Patients’ Role in Accountable Care Organizations

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If ever there were a crisis moment that crystallized the need for reforming the U.S. health care delivery system, this is it. The 2010 Affordable Care Act (ACA) promised to expand health insurance coverage, a key first step toward improving health equity. But newly insured Americans will gain access to a strained, fragmented system that often fails to deliver effective, efficient care. Meanwhile, the burden of chronic disease, coupled with incentives that reward providers when preventable complications occur, continues to drive up health care spending.

To address these escalating problems of quality and affordability, many analysts and policymakers support the development of accountable care organizations (ACOs). ACOs could take various forms, but they have generally been conceived of as groups of primary care physicians, specialists, and sometimes hospitals, joined together in either vertically integrated systems or networks that are accountable for improving the quality and affordability of care for a defined patient population and that are eligible for financial bonuses if performance goals are met. The ACA takes a first step in this direction by allowing Medicare to contract with ACOs; interest in this concept is also growing among commercial payers, Medicaid agencies, and several state legislatures (e.g., Colorado, Vermont, and Washington).

Understandably, much of the debate about ACOs has focused on structuring provider networks, reimbursing providers, and designing performance-based rewards and penalties for providers. Largely missing from these discussions is a role for patients. In many ACO-like models, including Medicare’s Physician Group Practice Demonstration project, patients who receive the majority of their care from participating providers have been assigned to an ACO through “invisible enrollment,” with no prospective notification and sometimes no awareness by the patients that they’re associated with an ACO. But a provider-based accountability model that is disconnected from the way patients seek care not only may fail to achieve its cost-saving and quality goals, but may also give rise to a backlash among patients and providers. Except in cases of closed, integrated delivery systems (such as Kaiser Permanente or certain large provider organizations with capitated payments), in which consumers choose to use an ACO through their choice of insurance, most patients are not obligated to obtain care only from a particular provider group.

Studies of the care patterns of Medicare beneficiaries, which helped to launch the ACO movement, offer some evidence that patients tend to stick to a given provider group: 73% of beneficiaries’ visits for evaluation and management services (inpatient and outpatient) took place within a primary hospital or involved its extended multispecialty medical staff (an ACO-like grouping), and, on average, 64% of admissions were to the primary hospital. Yet one quarter of evaluation and management visits and more than one third of hospital admissions involved outside providers. The fact that the ACO has imperfect control over an appreciable amount of the care provided suggests that increasing patients’ adherence to an ACO could improve efficiency and savings.

There has been little discussion about binding patients to ACOs, however, largely because the freedom to choose one’s providers is highly valued in U.S. health policy. The managed care backlash and the rise of preferred provider organizations in the late 1990s have been partially attributed to patients’ unwillingness to accept closed physician networks. Most Medicare beneficiaries have not enrolled in private plans that restrict patients’ choice of physicians, even though these plans offer more generous benefits than does the fee-for-service Medicare program. These consumer preferences suggest that policymakers should focus on creating incentives to build patients’ loyalty to an ACO (see table).

One way to do so is to allow patients to share in their ACO’s cost savings — for example, through a tiered provider network, which allows patients to pay less at the point of care depending on their choice of provider. Under such an arrangement, physicians would be sorted into tiers according to their ACO affiliation, and patients would pay lower copayments for visits to physicians within their ACO. Not only might this ap-
approach bring more patient care under the influence of the ACO, it might also motivate providers to join an ACO. One barrier to its effectiveness might be inadequate consumer awareness and low use of the networks.2

A second method for sharing savings with patients is to charge different premiums depending on whether patients choose to receive their care from an ACO and, if there’s more than one ACO option, which one they select. Patients choosing an ACO that has lower costs than an alternative ACO (or than non-ACO care) would pay lower monthly premiums; in principle, tiered copayments could be nested within such an arrangement. This strategy takes advantage of the considerable weight that consumers often place on their out-of-pocket premium (as compared with their total expected costs) when selecting a health plan. Experience shows that consumers do respond to premium differences in this type of arrangement.3 However, such premium tiering presumes that once an ACO is selected, the patient is either limited to it for the year or faces higher cost sharing for going outside the ACO for care; this approach might thus be perceived as locking in patients to their ACO choice at the beginning of the year and might therefore be unpopular.

Another strategy draws from the lessons of behavioral economics and findings that consumers frequently accept default settings and fail to switch out of them because of procrastination or a belief that a default reflects an expert’s recommendation.4 Private health plans could assign patients to primary care physicians within a low-cost, high-quality ACO as the default, perhaps charging lower premiums or copayments for visits with these providers, but allow patients to opt out and seek care with other providers if they are willing to pay more out of pocket.

Initiatives that use shared savings or opt-out models are available to commercial plans in most markets. Without new legislation, however, Medicare probably cannot offer such incentives; it will have to rely instead on other ways of encouraging patients to seek care within an ACO. One possibility is disseminating information to patients about the quality and cost-efficiency of the care they would get if they adhered to a particular ACO. There is mixed evidence regarding the influence of quality reporting on patients’ choices of providers or plans — suggesting that the way such information is presented will be important in determining the effectiveness of this approach. In a randomized experiment, Medicare beneficiaries who received personalized information about lower-cost Part D plans were more likely to switch plans than were beneficiaries who were simply directed to a Web site where they could find such information on their own (28% vs. 17%).5

Although minimizing “leakage” of the population for which an ACO is accountable may be important for coordinating and integrating care, there will always be some patients who would obtain more effective care by turning to multiple ACOs. More than half of Medicare beneficiaries have five or more chronic conditions that may be treated separately or in combination. Although some successful integrated systems provide efficient, high-quality care for multiple conditions, often the best cardiac care providers in a given market, for example, are not in the same system as the best orthopedic care providers.

Aligning consumer incentives so that patients choose to seek care within a single ACO will have important implications for the ability of ACOs to reach their cost-saving and quality goals. Policy alternatives such as delivering personalized information

<table>
<thead>
<tr>
<th>Policy</th>
<th>Includes a Financial Incentive</th>
<th>Provides Information on Quality of Care</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiered copayments that vary according to the consumer’s choice of physician</td>
<td>Yes</td>
<td>Yes</td>
<td>Low consumer awareness of tiered copayments to date</td>
</tr>
<tr>
<td>Tiered premiums that vary according to the consumer’s choice of ACO</td>
<td>Yes</td>
<td>Yes</td>
<td>May be disliked by consumers if perceived as restricting choice of physician</td>
</tr>
<tr>
<td>Use of defaults</td>
<td>Yes</td>
<td>Can, but not required</td>
<td></td>
</tr>
<tr>
<td>Public reporting or report cards</td>
<td>No</td>
<td>Yes</td>
<td>Targeted, personalized information is likely to be more effective</td>
</tr>
</tbody>
</table>
about quality and cost-efficiency, introducing tiered premiums or copayments, or using defaults and other related tactics may enhance the effectiveness of ACOs while avoiding the pitfalls of past capitation arrangements that left patients out of the equation.

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