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## AHIP Statement on ACO Regulations

Washington, DC – America’s Health Insurance Plans’ (AHIP) President and CEO Karen Ignagni released the following statement on the regulations released today by the Department of Health and Human Services on accountable care organizations (ACOs):

“Moving the health care system away from the outdated fee-for-service system to one that incentivizes quality and value will improve patient care and help put the nation’s health care system on a sustainable path. All across the country, health plans have partnered with providers to change payment models and create accountable care arrangements that are yielding significant results in improved quality, better health outcomes, and lower costs for patients and employers. A recent article in *Health Affairs* found that not all providers are equally prepared to enter into accountable care arrangements and that flexibility and the technical assistance and support of health plans will be key to the success of these arrangements. Through the CMS Innovation Center, there is an opportunity for Medicare and Medicaid to build on the successful programs that exist in the private marketplace today.

“The ACO program takes important steps towards achieving greater accountability and better quality care for patients across our health care system. Through this program, providers are incentivized to make critical investments in infrastructure and to redesign their care processes to meet new quality and cost targets. We appreciate that the agency is striving to achieve better alignment of quality metrics across the entire Medicare program by using measures similar to those used in the Medicare Advantage program and by focusing on the domains that are highlighted in the National Quality Strategy. However, the ACO program should move away from the traditional Medicare fee-for-service payment model and instead reimburse doctors and hospitals based on improving the quality, safety, and efficiency of patient care, rather than the volume of services provided.

“We appreciate that the Department of Justice (DOJ) and the Federal Trade Commission (FTC) today acknowledged the importance of protecting consumers from competitive harm, but we remain concerned about the trend of provider consolidation that drives up medical prices and results in additional cost-shifting to families and employers with private coverage. The initial regulation created an antitrust screening mechanism that would have protected consumers with a mandatory up-front antitrust review and exclusion from the program for those ACOs facing a legal challenge. Doing away with the mandatory review process raises concerns that provider market power may not be scrutinized sufficiently, potentially increasing health care costs for consumers and employers. We urge the DOJ and the FTC to take steps to ensure the ACO process is transparent and there is vigorous oversight and enforcement of antitrust laws to protect consumers and employers from higher prices and cost-shifting that could result from increased provider consolidation.”

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### Previous Statements by the Anti-Trust Agencies on the Potential Harm to Consumers if ACOs result in Increased Provider Consolidation

Guidance issued early this year by the DOJ and the FTC explaining the need for mandatory review of ACOs stated that “not all such ACOs are likely to benefit consumers, and under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care.” Moreover, the agencies said that “the analysis must remain sufficiently rigorous to protect both Medicare beneficiaries and commercially insured patients from potential anticompetitive harm.” Similarly, the proposed rule released by CMS said that competition “promotes quality of care for Medicare beneficiaries and protects beneficiary access to a variety of providers”, and that “all of these benefits to Medicare patients would be reduced or eliminated if we allow ACOs to participate in the Shared Savings Program when their participation would create market power.”

### AHIP Article in Health Affairs Examines Private-Sector Accountable Care Models

A recent AHIP study that appears in the September edition of *Health Affairs* found that new health care delivery and payment models in the private sector are being shaped by active collaboration between health insurance plans and providers. The article found that not all providers are equally prepared to enter into accountable care arrangements and that flexibility and the technical assistance and support of health plans will be key to the success of these arrangements. The AHIP study identifies several important lessons that can inform how the final ACO rule is developed. Click [here](http://www.ahip.org/content/pressrelease.aspx?docid=34338) (<http://www.ahip.org/content/pressrelease.aspx?docid=34338>) to read the full article in *Health Affairs*.

### AHIP Summit on Shared Accountability

AHIP recently hosted a Summit on Shared Accountability that showcased a variety of innovative payment models that regional and national health plans have implemented across the country, such as ACO-contracting, patient-centered medical homes, and bundled payments. Health plans and their provider partners discussed key program features, lessons learned, and results that have been achieved in terms of higher quality care, better health outcomes, and lower health care costs.