blue of california

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.[1] Further, we have found that market share often is not an adequate measure of provider market power and leverage.

[1] 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.

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.[2] 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);

[2] 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.

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