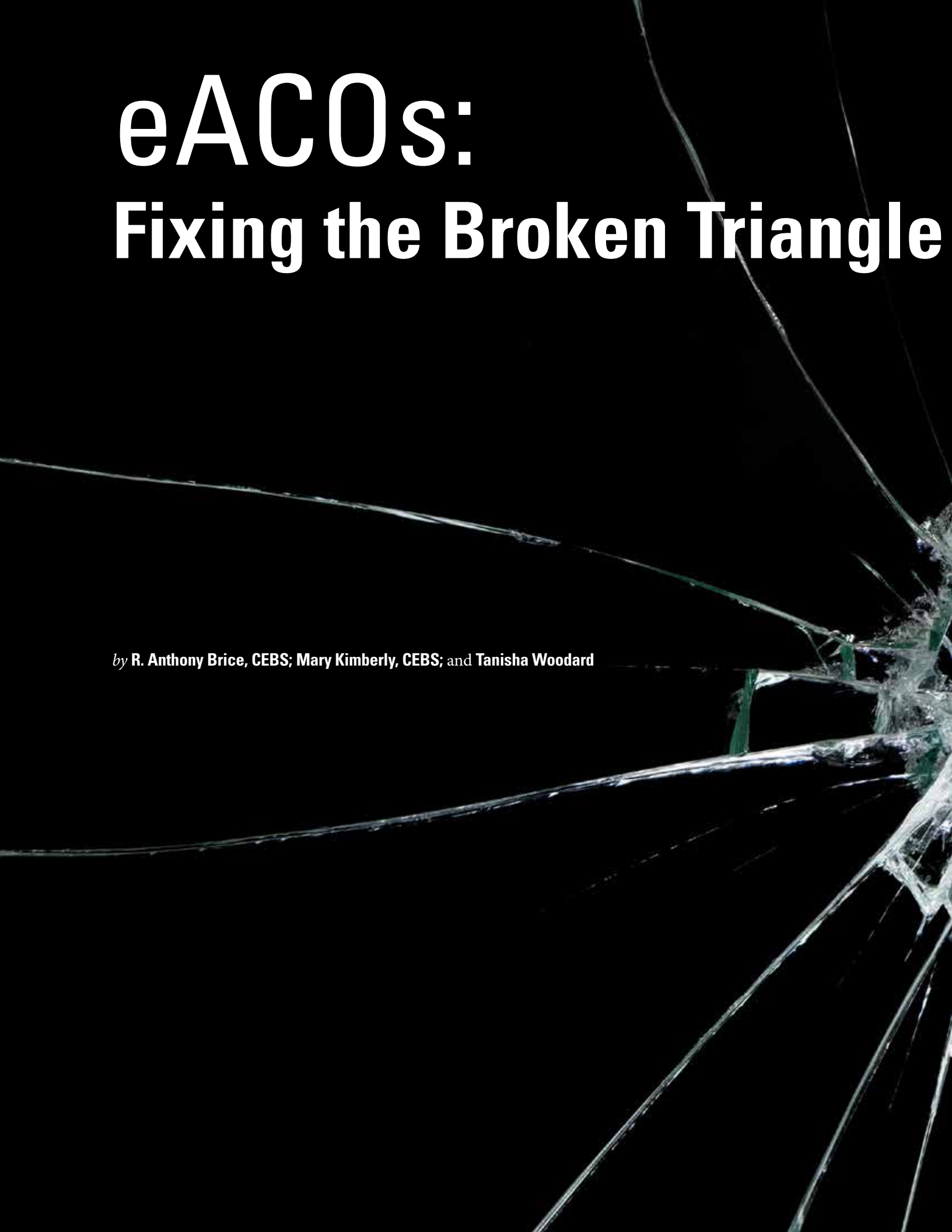
eACOs:
Fixing the Broken Triangle



by **R. Anthony Brice, CEBS; Mary Kimberly, CEBS;** and **Tanisha Woodard**

in Health Care

Interest in employee accountable care organizations (eACOs) is growing among employers looking for ways to control health care costs.

Is there an end in sight for health care benefit cost increases?

The cost of employer-sponsored health benefit plans continues to rise in the United States, despite efforts to curb costs. While the Affordable Care Act (ACA) created new rules, administrative burdens and consulting costs for employer-sponsored health benefit plans, it did little to address the underlying drivers of increasing cost and the poor quality of health care for employees and their covered family members.

In a word, the authors believe the root cause of rising health care cost for employers is misalignment. This misalignment starts with how doctors and hospitals get paid—through fee-for-service reimbursement—which encourages them to perform unnecessary tests and procedures and overprescribe medications. The cost drivers are compounded by an aging workforce and an increase in chronic diseases.

Intense debate continues in Washington about the repeal and replacement or repair of ACA, but none of the proposals removes the employer from the primary role in providing and managing health benefits, particularly employers with self-funded health plans. According to the Kaiser Family Foundation, employer-sponsored plans cover 155,965,800 people in the U.S., representing 49% of all U.S. citizens who are covered by insurance, including Medicare and Medicaid.[1]

The Next Era of Health Care Benefit Management

Employer-sponsored health benefit plans have evolved through multiple eras (Table I). Each era has shifted the focus on how to best manage the cost and cost increases of the employer-sponsored health plan. Each era has delivered limited success and, while many elements of the eras continue today, the overall results are lackluster because costs continue to rise.

The new era of health benefit plans may be the era of ownership. This era is represented by the accountable care organization (ACO). An *ACO* is a network of providers, such as hospitals, primary care physicians, specialists and other health care professionals, that agree to take on financial responsibility for the cost of care, the health outcomes and the consumer experience for a defined population. ACOs aim to transform the delivery system by moving away from fee-for-service payment arrangements toward value-based payments that reward effective and efficient care.[2] Value-based care, by definition, strives to remove barriers and align both financial and nonfinancial incentives (for both patient and provider) to preventive health and health improvement.

For employers, the definition of an ACO may sound like a health maintenance organization (HMO), but ACOs are fundamentally different because they are owned and led by physicians, not an insurance company as illustrated in Table II. Furthermore, an ACO creates accountability for how the plan performs, through risk sharing and other mechanisms.

While ACOs emerged from ACA as a payment reform mechanism for Medicare, employers are just beginning to recognize their potential. Most large employers (65%) said that payment reform and delivery-system change are among their top three priorities, but very few know how to go about implementing such plans that connect their benefits to value-based care.[3]

Nonetheless, ACOs are being considered as one of the key strategies in the next era of efforts to improve health care delivery and control health benefit costs. Roughly one in four large employers planned to pursue an ACO strategy in 2017, and that number is expected to grow in the coming years.[4]

The Broken Triangle of Health Care

For the last several eras in health care, physicians and hospitals—the true sellers of health care—have contracted with health insurance carriers that negotiate discounts for the volume of patients directed to their system through network plan design. These so-called "discounts" are often at least two to three times higher than Medicare rates whereby employers are subsidizing Medicare patients and overpaying for the services for their employees. In turn, the carriers (wrongly called *payers* by physicians and hospitals) contract with employers, which are the true buyers of health care. This triangle of stakeholders is missing a critical link, a direct relationship between the true buyer and seller of health care. This broken triangle is a big part of the problem with runaway costs and is the problem that needs to be fixed through realignment of incentives based on value-based accountable care between employer-buyers and provider-sellers.

In addition, the patient is not the center of care and often left confused and frustrated navigating the complex health care and insurance systems. In fact, according to *Accolade Consumer Health Survey,* people are more uncom-

TABLE I

The Eras of Health Benefit Plans

Era	Capture	Steer	Shift	Own
Products or Plan Type	Health maintenance organization (HMO)	Preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS)	High-deductible health plans (HDHPs), health savings accounts (HSAs)	Value-based care, employee accountable care organizations (eACOs)
Care Management Responsibility	Primary care physician (PCP) gatekeeper	Patient	Patient	Physician as part of clinically integrated network
Network and Care Delivery	Capitated physician payments, gated PCP, narrow network	Discounted fee-for-Service (FFS) in broad network	Discounted FFS in broad network	Outcomes-based physician reimbursements, narrow network
Incentives	Physician incentive to stay in budget	Patient incentive to stay in network	Patient incentives to build HSA balance	Aligned patient/physician health improvement incentives
Plan Design	Member copays	Deductibles and coinsurance	High deductibles offset by HSA contributions	Low member cost for high-value services

fortable navigating the health care system and their medical benefits than they are purchasing a car or even a house.[5]

The Core Elements of an eACO

A new generation of employee health benefit plans addresses these challenges. *Employee ACOs,* or *eACOs,* are employee health benefit plans that leverage the principles of value-based care via an accountable care platform.[6] An eACO can fix the broken triangle by creating a direct, accountable, aligned relationship between the buyer and seller of health care.

One model, developed by the Oliver Wyman organization, called the Roadmap to 2025, promises reductions in net cost of 10% to 20%.[7]

The core employer components of an eACO are:

- A commitment by leadership to build a robust and sustained culture of health that focuses on employees and their family members and emphasizes the well-being and productivity of employees through workplace food options and nutrition education, ergonomics and leadership values
- Health and pharmacy value-based insurance design that encourages the use of high-value care and discourages low-value care, provides incentives to participants to use providers in high-performance integrated networks, encourages smart decisions at the point of care and encourages conservation of dollars through account-based plans, such as those with health savings accounts and health reimbursement arrangements
- A powerful data management and measurement engine (accountable care platform), with technology that connects high-risk, chronically ill and complex-case patients to a physician-led care team and evidence-based clinical programs. Mining and analyzing this data should allow experts (with appropriate legal privacy clearance) to determine drivers of cost, program effectiveness and return on investment (ROI) and to inform changes in strategy.
- A contract with a high-performance, clinically integrated network of health system facilities and providers paid through value-based care models that share risk to deliver coordinated care, including primary care providers (PCPs) and specialists and facilities

TABLE II

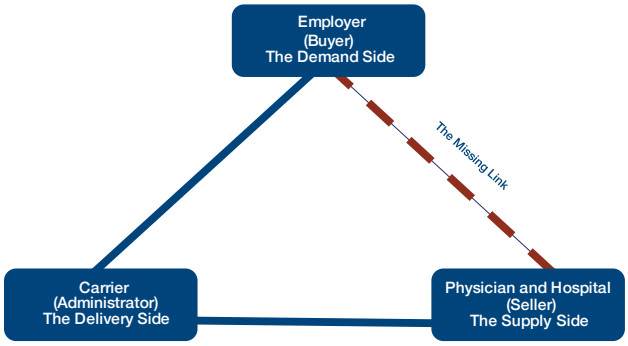
How Are ACOs Different From HMOs?

	HMO	ACO
Clinical Governance	Health plan-based	Physician-led
Network	Patients receive all care within a defined network.	Patients receive care from the ACO or from other network providers outside of the ACO.
Care Model	Primary care physician (PCP) is a gatekeeper to care through referrals.	PCP coordinates care among a care team.
Consumer Experience	Limited care coordination managed by the health plan	Highly coordinated care managed by a care team.
Technology and Analytics	Limited data exchange with providers	Information shared at point of care; extensive data exchange with plans and providers
Finance Model	Health plan may share risk with providers; capitation possible	ACO takes on and shares risk with providers based on cost of care, quality and patient satisfaction.

Source: National Business Group on Health, *ACO Toolkit: A Roadmap for Employers* (2017).

FIGURE 1

The Broken Triangle of Health Care



The consumer (the individual and family), is NOT at the center of the equation.

- An integrated and transparent clinical prescription drug management model with effective clinical programs and low-net-cost purchasing power to deliver efficient and effective prescription drug therapies
- A well-designed and -managed health promotion or workplace wellness strategy that aligns incentives for participants to engage in a broad spectrum of health improvement and management programs tailored to the individual, including evidence-based clinical programs such as complex care advising. These programs coordinate with PCPs or nurse practitioners to help people comply with treatment plans and healthy lifestyle behaviors, use technology to connect individuals with the right resources based on their health profile when they need care and, where possible, can be delivered through on-site health centers at the workplace.
- An ongoing management platform that facilitates all key administrative functions of the eACO, including integrated enrollment, customer support, network directory, transparency tools, wellness tool integration and employee engagement
- Specialized risk packages using captive reinsurance to mitigate the risk for the employer and provider.

Providers in an eACO must be health systems with multispecialty practices and sufficient primary care resources that make up the high-performance, clinically integrated network. They also must have population health management infrastructure and be guided by the principles of value-based care.

The provider assumes the risk for quality care across a number of diagnostic categories and will cap costs if performance fails to meet agreed-upon benchmarks such as:

- Improved health outcomes and total cost of care across the employee population
- Outperforming clinical targets such as reductions in admission and closing gaps in care
- Access to primary care with improved wait times and scheduling options
- Member engagement in care management programs.

If the provider performs well, it will share in the savings, but if the provider performs poorly, the employer will not be charged for excess cost.

Low Adoption Rate for ACOs

Because most ACOs for employers do not contain the core elements described above, the adoption rate has been slow. Employers have used various elements of value-based care on a limited basis, ranging from less than 1% for pay for performance, which is a narrow network of providers that agree to quality measures but are compensated on a fee-for-service basis, to capitation at about 15% (Figure 2). However, a new generation of employer risk packages is emerging whereby providers take direct risk for either a certain episode of care (back and joint surgery, heart surgery, maternity, etc.) and/or function as an ACO, taking risk for the total cost of care of a defined population. Other risk packages include trend guarantees, shared savings and partial capitation payments for managing populations.

Employer Participation in Embedded ACOs Limits Cost Reduction

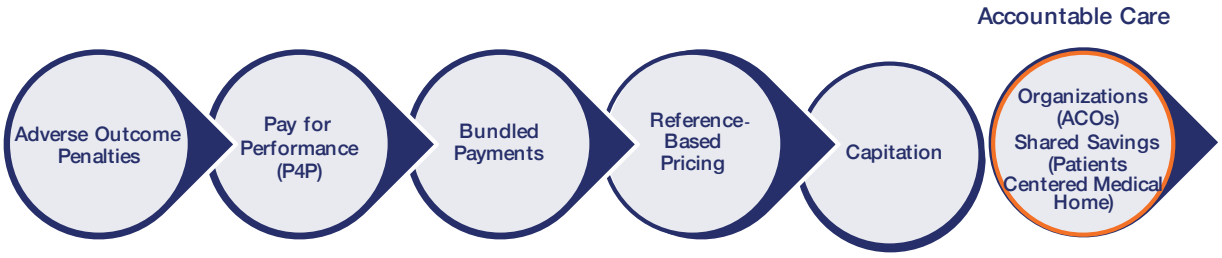
Most of the 800 commercial ACO contracts in place with employer-sponsored health plans use an *attribution model* that assigns members to ACO providers. Another name of this model is an *embedded ACO,* where part of the administration fee that employers pay to their third-party administrator (TPA) or carrier is distributed to participating health care providers to implement improved care coordination services. There is little education about the ACO to employers, employees and even providers because the funds flow behind the scene.

According to the National Business Group on Health (NBGH), 65% of employers are either not considering an

FIGURE 2

The Current State of Value-Based Care for Employers

Value-based care is a transformational change designed to shift from a predominantly fee-for-service reimbursement environment, where providers work independently from one another to care for individuals wrought with problems of waste and access, to compensation models that align incentives for teams of care providers to take ownership for managing the health, cost and outcomes of specific populations. Value-based care and compensation represent a move from volume to value.

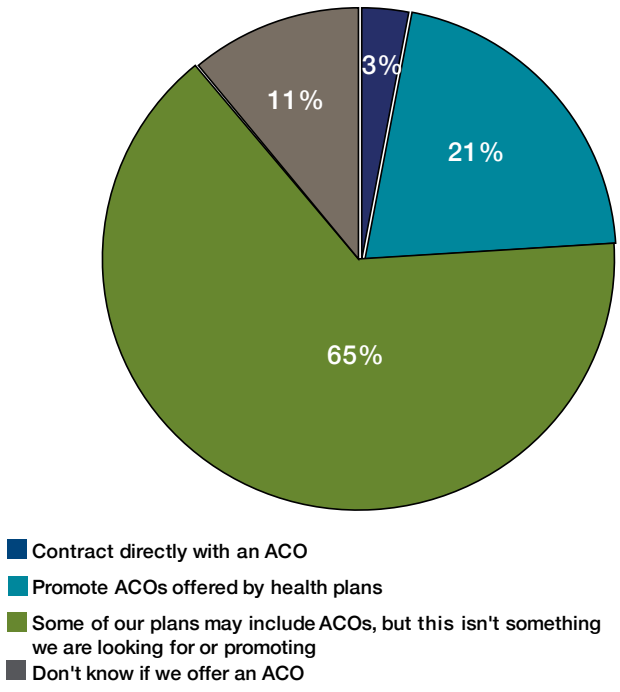


	Adverse Outcome Penalties	Pay for Performance (P4P)	Bundled Payments	Reference-Based Pricing	Capitation	Accountable Care Organizations (ACOs) Shared Savings (Patients Centered Medical Home)
Commercial Prevalence	High (>75%)	Low (12.8%)	Low (0.1%)	Low (6%)	Low (15%)	Low (<15%)
Effectiveness	Moderate *Up to 33% fewer readmissions and hospital-acquired infections*	Slight	Moderate *8-10% for certain procedures*	Moderate *Up to 26% for certain procedures*	Mixed *Kaiser*	Mixed *96 million saved in* Pioneer *ACOs, 13 have dropped out*

Sources: Evolent Health, National Business Group on Health (NBGH).

FIGURE 3

Employer Adoption of ACOs



Source: National Business Group on Health (NBGH).

ACO or may participate in one without their knowledge (Figure 3). In addition, employers still have a significant knowledge gap regarding what an ACO is and how an ACO should be evaluated.

Because of the employers' distance from an embedded ACO, they are not in a position to promote the features to employees. Employees often do not know they are seeing an ACO physician, nor do they understand the benefits of staying within the ACO network. Since employees have broad network choice, they may receive care from providers unaffiliated with the ACO, handicapping true clinical care integration. They may inadvertently undermine their physicians' ability to achieve their total cost-of-care targets.

Despite the limitations of embedded ACOs, employers continue to participate for three reasons:

1. Many do not have a sufficient employee population in each market to make a dedicated ACO investment worthwhile, and few ACOs have a significant track record to provide individualized targets and performance guarantees.
2. ACOs are fundamentally local entities, but large employers often prefer uniform plan design, benefit administration, communications and national network access for their employee population. In these cases, employers choose to participate in embedded ACOs and rely on their TPA/carriers to achieve results rather than be actively involved.
3. Employers are reluctant to take ownership and drive the change to overcome the status quo. Having executive sponsors in the C-suite driving decision making will accelerate the ability to have sellers take ownership.

Moving Employers From Passive to Active Participation in an eACO

Unlike an embedded ACO, an eACO is an active partnership between an employer, or group of employers, and a local seller of health care. It creates a new link between employers and sellers by creating a direct relationship between the two parties, bound by a financial contract to lower and stabilize costs. The eACO also implements targeted clinical programs to manage moderate- and high-risk individuals and creates an enhanced benefit design to promote steerage to the local seller. The relationship between the employer and the seller is communicated to employees who participate in this new model of care through the benefits plan(s). An eACO may be offered as a standalone benefit option or may be the only health benefit plan offered by the employer in certain markets. Employers and sellers are mutually invested in the outcomes and financial results of the eACO as described above.

Once employer-buyers engage in accountable relationships with the provider-sellers of health care through eACO arrangements, a paradigm shift will emerge. Health care expenses will be managed as a long-term, risk-based investment, rather than an annual cost-shifting exercise. When providers have skin in the game, employers will take a more strategic view of their health care benefits and leverage the partnerships to effectively manage the population.

Examples of Successful eACOs

Two notable examples of successful ACOs are those of-

fered to employees of Boeing and Intel corporations. Each company formed direct eACO-type partnerships with local health care providers that agreed to take risk for the total cost and quality of care for employees and their covered dependents enrolled in the eACO.

Boeing started an eACO in the Seattle, Washington area in 2014 with about 30,000 of its employees, retirees and their dependents and later expanded offerings to employees in St. Louis, Missouri and Charleston, South Carolina. Recently, Boeing added another 15,000 employees and their dependents in Southern California.[8] The eACO arrangements are available to employees as both a preferred provider organization (PPO) plan and a high-deductible alternative. At the time of rollout, participants had the choice of keeping their current health plan or choosing a new, narrower network of facilities offered by either Providence-Swedish Health Alliance or the UW Medicine Accountable Care Network. In exchange for choosing the smaller selection of providers, Boeing employees receive a range of perks, such as same- or next-day appointments, online access to scheduling and test results, and lower costs in the form of smaller contributions from their paycheck or free generic prescription drugs.[9]

In Charleston, Boeing has partnered with one health system, Roper St. Francis Health Alliance, to offer a preferred partnership option for employees, referred to as the Advantage + Plan, that is designed to improve quality, provide a better experience for eligible members and be more affordable. This preferred partnership option includes a broad provider network with PCPs, specialists, urgent care facilities and hospitals located throughout the Charleston area. In order to receive network benefits, the enrolled member needs to use only Charleston area providers in the Roper St. Francis Health Alliance network. Emergency care, however, is covered at the network level. Additional features of the Advantage + Plan include faster access to network PCPs and specialists, more after-hours care availability, highly personalized and coordinated care, and access to a patient portal that has scheduling tools, educational materials, electronic messaging and personal health records.

Computer chip giant Intel Corporation has entered into an unusual direct contract with Presbyterian Healthcare Services for a narrow-network, accountable care–style arrangement for its employees in New Mexico.[10]

The arrangement, which started in January 2013, covers about 5,400 individuals at the Intel manufacturing plant in Rio Rancho, New Mexico. Intel decided to contract directly with a single provider system rather than working with a national commercial health insurer carrier for some of its eight health plans options.[11]

The eACO offers Intel employees a narrow network of Presbyterian providers as two of four health plan options, which will enable the health system to better manage care, as noted in an article about the eACO. Outside the network, Intel officials said employees receive care that's not coordinated and may not be in their best interest. Presbyterian physicians can do more to control costs when patients cannot roam to independent or rival providers. Intel employees who selected Presbyterian's narrow network coverage will pay more for seeking care elsewhere. Intel projected that with Presbyterian the company could save $8 million to $10 million through 2017 as better care improves population health, though costs are initially expected to rise.[12]

The Challenges and Opportunities of eACOs

One of the challenges of implementing an eACO is that health care is still delivered locally, but national/regional employers prefer consistency and standardization in health plan delivery. Many employers prefer to manage one plan rather than multiple plans and may hesitate to adopt an eACO for concerns over increased administrative work.

However, trends in technology and health plan design

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bios

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make the environment more favorable for creating an eACO.

- Employers can focus more on strategy and health improvement since technology, specifically benefits platforms, has improved, allowing employers to streamline staff and improve administrative efficiencies.
- As private exchange vendors become less influenced by the major carriers, they may allow regional provider-sponsored health plans built on ACO principles to become a plan choice.
- The proliferation of defined contribution health plans means employees are looking for competitive health plan options that optimize their purchasing dollar.
- Health systems are enlarging their geographic footprint, and some are forming alliances in different geographic areas, expanding the reach of a network and the capability to provide a consistent health care experience to employers with multiple locations.

Employers should expect to meet some resistance to the eACO concept in certain geographic markets by providers that have not embraced value-based care. But employers located in progressive health care markets should expect to be courted by the providers themselves. Health insurers may argue that their purchasing power can produce a more advantageous value-based contract than any eACO.

Lastly, developing an eACO will not happen overnight. The process begins with direct discussions between employers and health systems, assisted by facilitation from a consultant knowledgeable in ACOs and risk-based provider contracting. Employers can pursue this strategy alone or ideally as part of a purchasing group or coalition or through some other common representation. Providers, too, can engage employers to develop a regional product/solution that fits the unique needs of the market.

Conclusion

Like an automobile, the U.S. health care system may have all the necessary working parts and well-developed set of systems, but when those systems are not aligned to work together in perfect harmony, the result is the broken triangle.

Health care has a multiplicity of systems. It is not any single system that makes things work but the interoperability between them that has the power to transform and invent new transformative architectures.[13]

By forming risk-based partnerships between employers and the providers of health care, the eACO offers an opportunity for employers to develop a cost-saving health plan in which both provider and employer have skin in the game and common incentives to succeed.

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Endnotes

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takeaways

- An *accountable care organization (ACO)* is a network of health care providers that agree to take on financial responsibility for the cost of care, the health outcomes and the customer experience for a defined population.
- *Employee ACOs* (eACOs) are employee health benefit plans that leverage the principles of value-based care via an accountable care platform.
- Many current commercial ACOs are *embedded ACOs* that lack a direct relationship between the employer and health care providers and are less effective at controlling costs.
- EACOs have a data management and measurement warehouse that connects certain patients, including those with chronic diseases, to a physician-led care team and evidence-based clinical programs.
- One essential element of an eACO is a high-performance, clinically integrated network of health system facilities and providers paid through value-based care models that share risk to deliver coordinated care.