The Antitrust Restraint on U.S. ACOs and Its Revelation to The Supply-side Reformation of Chinese Medical System

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Abstract: Accountable Care Organizations is an important measure for the new reform proposal of U.S. medical system. It seeks to introduce the competition mechanism to improve the efficiency and quality of health care services through supply side reforms. The supporting antitrust policy also provides a necessary safeguard measure to promote competition and to implement the effect of health care reform. As gradual deepening of the demand-side reformation of Chinese medical system, the supply-side reformation will be the focus of health care reform in the future. How to effectively integrate health care resources and improve the efficiency of health care industry? How to take full advantage of antitrust measures to monitor and constrain suppliers' behaviour in the case of the harming to health care beneficiaries by potential competing risks? The U.S. Health care reform experience has an positive revelation to the supply-side reformation of Chinese medical system for a better welfare effect.

Keywords: Accountable Care Organizations; Competitive Concerns; Antitrust Policy; Safety Zone; Supply-side Reformation

The sound development of the medical service industry related to the important livelihood issues. Governments and scholars all make efforts to promote the reform process and to seek effective system conducive to the sustainable development of medical industry. Although after years of reform Chinese health care system achieved some success, a variety of institutional disadvantages and the resulting new problems, such as runaway health care costs and continually rising health care service prices, gradually exposed in the process of reform. Issues of scarce medical resources and highly medical costs have become problems to be urgently solved in China’s health cause. Since the implementation of Views of the CPC Central and State Council on Deepening the Reform of Medical and Health System (“the new medical scheme”), China establish the medical insurance system to promote the demand-side reformation of medical system. After universal roll out of new rural cooperative medical system, China has established urban medical insurance system for urban unemployed people. At the same time, China has take some measures to promote supply-side reformation of medical system, for example, establishing the corporate governance structure of public hospital, reforming the mechanism of payment, improving the system of basic medical care service. But there are still strictly regulations and lack of competition in China’s medical industry. In the case of the public health insurance system having been essentially fully established, we also need to deepen the supply-side reformation of medical system ,in addition to further promoting and improving the system of medical insurance, to solve

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problems mentioned above as scarce medical resources and highly medical costs.

The ACO mechanism aims to introduce competition and incentive by the supply-side reformation of medical system. The competitive market mechanism not only improves the quality and efficiency of health care service but also ensures the medical system having a lasting and virtuous cycle. In addition, the U.S. Government supervise medical service providers with antitrust policy, which can ensure the realization of the Health Care Law's goal in United State to a large extent. Although there is a large gap between China and United States in terms of medical facilities and professionals, there are also some similar problems between them. The U.S. ACOs mechanism and the implementation of the supporting antitrust policy provides a new way to integrate medical resources effective, to reduce costs and to improve the quality of health care services.

1. Mechanism Design of ACOs in the New Reform Process of U.S. Medical System

1.1 Legal Basis and Connotation of ACOs

U.S. President Barack Obama signed the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act")\(^1\) that seek to improve the quality and reduce the costs of health care services in the United States by encouraging physicians, hospitals and other health care providers to become accountable for patient population through integrated health care delivery system. One delivery system reform is the Affordable Care Act's Medicare Shared Savings Program (the "Shared Savings Program"), which promotes the formation and operation of Accountable Care Organizations (ACOs) to serve Medicare fee-for-service beneficiaries. Under the Shared Savings Program, groups of providers of services and suppliers meeting criteria specified by the Department of Health and Human Services ("HHS") Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO. An ACO may share in some portion of any savings it creates if the ACO meets certain quality performance standards established by the Secretary of HHS through the Centers for Medicare and Medicaid Services ("CMS"). The Affordable Care Act requires an ACO that wishes to participate in the Shared Savings Program to enter into an agreement with CMS for not less than three years, and the scope of ACOs' services not only be limited to Medicare fee-for-service beneficiaries, they also may operate in commercial markets. ACOs is the most interesting content in the new US Health Care Law, there are many successful examples and gradually becoming more common in the medicare service industries in United States.

Independent doctors, hospitals, clinics, insurance companies and Health Maintenance Organizations ("HMOs")\(^2\) form the body of U.S. healthcare market. Under the traditional medical model of management, insurance companies looking for service providers in medical market and then patients contract with insurance companies for service. But under the mechanism of ACOs,
the new service provider provides a collection of hospitals, general practitioners and specialists as a whole, jointly responsible for the quality of medical care and medical costs. These service providers have a strong ability to provide basis medical care and become a supply-led organization of medical services through ACOs. In this model, eliminating insurance company in the traditional medical model of management, patients contact with medical service providers directly.

Therefore, the responsibility of health care service is based on the medical service provider, but not the medical insurance company. The quality and efficiency of health care become the two core indicators to the evaluation of medical providers, so government need to establish a robust system to monitor and evaluate health care system. When an ACO can meet the quality standards set by government and reduce the cost effectively, the ACO is available from balance of Medicare cost sharing. It is an incentive to ACOs to take positive measures, for example, an ACO may reduce the unnecessary duplication of medical checks, ensure better follow-up after discharge to lower readmission rate, or deal with the condition in patients with heavy properly through coordination between different medical institutions to reduce healthcare costs while improving service quality.

1.2 Mechanism Design of ACOs

Traditionally, hospitals and doctors in United States is both independent and interdependent relationships. In the separation of doctor and hospital management model, doctors are not the hospital's employees. Doctors can practice independently, take advantage of the facilities provided by hospitals and charge the physician fee. Hospitals provide operations and secondary testing according to the classification of disease and charge the facility fee. According to this traditional practice, the United States federal fiscal provides two types of pay systems, Facility fee and Physician fee. The federal health insurance pays to hospital and doctor separately. Economics of scope and economics of scale didn't come into use, due to failing to form a network between hospitals, doctors and other health care providers.

The US Government was aware of the efficiency improvement of space, the government provides policy guidance and incentives to promote the cooperation between the providers of medical services through ACOs, achieving the goal of reducing costs and providing a package of services to patient. ACOs system design is closely linked to characteristics of the supply-side of medical service market. The mechanism has four characteristics as follows.

1.2.1 Encourage Innovation and Improve the Quality of Service by Introducing Competition

Although ACOs seem to be similar to the existing HMOs in the United States on the surface, ACOs avoid the structural flaws of HMOs. HMOs control over patient referral and limit patients' choice, so it is not conducive to form the effective competition pattern between HMOs organization. But patients in the ACOs do not have to stay within the network, they can select services based on their satisfaction with service provider. ACOs must prove that it provides the best quality and lower cost services and encourage patients to pay to its product, so the mechanism promotes the competition between ACOs.

1.2.2 Encourage Health Care Provider to Save Costs by Transferring the Residual Claim

ACOs system promote to reduce costs and improve the quality of service by designing the model of payment and guiding health care provider to reform the type of organization. ACOs
system ensures that providers are jointly responsible for the health of patients, and encourages them to cooperate with each other by funds and reduce costs by avoiding unnecessary checks and procedures. Providers that meet the objective of service quality and save costs can keep part of the savings, it gives the provider incentive to reduce costs and to innovate by transferring the residual claim. According to estimates by HHS, ACOs can save up to $940 million for Medicare in the first four years and benefit from this saving funding.

1.2.3 Reduce Costs by Long-term Contract and Stability of Expectation

Before introducing ACOs system, Medicare beneficiaries get different services from different providers. In the implementation of ACOs system, health care providers are responsible for not only a specific disease but also the whole treatment process for patients. Although the scope of providers' responsibility become broader and the requirements of quality and effect become higher, on the other hand, the payment method and organization form based on the patient but not disease is helpful for ACOs to make a long-term programme for the health of patients, to establish stable expectations and to allocate scarce health care resources reasonably in one organization. Over the long term, linking the medical quality and service usage rate with payment, encouraging health care providers work in perfect union and jointly manage Medicare in the United States, but not encouraging supplier to mislead demander.

1.2.4 The Focus of Evaluation Transfer from Quantity to Quality and Effect

In the traditional payment method of Medicare, it may result in higher cost if physicians and hospitals let patients do more medical treatments and provide cumbersome programs and they often get more income. The mechanism design of ACOs do not eliminate the flaw of charging based on the number of service, but it allow the provider share the cost savings and it also build a incentive mechanism. Physicians and hospitals must meet the quality standard and pay close attention to how to prevent and take care of chronic patients. If ACOs fail to get cost savings and to meet the standard of quality and performance, they have to take efforts to improve the level of medical quality, or they have to pay the fine. The focus of evaluation transfer quantity to quantity and effect, this is a important historic change for payment system of Medicare. The Federal Financial will pay the service fee for 3500 hospitals in United States based on the quality of medical service.

2. The Antitrust Restraint on ACOs : Analysis Rule

2.1 Applicable Object: Collaborations Like ACOs

Some health care providers are likely to create and participate in ACOs that serve both Medicare beneficiaries and commercially insured patients. The Federal Trade Commission and the Antitrust Division of the Department of Justice (the "Agencies") recognize that ACOs may generate opportunities for health care providers to innovate in both the Medicare and commercial markets and achieve for many other consumers the benefits Congress intended for Medicare beneficiaries through the Shared Savings Program. The Agencies also recognize that not all such ACOs are likely to benefit consumers, and under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care.
To protect both Medicare beneficiaries and commercially insured patients from potential anticompetitive harm while allowing ACOs the opportunity to achieve significant efficiencies, the Agencies issued the *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (the "Policy Statement") in October 2011. The Policy Statement is intended to ensure that health care providers have the antitrust clarity and guidance needed to form procompetitive ACOs that participate in both the Medicare and commercial markets.

The Policy Statement applies to collaborations among otherwise independent providers and provider groups that are eligible and intend, or have been approved, to participate in the Shared Savings Program. For ease of reference, the Policy Statement refers to such collaborations as ACOs, although they may not yet have been approved to participate as ACOs in the Shared Savings Program. A "collaboration" comprises an agreement or set of agreements, other than merger agreements, among otherwise independent entities jointly to economic activity, and the resulting economic activity. The Policy Statement refers to the otherwise independent providers and provider groups that constitute the ACO as ACO participants. The Policy Statement does not apply to merger transactions, including transactions that meet the criteria set forth in Section 1.3 of the *Antitrust Guidelines for Collaborations Among Competitors*, will be evaluated under the Agencies' *Horizontal Merger Guidelines*. Of cause, the Policy Statement also does not apply to single, fully integrated entities.

### 2.2 Evaluate Standard: Conditions That Apply Rule of Reason Analysis

To evaluate the legality of cooperation, the key issue is whether the cooperation agreement or some part of the cooperation applies to "per se rule" or "rule of reason". The antitrust laws treat naked price-fixing and market-allocation agreements among competitors as per se illegal. Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration. It mean that, evaluating whether the collaboration is likely to have anticompetitive effects and, if so, whether the collaboration's potential procompetitive efficiencies are likely to outweigh those effects.

The American agencies have articulated the standards for both financial and clinical integration in various policy statements, speeches, business reviews, and advisory opinions. For example, the Agencies' *Statements of Antitrust Enforcement Policy in Health Care* (the "Health Care Statements") explain that where participants in physician or multiprovider joint ventures have agreed to share substantial financial risk and that provider joint ventures also may involve

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4 An ACOs participant can be an independent physician solo practice, a fully integrated physician group practice, an inpatient facility, or an outpatient facility.


6 The agencies treat a competitor collaboration as a horizontal merger in a relevant market and analyze the collaboration pursuant to the *Horizontal Merger Guidelines* if appropriate, which ordinarily is when: (a) the participants are competitors in that relevant market; (b) the formation of the collaboration involves an efficiency-enhancing integration of economic activity in the relevant market; (c) the integration eliminates all competition among the participants in the relevant market; (d) the collaboration does not terminate within a sufficiently limited period by its own specific and express terms. Collaboration Guidelines, supra note 3, 1.3.

clinical integration sufficient to ensure that the venture is likely to produce significant efficiencies. The risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the participants to meet that goal. Accordingly, the setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason. Clinical integration can be evidenced by the joint venture implementing an active and ongoing program to evaluate and modify practice patterns by the venture's providers and to create a high degree of interdependence and cooperation among the providers to control costs and ensure quality. Therefore, joint ventures involving clinical integration may achieve significant efficiencies. Although the American agencies have not previously listed specific criteria required to establish clinical integration, the Agencies have determined that CMS's eligibility criteria are broadly consistent with the indicia of clinical integration that the Agencies previously set forth in the Health Care Statements and identified in the context of specific proposals for clinical integration from health care providers.

To assess whether an ACO has improved quality and reduced costs to Medicare, CMS will collect and evaluate cost, utilization, and quality metrics relating to each ACO's performance in the Shared Savings Program. The results of this monitoring will help the Agencies determine whether the CMS eligibility criteria have required a sufficient level of clinical integration to produce cost savings and quality improvements, and may help inform the Agencies' future analysis of ACOs and other provider organizations. In light of CMS's eligibility criteria, and its monitoring of each ACO's results, the Agencies will treat joint negotiations with private payers as reasonably necessary to an ACO's primary purpose of improving health care delivery, and will afford rule of reason treatment to an ACOs.

3. Antitrust Analysis Method of ACOs

To decide whether an ACO may rise competitive concerns or not, we must evaluate if their behaviour brings about exclusion and restriction effects and harms the effective operation of the competitive market. If not, the ACOs will not rise competitive concerns. The antitrust regulator sets forth an antitrust safety zone for ACOs that are highly unlikely to raise significant competitive concerns. Absent extraordinary circumstances, for example, ACO participants engaging in collusion or improper exchanges of price information or other competitively sensitive information with respect to their sale of competing services outside the ACO, the agencies will not challenge ACOs that fall within the safety zone. But the creation of a safety does not mean that ACOs outside the safety zone must be anticompetitive and illegal, if an ACO that does not impede the functioning of a competitive market will not raise competitive concerns. The statement also offers options for ACOs that seek additional antitrust guidance. It describes certain conduct all ACOs generally should avoid, other conduct that ACOs with high Primary Service Area ("PSA") shares or other possible indicia of market power may wish to avoid, and the process by which a

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9 The No. 3022 item in Affordable Care Act provides eligibility criteria that CMS give a licence to ACOs and CMS detailed those eligibility criteria. See Patient Protection and Affordable Care Act, Public Law 111–48, 3022, 124 Stat. 119, 395–99 (2010); and Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 CFR part 425 (2011).
newly formed ACO may obtain a voluntary expedited antitrust review.

3.1 The Antitrust Safety Zone for ACOs

To determine whether an ACOs falls within the safety zone, it should evaluate the ACO's share of services in each ACO participant's PSA. The PSA for each participant is defined as the lowest number of postal zip codes from which the ACO participant draws at least 75 percent of its patients, separately for all physician, inpatient, or outpatient services. The Policy Statement focuses on PSA shares for three major categories of services: physician specialties, major diagnostic categories ("MDCs") for inpatient facilities, and outpatient categories, as defined by CMS, for outpatient facilities. Although a PSA and these services do not necessarily constitute a relevant antitrust geographic and product market, they serve as a useful screen for evaluating potential anticompetitive effects.

For an ACO to fall within the safety zone, independent ACO participants that provide the same service (a "common service") must have a combined share of 30 percent or less of each common service in each participant's PSA, wherever two or more ACO participants provide that service to patients from that PSA. There are three steps to calculate the ACO's PSA Share, see table 1 as follow.

Table 1: Steps of Calculating an ACO's PSA Shares

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<th>Steps</th>
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<tr>
<td>a. Identify each service provided by at least two independent ACO participants (i.e., each common service);</td>
<td>For physicians, a service is the physician's primary specialty, as designated on the physician's Medicare Enrollment Application. Each specialty is identified by its Medicare Specialty Code (&quot;MSC&quot;), as defined by CMS. For inpatient facilities (e.g., hospitals), a service is an MDC. For outpatient facilities (e.g., ASCs or hospitals), a service is an outpatient category, as defined by CMS.</td>
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<tr>
<td>b. Identify the PSA(s) for each participant in the ACO that provides any common service;</td>
<td>The participant include each independent physician solo practice, each fully integrated physician group practice, each inpatient facility (even if part of a hospital system), and each outpatient facility will have its own PSA. In addition, each inpatient facility will have a separate PSA for inpatient services, outpatient services, and physician services provided by its physician employees.</td>
</tr>
<tr>
<td>c. Separately for each common service, calculate the ACO's PSA share in the PSA of each participant that provides that service if at least two participants provide that service to patients from that PSA.</td>
<td>If an entity owned by an ACO participant provides services in a PSA, those services should be included in the share calculation regardless of whether the affiliated organization participates in the ACO.</td>
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The availability of the PSA safety zone also depending on whether an ACO participant is

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10 For example, if two independent physician group practices form an ACO and each includes cardiologists and oncologists, so cardiology and oncology are common services; if one physician group practice consists only of cardiologists and the other only of oncologists, then there would be no common services.

11 The policy statement identifies data sources available for these calculations and provides illustrative examples. The policy statement, see spur note 3.
exclusive or non-exclusive to the ACO. To participate in an ACO on a non-exclusive basis, a participant must be allowed to contract with private payers through entities other than the ACO, including contracting individually or through other ACOs or analogous collaborations. In other words, an ACO participant must be non-exclusive to the ACO to fall within the safety zone, regardless of its PSA share. If an ACO participant fall within the rural exception and dominant participant limitation described below, the ACO will also fall within the safety zone, regardless of whether the participant are exclusive or non-exclusive.

(a) Rural Exception: An ACO that exceeds the 30 percent PSA share may still fall within the safety zone if it qualifies for this rural exception. The rural exception allows such an ACO to include one physician or physician group practice per specialty from each rural area on a non-exclusive basis and still fall within the safety zone, provided the physician's or physician group practice's primary office is in a zip code that is classified as "isolated rural" or "other small rural". Thus, an ACO may qualify for the safety zone as long as it includes only one physician or physician group practice per specialty for each county that contains at least one "isolated rural" or "other small rural" zip code, even if the inclusion of these physicians causes the ACO's share of any common service to exceed 30 percent in any ACO participant's PSA. Likewise, an ACO may include Rural Hospitals on a non-exclusive basis and qualify for the safety zone, even if the inclusion of a Rural Hospital causes the ACO's share of any common service to exceed 30 percent in any ACO participant's PSA.

(b) Dominant Participant Limitation: The dominant participant limitation applies to any ACO that includes a participant with a greater than 50 percent share in its PSA of any service that no other ACO participant provides to patients in that PSA. (For example, a physician group participating in the ACO may comprise a specialty not found in any other ACO participant.) Under these conditions, the ACO participant must be non-exclusive to the ACO for the ACO to fall within the safety zone. In addition, to fall within the safety zone, an ACO with a dominant participant cannot require a private payer to contract exclusively with the ACO or otherwise restrict a private payer's ability to contract or deal with other ACOs or provider networks.

3.2 The Antitrust guidance to ACOs Outside the Safety Zone

ACOs that fall outside the safety zone may be procompetitive and lawful. An ACO that does not impede the functioning of a competitive market will not raise competitive concerns. The American Agencies emphasize the safety zone are useful screening device and that alternative data and information also may be useful in evaluating the likely competitive significance of a particular ACO. The Agencies recognize that an ACO can also provide other evidence which the ACO may reasonably conclude that the ACO is unlikely to raise competitive concerns. The policy statements do not provide a whole antitrust analysis structure to ACOs outside the safety zone, but it describes some types of conduct by an ACO that, under certain circumstances, may raise competitive concerns.

3.2.1 Avoid Improper Sharing of Competitively Sensitive Information

Regardless of an ACO's PSA shares or other indicia of market power, significant competitive concerns can arise when an ACO's operations lead to price-fixing or other collusion among ACO

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12 The Health Care Statements further explain the indica of non-exclusivity that the Agencies consider relevant to this evaluation. Health Care Statements, see supra note 8, pp 66-67.
participants in their sale of competing services outside the ACO. For example, improper exchanges of prices or other competitively sensitive information among competing participants could facilitate collusion and reduce competition in the provision of services outside the ACO, leading to increased prices or reduced quality or availability of health care services. So all ACOs should refrain from conduct that may facilitate collusion among ACO participants in the sale of competing services outside the ACO.

3.2.2 Conduct by ACOs With High PSA Shares or Other Possible Indicia of Market Power May Raise Competitive Concerns

For ACOs with high PSA shares or other possible indicia of market power, the Policy Statement identify four types of conduct that may raise competitive concerns. (a) Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through "anti-steering", "anti-tiering", "guaranteed inclusion", "most-favored-nation", or similar contractual clauses or provisions. (b) Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the private payer's purchase of other services from providers outside the ACO, including providers affiliated with an ACO participant. (c) Contracting on an exclusive basis with ACO physicians, hospitals, ASCs, or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO, either individually or through other ACOs or analogous collaborations. (d) Restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Shared Savings Program.

An ACO with high PSA shares or other possible indicia of market power may wish to avoid the conduct set forth in (a) through (d) above. Of course, there are other conducts that an ACO should be avoided. The policy statement recognize that some of the conduct described in (a) through (d) above may be competitively neutral or even procompetitive, depending on the circumstances, including whether the ACO has market power. For example, based on competitive ACOs market, independent providers are more likely to sign a contract with consumers and to participate in competitive ACOs or other similar organization. An ACO and its participants need to sign a contract exclusively to increase the efficiency of ACOs. What’s more, these is generally less likely to raise competitive concerns.

4. Revelation to the Supply-side Reformation of Chinese Medical System

4.1 Competition Rules Supporting the Supply-side Reformation

China has been trying to advance the process of medical system reformation, which has got a

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13 Health Care Statements 4, 5, and 6 relate to the sharing of data and information among competing providers. The Health Care Statements set forth safety zones for providers' collective provision of fee- and non-fee-related information to health care purchasers and participation in exchanges of price and cost information. The Health Care Statements also provide further guidance on the distinctions between legitimate information sharing and information sharing that may facilitate collusion or otherwise raise competitive concerns. See U.S. DOJ & FTC, Statements of Antitrust Enforcement Policy in Health Care, pp 40-52 (1996).
significant development of providers' facilities and the serviceability of medical institutions. Also
there are many institutional flaws which raise some new problem during this process. Those
problems, such as health costs getting out of control, service prices rising, visiting doctor being
difficult and expensive, need us to deal with. With the implementation of the new medical scheme
for three years, China has basically established the medical insurance system nationwide. At the
same times, medical security levels have increased accordingly by means of financial subsidies.
However, it becomes a major challenge that the medical security levels can achieve a much higher
level while expanding in coverage and increasing the amount of financial subsidy. On account of
China's huge population base, just raising the level of subsidies will inevitably increase the burden
of government spending and lead to inability to achieve the sustainable development of the
medical security system. Therefore, in addition to controlling medical costs and reducing the price
of medical services by improving the medical security system, the supply-side reformation of
medical system should be the main focus of the medical system reform in the future.

China's healthcare reform is similar with the United States in a sense, which is necessary to
expand health insurance coverage and reduce the rapid growth in medical costs at the same time to
ensure its sustainable development. The ACOs system Shared Savings Program established is the
Obama administration's reforming measure for the supply-side of medical service market. The
establishment of ACOs system has a solid theoretical foundation, practice basis and the
introduction of competition mechanism ensuring a virtuous circle of medical system. Though
there is still a large gap about medical facilities and professional between China and that of the
United States, the design idea of ACOs system has an important practical significance for the
effective integration of the health care resources, improving the efficiency of supply of medical
services and reducing price of medical services. And the design idea of ACOs system also
improves the effect and coverage of financial subsidies and ensures the implementation effect of
China's new medical scheme.

With the implementation of the new medical scheme for three years, China has also taken a
number of measures for the supply-side reformation, such as establishing public hospital, reforming
billing system, improving the system of primary health care services and so on. However, the
health care market still exists much government intervention and lacks competition. At present,
public hospitals still control over 90 percent of medical resources in China and it has became a
major medical insurance designated hospitals. Regional health planning relies on the public
hospital, which forms barriers of social capital entering into health care market and strengthens the
monopoly power of public hospitals. It will be difficult to solve the problems like high medicare
costs and high medical services price if the market is lack of incentive and mechanism of
competition. Therefore, a reasonable mechanism design for medical service suppliers, the
introduction of market competition mechanism and the establishment and application of
supporting competition rules become the key foothold to ensure the implementation effect of
China's new medical scheme.

4.2 Establish Competition Assessment Mechanism and Antitrust Constraint
System for Medical Industry

To ensure the smooth implementation of the new health reform and to provide a good
development environment of the medical service industry, the US Government published a
supporting antitrust policy to monitor and constrain the behavior of medical service providers
while promoting the supply-side reformation of medical system. This is one feature of the American legal system which took effective measure of the market competition mechanism to achieve the economic efficiency, and antitrust policy became an effective means of promoting competition. In the antitrust policy statements regarding ACOs, the agencies did not list specific standards in advance meeting clinical integration need. However, in the context of the Shared Savings Program, the agencies provided a detailed antitrust guidance in evaluating on wether an ACO might subject to an antitrust investigation or not and the potential challenge as engaging in per se illegal conduct. Moreover the health care providers seeking to create ACOs could benefit from this additional antitrust guidance. To a large extent, the regime set a prior risk prevention and provided a necessary protection to ensure a feasibility of the implementation policy.

The supply-side reformation of Chinese medical system has been started, and we can anticipate that it will be a success in market access, construction of competitive landscape etc to some extent. The concomitant problem is how to establish and apply competition rules in medical industry. Lacking competition rules will lead market competition to another form of monopoly, that is an economic monopoly from the original administrative monopoly. In this case, consumers cannot gain the supply-side reformarion benefit of low price and high quality services, but be hurted by explicit or implicit monopolistic behavior. Market mechanism is an effective means to optimize the allocation of resources and which has a significant meaning of medical reform. With the deepening of China's medical system reform, the potential anticompetitive harm, such as highly concentrated market structure and monopolists' anti-competitive behaviour, will reduce the supply efficiency of medical services and not achieve the target of healthcare reform. The US Government takes full use of antitrust policy to monitor and constrain healthcare providers to avoid the medical service provider with a relatively high concentration abusing its dominant market position by lack of antitrust restraint and affecting the welfare of patients. The practice of US Government is a good lesson for China.

We need to establish competition assessment mechanism and draft supporting antitrust guidance of medical industry policy along with the design mechanism of medical system reform. At the same time, avoid the unjust policies of medical industry, such as regional planning and access to medical services policy, which may arise limitations and exclusions to market competition. It is necessary that we should evaluate the competitive effects of industry policy, avoid the emergence of monopoly at the source and ensure small and medium medical institutions and private or foreign services institutions having equal opportunity to compete. Meanwhile, strengthening antitrust enforcement should concern policy and regulation in medical service areas, the administrative behavior, and the dominant firms behavior in the relevant market, and making up professional antitrust guidance timely. Firstly, it provides a more antitrust guidance to medical service providers and avoids conflicting with the law due to ignorance or there is no law to follow. On the other hand, it provides plays a role of preventive deterrent and constrains healthcare providers' anti-competitive behaviour before it happen. In the context of this mechanism, the antitrust restraint on medical service providers becomes a part of a complete medical system and plays an active role in the medical service area. This also is an important significance of competition rule and antitrust rule to promote effective competition.
References


