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DOI: 10.1377/hlthaff.2012.0360
HEALTH AFFAIRS 32,
NO. 8 (2013): 1426–1432

ANALYSIS & COMMENTARY

Regulatory Neutrality Is Essential To Establishing A Level Playing Field For Accountable Care Organizations

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ABSTRACT Accountable care organizations (ACOs) are among the most widely discussed models for encouraging movement away from fee-for-service payment arrangements. Although ACOs have the potential to slow health spending growth and improve quality of care, regulating them poses special challenges. Regulations, particularly those that affect both ACOs and Medicare Advantage plans, could inadvertently favor or disfavor certain kinds of providers or payers. Such favoritism could drive efficient organizations from the market and thus increase costs or reduce quality of and access to care. To avoid this type of outcome, we propose a general principle: Regulation of ACOs should strive to preserve a level playing field among different kinds of organizations seeking the same cost, quality, and access objectives. This is known as *regulatory neutrality*. We describe the implications of regulatory neutrality in four key areas: antitrust, financial solvency regulation, Medicare governance requirements, and Medicare payment models. We also discuss issues relating to short-term versus long-term perspectives—to promote the goal of regulatory neutrality and allow the most efficient organizations to prevail in the marketplace.

A recent drive for payment reform in both the public and private sectors is creating powerful incentives for integration in health care finance and delivery. One of the best-publicized models for encouraging a movement away from the fee-for-service payment arrangements that dominate the nation's current health care delivery system is the accountable care organization (ACO).

Although the term *accountable care organization* can mean different things to different people, it is generally used to describe a group of providers that create a formal legal entity and jointly agree to be held at least partially accountable for both the cost and the quality of care provided to a defined population of enrollees.[1] Although accountable care models can take a variety of forms and use a variety of tools to promote these objectives, they have in common a focus on promoting accountability, coordinating care across settings, and investing in the infrastructure and processes needed for high-quality care delivery consistent with section 3022, title III, of the Affordable Care Act. ACOs usually involve a broad range of providers, including primary care providers, specialists, and hospitals and other facilities. They typically bring together acute care providers, but the incentives associated with taking on accountability for the health care of a population also encourage a focus on postacute care and better

integration of care provided in both settings. Health plans can also play a substantial role in the establishment and operation of ACOs through collaboration with providers.

Perhaps the most publicized application of accountable care organizations is the Medicare Shared Savings Program. Created by section 3022, title III, of the Affordable Care Act, this program allows provider groups to qualify for additional payments from Medicare if they achieve certain cost savings while meeting defined quality metrics.

Regulating accountable care organizations poses unique challenges. In particular, regulation should strive to create a level playing field both among the various providers and organizations seeking to form an ACO and between ACOs and health plans. This level playing field is known as *regulatory neutrality*. Regulatory neutrality refers to the concept that similar products or models for financing or delivering care should be regulated in similar ways to try to prevent regulation from favoring any particular approach or product. Regulatory neutrality also seeks to avoid favoring any one type of organization (for example, payer over provider) in the creation or offering of a particular product or model, to avoid the adverse effects of favoritism. For example, if health plans are better able than provider-based organizations to offer a wide choice of providers, regulations that disadvantage health plans could lead to fewer options for consumers. Similarly, if provider-based organizations are better able than health plans to manage physician behavior and thus encourage more efficient care, regulations that disadvantage provider-based organizations could hamper cost containment.

In this article we suggest how regulatory neutrality can best be achieved. We examine four areas of regulation: antitrust, solvency regulation, Medicare governance requirements, and Medicare payment models. We also discuss how short-term interventions can be used to achieve long-term goals. Our analysis recognizes that policy interventions that might be viewed as "nonneutral" in the short term may be necessary to promote policy goals, such as maintaining a competitive marketplace, that facilitate regulatory neutrality over the longer term.

Regulatory Neutrality

POLICY ISSUES Accountable care organizations are affected by a number of different regulatory regimes—including antitrust, solvency regulation, Medicare's Shared Savings Program governance regulations, and Medicare payment rules. An uncoordinated approach to policy among these regimes creates a heightened risk that ACOs will be inadvertently favored or disfavored relative to other entities that accept financial responsibility and arrange for the delivery of care, such as Medicare Advantage plans (private managed care plans operated under the auspices of Medicare).

For example, seemingly small, technical differences—such as reserve requirements—for ACOs versus Medicare Advantage plans can place ACOs at an advantage (or disadvantage) relative to organizations participating in the Medicare Advantage program. Even if each regulatory regime were functioning perfectly in terms of its own objectives, the interaction among regimes can have unintended consequences that affect the neutrality of the system as a whole.

Although it has received little attention from health policy researchers,[2] the concept of regulatory neutrality has been studied extensively in other contexts.[3] For example, the testimony of Jason Furman to the Senate Finance Committee in a hearing on tax reform on April 15, 2008, discussed the importance of neutrality to tax reform. This literature offers three key lessons also applicable in the health care setting.

First, in general, neutrality favors less over more prescriptive regulation. Simply put, more-prescriptive regimes affect a greater number of decisions, and thus they entail a greater risk of inadvertently favoring one organizational form over another.

Second, neutrality favors "functional" over traditional "institutional" regulation.[4] That is, when different types of institutions are serving the same function, they should be supervised by the same regulator according to the same set of rules, regardless of the labels that may have been applied to them in the past.

Third, the first two rules are not absolute. As we show in our discussion of antitrust policy below, the pursuit of neutrality can support a more activist approach and special rules directed at the health care sector, even if that might be viewed as nonneutral in the short term.

KEY AREAS OF APPLICATION Applying these principles to regulation of accountable care organizations leads to specific policy prescriptions in the four areas described above.

▶**ANTITRUST:** Federal antitrust regulators have noted that although ACOs may have benefits, "under certain conditions [they] could reduce competition and harm consumers through higher prices or lower quality of care."[5] Accountable care organizations by definition involve a level of "horizontal" integration—or, at least, coordination—among providers who might otherwise be competitors as well as "vertical" integration between providers at different

levels, such as hospitals and physicians. This coordination is fundamental to the goal of ACOs, but it raises antitrust concerns. Horizontal coordination may make it possible for providers to obtain pricing power over commercial insurers. Vertical integration may enable participants in ACOs to use market power to inhibit competition by depriving their rivals of a source, or destination, for referrals.

Antitrust policy toward accountable care organizations thus faces a trade-off.[6–8] On the one hand, imposing constraints on ACOs' size and market coverage may be important to ensuring a competitive marketplace. On the other hand, imposing those constraints may make it more difficult for ACOs to effectively integrate their operations, achieve the scale required to improve the coordination of care for their patients, or acquire and efficiently deploy the capital needed for investment in care system infrastructure.

Although regulatory neutrality generally favors less intervention, that may not be the case in the context of antitrust. Active antitrust enforcement can be consistent with neutrality if it prevents a dominant accountable care organization from inhibiting competition in markets for physician or hospital services on which its rivals depend. This is in line with the well-established idea that regulatory intervention is appropriate to address a market failure but that the intervention should be tailored as much as possible, to limit any unintended effects associated with the intervention.

For example, some states have passed health sector–specific statutes that restrict the range of permissible contracts among providers or between providers and purchasers. In 2010 Massachusetts added section 9A to chapter 176O of the state's General Laws, making it illegal (with some exceptions) for a provider to refuse to deal with an insurer in response to the insurer's offering of a tiered network (or the provider's placement in the insurer's tiered network). This law is intended to prevent providers from using their market power to inhibit benefit designs intended to create incentives for cost-conscious patient choice.[9] And in 2011 California banned contracts between providers and insurers that contain provisions restricting an insurer's ability to furnish information to its policy holders about the cost or quality of the providers' services. This law, incorporated into section 1367.49 of the California Health and Safety Code and section 101.33.64 of the California Insurance Code, was intended to prevent providers from using their market power to inhibit price transparency.[10] Similar legislation was enacted in Massachusetts in 2012, amending section 9A of chapter 176O to further prohibit plans from entering into agreements with providers that limit either party's ability to disclose information on costs.

Policy interventions that appear not to be neutral in the short run may be necessary to promote long-run neutrality.

On the surface, antitrust laws that single out certain types of contracts in the health sector might seem to be at odds with the principle of neutrality. But even if such criticisms were valid in the past, the advent of accountable care organizations and the tightening of relationships among providers that would otherwise operate on a more arm's-length basis may alter this balance. Because ACOs encourage vertical integration between hospitals and physicians and thus raise anticompetitive concerns, neutrality may be best served by the adoption of targeted policy interventions that address these concerns.

The examples from Massachusetts and California provide a window into thinking about how targeted policy interventions can accomplish this goal. These are targeted regulations that make it more difficult for incumbents with market power to exclude competitors or to secure a competitive advantage—key anticompetitive concerns associated with ACOs—but do not, at the same time, undermine the value of integration.

Although such interventions would represent a more activist approach, they may be necessary to ensure that ACOs do not in practice lessen competition. Therefore, we believe that the use of targeted interventions aimed at counterbalancing these potential anticompetitive effects is consistent with neutrality and offers a plausible approach to the challenge of preserving competition in an era of payment reform.

▶**SOLVENCY REGULATION:** Health plans, which contractually accept the obligation to cover the risks of others, are generally subject to extensive solvency regulation by states to ensure that they have the resources necessary to meet their obligations. These can include extensive financial reporting requirements, as well as

requirements such as those regarding minimum capital and surplus and restrictions on investment. In contrast, provider groups have not traditionally accepted such risk and thus have not been subject to such regulation. Accountable care organizations tend to blur this traditional distinction, however, because they can involve the assumption of financial risk by a group of providers. Thus the issue of solvency becomes an important concern.[11] Unforeseen contingencies can threaten the viability of accountable care organizations, subjecting patients and providers to the possibility of unexpected losses. But should state insurance regulation subject ACOs to the full gamut of rules facing health insurers, or to something less?

From the standpoint of regulatory neutrality, the key consideration is what functions the ACO is undertaking. Specifically, does the ACO primarily compete with or collaborate with health plans? If it competes with plans, then neutrality would suggest that it be regulated as an insurer. But if it collaborates with plans (for example, through a contract that shares risk between a plan and the organization), then neutrality would suggest that the function of each organization be viewed as part of an integrated whole.

In the insurance literature, this kind of collaboration between health plans and provider organizations is associated with the concept of "downstream risk." Under this model, ACOs that operate under a contract with a licensed health insurer would not be subject to solvency requirements. Such arrangements could range from a shared-savings model, in which a provider group receives bonus payments if it achieves savings, to other forms of incentive-based reimbursement, in which providers take on "performance risk" associated with meeting cost and quality targets for the care provided to a defined group of enrollees. Such arrangements allow risk to be allocated between provider organizations and insurers by private contract, but the licensed insurer retains the ultimate risk and is subject to solvency regulation. If, however, the ACO seeks to compete with health plans—for example, by contracting with employers or individuals directly to accept risk—it should be subject to the same state solvency standards as any health insurer.

This regulatory differentiation between the two models gives provider organizations the discretion to decide how much risk they will assume, while varying the intensity of oversight with the extent of risk assumed, which is consistent with the principles of functional regulation. This approach therefore allows for variety by declining to pigeonhole provider organizations acting as accountable care organizations into serving as either competitors of or collaborators with insurers. This is effectively the approach that Massachusetts has taken in its 2012 law designed to control health care cost growth. The law exempts "risk bearing provider organizations" from most insurance regulation but notes that a provider organization that directly contracts with individuals or employers to assume risk could be subject to such regulation (section 2 of Massachusetts General Laws, chapter 176T).

▶**MEDICARE GOVERNANCE REQUIREMENTS:** As noted, the Medicare Shared Savings Program allows qualifying groups of providers to form ACOs, which will be eligible for additional payments from Medicare if they achieve certain cost savings and quality thresholds for a defined group of Medicare beneficiaries.

Organizations that choose to participate in the Medicare Shared Savings Program are subject to governance requirements to ensure that they have the ability and incentives to pursue the goals of the program. By *governance*, we mean rules that affect the types of constituent organizations that can form and participate in accountable care organizations, in addition to operational rules that affect the relationship of these constituent organizations to individual practitioners. The principle of neutrality suggests that these governance requirements should seek to allow as many different types of organizations as possible to participate, and compete, in the program on equal terms.

However, the Shared Savings Program's requirements impose several restrictions that run contrary to this principle. In particular, regulations found in title 42 of the Code of Federal Regulations (sections 425.20 and 425.204) state that only certain types of providers and organizations—such as various combinations of physicians, nurse practitioners, physician assistants, clinical nurse specialists, and acute care hospitals—are allowed to independently form ACOs. Postacute care providers such as nursing homes, inpatient rehabilitation facilities, hospices, and home care agencies are allowed to participate only in conjunction with one of these other types of providers. Health plans are also not permitted to form an ACO operating under the Medicare Shared Savings Program. Because there is no functional rationale for these restrictions, greater flexibility about who can form an ACO under the Medicare Shared Savings Program would be more consistent with the principle of neutrality.[12]

The Shared Savings Program rules also illustrate how provisions on governance can interact with other requirements and create unintended consequences, such as limiting competition. The rules require that any participant in an ACO

(defined in relation to the provider organization as opposed to individual practitioners) that bills for primary care services must be exclusive to a single ACO.[13,14] This rule is designed to allow regulators to determine from which ACO an enrollee is receiving primary care and thus to assign enrollees to the correct organization. However, the rules apply this exclusivity restriction more broadly than is necessary. Regulators initially proposed to apply this rule only to primary care physicians. But under the final rules, the exclusivity requirement was expanded to include specialists who billed for any primary care services as well as specialists who bill through a group that provides any primary care services, even if a particular specialist does not bill for such services.

The expansion of this exclusivity requirement to include specialists creates a barrier for specialists wishing to participate in multiple accountable care organizations, even when they could technically do so if they were willing or able to affiliate with and practice through multiple practice groups, each of which would be exclusive to a different ACO. As a result, the expanded exclusivity requirement makes the vertical integration between the specialists and ACO participants tighter than it needs to be. This potentially reduces competition in the market for both specialist and hospital services.

In addition, current Medicare regulations make it more difficult for existing organizations, such as independent practice associations, to act as ACOs. Independent practice associations are formed to allow independent physicians and physician practices to share resources and jointly contract with payers, while still maintaining separate ownership and control of their practices. Under the Medicare Shared Savings Program rules, an independent practice association that wished to participate in an ACO would have to obtain the agreement of all of its members, even if those who did not agree to participate accounted for only a minimal share of the association's patient volume. If an association failed to gain the consent of all of its members, each individual practice could theoretically participate in the ACO separately, but the association could not join the ACO as a whole.

The negative consequence of this rule is that it can substantially complicate ACOs' ability to rely on existing physician networks. The eventual results could include limits on an ACO's reach in serving beneficiaries, complications in the provider network contracting process, and unnecessary additional costs. Independent practice associations might also be discouraged from participating in the Shared Savings Program.

▶**MEDICARE PAYMENT RULES:** Accountable care organizations operating under the Medicare Shared Savings Program compete with Medicare Advantage plans for both beneficiaries and providers. A beneficiary enrolled in Medicare Advantage cannot be enrolled in an accountable care organization, and vice versa. Providers participating in an accountable care organization are also potential members of provider networks for Medicare Advantage plans.

As a result, neutrality between Medicare Advantage and accountable care organizations is important. Although the Medicare Shared Savings Program regulations attempt to address this point,[13] they also show how even small, technical differences can have an effect on the attractiveness of the different models to beneficiaries and providers.

For example, both accountable care organizations and Medicare Advantage plans receive incentive payments if they are able to keep costs below a predetermined benchmark. The method by which those benchmarks are calculated, however, differs between the two programs. In the Shared Savings Program, the costs are benchmarked against the historical expenses associated with the specific population of patients assigned to the accountable care organization. Under Medicare Advantage, rewards for cost savings are benchmarked against a percentage of the average spending for all fee-for-service Medicare beneficiaries in a given county. This percentage is higher in historically low-cost counties and lower in high-cost counties. For example, in a historically low-cost county the benchmark might be set at 115 percent of the average, while in a high-cost county the benchmark might be set at 95 percent.[15]

This difference could have important effects on provider incentives. Benchmarking payments to accountable care organization against historical spending for a group's specific beneficiaries makes sense to the extent that historical spending is a realistic predictor of future spending. However, doing so while Medicare Advantage plans are benchmarked against average spending at the county level makes the Shared Savings Program more attractive to historically high-cost and potentially inefficient groups and less attractive to efficient ones. Thus, providers with high historical spending will potentially receive higher payments in the Shared Savings Program. In Medicare Advantage, however, plans would have no incentive to offer such a provider commensurate compensation, because payments to plans do not depend on their providers' historical performance.

Similarly, benchmarking Medicare Advantage plans in high-cost counties against less than 100 percent of the average spending in the

counties also makes sense, insofar as high-cost counties are likely to have more "low-hanging fruit" opportunities for cost reduction. However, doing so while Shared Savings payments in high-cost counties are benchmarked against 100 percent of beneficiaries' historical cost disfavors the Medicare Advantage model in high-cost counties and favors it in low-cost ones (where rates for Medicare Advantage plans are set at more than the county average).

In Medicare Advantage, plans in high-cost counties will not, on average, be able to pay their providers at 100 percent of fee-for-service rates while being paid less than 100 percent of a county's average spending. In contrast, the Shared Savings Program, which is not subject to the same constraints, will be able to pay providers at 100 percent of the fee-for-service rates. The effect of these differences could be to favor one model over another in different parts of the country and, in so doing, encourage unwanted behavior among providers and Medicare Advantage sponsors that is aimed at handicapping one of the models in comparison to the other.

Short-Term Accommodation Versus Long-Term Neutrality

The debate over the extent to which the start-up costs of providers participating in the Medicare Shared Savings Program should be financed by Medicare rather than the providers themselves illustrates another important principle in regulatory neutrality. Neutrality can sometimes involve a fundamental trade-off between the short and the long run. Short-run neutrality can call for the temporary accommodation of emerging models to help entrants "get on their feet" and create a greater number of options in the long run. This is especially important in the case of accountable care organizations. Establishing such an organization requires substantial sunk-cost investments in information technology and other infrastructure, some of which might be used only in serving Medicare beneficiaries.

Yet short-run accommodations carry the risk of persisting beyond the end of their useful life. Subsidies are always politically easier to give than to take back, and the negative consequences of favoring one form over another for too long may perpetuate an unfair advantage for one organizational form that works against the interest of consumers.

This trade-off is apparent in the debate over the extent to which Medicare should finance the start-up costs of providers participating in the Medicare Shared Savings Program.[11] In a perfect world striving for long-run neutrality, the costs would be borne by the providers. In practical terms, however, the uncertainty surrounding the regulation, operation, and stability of new payment and delivery models may mean that private investment is not readily available for the new organizations needed for the program to work. The focus of such an accommodation, however, should be to level the playing field in the face of temporary or "artificial" barriers, not to give one model an advantage over another.

Conclusion

Regulating accountable care organizations poses unique challenges. Because of their nature, they are affected by at least four different regulatory regimes. The complexity inherent in this situation requires that policy makers pay special attention to coordination to avoid unintended consequences. To address this concern, the government should seek to maintain a level playing field (what we call *regulatory neutrality*), so that different models of care and those seeking to offer them are permitted to stand or fall on the cost and quality of care each provides. We conclude that neutrality generally favors less, rather than more, prescriptive regulation. Nonetheless there are exceptions to this rule, with antitrust policy as the most prominent example.

More broadly, the pursuit of neutrality may need to be tempered by a recognition of competing goals. Like so many areas in health care policy, accountable care organizations present both potential opportunities and new challenges. Considerations of regulatory neutrality can add depth and clarity to considerations of how to strike the balance in determining how to regulate these new entities. ■

Daniel Kessler acknowledges and thanks the Institute for Health Systems Solutions at the AHIP Foundation for support in conjunction with this article. The views expressed in this article reflect those of the authors and not necessarily those of their respective institutions, affiliated organizations, or clients.

NOTES

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12 As an example of a less prescriptive regulatory alternative, section 15 of the Massachusetts General Laws, chapter 6D, provides for certification of accountable care organizations independent of Medicare. With respect to governance, it simply requires that an accountable care organization be a legal entity separate from its constituent members; have a governance structure that includes "an administrative officer, a medical officer and patient and consumer representation"; and adopt certain governance structure standards, including standards relating to financial conflicts of interest and transparency.

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