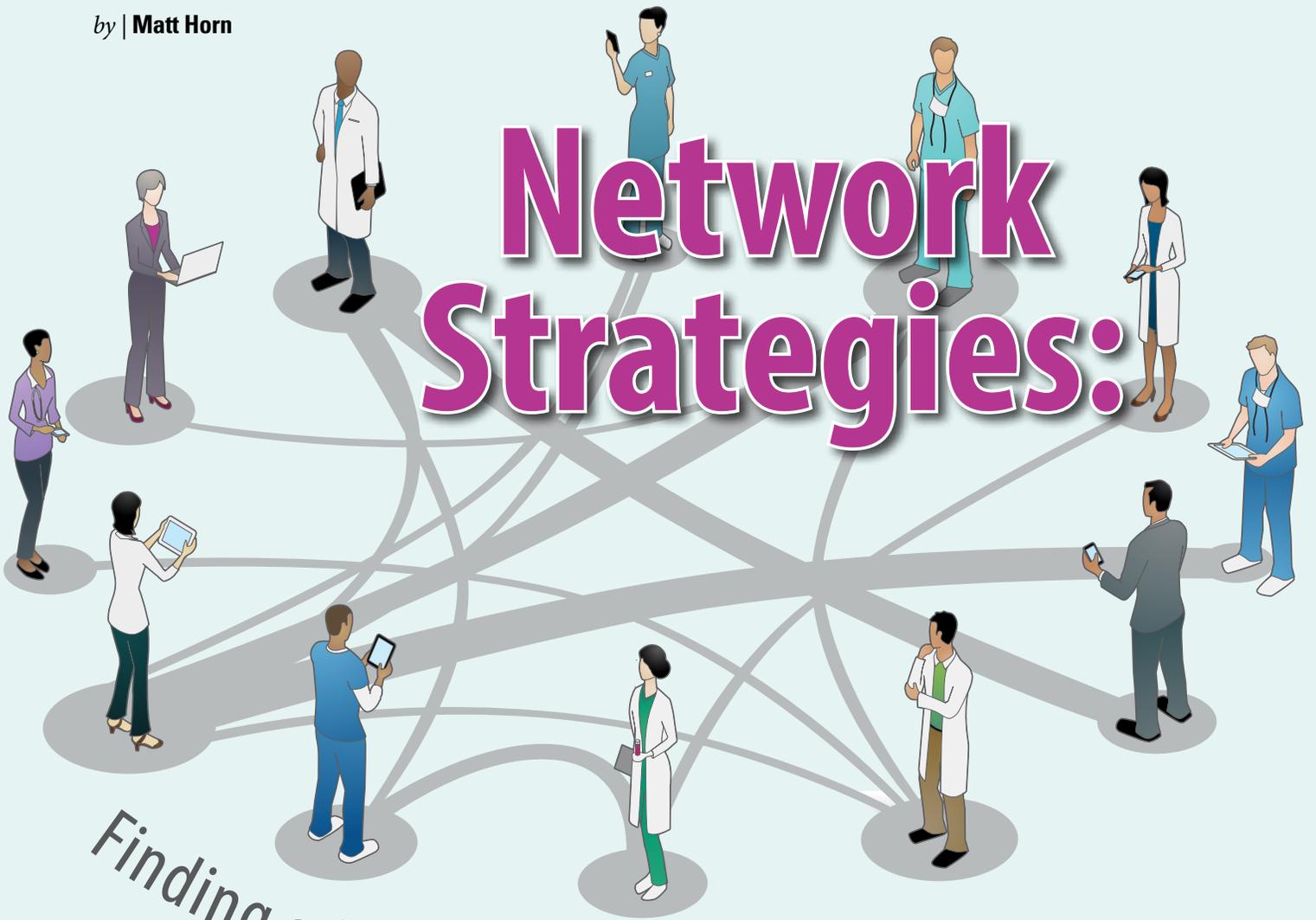


The Affordable Care Act made accountable care organizations (ACOs) more prominent, but they have existed for decades. ACOs show promise in reducing health care costs while improving the quality of care and patient experience.

by | **Matt Horn**

Network Strategies:



Finding a Better Path Through Coordinated Care

Much has been written lately about “narrow,” “limited” and “skinny” health care networks. Insurers have said this type of network strategy is a key way to control costs. Another term that has started to appear more often is *accountable care organization* (ACO). Are these strategies the long-sought-after solution to rising health care costs—or just another way to give the consumer less and maintain the status quo?

The concept of networks in health plans is not new. Many people are used to going online to check whether their doctors are in their insurer’s network. An insurer’s ability to negotiate lower rates for service has become increasingly important as health care costs continue to rise. However, network discounts from insurance carriers have not been effective in controlling medical inflation.

For many years, insurance covered costs for services when a member would file a claim. There were low deductibles but no copays. These indemnity plans were effective when the full cost of a doctor’s visit rarely exceeded \$20. They were designed to help with a stay in the hospital. As health care costs continued to rise and became a larger part of the economy, a new system was needed.

In the 1980s and 1990s, the *health maintenance organization* (HMO) became popular. HMOs established a network of doctors, and most required a “gatekeeper,” a doctor whom a member chose to manage all of his or her medical care. The insurance company also gave doctors a flat fee, called *capitation*, for each patient under their care. But as insurance companies once again began to see premiums rise, they implemented protocols that interfered with the relationship between patient and doctor. The decisions of insurance companies were not always wrong, but insurance representatives were not in the exam room with the patient. Although insurance companies actually were saying only what they were willing to pay for, the protocols gave the impression that the insurance company was telling doctors what they could or could not do for a patient.

The next wave of managing a network was in the form of a *preferred provider organization* (PPO), a

network-based plan that gave more control to the doctor and tended to be less heavy-handed on the medical management aspect. PPOs also allowed patients to see providers who were not in their network, but they had to pay a higher percentage of the costs. PPO plans did little to control rising health care costs.

Over the years, there came to be an alphabet soup of different network options—HMO, PPO, POS, EPO—and open access. None has done much to control the rate of medical inflation, so insurance companies have been looking at the prospect of narrow networks of specific doctors. Many of these are simply smaller networks based on an insurance company’s strategy for cost control, but some fall into the category of ACOs.

Why are we to believe that the ACO would be any different? Aren’t they just a reinvention of the HMO?

Depending on the way they are structured, ACOs are showing great promise in controlling health care costs. To understand why they are working, it’s helpful to know the history of the model.

Many people think ACOs were established by the Affordable Care Act (ACA). This is not true, although ACA saw promise in these types of organizations for managing Medicare expenses. Arguably, the first ACO was formed in the 1940s to care for industrial workers who traditionally did not have access to quality, affordable care. This organization became what is known as Kaiser Permanente.

There also were successes during that time with multispecialty care centers like Mayo Clinic that found quality to be the best way to drive positive financial outcomes. Over the years, systems have sprung up across the country looking to build on the successes of these organizations and improve the model. There are physician groups, hospital groups and conglomerations of both, all with the same goal: to improve the quality and efficiency of medical care for their patients. Some start their own insurance companies; some partner with insurance carriers or third-party administrators to build products for the public.

The *Dartmouth Atlas* reports on these organiza-

takeaways >>

- Network discounts from insurance carriers have not been effective in controlling medical inflation.
- ACOs show promise in improving the patient experience and the health of a defined population and reducing the cost of health care on a per capita basis.
- ACOs come in various models and can be tailored for the markets they serve.
- Much of the efficiencies in accountable care come from keeping patients engaged with their care so that preventable hospital admissions are avoided.
- Pay-for-performance payment methods in ACOs tie provider compensation to results.
- An ACO is local and generally serves a population for a specific area, so it may not be right for every employer. Employees who live outside of the ACO catchment may believe that they do not have access to the same level of benefits as other employees.

tions and named them accountable care organizations. Dartmouth continues to monitor their evolution and successes. The key characteristics are that these organizations are not led by insurance companies but by providers. These providers must take responsibility for the full spectrum of care for a population, from preventive services through hospitalization. They must also demonstrate that they are reducing costs while maintaining quality. These operations and results must be measurable and quantifiable in order to assure that cost savings do not come at the expense of patient outcomes.

The ACO concept shows great promise of achieving the “triple aim” set forth by the Institute for Healthcare Improvement. The triple aim revolves around improving the patient experience, improving the health of a defined population and reducing the cost of health care on a per capita basis—all things that traditional plans have tried over the years with marginal results.

With this goal and these requirements, it is easy to see that the term “ACO” can apply to a wide variety of plans. A common saying is: If you have seen one ACO, you have seen one ACO. That may be a positive development, as a variety of systems and their outcomes can be evaluated.

Also, an ACO can be tailored for the market it serves. A consumer of health care in Boston is different from one in San Diego and different from one in Houston.

Health Affairs laid out examples and characteristics of five models of ACOs.

1. *Multispecialty group practices*, where doctors are employees of the organization, which contracts with hospitals or health plans, and base their practice on coordination of care
2. *Integrated delivery systems*, which generally have a hospital that employs doctors and own their own health plan
3. *Physician-hospital organizations*, where doctors are not employees but function like a multispecialty practice
4. *Independent practice associations*, where private practice physicians join together to contract with health plans
5. *Virtual physician organizations*, which focus on rural areas and provide a structure for small rural practitioners to coordinate care.

A handful of provider groups across the country began implementing the accountable care strategy of coordinated care. With advances in technology, many of these saw their success tied to the implementation of electronic medical records (EMR). EMR systems allow for a more complete picture of the patient that helps provider teams identify and eliminate gaps in care and facilitate discussions among all clinical partners. Some incorporate a robust series of best practice alerts and prescription management, all coordinated and controlled by providers instead of insurance companies or third-party administrators. With a focus on patient health instead of acute intervention, much of the efficiencies in accountable care come from keeping patients engaged with their care and avoiding preventable hospital admissions.

When ACA was passed in 2010, rules were set forth allowing health systems to apply for enhanced reimbursements on their Medicare patients if they met specific guidelines for

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quality and cost control. This was especially attractive for hospital-based groups that see a significant difference in compensation between their Medicare rates and their insured rates.

In 2012, the National Committee for Quality Assurance began accrediting ACO systems. This organization reviews the structure of ACOs and Healthcare Effectiveness Data and Information Set (HEDIS) data to ensure adherence to the tenets of accountable care and that they are achieving the expected results.

Payment reform also is a key aspect of successful ACOs. *Fee-for-service* arrangements, where a doctor is paid based on the services he or she delivers, provide a perverse financial incentive to do more, which is not necessarily “good” for the patient. Expanded payment methods have built a system that ties compensation to results. These payment methods include *episodic bundling*, where a flat amount is paid to providers based on the condition for which the patient is being treated; *pay for performance*, where an additional amount is paid on a fee-for-service basis as long as clinical outcome measures are met; and *capitation*, where a group is paid a flat amount per member per month and is required to manage the patient population with those funds.

In today’s markets, some carriers are realizing that ACO structures are performing, and those carriers are building ACO partnerships. However, ACOs are provider-run by their very definition. Insurance companies are left to do what they do well in assessing and administering the plans and managing the block of risk. Providers are allowed to do what they do best—managing a population of patients. This is a key difference from the HMO

that put the insurance company in charge of all aspects. When these key differences are respected and providers and insurance companies each are given the responsibility to manage their core competencies, patients and purchasers of ACO-based plans may be better off.

An ACO may not be a match for every health care plan. An ACO usually is local in nature and tends to serve a population for a specific area. This can cause challenges to employers that are not ready to consider a regional benefit strategy. Also, an ACO often offers richer benefits at a lower price, so that employees living in an area outside of the ACO catchment may believe that they do not have access to the same level of benefits as other employees. Employers that are looking for an ACO partner must also be prepared to address the possibility of network disruption.

Health plan sponsors considering an ACO benefits strategy should ask:

- What is the coverage area of the ACO provider group and is it accepting new patients?
- Does the ACO provider network have a local service team?

- How is urgent and emergency care covered?
- When is a referral required?
- Is a designated primary care physician required?
- Are there robust preventive and disease management programs in place?
- How do the doctors coordinate with one another?
- Do the doctors work from a single EMR?

Knowing the answers to these questions up-front can lead to a successful outcome for the plan sponsor.

As long as a narrow network is limited in order to achieve quality results, the term may not be as scary as some people think. An ACO partnership may be the most effective strategy for a narrow network. This type of partnership is not a new idea from an insurance company but rather the result of decades of success in managing quality and cost. As the term “ACO” is moving away from ambiguity with accrediting programs and defined measures of success, patients and employers are reaping the benefits with higher satisfaction and better outcomes. **b**

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