality control and implement initiatives that may yield cost savings. The DOJ may have agreed with this assessment, as they investigated Health First and decided not to intervene with an enforcement action.<sup>42</sup>

Vertical healthcare integration does not appear to raise significant anticompetitive concerns. At the same time, the most recent past Director of the FTC Bureau of Competition recently stated during a healthcare law symposium that the Commission may bring a vertical merger case where such arrangements “cause problems”<sup>43</sup> and would examine “whether competition as a whole would be harmed from the foreclosure.”<sup>44</sup> Any enforcement action may be aimed at securing conduct relief based on the recent FTC merger retrospective concluding that “[a]ll vertical merger orders were judged successful” in restoring competition through conduct relief.<sup>45</sup>

<sup>41</sup> GOLDSMITH ET AL., *supra* note 38, at 10.

<sup>42</sup> See Pls.’ Mot. Order Allowing DOJ Personnel Join Confidentiality Stipulation, *Omni* (Feb. 12, 2016), ECF No. 227.

<sup>43</sup> Deborah L. Feinstein, Is Health Care Consolidation Good or Bad—and What Should Be Done About It?, Panel Remarks at George Washington Law School Health Care Law Symposium (Oct. 27, 2016).

<sup>44</sup> Deborah L. Feinstein, Antitrust Enforcement in Healthcare: Proscription, Not Prescription 8, Speech at the Fifth National Accountable Care Organization Summit (June 19, 2014), [https://www.ftc.gov/system/files/documents/public\\_statements/409481/140619\\_aco\\_speech.pdf](https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf).

<sup>45</sup> FED. TRADE COMM’N, REPORT ON THE FTC’S MERGER REMEDIES 2006–2012, at 17 n.34 (Jan. 2017), [https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100\\_ftc\\_merger\\_remedies\\_2006-2012.pdf?utm\\_source=govdelivery](https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100_ftc_merger_remedies_2006-2012.pdf?utm_source=govdelivery).

CMS recently projected an expected average 5.6 percent annual increase in national health-care expenditures over the next decade.<sup>46</sup> As the United States continues to strive to improve quality and reduce healthcare costs, we expect vertical healthcare arrangements to continue to flourish irrespective of what changes occur to the ACA.

Based on our analysis of the recent empirical evidence, we recommend that competition regulators who are keeping a watchful eye over healthcare industry consolidation give due consideration to efficiency claims made by companies integrating along the healthcare delivery supply chain. We also recommend that healthcare companies seeking to take advantage of the substantial benefits that vertical integration offers be prepared for a detailed antitrust review in markets where they have dominant positions that carefully scrutinizes the merger-specific efficiencies and evaluates whether the combination results in any structural marketplace changes that facilitates anticompetitive conduct. ●

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<sup>46</sup> Press Release, CMS, 2016–2025 Projection of National Health Expenditures Data Released (Feb. 15, 2017), [https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-02-15-2.html?elq\\_cid=2466868&x\\_id](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-02-15-2.html?elq_cid=2466868&x_id).