Why Accountable Care Organizations Are Not 1990s Managed Care Redux

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Many people are concerned that accountable care organizations (ACOs) and other delivery system reforms in the Affordable Care Act will simply bring back the managed care days of the 1990s. These skeptics suspect that payment reforms to control high and increasing costs will simply lead to gate keeping and service denial rather than the promise of care redesign and coordination that removes unnecessary cost and delivers better outcomes.

**Managed Care of the 1990s**

Managed care alienated many physicians by excluding many of them from networks, intensely bargaining on payments, empowering primary care physicians as gatekeepers, and requiring prior authorizations for many tests and treatments. Physicians in turn denigrated managed care, often blaming managed care companies for prohibiting them from providing services they thought were necessary. Physicians’ hostility to managed care seemed confirmed by patients’ experiences. Managed care companies were perceived as simply saying “No” to requests for many diagnostic tests and treatments; “No” to requests for seeing physicians outside the network; and “No” to requests for experimental treatments. Although these apparent denials of care may have been warranted based on standards that required evidence of clinical effectiveness for covered services, the approach and opaque rules undermined public trust. Physician and patient dissatisfaction fed off each other, leading to a managed care backlash.

Probable nothing characterizes the managed care experience better than the way bone marrow transplants for metastatic breast cancer evolved. This very expensive new technology was developed with some promising but inconclusive results. Frustrated by the intransigence of managed care organizations to cover the treatment, physicians and patients sued managed care companies and lobbied state legislatures; courts ordered treatment; and some states even enacted laws mandating coverage for bone marrow transplant for metastatic breast cancer before there was evidence about its effectiveness.

In the end, the managed care companies won the battle but lost the war. A definitive trial showed that bone marrow transplants neither cured nor prolonged survival of women with metastatic breast cancer but were instead accompanied by substantial morbidity. The confrontational nature of the approach transformed the phrase “managed care” into one of utter disparagement in health care.

**Differences Between ACOs and Managed Care**

Accountable care organizations are unlikely to be a return to the managed care days. Five significant changes make ACOs different.

**More Knowledge.** In 2012, more is known about health care costs than during the managed care era. Nearly two-thirds of health care costs are concentrated in 10% of patients, so to control costs, the focus needs to be on these patients, not the 50% of the population that is relatively healthy and uses just 3% of the health care dollars.

In addition, just saying “No” is frequently unproductive. There certainly is overuse of many discretionary services—such as hysterectomies, knee replacements, stents for chronic coronary disease, and cesarean deliveries—costly treatments such as vertebroplasties and certain chemotherapies are proven not beneficial. This overuse of services needs to be reduced. But a blanket “No” that makes it more difficult to access essential services actually increases costs. For instance, raising drug co-payments often leads to more expensive hospitalizations. Reducing overutilization and controlling costs requires more granular approaches.

Good models of practices are able to control costs while generating high quality of care. Most of these models are just the opposite of a model based on “No.” They tend to deploy significant resources on an outpatient services actually increases costs. For instance, raising drug co-payments often leads to more expensive hospitalizations. Reducing overutilization and controlling costs requires more granular approaches.

**More Data.** In the 1990s, managed care plans did not necessarily have data on outcomes, utilization, and overall costs.
and did not systematically share their data with physicians or hospitals. Physicians' decisions about how to practice were often made with little information about what was happening to patients. Although most patients today still lack an electronic health record (EHR), substantial improvements in information technology have occurred since the 1990s and offer significant amounts of data from claims and pharmaceutical records in a timely manner. By the end of 2012, more than 40% of practitioners will be using EHRs, a huge increase from 12% in 2009. Close to 100% of professionals and health care systems operating in ACOs or risk-based reimbursement models will be using EHRs, enabling smart predictive modeling, patient monitoring, and performance management of the delivery system. Insurers and others have developed much more powerful analytics to track patient use of services and physician performance. Although not perfect, these data and analytics allow for much closer and more timely assessments of the quality of patient care and physician performance than was possible in the 1990s.

More Guidelines and Quality Metrics. In the 1990s, few guidelines about how to care for many patients existed. Today, there are myriad professional guidelines, pathways, and standards of practice. Many of the most prevalent and costly chronic diseases—coronary artery disease, diabetes, many cancers, asthma, and hypertension—have well-established, professionally developed guidelines. These guidelines also allow for clear explanations about coverage policies for patients, physicians, and health care systems.

More Collaboration. A major problem of 1990s-style managed care was that it frequently gave physicians capitated payments and expected them to manage the risk. Lacking data, financial skills, and management experience, many physician groups failed miserably. Today, insurers and others have learned and are collaborating with physicians and hospitals, providing them data for patients and finances and working with them to implement change. For instance, one interesting model is an ACO in which Blue Shield of California is working with Hill Physicians and Catholic Healthcare West to reduce the cost of caring for 40,000 CalPERS (the California Public Employees' Retirement System) members. Together they identified and reduced overutilization of specific services, hospital readmission rates, and reduced use of out-of-network physicians. After a year, they saved more than $15 million. This kind of collaboration is the anti-managed care of the 1990s.

More Physician Control. Under the managed care model of the 1990s, insurance companies forced physicians and hospitals to change through reduced payments. Physicians could blame managed care, as the the outsider, and tell their patients it was imposing the limits. Accountable care organizations are likely to be different. The Affordable Care Act final rule for ACOs states that "at least 75 percent of the ACO's governing body must be held by the ACO's participants" and should also include beneficiary representation. Under ACOs, physicians decide together, with information on patient utilization and physician performance and with profession-developed guidelines, how best to manage their patients. If physicians in ACOs are to blame anyone for practices they do not like, it will be their physician colleagues, not insurance company executives.

The Cost of Failure
An additional reason that ACOs are unlikely to be managed care redux is the strong incentive for physicians, other health care practitioners, and insurers to make ACOs succeed. If they fail to control health care costs, the federal government is likely to resort to its most reliable method of reducing Medicare spending: significant payment reductions. For instance, the government might not fix the sustainable growth rate formula, resulting in drastic reductions in Medicare reimbursement rates. Most health care professionals would view this as disastrous. But it would also be bad for insurers because physicians and hospital administrators would try to negotiate higher rates from private payers to compensate for lower Medicare rates. Thus, it turns out to be in everyone's interest to avoid such a scenario. Although this does not guarantee the success of ACOs, looming, significant price reductions have a way of focusing efforts and bringing people together.

Conclusions
As the health system experiments with new delivery system reforms in an attempt to control costs, the conventional approach is that of the skeptic: these reforms will not succeed because every previous reform has failed. In part, this skepticism manifests in arguments that ACOs are just managed care organizations of the 1990s in another guise.

Sometimes, there is something new under the sun. Today is different from the 1990s—physicians and others in the health system know more; have better data, guidelines, and metrics; and, despite antagonisms, can collaborate better. This does not guarantee that ACOs will succeed in controlling costs, but it does suggest that the problems of the 1990s will not be repeated.

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REFERENCES