



May 27, 2011

Federal Trade Commission  
Office of the Secretary  
Room H-113 (Annex W)  
600 Pennsylvania Avenue, N.W.  
Washington, D.C. 20580

Re: Proposed Statement of Antitrust Enforcement Policy Regarding ACOs  
Participating in the Medicare Shared Savings Program, Matter V100017

Dear Sir or Madam:

The following comments are being submitted on behalf of Blue Shield of California in response to the March 31, 2011 notice issued by the Federal Trade Commission (“FTC”) and the Antitrust Division of the Department of Justice (“DOJ,” and collectively, the “Agencies”), regarding the Agencies’ Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program (“Policy Statement”), and request for comments.

Blue Shield of California is an independent member of the Blue Cross Blue Shield Association and a not-for-profit health plan with 3.4 million members, 4,800 employees, and some of the largest provider networks in California. Blue Shield offers a wide range of commercial and government health insurance products (underwritten and self-funded) throughout California. Blue Shield previously submitted comments prior to the issuance of the Policy Statement regarding the proposal last October by FTC Chairman Jon Leibowitz to define a safe harbor for accountable care organizations (“ACOs”), (see November 4, 2010 letter, to Attn: ACO Legal Issues, the Centers for Medicare and Medicaid, from Blue Shield of California, “November 4 Letter,” attached as Exhibit 1 to this letter), and hereby incorporates the contents of that letter into these current comments.

The Policy Statement makes an important contribution to the development of ACOs by recognizing their procompetitive potential while at the same time providing health care providers with substantive guidance and a reasonable procedure for review of certain proposed ACOs, both of which are intended to limit the potential anticompetitive effects of increased provider consolidation. Blue Shield is concerned, however, that as currently written the Policy Statement, and in particular the safety zone requirements, create a serious risk that ACOs will be

encouraged to form that have a greater ability to exercise market power against health plans and their enrollees, with the result being higher health care costs for consumers.

Specifically, in comparison to the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care (“1996 Health Care Statements”), the Policy Statement relaxes both the requirements for provider integration necessary to qualify for rule of reason treatment under the Sherman Act, and the market share limitations required to qualify for safety zone treatment. In addition, the Policy Statement fails to address the potential for provider systems with broad geographic coverage to leverage the market power they have in particular geographic areas to insist that payers contract with them on an “all-or-nothing basis.” Further, the safety zone does not contain transparency requirements with respect to provider rate and quality information that would make it more difficult for provider networks with market power to exercise that power in an anticompetitive manner. Based on Blue Shield’s own experiences in negotiating with such networks, the Policy Statement should be revised and strengthened to address these concerns and increase the likelihood that ACOs, particularly those that qualify for safety zone treatment, actually operate in a manner that reduces costs and improves quality of care. These concerns, and Blue Shield’s recommended changes to the Policy Statement, are described in detail below.

## **Concerns Regarding the Proposed Policy Statement**

Blue Shield’s concerns regarding the Policy Statement fall into three major categories:

### 1. Insufficient Requirements for Provider Integration

In Blue Shield’s experience, including with three existing ACOs in our provider network that currently serve approximately 70,000 enrollees, strong, clear requirements for network provider integration are necessary to drive cost savings and ensure a procompetitive outcome. In contrast, Blue Shield has at times been required to negotiate with networks that do not appear to engage in any meaningful provider integration and have used their market power to raise rates. We believe the requirements in the 1996 Health Care Statements for specific, clearly defined types of financial integration, as well as the principles set out regarding clinical integration, were well suited to ensuring that provider networks engage in an appropriate degree of integration to warrant rule of reason treatment.<sup>1</sup> The Policy Statement safety zone, however, does not require financial integration. While it states that the eligibility criteria proposed by the Centers for Medicare and Medicaid (“CMS”) for the Medicare Shared Savings Program are “broadly consistent” with the criteria in the 1996 Health Care Statements for clinical integration, it is not clear what degree of integration will be required, and is likely to actually take place, in specific circumstances. Thus, there is a lack of clarity and uncertainty about the nature and extent of integration that is required. Because meaningful integration—both clinical and financial—are

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<sup>1</sup> The FTC has defined the requirements for clinical integration more specifically in a number of advisory opinions. See e.g., MedSouth, Inc. Advisory Opinion (February 19, 2002); Greater Rochester Independent Practice Association, Inc. Advisory Opinion (September 17, 2007).

core requirements for any procompetitive outcomes, they should be explicit requirements of the Policy Statement safety zone.

## 2. Need for Stricter Market Share Screens

As discussed in Blue Shield's November 4 Letter, market share often is not a reliable indication of market power. In California, for example, market shares of providers located in areas near Kaiser facilities are understated because Kaiser's large network is included when their market shares are calculated even though the Kaiser facilities are not available to competing payers. In addition, health plans must obtain advance permission from the Department of Managed Health Care to transfer members from a provider that is being removed from a network. These providers often insist, and sometimes persuade the Department, that alternative providers are not adequate substitutes, leaving the health plan with no choice but to negotiate with the incumbent provider who has been given significant leverage.

Further, in recent years, an increasing number of provider networks with locations in multiple geographic areas in California have insisted Blue Shield contract with them on an "all-or-nothing" basis—meaning that Blue Shield must contract with their providers in every geographic location or none at all. Because Blue Shield needs these networks in certain areas that include hospitals with high market shares or other "must have" hospitals, but not others, Blue Shield is forced to contract with other network hospitals in areas in which Blue Shield has competitive hospital alternatives and could contract separately with a competing hospital at a much lower rate. As a result of these factors, providers can have a high degree of market power in a local area(s) even with shares well below the 30 percent primary service area ("PSA") threshold in the Policy Statement safety zone.<sup>2</sup>

The Policy Statement does not adequately address these concerns. It relaxes the safety zone market share screen in the 1996 Health Care Statements for physicians from 20 percent for each specialty for exclusive networks and 30 percent for non-exclusive networks to 30 percent of PSA share regardless of exclusivity, and permits hospitals, ambulatory surgery centers ("ASCs")

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<sup>2</sup> The Policy Statement measures market shares for particular types of provider services based on PSAs, defined as the lowest number of contiguous postal zip codes from which a provider draws at least 75% of its patients for a given service. In theory, the use of PSAs as a surrogate for geographic markets is likely to result in ACOs being evaluated in narrower geographic areas than under the 1996 Health Care Statements. That is because PSAs are based solely on the areas in which providers historically have obtained their patients while geographic market analysis under the 1996 Health Care Statements employed the geographic market definition principles in the FTC/DOJ Horizontal Merger Guidelines, which consider the alternatives in other geographic areas to which existing patients could turn in response to a price increase. (See 1996 Health Care Statements, Statement No. 8, Section B.2 ("Applying Rule of Reason")). In reality, however, analysis of whether a physician network qualifies for the safety zone in the 1996 Health Care Statements often involved an approximation of the geographic market, such as using a county or MSA, that arguably is closer to a PSA than a geographic market properly defined for antitrust purposes. See, e.g., *MedSouth, Inc. Advisory Opinion* (February 19, 2002) (advisory opinion evaluating proposed network based on geographic area consisting of a portion of the Denver, Colorado MSA); see also *Tri-State Partners, Inc., Advisory Opinion* (April 13, 2009) (evaluating physician hospital network with respect to primary service area, which was limited to single county).

and other providers with a PSA share of up to 50 percent to participate in the network. In addition, while the Policy Statement advises that networks with PSA shares between 30-50 percent, which do not qualify for safety zone treatment or require mandatory review, avoid tying sales of the ACO's services to a commercial payer's purchase of services from affiliated non-ACO providers (e.g., requiring a payer to contract with a non-ACO hospital affiliated with an ACO hospital), the safety zone does not address the type of "all-or-nothing" contracting conditions that have been imposed on Blue Shield (and, we suspect many other payers around the country), perhaps based on the mistaken assumption that networks with shares of less than 30 percent cannot exercise market power to impose such provisions on commercial payers.<sup>3</sup> Further, the Policy Statement permits networks with provider shares of up to 50 percent, under certain circumstances, that may have considerable potential to exercise market power, to operate without any prior Agency review.

3. Need for Requirements Regarding Provider Transparency and Ability of Payers to Create Provider Incentives

As noted in Blue Shield's November 4 Letter, providers may use their market power not only to increase rates, but to impose non-price requirements on payers that prevent the achievement of critical cost-containment and transparency goals. These include provisions that restrict the use of cost and quality data and other information in a manner that limits the ability of health plans and their members to evaluate whether providers are providing a high and improving quality of care, and blocks consumers from making informed choices. Providers also impose provisions that limit health plans' ability to offer "centers of excellence" or other tiered products that create strong incentives for providers to reduce costs and improve quality by steering patients to those providers most proficient in meeting cost and quality goals. On the other hand, Blue Shield's experience, including with its existing ACOs, is that provider transparency with respect to the types of data described above, as well as the ability of payers to offer tiered products, are critical if ACOs are to achieve their procompetitive potential. Moreover, provider transparency with respect to these data will facilitate public sharing of absolute and relative costs and quality data within a community, and is more likely to motivate providers, including those with market power, to maintain rates at competitive levels and improve quality of care.

Once again, however, while the Policy Statement advises ACOs in the 30-50 percent PSA share range to avoid restricting use of a commercial payer's ability to share provider cost, quality and efficiency information with enrollees to aid them in selecting a provider, as well as to

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<sup>3</sup> The *Dominant Provider Limitation* to the Policy Statement's 30% PSA share safety zone requirement states that a provider with a share in excess of 50% can participate in the ACO under the safety zone so long as that provider does not compete on the relevant service with any other ACO participant in its PSA, the provider participates in the ACO on a non-exclusive basis, and the ACO does not require "a commercial payer to contract exclusively with the ACO or otherwise restrict a commercial payer's ability to contract or deal with other ACOs or provider networks." While this language could be read as restricting an ACO from insisting that a commercial payer contract with it and its affiliated providers on an "all-or-nothing" basis, it clearly falls short of explicitly prohibiting that practice.

avoid “anti-steering” type clauses to discourage payers from incentivizing their insureds to use certain providers, the safety zone requirements are silent on these matters.

## Recommendations

To address the concerns outlined above, Blue Shield recommends that the proposed Policy Statement be amended as follows:

1. In order to qualify for safety zone treatment, the ACO be required to engage in financial integration or clinical integration that is, in fact, consistent with the criteria applied under the 1996 Health Care Statements.

2. The safety zone threshold for exclusive networks be reduced to a 20 percent PSA share threshold consistent with the 1996 Health Care Statements;

3. The *Dominant Provider Limitation* threshold be reduced to 35-40 percent of PSA share (a level more consistent with traditional measures of when market power concerns may arise<sup>4</sup>);

4. For similar reasons, the mandatory review PSA share threshold be reduced to 35-40 percent;

5. A prohibition on tying sales of the ACO’s services to the purchase of services from affiliated providers, including an explicit prohibition on “all-or-nothing” contracting requirements, be added to the safety zone as requirements; and

6. In order to qualify for safety zone treatment, an ACO also be required to meet each of the following transparency requirements:

a. The ACO agree to allow all of its contracted payers to share publicly—including with enrollees to aid them in selecting providers and health plans—quality, service, efficiency, performance, and aggregated cost information by individual provider for every provider the ACO or its parent represents in negotiations (“Affiliated Providers”); and

b. The ACO and its Affiliated Providers agree that payers can use the ACO’s claims data to monitor cost and quality.

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<sup>4</sup> See e.g., 1996 Health Care Statements, Statement No. 8 (safety zone); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 46 (O’Connor, J. concurring) (agreement foreclosing 30% or less of relevant market unlikely to be held anticompetitive); *United States v. Microsoft*, 253 F.3d 34, 70 (D.C. Cir.), *cert. denied*, 122 S.Ct. 350 (2001) (40% or greater foreclosure can sustain Section 1 claim that exclusive contract is anticompetitive).

## **Conclusion**

Blue Shield recognizes the importance of encouraging providers to cooperate and integrate their efforts more closely to promote greater care coordination, achieve quality objectives and meet cost containment goals. The formation of ACOs, both for the Medicare Shared Savings Program and contracting with commercial payers, holds potential for these purposes. But providers who form ACOs should be subject to the same requirements, such as those reflected in the 1996 Health Care Statements, that the Agencies have deemed necessary to ensure that other competing providers do not consolidate for purposes of exercising market power and preventing achievement of the very goals ACOs are intended to meet. We believe the proposed Policy Statement, with the amendments we propose, strikes a proper balance between procompetitive provider integration and anticompetitive consolidation and the inappropriate exercise of market power that would result in continuing excessive provider rate increases and the failure to achieve necessary quality improvements.

Blue Shield would be happy to discuss these comments further.

Sincerely,

Paul Markovich  
Executive Vice President  
Chief Operating Office  
Blue Shield of California

cc: Robert E. Bloch  
Scott P. Perlman  
Mayer Brown LLP  
1999 K Street, N.W.  
Washington, D.C. 20006

# Exhibit 1



November 4, 2010

Attn: ACO Legal Issues  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Re: Blue Shield of California -- Comments Relating to Workshop Regarding  
Accountable Care Organizations

Dear Sir or Madam:

The following comments are being submitted on behalf of Blue Shield of California as a follow-up to the Workshop held by the Federal Trade Commission (FTC), Centers for Medicare & Medicaid Services (CMS), and the Office of the Inspector General (OIG) of the Department of Health and Human Services (DHHS), regarding Accountable Care Organizations (ACOs) on October 5, 2010. In particular, Blue Shield is submitting these comments to address the proposal by FTC Chairman Jon Leibowitz to define a safe harbor for ACOs with respect to agency enforcement of the antitrust laws.

Blue Shield of California is an independent member of the Blue Cross Blue Shield Association and a not-for-profit health plan with 3.4 million members, 4,800 employees, and some of the largest provider networks in California. Blue Shield offers a wide range of commercial and government health insurance products (underwritten and self-funded) throughout California.

Based on our experience in contracting with a variety of provider networks and delivery systems, including those located both in highly populated and rural areas, Blue Shield has found that provider expansion and consolidation generally has resulted in higher rates for provider services, and that there does not appear to be any link between such higher rates and increased quality of provider services.<sup>1</sup> Further, we have found that market share often is not an adequate measure of provider market power and leverage.

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<sup>1</sup> This observation regarding the lack of any direct correlation between provider rates and quality is similar to the findings reported in "Examination of Health Care Cost Trends and Cost Drivers," Office of the Massachusetts Attorney General, March 16, 2010 (Mass. AG Report), 16-17 ("Our results indicate there is no correlation between price and quality, and certainly not the positive correlation between price and quality we would expect to see in a rational, value-based health care market.") The report also found that provider price increases are correlated with provider market leverage. Mass. AG Report, 4. See [http://www.mass.gov/Cago/docs/healthcare/final\\_report\\_w\\_cover\\_appendices\\_glossary.pdf](http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf).

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Particularly in California, the market shares of providers located in the same areas as Kaiser facilities often are greatly understated because Kaiser's large network is included when their market shares are calculated, notwithstanding that Kaiser is a closed provider system that is not available to contract with competing network health plans. In addition, network health plans must gain advanced permission from the Department of Managed Health Care to transfer members from a provider that is being terminated from the network, but these providers often insist, and sometimes persuade the Department, that alternative providers are not adequate substitutes, leaving the health plan with no choice but to deal with the incumbent provider. As a result of these factors, providers can have a high degree of market power in local areas even though their market share falls below the 20%-30% safety zone thresholds employed by the FTC and the Department of Justice (DOJ) in the past. Similarly, market share screens may not provide adequate protection when a provider network with multiple facilities and/or physicians uses its status as the only provider in some areas to require payers to contract on an "all-or-nothing" basis that includes providers in other areas where the network has a much smaller market share.

Further, providers have used their market power for more than just negotiating higher reimbursement. Some have exercised their leverage to restrict the use of cost and quality data and other information in a manner that limits the ability of health plans and other health care customers to evaluate whether provider rates are competitive, to evaluate whether providers are providing a high and improving quality of care, and that restrict payers' ability to develop "centers of excellence" or other tiered products that would create strong incentives for providers to compete on cost, quality, and service. In short, it is not uncommon for providers to use the leverage they gain from integration, and the resulting increase in provider consolidation, to prevent competition with respect to the very characteristics integration is supposed to promote; namely, better clinical quality and efficiency.

We also believe that without strong requirements for financial or clinical integration, such as those included in the current DOJ/FTC safety zones, provider and payer incentives will not be aligned sufficiently to drive costs savings. Blue Shield's involvement with integrated networks in which relevant cost and utilization data are shared has shown that significant cost savings can be achieved when transparency and proper incentives are present. Financial and clinical integration are critically important to achieve the promise of improved performance, but also carry the risk of market abuse. The question is how to get the benefit of integration without the drawbacks.

Given these considerations, Blue Shield believes a safe harbor should focus on meaningful financial or clinical integration coupled with requirements that providers allow some specific terms in all of their payer contracts. Chief amongst these is transparency with respect to the availability and use of provider rate and quality data, and



the ability to use that data for benchmarking and similar purposes. Such a requirement will facilitate the public sharing of absolute and relative costs and quality data within a community, and is more likely to motivate providers, including those with market power, to maintain rates at competitive levels and improve quality of care. Such a transparency-based approach is supported by efforts undertaken by industry stakeholders such as the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs,” which was announced in April 2008 by the Consumer-Purchaser Disclosure Project, and which relies on clear standards for measuring and reporting on provider performance to drive cost-containment and quality improvements.<sup>2</sup> Similarly, the Massachusetts Attorney General’s Office, in its report, “Examination of Health Care Cost Trends and Cost Drivers,” March 16, 2010 (Mass. AG Report), recommends that cost containment goals be achieved through, among other means, “[i]ncreasing transparency and standardization in both health care payment and health care quality to promote market effectiveness and value-based purchasing by employers and consumers . . . ,” as well as prohibitions on “insurer-provider contract provisions that perpetuate market disparities and inhibit product innovation,” including “provider participation provisions” that prevent payers from creating limited network and/or tiered products. Mass. AG Report, at 5, 41.

Blue Shield therefore proposes that in order to qualify for safe harbor treatment under the antitrust laws, an ACO should be required to meet the following conditions:

1. That it be approved by the Secretary of DHHS as meeting requirements for being responsible for costs and quality of care;
2. The ACO should engage in meaningful financial and/or clinical integration as required under the current DOJ/FTC Health Care Statements, and should report publicly on at least an annual basis on the type(s) of integration it is using and the steps it is taking to achieve this integration;
3. The ACO agrees to allow all its contracted payers to publicly share quality, service, and aggregated cost information by individual provider for every provider the ACO or its parent represents in negotiations (affiliated providers);

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<sup>2</sup> The Patient Charter was endorsed by a broad variety of industry participants, including the American Medical Association, American Association of Retired Persons, the National Business Coalition on Health, and America’s Health Insurance Plans. See <http://healthcaredisclosure.org/docs/files/PatientCharterDisclosureRelease040108.pdf>.

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4. The ACO and its affiliated providers agree that payers can use the ACO's claims data to monitor cost and quality;

5. The ACO and its affiliated providers agree not to impose any limitations on payers using the ACO's claims data to differentiate among providers based on quality metrics (e.g., including that payers can offer tiered products and create and/or designate centers of excellence); and

6. The ACO and its affiliated providers agree that if the ACO is part of a multi-provider network or system, it will not require payers to negotiate with the network or system on an all-or-nothing basis that would require the payer to include network or system facilities or physicians that are not part of the ACO.

Blue Shield believes that these requirements, in combination with a market share screen, will properly motivate ACOs to control their costs and improve quality, while limiting the exercise of provider market power that has driven higher health care costs. Further, these requirements will make information available to create a dataset that can be used by DHHS, CMS and the antitrust agencies to enforce both antitrust and accountability requirements.

Please let me know if you would like to discuss these comments further.

Sincerely,

Paul Markovich  
Executive Vice President and  
Chief Operating Officer  
Blue Shield of California