



# DEPARTMENT OF JUSTICE

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## **Competition and Health Care: A Prescription for High-Quality, Affordable Care**

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**Remarks as Prepared for the  
World Annual Leadership Summit on  
Mergers and Acquisitions in Health Care**

**Orlando, Florida**

**March 19, 2012**

Good afternoon. I am pleased to have this opportunity to talk about the Antitrust Division's work in the health care industry and the essential role competition plays in the development of effective and efficient health care markets.

The cost of health care in the United States remains an important concern for American consumers. The challenges we face in controlling such costs and also providing a better health care system are numerous and complex and, in many cases, in the domain of the Department of Health and Human Services (HHS) or other federal or state agencies. But the antitrust agencies also have a role in ensuring competitive markets, which lower costs, encourage innovation, and enhance quality and choice for American consumers. The Affordable Care Act, and with it the opportunity for greater innovation and consumer choice, only increases the importance of our efforts.<sup>1</sup> Therefore, the Antitrust Division has made promoting and protecting competition in the health care industry one of its top priorities.

Today, I will focus on our activities in two key sectors of the health care industry—health insurance and health care provider markets—both areas where the division seeks to promote open and vigorous competition.

As you know from your own experience, insurance and provider markets present distinct challenges and opportunities for competition. The division recognizes that many health insurance markets are highly concentrated, which increases the risks to competition from mergers or exclusionary conduct in those markets. In health care provider markets, we support and applaud physicians, hospitals, and other providers when they find procompetitive, innovative ways to control costs and improve the quality

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<sup>1</sup> Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (2010); Patient Protection and Affordable Care Act, Pub. L. No. 111-48, 124 Stat. 119 (2010).

of health care. However, providers too must avoid engaging in exclusionary practices that reduce competition, such as using seemingly quality-improving or cost-reducing measures simply to raise prices.

By sharing with you the Antitrust Division's accomplishments during the last three years in these two vitally important sectors of the health care industry, I will offer insights on the processes and analysis used by the Antitrust Division when we consider competition issues in the health care sector in both the merger and non-merger areas. When the Antitrust Division investigates the competitive effects of a proposed merger, we consider whether the "effect of [such an] acquisition may be substantially to lessen competition, or to tend to create a monopoly."<sup>2</sup> Our concern in merger review is the competitive market structure, and our job is to prevent anticompetitive harms.

The division is also committed to bringing enforcement actions to stop non-merger anticompetitive behavior. Through such actions, the division aggressively pursues exclusionary or collusive practices that might eliminate competitors, deter entry, or reduce rivals' incentives to compete. There can be no doubt that vigorous and responsible antitrust enforcement through these means is crucial if we are to benefit from innovation and efficiency in our health care delivery system and stem the rise of health care costs in both the public and private sectors.

The role of effective competition advocacy is also important and supplements our enforcement efforts. Since passage of the Affordable Care Act, the division's competition advocacy and regulatory outreach efforts have been particularly focused on the newly-devised health insurance exchanges and Accountable Care Organizations (ACOs). Our advocacy efforts help ensure that regulation and competition function

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<sup>2</sup> 15 U.S.C. § 18.

effectively together to lower cost, expand choice, and improve quality. These efforts are important—if we miss the chance to be involved as our health care system undergoes significant reform, the effectiveness of antitrust enforcement could be much more limited.

In short, both enforcement and advocacy are key to securing efficient and well-functioning markets for health care consumers and promoting economic freedom and fairness for all stakeholders in the health care industry.

## **I. Competition in Health Insurance Markets**

At the beginning of this Administration, the Antitrust Division recognized that competition in health insurance markets was critical to lowering the cost of health care delivery and acted immediately to focus its efforts there. Since that time, we have been active with investigations and enforcement actions directed at anticompetitive mergers and exclusionary conduct. Moreover, as new health care delivery systems develop and reform takes shape under the Affordable Care Act, health insurance markets, in particular, can benefit from greater transparency, certainty, and active competition advocacy.

### **A. Merger Cases**

The Antitrust Division reviews all mergers closely. But due to the market structures we have seen in many health insurance markets, careful review of mergers in this sector is particularly important.

To help ensure clarity, certainty, and transparency, it is important for the health insurance industry to understand when we do and do not challenge a merger. The recently revised Horizontal Merger Guidelines, which are publicly available on the division's website, are among the most important articulations of our analytical techniques and enforcement practices and policies with respect to mergers of actual or potential competitors.<sup>3</sup> These Guidelines reflect the principle that mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise.

Our recent enforcement actions, and our public filings and statements in those cases, are important signposts for the division's merger enforcement approach. Vigorous enforcement includes efficient and effective determination of whether a proposed transaction raises competitive concerns. Thus, whenever a merger does not raise competitive concerns, the division will let the parties know in the timeliest manner possible so they can proceed with closing the transaction. On the other hand, we are committed to going to court to block those health insurance mergers that will substantially reduce competition and harm consumers. In some of those cases, however, parties will offer a remedy to address our competitive concerns, and if we conclude that a remedy will eliminate the anticompetitive aspects of a merger, we will enter into a settlement with the parties and allow the transaction to proceed.

In recent years, the division has brought a number of enforcement actions against health insurance mergers. For example, in 2010, the division informed Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan (PHP) of our intent to challenge their plans to merge, leading the companies to abandon the proposed

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<sup>3</sup> U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (rev. ed. 2010), available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.pdf>.

transaction.<sup>4</sup> Blue Cross-Michigan had almost a 70 percent market share in Lansing, Michigan, while PHP, its largest competitor, had a market share of approximately 20 percent.

We determined that the merger would have harmed competition in the Lansing market for commercial group health insurance as well as for the purchase of physician services. Because these two companies were each other's most significant rivals, the merged firm likely would have increased prices in the wake of a merger—in fact, we found that it was competition between the two companies that had led them to offer lower prices, better service, and more innovative products to employers and their employees. The acquisition also would have given Blue Cross-Michigan the ability to control physician reimbursement rates in a manner that could have harmed the quality of health care delivered to consumers.

In a more recent case, in November 2011, the Antitrust Division and the Montana Attorney General's Office filed a complaint against Blue Cross Blue Shield of Montana challenging its exclusive agreement with the owners of New West, a competing insurance company.<sup>5</sup> The proposed transaction would have eliminated New West as a viable competitor in the sale of commercial health insurance to the detriment of Montana consumers.

Several Montana hospitals formed New West to challenge Blue Cross's "dominating presence." New West grew to become the third-largest commercial health

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<sup>4</sup> Press Release, U.S. Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans (Mar. 8, 2010), *available at* [http://www.justice.gov/atr/public/press\\_releases/2010/256259.pdf](http://www.justice.gov/atr/public/press_releases/2010/256259.pdf).

<sup>5</sup> Complaint, United States v. Blue Cross and Blue Shield of Mont., Inc., No. 1:11-cv-00123 (D. Mont. Nov. 8, 2011), *available at* <http://www.justice.gov/atr/cases/f277100/277177.pdf>.

insurer in Billings, Bozeman, Helena, and Missoula. Approximately one-third of New West's customers were the employees of its six hospital owners.

Blue Cross entered into an agreement with five hospital owners of New West to make Blue Cross the exclusive insurance provider of the hospitals' employees for six years. The agreement also offered two seats on Blue Cross's board of directors to the hospitals that did not own or belong to an entity (specifically, New West) that competes against Blue Cross. The agreement would have deprived New West of one-third of its customer base and destroyed the incentives of New West's owners to compete against Blue Cross. The owners likely would have pushed New West to exit the market.

At the same time that the division filed this case, it also filed a settlement that required New West to divest its remaining commercial health insurance business to a third party with the intent and capability of effectively competing in the commercial health insurance market in Montana.<sup>6</sup> That third party is PacificSource, a health insurer based in Oregon. Moreover, New West's hospital owners must participate in PacificSource's network on terms that are substantially similar to their existing contractual terms with New West, ensuring that PacificSource has a network of health care providers at competitive rates and is able to compete effectively against Blue Cross. As a result of this settlement, competition has been restored to this market, with what we hope will be another competitor with an effective provider network.

These cases are just two public examples of the division's commitment to carefully review mergers in the health insurance industry and challenge those mergers that may substantially lessen competition in properly defined markets.

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<sup>6</sup> Proposed Final Judgment, *Blue Cross and Blue Shield of Mont.*, No. 1:11-cv-00123 (D. Mont. Nov. 8, 2011), available at <http://www.justice.gov/atr/cases/f277100/277165.pdf>.

While our analysis of health insurance mergers has not changed, our willingness to accept that entry can and will occur to constrain the merged firm will be reviewed carefully and with some skepticism. To refine and expand our understanding of market structures and dynamics in health insurance markets, the division recently undertook an extensive review of entry and expansion in the health insurance industry. We looked to sources both inside the division, which has extensive experience conducting health insurance investigations, and outside, through interviews of insurance brokers, economists, state officials, and health plans.

As a result of this review, we reached several important conclusions. We confirmed that there is a significant obstacle of scale because entrants into health insurance markets need provider discounts, but they also need a large number of enrollees to negotiate those discounts. Importantly, we found that in less concentrated markets, new entrants or niche players tend to receive discounts comparable to their competitors'—which is not the case in markets dominated by one or two plans. Thus, it may be harder to enter markets with one or two dominant plans than markets with several large but relatively equal-sized insurers, which undercuts the critical economic assumption in antitrust analysis—namely, that the higher profits often associated with concentrated markets will attract new entrants who will help restore competitive pricing.

Moreover, our interviews reconfirmed that brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates. Our concerns about strong barriers to entry and expansion in health insurance markets mean that we will devote more attention to entry analysis to

protect these markets from harmful consolidation and that it may be even more important to preserve the choices already available.

**B. Conduct Cases**

In addition, and as I suggested at the beginning of my remarks, the division aggressively pursues dominant health insurers that abuse their market power through anticompetitive conduct to eliminate competitors, deter entry, or dull rivals' incentives to compete. These cases are vital to preventing further illegal consolidation and to lowering concentration by preserving conditions for increasing competition and innovation.

In October 2010, the division filed a complaint to prevent Blue Cross Blue Shield of Michigan from using anticompetitive agreements with Michigan hospitals that the division alleges stifle competition and raise health insurance prices for Michigan consumers.<sup>7</sup> This case is ongoing but as alleged in the complaint filed with the court, Blue Cross's contracts with hospitals included provisions known as "Most Favored Nation" clauses, or MFNs. We allege that these MFNs guarantee that no other insurer can get a better rate than Blue Cross. Some Blue Cross MFNs—"MFN-plus" agreements—require that competitors pay higher rates, sometimes much higher, than Blue Cross. Without Blue Cross's MFNs, some hospitals had an incentive to offer lower prices to other insurers to increase competition in the hospital's service area. With these MFNs, some hospitals that do not raise their prices to competing health care plans risk being paid less by Blue Cross, the dominant insurance provider in Michigan. Blue Cross's MFNs inhibit competitive entry and expansion from other health insurance plans and likely raise insurance rates.

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<sup>7</sup> Complaint, *United States v. Blue Cross Blue Shield of Mich.*, No. 2:10-cv-14155 (E.D. Mich. Oct. 18, 2010), available at <http://www.justice.gov/atr/cases/f263200/263235.pdf>.

The division alleges that Blue Cross insures more than 60 percent of Michigan's commercially insured population. In recent years, Blue Cross became concerned because competition from other insurers was eroding its hospital discount advantage. Blue Cross has contracts including MFNs with more than half of the general acute care hospitals in Michigan. As a result, consumers in Michigan are likely paying more for their health care services and health insurance.

The division's lawsuit seeks to stop these anticompetitive practices quickly so that consumers in Michigan will benefit. In August 2011, the division, along with the Michigan Attorney General, prevailed against Blue Cross's motion to dismiss.<sup>8</sup> The lower court articulated several reasons why Blue Cross's motion failed. Significantly, the court ruled that the anticompetitive effects of MFNs alleged in the complaint are plausible and, therefore, cannot be evaluated without a factual inquiry. The court also rejected Blue Cross's claim to state action immunity. Blue Cross claimed immunity as a quasi-public entity operating in a regulated industry. However, the court determined Blue Cross is a private entity. The courts require parties seeking state action immunity to meet significant factual prerequisites before successfully invoking immunity. And with no state policy articulating an intent to displace competition with regulation and no active state supervision of Blue Cross's MFNs, the court determined Blue Cross was not entitled to state action immunity. The Court of Appeals in the Sixth Circuit recently dismissed Blue Cross's appeal of this lower-court decision.

The Blue Cross case is significant for Michigan and more broadly for the rest of the country. Any time a dominant insurer uses anticompetitive MFNs, the market can

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<sup>8</sup> *Blue Cross Blue Shield of Mich.*, No. 2:10-cv-14155 (E.D. Mich. Aug. 12, 2011) (order denying motion to dismiss).

suffer. The Antitrust Division will vigorously pursue anticompetitive MFNs and other agreements and transactions that stand in the way of consumers' access to affordable health care and competitive prices.

Indeed, our experience in the Michigan case led us to believe we might find similar practices in other parts of the country. Accordingly, in coordination with state Attorneys General, the division sought to identify the types of MFN clauses and market conditions that would make it likely that a dominant insurer's use of MFNs or similar provisions would harm competition. Working with every state, the District of Columbia, and Puerto Rico, we have combined the division's MFN expertise with the states' knowledge of local market conditions to open investigations of various MFN clauses in a number of markets.

Finally, and equally important, these enforcement actions have signaled to dominant insurers across the nation that the Antitrust Division will examine carefully any contracting practices that may undermine competitors' ability to effectively compete in the marketplace.

### **C. Competition Advocacy and Health Insurance Exchanges**

As I noted at the outset, advocacy is another critical tool the division uses to promote competition. Advocacy is particularly significant in light of health care reform and the development of new state-based health insurance marketplaces called exchanges. The exchanges will offer individuals and small employers a range of competing health insurance products that might otherwise be unavailable or unaffordable, with the goals of ultimately providing better quality health care to more Americans while reducing the rising cost of health care. However, health care insurers also must have the incentive and

opportunity to compete vigorously in the exchanges. The division has been working, and will continue to work, closely with HHS and the states to help ensure that is the case.

Many health insurance markets have one or two dominant insurers, and, as I explained earlier, it can be extremely difficult for new insurers to enter these markets. Accordingly, the exchanges should encourage insurance companies to enter markets and to prevent incumbent, dominant insurers from hampering competition through exclusionary or collusive conduct. As our enforcement actions demonstrate, dominant insurers can engage in a variety of exclusionary practices that hinder competition within the exchanges and violate the antitrust laws.

Likewise, the exchanges also need to guard against the potential for exchange participants or applicants to engage in bid rigging, price fixing, market allocation, or other collusive conduct that invariably and directly harms consumers through higher prices or reduced choice. Such conduct typically amounts to blatant violation of the antitrust laws. The Antitrust Division stands ready to work with exchange operators and regulators, as well as with state Attorneys General, to detect, prevent, and, if appropriate, punish those violations.

Finally, let me be clear that the division fully recognizes that the exchanges will need to carefully balance the benefits and costs of regulatory oversight against those of competition. However, we firmly believe that the power of market incentives can work with and greatly assist regulation in providing consumers access to high-quality, affordable health care.

## **II. Competition in Provider Markets**

As is true in the health insurance market, robust competition among health care providers also is imperative to improving the quality and controlling the cost of health care. The Antitrust Division encourages legitimate endeavors among health care providers to improve quality and control costs. As part of its competition advocacy mission, the division provides antitrust guidance for such endeavors through business review letters,<sup>9</sup> formal guidelines, and policy statements.<sup>10</sup> Just this past October we issued the joint DOJ/FTC *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (the “Policy Statement”),<sup>11</sup> which I will discuss today. And, the Division’s enforcement actions demonstrate, we are on the lookout for agreements or arrangements purported to improve quality but where the real goal is simply to raise prices. Those we will not tolerate.

#### A. Cases

The Antitrust Division is particularly concerned about markets where a dominant hospital can use contracting practices or agreements to shore up or expand its market power or where a dominant hospital and a dominant health plan might find it mutually advantageous to protect each other’s market power rather than encourage and support

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<sup>9</sup> The division’s business review program is an important avenue for effective competition advocacy in the health care industry. *See, e.g.*, Letter from Christine A. Varney, Assistant Att’y Gen., U.S. Dep’t of Justice, Antitrust Div., to Mit Spears, Esq. (Apr. 26, 2010), *available at* <http://www.justice.gov/atr/public/busreview/258013.pdf> (approving the formation of a data exchange program for hospital services); Letter from Christine A. Varney, Assistant Att’y Gen., U.S. Dep’t of Justice, Antitrust Div., to T. Mills Fleming, Esq. (Sept. 4, 2009), *available at* <http://www.justice.gov/atr/public/busreview/249766.pdf> (approving hospitals’ entrance into an exclusive joint purchasing agreement with respect to the purchase of certain medical and surgical supplies).

<sup>10</sup> *See, e.g.*, U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), *available at* <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>; U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), *available at* <http://www.ftc.gov/reports/hlth3s.pdf>.

<sup>11</sup> Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011), *available at* <http://www.ftc.gov/os/fedreg/2011/10/111020aco.pdf>.

competition at either level. Moreover, because entry into hospital markets already is hard, there is sound justification for careful antitrust scrutiny of contracts or other agreements involving dominant hospitals that might further deter competition.

For example, just last year the division reached a settlement that successfully concluded its case against the United Regional Health Care System of Wichita Falls, Texas.<sup>12</sup> The division alleged that United Regional engaged in unlawful monopolization in violation of Section 2 of the Sherman Act.<sup>13</sup> This was the first case brought by the division since 1999 that challenges a monopolist with engaging in traditional anticompetitive unilateral conduct.

United Regional had a monopoly in hospital services in Wichita Falls with 90 percent of the general acute-care inpatient hospital services and more than 65 percent of outpatient surgical services. It was the region's only provider of certain essential services, such as cardiac surgery, obstetrics, and high-level trauma care. To preserve its monopoly, United Regional entered into exclusionary contracts with almost all of the insurers in Wichita Falls. These contracts exacted substantial penalties on health insurers if they contracted with United Regional's competitors and were effective at inhibiting entry and expansion by its competition. Thanks to its monopoly, United Regional was among the most expensive hospitals in Texas. It charged commercial health insurers 70 percent more than its closest competitor for the same inpatient hospital services.

The settlement, which the Northern District of Texas approved in September 2011, prohibits United Regional from entering into or enforcing exclusionary contracts or

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<sup>12</sup> Final Judgment, *United States v. United Reg'l Health Care Sys.*, No. 7:11-cv-00030 (N.D. Tex. Sept. 29, 2011), available at <http://www.justice.gov/atr/cases/f276000/276027.pdf>.

<sup>13</sup> Complaint, *United Reg'l Health Care Sys.*, No. 7:11-cv-00030 (N.D. Tex. Feb. 25, 2011), available at <http://www.justice.gov/atr/cases/f267600/267651.pdf>.

taking any retaliatory action. The result is helping restore competition for the residents of Wichita Falls on the price and quality of their health care services. Indeed, some insurers have already begun contracting with United Regional's rivals.

Also, in May 2010, the division and the Idaho Attorney General's Office filed a civil antitrust suit against the Idaho Orthopedic Society, an orthopedic practice group, and five orthopedists.<sup>14</sup> The division reached a successful settlement to prohibit the competing Idaho orthopedists from conspiring with one another, which the court approved in August 2010.<sup>15</sup>

The named defendants entered into two conspiracies between 2006 and 2008. In the first conspiracy, through a series of meetings and communications, the defendants agreed not to treat most patients covered by workers' compensation insurance. The group boycott resulted in a shortage of orthopedists willing to treat workers' compensation patients and led to higher rates for orthopedic services. In the second conspiracy, most of the defendants conspired and threatened to terminate their contracts with Blue Cross of Idaho unless Blue Cross offered better rates.

The division's settlement prevents the Idaho Orthopedic Society and the named individual defendants from agreeing with their competitors on fees and contract terms. The settlement also prohibits them from collectively denying medical care to patients, refusing to deal with any payer, or threatening to terminate contracts with any payer.

## **B. Competition Advocacy**

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<sup>14</sup> Complaint, *United States v. Idaho Orthopedic Soc'y*, No. 1:10-cv-00268 (D. Idaho May 28, 2010), available at <http://www.justice.gov/atr/cases/f259200/259206.pdf>.

<sup>15</sup> Final Judgment, *Idaho Orthopedic Soc'y*, No. 1:10-cv-00268 (D. Idaho Aug. 30, 2010), available at <http://www.justice.gov/atr/cases/f262000/262061.pdf>.

The division's competition advocacy program is important in provider markets as well. For example, in May 2011, the division provided comments on the Tennessee state legislature's consideration of a bill to repeal the state's antitrust exemption for public hospitals.<sup>16</sup> In 2005, the U.S. Court of Appeals for the Sixth Circuit held that a provision in Tennessee law creates an antitrust exemption for public hospitals for a wide range of potentially anticompetitive actions, including exclusive contracts with health insurers.<sup>17</sup> The division has long opposed unwarranted extensions of the state action doctrine, and indicated that repealing the state action exemption for public hospitals in Tennessee will likely promote competition and benefit consumers. As our comments noted, anticompetitive conduct by dominant hospitals—including dominant public hospitals—can lead to higher prices and lower quality for health care consumers. Since competition advocacy is likely the only avenue for promoting and protecting competition in this context, the division has been active in providing states with comments and guidance to ensure that they protect their own consumers while also fully preserving the role of federal antitrust enforcement.<sup>18</sup>

Finally, let me return to the division's most recent efforts to provide antitrust guidance to health care providers that want to pursue new business models aimed at improving the quality and reducing the cost of health care without running afoul of the antitrust laws. Section 3022 of the Affordable Care Act encourages health care providers to form Accountable Care Organizations—or ACOs—to deliver more efficient, high-

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<sup>16</sup> Letter from Joshua Soven, Chief, Litigation I Section, Antitrust Div., U.S. Dep't of Justice, to State Rep. Phillip Johnson (May 18, 2011), *available at* <http://www.justice.gov/atr/public/comments/271584.pdf>.

<sup>17</sup> Jackson, Tenn. Hosp. Co., LLC v. West Tenn. Healthcare, Inc., 414 F. 3d 608 (6th Cir. 2005).

<sup>18</sup> For example, the division also filed comments regarding the Michigan state legislature's consideration of certificate of need requirements for new facilities offering important cancer treatments. Relying on the division's analysis, the Governor of Michigan vetoed the legislation. Letter from Joseph Miller, Assistant Chief, Litigation I Section, Antitrust Div., U.S. Dep't of Justice, to State Sen. Michael D. Bishop (Jun. 6, 2008), *available at* [www.justice.gov/atr/public/comments/234407.pdf](http://www.justice.gov/atr/public/comments/234407.pdf).

quality care to Medicare fee-for-service beneficiaries under the new Medicare Shared Savings Program.<sup>19</sup> However, providers wanted, among other things, additional antitrust guidance and clarity before forming ACOs, particularly ACOs that would also operate in the commercial market. The division and the FTC responded. First, we sought to identify and understand the key antitrust concerns of health care providers and other stakeholders in the industry. Then, after more than a year of close coordination with HHS and other federal agencies, in October 2011, the division and the FTC issued their joint ACO Policy Statement.<sup>20</sup>

The division and the FTC recognize that ACOs under the Medicare Shared Savings Program have the potential to bring about higher quality care and cost savings that can benefit both Medicare beneficiaries and commercially insured patients. At the same time, we recognize that collaboration among competing health care providers—as will likely occur through many of these ACOs—may raise competitive concerns if the ACOs obtain market power or otherwise engage in anticompetitive conduct. The Policy Statement, therefore, seeks to help providers form procompetitive ACOs that can benefit both Medicare beneficiaries and patients with private health insurance while protecting health care consumers from higher prices and lower quality.

At the outset, the Policy Statement makes clear that all ACOs that participate in the Medicare Shared Savings Program and use the same governance and leadership structures and clinical and administrative processes to service patients in both the

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<sup>19</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-48, § 3022, 124 Stat. 119, 395-99 (2010). Specifically, under this provision, “groups of providers of services or suppliers meeting criteria specified by the [Department of Health and Human Services] Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an [ACO].” 124 Stat. at 395.

<sup>20</sup> The division and the FTC also coordinated closely with the Center for Medicare and Medicaid Innovation (CMMI), the new Innovation Center in the Centers for Medicare and Medicaid Services (CMS), as it sought to develop, test, and expand innovative payment and delivery systems, including a Pioneer ACO program.

Medicare and commercial markets will be analyzed under the rule of reason. The rule of reason weighs the potential harm to competition against the likely efficiencies, such as quality improvements or cost savings.

For rule of reason treatment to apply to ACOs comprised of otherwise competing providers, the ACO must be integrated, either financially, clinically, or both, and any joint pricing must be reasonably necessary to achieve the benefits of that integration. Accordingly, the division and the FTC worked closely with CMS to ensure that the clinical, administrative, and management requirements for ACOs under the Medicare Shared Savings Program are essentially consistent with the indicia of clinical integration that the antitrust agencies have recognized and accepted in other circumstances.<sup>21</sup> In effect, the antitrust agencies and CMS recognized that ACOs need to be clinically integrated to achieve the goals of the Medicare Shared Savings Program. At the same time, however, neither CMS nor the antitrust agencies want to be unduly prescriptive or confine providers to one specific delivery model. Rather, the ACO rules aim to encourage providers continually to innovate and develop better ways of improving care, utilizing health IT, controlling costs, and increasing coordination overall. The ultimate objective is that ACOs and ACO participants commit to the necessary changes in leadership, management, and clinical structures and procedures that will lead to real cost containment and quality improvements. Moreover, CMS will collect and evaluate cost,

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<sup>21</sup> See, e.g., FED. TRADE COMM'N, BUREAU OF COMPETITION, TRISTATE HEALTH PARTNERS, INC. ADVISORY OPINION (Apr. 13, 2009), *available at* <http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf>; FED. TRADE COMM'N, BUREAU OF COMPETITION, HEALTH CARE DIV., FOLLOW-UP TO 2002 MEDSOUTH, INC. STAFF ADVISORY OPINION (June 18, 2007), *available at* <http://www.ftc.gov/bc/adops/070618medsouth.pdf>; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 8 (1996), *available at* <http://ftc.gov/reports/hlth3s.pdf>.

utilization, and quality data from all participating ACOs to ensure that these goals are met.

In addition to affording rule of reason treatment to all ACOs in the Medicare Shared Savings Program, the Policy Statement provides a 30 percent antitrust safety zone for ACOs that are highly unlikely to raise competitive concerns. The antitrust agencies will not challenge ACOs that fall within the safety zone, absent extraordinary circumstances. However, an ACO can include one physician or physician group practice per specialty from a rural area as well as rural hospitals on a non-exclusive basis and still fall within the safety zone, regardless of share.

Importantly, the Policy Statement emphasizes that the safety zone is simply that—a safety zone. ACOs that fall outside the safety zone may be perfectly lawful and procompetitive. At the same time, the Policy Statement provides some guidance on circumstances that could present competitive concerns. Notably, the Policy Statement makes clear that all ACOs should avoid sharing price or other sensitive competitive information about how they compete outside the ACO. The Policy Statement also describes other conduct that ACOs with market power may wish to avoid to minimize competitive problems, including exclusive contracting with ACO providers or tying sales of the ACO's services to services outside the ACO.

Finally, the Policy Statement allows all ACOs formed after March 23, 2010, and not yet participating in the Medicare Shared Savings Program, to obtain expedited antitrust review from the division or the FTC, and CMS has encouraged newly formed ACOs with any antitrust concerns to take advantage of this opportunity.

In sum, the division and the FTC have worked closely with CMS and other federal agencies to provide clear and consistent guidance to health care providers that want to form beneficial, procompetitive ACOs. Our goal is to encourage and support the formation of innovative ACOs that will provide Americans with high-quality, cost-effective health care, while ensuring that competition is not harmed. The division will continue to monitor health care markets and vigorously enforce the antitrust laws, consistent with this Policy Statement and the goals of the Medicare Shared Savings Program.

### **III. Conclusion**

We are at a critical juncture for our nation's health care system and also at a critical time for antitrust enforcement. The success of health care reform will depend as much upon healthy competitive markets as it will upon regulatory change. If health care reform is to produce more efficient systems, bring health care costs under control, and provide higher-quality health care delivery, then we must vigorously combat anticompetitive mergers and conduct that harm consumers with responsible antitrust enforcement. We will also continue our advocacy and inter-governmental efforts to ensure that competition policy actively guides and encourages innovation in our health care delivery systems, while promoting fair and competitive markets for all stakeholders in the health care industry.