NATIONAL CENTER FOR POLICY ANALYSIS

Accountable Care Organizations: Panacea or Train Wreck?

Brief Analysis No. 769 by Roberta Herzberg and Chris Fawson August 14, 2012

One of the hottest new ideas in health care is the Accountable Care Organization (ACO). Similar to health maintenance organizations (HMOs), ACOs are designed to bring hospitals, physicians and insurers together to reduce health care costs by improving quality and reducing expenditures for unnecessary tests and procedures.

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Researchers note that delivering appropriate, scientifically justified services will produce better and more cost-effective results. The problem is how to get health care providers to offer only these efficient services. ACOs aim to do so by restructuring the financial incentives for providers. So did HMOs; but HMOs were largely rejected by consumers in the mid-1990s as too heavy-handed.

ACOs are a feature of the 2010 Affordable Care Act. Although designed for Medicare, the thrust of health reform is to encourage them system-wide. Under this arrangement, providers share savings generated by delivering lower cost, quality services to patients. To do so, providers must be financially integrated, and doctors and patients must share power over their health care decisions with the organization.

Networks can be set up to serve patients who are privately insured or covered by Medicare. However, providers exhibited only lukewarm interest in becoming a designated ACO in the Medicare Shared Savings Demonstration under the first set of rules proposed by the secretary of Health and Human Services. Observers noted that many ACO pioneers did not sign up for the designation. This sent regulators back to the drawing board. The resulting final rules were far more favorable to providers, as they reduced risk and eased many regulatory requirements. But the revised rules raise concerns that the balance has tipped too far toward ACO providers and away from consumers and other insurers.

Problem: ACOs Assume Financial Risk, but Have No Formal Control Over Patients' Choice of Treatment or Providers. In the 1990s, instead of being paid fees for each service, providers in private health plans agreed to a set fee per enrollee and hoped to reduce costs to below that average amount through improved efficiency in service delivery and a reduction in unnecessary services. The resulting HMOs required patients to get referrals from a primary care physician in order to see a specialist. For certain tests and procedures, providers were also required to get permission from a gatekeeper working for the HMO. Unfortunately, patients saw the reduction in unnecessary services as rationing by providers who had an economic incentive to do less regardless of need.

Unlike HMOs, however, ACOs will not require patients to use a particular set of providers. In this model, there is no explicit gatekeeping. Instead, providers rely on education and persuasion to direct patients to appropriate

care. Patients are free to seek care from any Medicare provider, in or out of the network. Regulators worried providers would game the system by denying costly care. They have freed consumers, but require providers to assume financial risk without control over decisions that will impact costs.

Problem: Patients Are Assigned to an ACO Based on Past Service Use, Not Explicit Agreement. Providers do not know in advance which patients count as members of their ACO. Patients are retrospectively assigned to an organization based on receiving much of their primary care from the ACO. Medicare and other insurers want providers to use efficient, high quality decision making with every patient, not simply those assigned to the group. But providers will not know whether they will be saddled with noncompliant or overusing patients, nor can they focus additional incentives or resources on participants to influence their behavior. As a result, providers face added risks that may be impossible to control.

Problem: Higher Regulatory Burdens. To qualify as an ACO, a provider network must meet a variety of benchmarks for quality measurement, governing structure and information transmission. Meeting these requirements and demonstrating compliance is expected to add millions of dollars in administrative costs, at least in the short run. Whether the expected savings will offset the additional costs is unclear. Many analysts believe the significant start-up requirements will limit the economic benefits of the organizations to traditional HMOs or managed care organizations.

Problem: Reduced Competition. The creation of large ACO provider networks will reduce competition for the business of consumers and insurers. The organizations must coordinate decisions regarding service delivery and pricing in ways potentially inconsistent with antitrust laws. For instance, coordination could be used to maintain higher cost service through collusion or anticompetitive behavior. Thus, there are two problems: reduced competition between providers and the increased vulnerability of providers until they obtain a competitive exemption. If regulators refuse to grant exemptions from the extensive reporting and data-gathering requirements associated with existing antitrust laws, networks could be vulnerable to legal action for behavior required by ACO rules, or they could be stuck with start-up costs when they cannot participate.

"ACO providers assume financial risks without control over decisions that affect costs."

Problem: Data Collection Requirements Raise Costs and Privacy Concerns. In order to know that an ACO is delivering high quality health care efficiently, Medicare regulators will collect extensive data, raising privacy concerns and administrative costs. To avoid privacy problems, patients must know they are participating in a group with economic incentives to reduce costs. They must have the opportunity to opt out.

However, if higher or lower cost groups of consumers opt out, it could impact overall evaluation of the provider's performance and lead to false conclusions regarding the effectiveness. Organization's concerns regarding data collection feasibility and costs convinced the Department of Health and Human Services to reduce the required quality measures from 65 to 33 in the final rule.

Problem: Providers Will Be Tied to ACOs. Finally, there are concerns that providers are being enticed into ACO networks with promises of rewards for efficient behavior, but over time their reimbursements could be squeezed. Providers may be hesitant to leave as the economics change. Moreover, since other providers and regulators have information regarding a provider's practice, it may be impossible for that provider to operate independently again.

Conclusion. The Obama administration has little trust for real markets and believes that consumers are incapable of directing their own health care in a competitive market. It believes that government experts must manage consumers to protect them from unscrupulous providers. The result is a top-heavy regulatory system in which administrators in government and the ACOs could soak up health care dollars without improving patient outcomes or reducing overall health care costs.

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