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The Honorable Jon Leibowitz
Chairman, Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, D.C. 20580

The Honorable Christine A. Varney
Assistant Attorney General, Antitrust Division
United States Department of Justice
950 Pennsylvania Avenue NW
Washington, D.C. 20530

RE: **Comments on Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program from the Attorney General of California**

Dear Chairman Leibowitz and Assistant Attorney General Varney:

This letter sets out the comments of the Attorney General of California on the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program ("Proposed Policy Statement"). Health care markets are primarily local markets. The Office of the Attorney General, as an antitrust enforcer, has endeavored to safeguard the competitiveness of health care provider and insurance markets, often working closely with your agencies. This Office has filed lawsuits to block anticompetitive mergers of providers, to prevent anticompetitive conduct by insurers, and to safeguard the elderly against fraud and deception in the delivery of their medical care.

The Attorney General recognizes competitive health care insurance and provider markets are necessary to controlling health care costs while ensuring patients continue to receive quality health care. For reasons we detail below, the Proposed Policy Statement accomplishes the dual goals of both encouraging the growth of Accountable Care Organizations ("ACOs"), integrated medical groups

for the purpose of delivering better care to patients, while ensuring that these organizations do not become a cover for medical care providers simply to fix prices and increase health care costs. We offer our comments for your agencies to take into account in finalizing the Proposed Policy Statement.

The History and Development of Accountable Care Organizations

The Patient Protection and Affordable Care Act and the Health Care and Education Reform Act of 2010 (collectively the "PPACA")[1] set up a Medicare program by which integrated health care delivery systems involving groups of providers such as physicians, hospitals, and other medical organizations could service Medicare fee-for-service beneficiaries.[2] These organizations, known as ACOs, would offer managed and coordinated care for patients in order to generate savings for the Medicare program in exchange for a share of those savings if certain quality benchmarks are met.

However, before the enactment of the PPACA, it was recognized that integrated groups of physicians and other providers could deliver better quality health care to patients at a more affordable cost for insurers via the following measures: following quality metrics overseen by doctors; having patient records available at a doctor's fingertips; treating patients early and monitoring their health so as to avoid unnecessary hospital visits; providing an integrating set of services, including primary care, specialty care in different areas, clinical services, and even in-home services; and educating/tracking patients.[3] Such integrated groups with a reported success in treating patients at a cheaper cost include Kaiser Permanente in California and Intermountain in Utah.[4] Integrated health care was thus a key part of the solution to driving down health care costs while improving patient outcomes in a highly

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[1] *See, e.g.,* Pub. L. No. 111-48, §2706 (2010).
[2] *See e.g.,* Barack Richman, H.E. Frech, & Thomas Greaney, *Resisting Another Threat to Competition in Health Care* (Apr. 15, 2011), *available at* http://www.antitrustinstitute.org/sites/default/files/AAI-oped-final.pdf ("The Affordable Care Act evinces a belief that encouraging providers of various kinds to integrate themselves in ACOs can achieve important cost savings for Medicare without diminishing the quality of care.").
[3] *See, e.g.,* Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care , supra* note 2 (giving examples of ACOs prior to the new law); David Leonhardt, *Making Health Care Work,* N.Y. TIMES MAGAZINE (Nov. 3, 2009), *available at* http://www.nytimes.com/2009/11/08/magazine/08Healthcare-t.html (discussing Intermountain).
[4] The integration model has not just been a success among high- or middle- income demographics. A New Yorker article reported on a community-type of ACO in a low-income urban area in Camden, New Jersey that was able to deliver integrated medical care to patients and improve their health outcomes at lower cost. Atul Gawande, *The Hot Spotters*, NEW YORKER (Jan. 24, 2011) (document in possession of staff of undersigned).

fragmented health care market.[5] However, private insurers followed prior Medicare reimbursement rules in failing to reward providers for the delivery of integrated health care.[6] Instead, providers were reimbursed based on an individual fee for individual service schedule, no matter the improvement (or lack thereof) in patient outcomes, causing an explosion in Medicare and non-Medicare costs alike and the need to try something different.[7]

The shift in Medicare to rewarding integrated medical networks is one that private insurers intend to follow in order to achieve cost savings *and* better patient outcomes. There is universal consensus as to its desirability from all stakeholders in the medical community who are right now proceeding to set up ACOs even as to commercial insurers. This shift is accordingly one that is likely here to stay.[8]

The Need to Propose Antitrust Enforcement Guidelines as to Accountable Care Organizations

The rise of ACOs, however valuable, can present potential anticompetitive problems. For example, hospital mergers, to use an analogous example, did not necessarily deliver on promised efficiencies but rather became vehicles for raising the fees charged to insurers and ultimately premium

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[5] *See, e.g.,* Thomas Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT L. REV. 217, 235-39 (2009) (insurance plans that do nothing more than transfer more responsibility to consumers will not bring down health care costs as long as providers charge on a fee-for-service basis rather than on an integrated basis based on health outcomes); *cf.* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care,* 5 AM. ECON. REV. 941, 954, 957 (Dec. 1963) (medical care market does not act in a competitive fashion because, among other reasons, physicians were refusing to accept a flat prepayment (which would function as a type of insurance in placing the risk of extensive or excessive care on doctors) and instead insisted on fee-for-service).

[6] *See, e.g.,* David Leonhardt, *Making Health Care Work, supra* note 3, at 7 ("But in our current health care system, there is no virtuous cycle of innovation, success and expansion. When Intermountain standardized lung care for premature babies, it not only cut the number who went on a ventilator by more than 75 percent; it also reduced costs by hundreds of thousands of dollars a year. Perversely, Intermountain's revenues were reduced by even more. Altogether, Intermountain lost $329,000. Thanks to the fee-for-service system, the hospital had been making money off substandard care. And by improving care — by reducing the number of babies on ventilators — it lost money. As James tartly said, "We got screwed pretty badly on that." The story is not all that unusual at Intermountain, either. That is why a hospital cannot do as Toyota did and squeeze its rivals by offering better, less-expensive care.").

[7] *See, e.g., id.* at 8 ("But given the scale of Medicare's long-term budget shortfall, the only sensible strategy is to try anything that seems promising. At the top of that list is moving medicine away from the fee-for-service system and toward something like a fee-for-health system. As dispiriting as the health care debate has been at times, Congress still has a chance to pass a bill that would begin to make life easier on the hospitals trying to do the right thing and, eventually, nudge many more hospitals into that category. That would be no small thing.").

[8] *See,, e.g.,* Jenny Gold & Phil Galenwitz, *Health Care Providers: Accountable Care Organizations Bring Legal Worries*, KAISER HEALTH NEWS (Oct. 5, 2010) (document in possession of staff of undersigned) (noting the formation of ACO-type of organization that would set up with insurers a shared-savings model similar to that set out in the new law as to Medicare).

costs to consumers.[9] Similarly, the FTC has found that physician collaboration supposedly intended to improve patient outcomes simply fixed the fees they charged to insurers.[10] Indeed, insurers and others have noticed a correlation between provider expansion and consolidation on one hand, and higher fees charged by those providers on the other hand, *without* any corresponding increase in quality.[11] In short, the acquisition by ACOs of market power could reduce or eliminate the ACOs' benefits for insurers and patients alike.[12] Thus, in evaluating ACOs, the Attorney General believes that prudence is required: while antitrust enforcers do not want to chill the formation of integrated organizations that can benefit patients, they do not want those organizations to become a vehicle for establishing a cartel.[13]

Accordingly, there is a strong need for antitrust enforcement guidelines as to ACOs. This letter therefore turns to the analysis of the Proposed Policy Statement.

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[9] *See, e.g.,* Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, FTC Bureau of Economics Working Paper No. 293 (Nov. 14, 2008) (concluding that the California Attorney General was correct after all in trying to oppose the purchase of Summit hospital by the Sutter hospital group because the transaction led to an increase in prices that was among the highest in California).

[10] *E.g., North Texas Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008).

[11] *See e.g.,* Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care , supra* note 2 (discussing recent study that showed hospitals in competitive markets saved more lives and noting other studies had shown that health care providers with monopoly power charge much higher prices, ensure less patient satisfaction, and provide poorer quality); Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations, 1 (Nov. 4, 2010), *available at* http://www.ftc.gov/os/comments/aco/101104bsc.pdf ("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."); *see also, e.g.,* MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS 4, 16-17 (Mar. 16, 2010) (same); Peter Waldman, *Hospital Monopolies Ruin MRI Bill as Sutter Gets Price It Wants,* BLOOMBERG NEWS (Aug. 20, 2010), *available at* www.MercuryNews.com (same); Robert A. Berenson et. al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS No. 4 (Apr. 2010) (same). Insofar as the Massachusetts and California reports are concerned, those reports did not purport to do a rigorous antitrust-type of market power analysis but rather looked at price increases and correlated those effects with the growing size of hospital and physician groups in given local geographic areas.

[12] CMS Notice of Proposed Rule-Making, Medicare Program; Medicare Shared Savings Accountable Care Organizations, 145 (2011) ("CMS NPRM on ACOs").

[13] *See, e.g.,* CMS NPRM on ACOs ("CMS NPRM on ACOs") (citing *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982) and quoting Ltr. from Jeffrey Brennan, Assistant Director, Bureau of Competition, Federal Trade Commission to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002), *available at* http://www.ftc.gov/bc/adops/medsouth.shtml) ("The Antitrust Agencies have developed criteria to assess whether collaborations of otherwise competing health care providers should be condemned as per se illegal under antitrust law or subject to a more thorough evaluation under the 'Rule of Reason' which would examine likely precompetitive and anticompetitive effects. To avoid per se condemnation as 'shams' that facilitate price-fixing or other per se illegal activities, collaborations of competing health care providers must show that they are integrated ventures that are likely to, or do, enable their participants jointly to achieve cost efficiencies and quality improvements in providing services. The efficiency-enhancing integration 'must likely generate pro-competitive benefits that enhance the participants' abilities or incentives to compete, and thus offset any anticompetitive tendencies of the arrangement'.").

The Views of the Attorney General on the Proposed Antitrust Enforcement Policy Statement

The Proposed Policy Statement encourages the formation of legitimate ACOs that will improve the outcome for patients without leading to results that would restrict competition in the health care market and raise costs.[14] Those steps include the development of a screening test utilizable by the federal antitrust agencies and ACOs alike to assess quickly ACOs' market share; the creation of a mandatory 90-day review process for ACOs with heightened market shares; the creation of a safe harbor created for ACOs with low market shares; and the dispensing of guidance to ACOs - that fall within a grey area in terms of market share - as to the type of exclusionary or predatory conduct that they should avoid to dispel concerns. The use of special rules for ACOs located in rural areas and the imposition of special restrictions on ACOs whose market shares bring them within the threshold for mandatory federal review is appropriate. Coupled with the proposed CMS rules, which set out requirements for an ACO to be a true integration of medical services that will benefit patients, the Proposed Statements should be effective in insuring that legitimate ACOs thrive and illegitimate ACOs are stopped before they can do any harm.[15]

True financial and clinical integration by medical providers are properly subject to rule of reason inquiry (rather than being automatically barred as being per se illegal) as such integration can bring efficiencies for consumers of medical services, i.e., patients and insurers.[16] In that context, the joint negotiation of fees with insurers by participants in such an integrated venture is also subject to rule of reason inquiry.[17] A rule of reason inquiry closely looks at the anticompetitive and procompetitive aspects of a restraint according to a burden-shifting and balancing test: plaintiffs must first show that a restraint is anticompetitive in its potential effect or in actual effect; then defendants

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[14] The Attorney General interpreted the Proposed Policy Statement in conjunction with the proposed rules of the Center for Medicare and Medicaid Services ("CMS") on ACOs.

[15] *Accord, e.g.,* Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care, supra* note 2 ("On the whole, however, the statement provides a workable process that will not sweep competitive issues underneath the rug.").

[16] *Accord, e.g.* CMS NPRM on ACOs at 59-60 (citing case decision as well as policy pronouncement of FTC), Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care, supra* note 2. Both Republican and Democratic administrations have held this view. *See, e.g.,* DEPT. OF JUSTICE & FED. TRADE COMM'N, STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) ("HEALTH CARE STATEMENTS"), *available at* http://www.ftc.gov/reports/hlth3s.pdf.

[17] HEALTH CARE STATEMENTS, *supra*, note 16.

must show that a particular restraint is procompetitive; following which anticompetitive and procompetitive effects must be balanced to determine if the procompetitive effects outweigh any anticompetitive tendencies.[18]

The Proposed Policy Statement is an appropriate and judicious interpretation of rule of reason requirements. The proposed CMS rules for establishing a sufficient integration (applicable not only to Medicare beneficiaries but also to commercial insurance enrollees per the Proposed Policy Statement)[19] ensure that ACOs will reflect the benefits of both financial and clinical integration. For example, these proposed rules provide criteria for evaluating whether ACOs encompass a sufficient number of clinical practices; adequately use IT for universal access to patient records; require risk-sharing and meaningful commitment among its provider members; follow quality-performance metrics; provide coordinated care; and set in place procedures to ensure that each provider-member has an appropriate say (with some sort of community stake-holder involvement) in the workings of ACOs.[20]

To classify the anticompetitive potential of ACOs, the Proposed Policy Statement uses a screening test to divide prospective ACOs into three groups based on their market shares: ACOs with a market share below 30% fall into a safe harbor; ACOs with a market share greater than 50% are subject to a mandatory 90-day review process; and ACOs with a market share between 30-50% are in a grey area in which those ACOs may, but are not required to, obtain preclearance from the federal antitrust authorities.[21] In the first instance, the screening test itself for determining market share is an appropriate one: it takes Medicare data as to patient visits with providers by zip codes, determines which providers for a given specialty are used by 75% or more of patients from a given zip code, and

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[18] CMS NPRM on ACOs at 59-60 (citing case and policy pronouncement of FTC); *see, e.g., Realcomp II v. FTC*, No. 09-4956, slip. op. 11-27 (6th Cir. Apr. 06, 2011) (setting out and applying actual rule of reason analysis).

[19] DEPT. OF JUSTICE & FED. TRADE COMM'N, PROPOSED STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PLAN (2011).

[20] CMS NPRM on ACOs at 47- 67. The list is not inflexible. *See id.* And, it is not unprecedented. Professor Lawton Burns of Wharton University has compiled an exhaustive checklist as to the criteria that one should look for to determine if vertical integration among clinical providers actually creates clinical integration and is not merely a scheme to exclude competitors.

[21] The screening test is predicated on the determination of the services offered in common by the various participants in the ACO: "For example, if two physician group practices form an ACO and each includes cardiologists and oncologists, then cardiology and oncology would be common services." PROPOSED STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS, *supra* note 19, at n.26. However, there is an appropriate caveat: any ACO participant that has a greater than 50% market share in any single service will cause the ACO itself to be regarded as a dominant provider subject to the 90-day review process unless the ACO itself agrees that this participant may be non-exclusive to the ACO (i.e., may participate in other ACOs). *See id.* at 7.

then examines those specialties covered by the ACO to determine if the number of patients seen by the ACO meet the requisite targets, e.g., equal to or greater than 50% for required preclearance review. The screening test is just a screen: the test does not preclude the federal antitrust agencies, or the Attorney General, from using other tests to determine if an ACO has market power.[22]

The mandatory preclearance for ACOs with a 50% or greater market share ensures those ACOs with the greatest anticompetitive potential are reviewed while the safe harbor for ACOs with a less than 30% market share ensures that those ACOs with little anticompetitive potential will be able to get off the ground quickly. Furthermore, the creation of special rules for ACOs in rural areas are appropriate, e.g., the exemption of ACOs in rural areas from pre-clearance, no matter how high are their market shares, so long as these ACOs include no more than one physician per specialty and that physician is included on a non-exclusive basis.

The Attorney General is familiar with circumstances in California's rural areas. ACOs have a far smaller pool of doctors and hospitals to draw from in rural areas.[23] Absent the proposed exception for ACOs in rural areas, the dearth of doctors in those areas would make mandatory preclearance quite certain for *all* ACOs in those areas. This would either deter the formation of ACOs in those areas by raising their costs or risk swamping the agencies with the unnecessary review of a host of rural ACOs.

Of particular interest to the Attorney General are the exclusivity provisions in the Proposed Policy Statement. Avoiding such exclusivity restraints is important to prevent ACOs from using their market power to increase health care costs by eliminating competition or preventing entry by new competitors.

Speaking generally, the "lock" up by one provider with a significant or dominant market share of another provider that formerly provided a competitive alternative has been shown to raise the prices

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[22] Patient flow data per specialty is a perfectly appropriate screen. But, demand analysis, either *the time-elasticity approach* (looking at travel elasticity pre-merger, e.g., the willingness to travel to save money as indicative of post-merger price elasticity), the *competitor share approach* (looking at individual services provided by different competitors and the heterogeneity of those services to determine relevant submarkets in which two or more providers operate), or the (preferred) *option demand approach* (factoring in the existence of patient restrictions to preferred networks), reveal that even if 30% of patients travel to distant hospitals, a merger can still, contrary to expectations, result in a price increase of 10% or more. Cory Capps, David Dranove, Shane Greenstein, & Mark Satterthwaite, *Antitrust policy and hospital mergers*, ANTITRUST BULLETIN (WINTER 2002) 679-82. That patients with one set of needs can travel further distances does not mean that patients with a different set of needs (or belonging to a lower-income demographic) will also travel as far. *Id.* at 714.

[23] *E.g.,* David Freed, *Rural areas try to locate doctors to avoid shortage*, S.F. GATE (Jan. 3, 2011), *available at* http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2011/01/03/BAFN1GV529.DTL (discussing shortage of doctors, particularly the primary-care physicians needed for ACOs, in rural areas).

paid by insurers (and ultimately the premiums by consumers) without any countervailing benefit such as an increase in better patient outcomes.[24] While this obviously occurs in the context of a merger, long-term and/or evergreen exclusivity agreements among providers can function as a *de facto* merger in that regard, with similar consequences for prices. Similarly, agreements by providers that *de facto* or *de jure* prevent insurers from choosing lower-cost providers also raise the prices paid by insurers (and ultimately the premiums by our consumers) without necessarily any countervailing benefit such as an increase in better patient outcomes.[25]

The exclusivity limitations in the Proposed Policy Statement that apply to dominant ACOs address those potential harms.[26] First, they require that any member of an ACO with a dominant market share in one or more specialties cannot lock itself up exclusively with that ACO such that it could force patients to use provider-members of that ACO in other specialties. Second, they prohibit any ACO with a dominant market share in one or more specialties from requiring an insurer to contract exclusively with the other members of the ACO. Third, they counsel dominant ACOs that they can reduce the likelihood of antitrust concerns by avoiding the imposition of exclusivity restraints set forth in a laundry list, including anti-steering provisions that prevent insurers from choosing certain providers, tying practices that can "leverage one empire into the next,"[27] and contracting with specialists on an exclusive basis (except for primary care physicians).

Exclusivity restraints are deemed anticompetitive only if the participants in the restraint have market shares that are sufficiently substantial that they can exercise market power, i.e., affect the prices that insurers can receive in a relevant market for medical services, or if the restraints have caused an actual anticompetitive effect in the increase of price or the diminution in quality. However, ACOs that have the significant potential to exercise market power and that employ such restraints may still

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[24] *See, e.g.,* Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care, supra* note 2; Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations at 1.

[25] *See, e.g.,* Richman, Frech, & Greaney, *Resisting Another Threat to Competition in Health Care, supra* note 2; Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations at 2-3; *see also* MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS, at 5, 41 (recommending barring such contractual prohibitions because they "perpetuate market disparities and inhibit product innovation").; David Dranove, Richard Lindrooth, William White, & Jack Zwanziger, *Is the impact of managed care on hospital prices decreasing?* 27 J. HEALTH ECON. 362-76 (2008) (refusal of consumers to accept being steered by managed care insurers to lower-cost hospitals led to price increases by hospitals).

[26] The Attorney General agrees that exclusivity restrictions covered by this Proposed Policy Statement should include those restrictions that operate in fact as well as those that operate in name.

[27] *See Eastman Kodak v. Image Technical Services*, 504 U.S. 451, 479 n.29 (1992); *Times-Picayune v. United States,* 345 U.S. 594, 611 (1953).

present incipient threats to competition.[28] Any ACO, whether it is in the dominant or grey area, should avoid any of the exclusivity restraints on the list. [29]

This list of anticompetitive restraints that dominant and grey area ACOs are strongly counseled to follow does include two non-exclusivity restraints. The need of ACOs that fall within the grey or dominant zones to avoid those restraints as well is of critical importance to ensuring competitive health care markets.[30] The first non-exclusivity restraint involves restricting an insurer's ability to make available to its beneficiaries (i.e., potential patients) significant information such as cost and quality necessary for those enrollees to evaluate and select providers in an insurance plan. The second non-exclusivity restraint involves the sharing of competitively-sensitive prices or other data among members of the ACO for services they provide outside of the ACO.

In particular, insurers have been prevented from disseminating cost and quality data to consumers, thus preventing consumers from evaluating providers and choosing the best ones based on cost and quality and thereby contributing to the dysfunctionality of health care markets.[31] Government

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[28] *See FTC v. Brown Shoe*, 384 U.S. 316 (1966) ; *Atlantic Refining Co. v. FTC*, 381 U.S. 357 (1965); *Sun Microsystems v. Microsoft*, 87 F.Supp.2d 992 (N.D. Cal. 2008).

[29] The Attorney General also agrees with the requirement that any hospital or ambulatory service center (ASC") participating in an ACO must be able to contract individually with other ACOs or with any insurer to fall within the safe harbor. Whether an ACO with a less than 30% market share could be found to violate the law if it nonetheless had such exclusivity restrictions is not the issue here. For example, certain hospitals can affect rates charged by insurers, or whether those insurers will get patient business, even if those hospitals or ASCs lack market power because they are "must have" providers for insurers. *See, e.g.,* Ha Tu & Joanna Lauer, *Issue of Health Care Price Transparency on Health Price Variation*, Findings from Health System Change, Issue Brief No. 128, at 3 (Nov. 2009) (document in possession of undersigned's staff) (noting that a hospital generally regarded as being the most expensive in the state was regarded as a "must have" hospital by patients even though there were three other hospitals close by). If an ACO can lock such a hospital into its network, it can leverage that "must have" status for its other provider-members at the expense of insurers and consumers. *See, e.g.,* Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations at 2; *cf. Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2008) (hospital used its position in being able to supply primary, secondary, and tertiary services to offer bundled discounts that competing hospital which supplied only primary and secondary services could not match on the condition that insurers designate it the sole preferred provider). It is fair therefore to ask as a trade-off for such safe harbor status that prospective ACOs not impose such restrictions.

[30] *See, e.g.,* Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations at 2 ("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.").

[31] *E.g.,* Ltr. from Blue Shield of California, Comments Relating to Workshop Regarding Accountable Care Organizations at 2 (("Furthermore, 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 abilities 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 rate 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."); MASSACHUSETTS ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 5, 41 (report recommends "[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, ..."); *see* Ha Tu & Joanna

rules that place more information in the hands of consumers to make informed decisions about cost can make a material contribution to the competitiveness of free markets and perhaps brake rising costs.[32]

Moreover, especially in concentrated markets, the sharing of current or future pricing or other competitively sensitive data among competitors has been found to be a presumptively anticompetitive restraint because it paves the way for overt or tacit price-fixing to the detriment of health care consumers and the general economy.[33] While such information-sharing has been properly excused in joint ventures which set an integrated price for their services, such sharing is not excused if it occurs on services that are not produced by the joint venture.[34]

However, we do have comments for your agencies to consider as to a couple of points in the Proposed Policy Statement. Those comments are as follows:

1. Underserved low-income urban areas are in similar dire straits as rural areas because of a similar dearth of doctors and hospitals. The Attorney General believes that sources of data may exist that could be used to define what would be an underserved urban area.[35] Accordingly, the Attorney General respectfully suggests that your agencies consider an extension of the Rural Exception of the

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Lauer, *Issue of Health Care Price Transparency on Health Price Variation*, , *supra* note 29 (2007 price transparency law of New Hampshire had by 2009 not eliminated price variation but it had dampened provider demands for large rate increases; New Hampshire stakeholders believed it would have a greater effect in a community with strong provider competition such as Los Angeles); *see generally* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care,* 5 AM. ECON. REV. 941, *supra* note 5 (medical insurance market does not act in a competitive fashion because of uncertainty due to a lack of knowledge of provider prices by consumers, the unpredictable and costly nature of remedying one's health, and uncertainty as to quality of medical care).

[32] F.A. Hayek, THE ROAD TO SERFDOM, 45 (1944) ("An effective competitive system needs an intelligently designed and continuously adjusted framework as much as any other. Even the most essential prerequisite of its proper functioning, the prevention of fraud and deception (including exploitation of ignorance), provides a great and by no means fully accomplished object of legislative activity."); *see, e.g.,* Ha Tu & Joanna Lauer, *Issue of Health Care Price Transparency on Health Price Variation*, *supra* note 29 (2007 price transparency law enacted in New Hampshire to lower costs); *cf.* CAL. STATS. 2010, Ch. 655, §6(c)-(e), *available at* http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html (California passed law requiring transparency on insurance products offered through the exchange so that consumers could do a comparative evaluation and make an informed choice).

[33] *See United States v. United States Gypsum*, 438 U.S. 422, 457 (1978).

[34] *See Texaco, Inc. v. Daugher*, 547 U.S. 1, 8 (2006) (restraint on pricing must be necessary to the joint venture).

[35] For example, the Health Resources and Services Administration ("HRSA") seems to track this information and make it available to the public. HRSA uses this information to create the following areas for tracking purposes: "Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility)." *See* http://muafind.hrsa.gov/index.aspx (last visited May 3, 2011).

Proposed Policy Statement to underserved low-income urban areas.[36]

2. We interpret the Proposed Policy Statement as requiring a careful analysis of the procompetitive impact of a proposed ACO on the commercial insurer side, as well as the Medicare side, to ensure that it is delivering benefits to patients covered by commercial insurance as well as patients covered by Medicare.[37] We further interpret the Proposed Policy Statement as requiring a careful analysis of the anticompetitive effects of the proposed ACO on the commercial insurer side as well as the Medicare side.[38] However, the Proposed Policy Statement does not expressly state what happens if the proposed ACO has anticompetitive effects on balance insofar as commercial enrollees are concerned but not insofar as Medicare patients are concerned. Although this scenario of a disparate impact may be rare, your agencies should expressly provide that clearance may be denied in such circumstances.[39]

3. ACOs with their own insurance arms can be beneficial for consumers and patients; they can provide lower-cost, higher-quality medical care in competitive markets via the tight integration of medical services and using growth rather than acquisition to extend the services they provide. A historic example of such an ACO has been Kaiser Permanente in California. Nonetheless, the Attorney General is concerned that ACOs with their own insurance arms may choose to "lock out" rival insurers either by purchasing providers or by locking up providers in long-term or evergreen exclusivity restraints. In turn, those tactics may lessen competition and increase health care costs even if the ACO were in fact delivering integrated health care that benefitted patients. To avoid confusion, your agencies should clarify that ACOs may not decide to reject the guidance set out in the Proposed Policy Statement on avoiding exclusivity restraints (or complying with exclusivity restraints) merely because they own their own insurance arm.

4. ACOs with a market share below 50% will not be subject to reassessment under the

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[36] *Cf.* CMS NPRM on ACOs at 49 (goals of the program are "to allow for greater opportunities for broadly transforming the health care delivery system and increasing access to high quality and lower cost care under the Shared Savings Program for Medicare beneficiaries regardless of where they live.").

[37] DEPT. OF JUSTICE & FED. TRADE COMM'N, PROPOSED STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PLAN (2011) ("Further, if a CMS-approved ACO provides the same or essentially the same services in the commercial market, the Agencies have determined that the integration criteria are sufficiently rigorous that joint negotiations with private-sector payers will be treated as subordinate and reasonably related to the ACO's primary purpose of improving health care services.").

[38] For example, the documents that must be supplied by a dominant ACO that is required to undergo mandatory clearance expressly cover both the Medicare and commercial insurance markets. *Id.*

[39] The Proposed Policy Statement states only that proposed ACOs on the commercial insurer side which meet the CMS' regulations for a sufficient integration will receive "rule of reason treatment." *Id.*

standards of the Proposed Policy Statement if a subsequent growth in market share arises because it attracted more patients (as opposed to a change in provider composition). Reading these standards in context, the Attorney General believes that this exception for patient growth does not apply if the growth in patients does not arise from the successes of the ACO in improving patient care but rather from anticompetitive restraints such as those which your agencies counsel against in the Proposed Policy Statement. However, the Proposed Policy Statement does not state this point expressly.

Conclusion

Ensuring that our consumers will have available to them ACO options that can markedly improve their health is a top priority for us. At the same time, we do not want ACOs that serve primarily as a mechanism for increasing the fees charged to insurers (and ultimately the premiums paid by our consumers) with very little in the way of improved patient outcomes to show for it. We therefore welcome the Proposed Policy Statement as having laid out a set of principles and processes that properly strike this balance.[40]

Health care issues can best be addressed by my office and your agencies working hand-in-glove. In that spirit, you will hopefully find our comments and suggestions to be helpful to you. We look forward to the opportunity to work closely with you on ACOs and other health care issues going forward in order to bring competition and choice to the health care markets.

Sincerely,

KAMALA D. HARRIS
Attorney General of the State of California

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[40] The Attorney General may have special responsibilities in the review of ACOs, e.g., if the proposed ACOs involve a transfer of control by non-profits to for-profits in which case a "public interest" standard of review by the Attorney General may apply - *see, e.g.*, CAL. CORP. CODE §§5914, 5917, or if state or local government entities are involved in the formation of the ACO. The Attorney General will endeavor to execute our special responsibilities here in a manner that does not inappropriately discourage ACOs. *Cf. e.g.,* CMS NPRM on ACOs at 56 ("Moreover, our intent is to encourage not-for-profit, community-based organizations to participate in the Shared Savings Program.").