CHRT
CENTER FOR HEALTHCARE RESEARCH & TRANSFORMATION

Commercial ACO Products: Market Leaders and Trends

November 2014

In 2006, Elliott Fisher of Dartmouth coined the term "accountable care." Accountable care arrangements are based on three principles:[1,2]

- **Accountability for Quality:** A group of providers is clinically and financially responsible for the entire continuum of care for a group of patients. Depending on the arrangement, providers, hospitals, and health insurers may share responsibility for the patients' care.
- **Shared Savings:** Payers share savings with providers if certain quality and cost goals are met and spending growth is slowed. In certain arrangements, providers may also face payment reductions if they don't meet specified goals.
- **Performance Measurement:** Provider performance is tracked and rewarded based on process, outcome, and patient experience measures.

ACOs are networks of clinicians and hospitals who share medical and financial responsibility for the full continuum of patient care. The Affordable Care Act formalized the term by establishing the Medicare Accountable Care Organization (ACO) program and launching several other ACO models. More than 18 percent of hospitals across the country are estimated to be participating in some form of an ACO, with more expected by the end of 2014.[3]

Simultaneously, many private sector health plans have launched an ACO network that they offer as a distinct insurance product option to individuals and employer groups. These products are based on contractual agreements with selected providers who are chosen based on financial and quality measures. Often, they are offered through Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) structures to encourage members to receive care from network providers.

This paper describes activity concerning commercial insurance products based on ACO networks and builds off the companion brief, "Emerging Health Insurance Products in an Era of Health Reform."[4]

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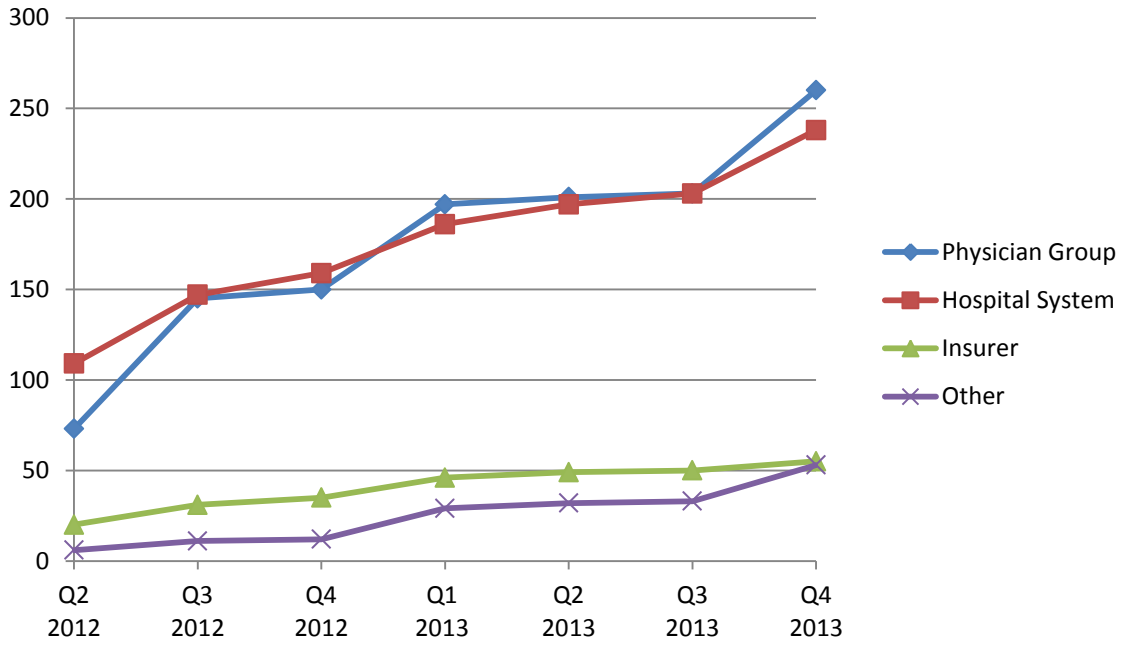
[1] The Dartmouth Institute for Health Policy and Clinical Practice. 2012. Accountable Care Organizations. http://tdi.dartmouth.edu/research/evaluating/health-system-focus/accountable-care-organizations (accessed 8/5/14).
[2] E. Shigekawa and M. Udow-Phillips. November 2013. Emerging Health Insurance Products in an Era of Health Reform. (Ann Arbor, MI: CHRT).
[3] J. Damore and W. Champion. January 19, 2014. The Great ACO Debate: 2014 Edition. The Health Care Blog. http://thehealthcareblog.com/blog/2014/01/19/the-great-aco-debate-2014-edition/ (accessed 8/5/14).
[4] E. Shigekawa and M. Udow-Phillips. November 2013. Emerging Health Insurance Products in an Era of Health Reform. (Ann Arbor, MI: CHRT).

Market Overview

In January 2014, Leavitt Partners reported that a total of 606 public (e.g. Medicare) and private commercial market ACOs delivered care to approximately 18.2 million individuals nationwide, up from 356 ACOs delivering care to 13.6 million people at the end of 2012.[5] Physician groups sponsored 260 of these ACOs, hospitals sponsored 238, payers sponsored 55, and other organizations (such as community organizations and practice management companies) sponsored the remaining 53[6] (see Figure 1).

FIGURE 1: Total Accountable Care Organizations, by Sponsoring Entity[7]



SOURCE: Leavitt Partners Center for Accountable Care Intelligence, as cited in D. Muhlestein, Accountable Care Growth in 2014: A Look Ahead, *Health Affairs Blog*, January 29, 2014.

Leavitt Partners released an updated report in June 2014 that revealed the total number of ACOs had grown to 626 during the first quarter of 2014. Of the 626 ACOs, 287 were commercial ACOs delivering care to an estimated 12.4 million people.[8] Health plan products based on ACO networks are becoming more common, and being offered as one version of a product option based on a limited provider network that includes population health management and financial risk (i.e., possibility to gain or lose money if spending is less than or exceeds predetermined targets). CHRT estimates that as of March 2014, there were 40 health plan–based ACO products available across the country.[9] FIGURE *2* provides a list of the commercial payers offering ACO products.

[5] D. Muhlestein. January 29, 2014. Accountable Care Growth In 2014: A Look Ahead. Health Affairs Blog. http://healthaffairs.org/blog/2014/01/29/accountable-care-growth-in-2014-a-look-ahead/ (accessed 8/5/14).
[6] Ibid.
[7] Ibid.
[8] M. Petersen, P. Gardner, T. Tu, and D. Muhlestein. Growth and Dispersion of Accountable Care Organizations: June 2014 Update. (N.p.: Leavitt Partners, June 2014).
[9] CHRT Analysis of press releases, news articles, and Oliver Wyman research (P. Barlow, S. Wolin, S. Shah, and N. Shah. October 2013. Turning An ACO Into An Insurance Product. http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/archive/2013/NYC-MKT08001-015_ACO_to_ins_product%282%29.pdf).

Figure 2: Commercial Payers Offering ACO Products

Payer	Market Locations	Number of Commercial ACO Products
Aetna	Local offerings in several states	32
Anthem Blue Cross	California	2
Anthem Blue Cross Blue Shield	Wisconsin	1
Blue Cross Blue Shield of Rhode Island	Rhode Island	1
Blue Shield of California	Sacramento and Modesto, CA	1
Health Net	Phoenix, AZ	1
Tufts Health Plan	Boston, MA	1
UnitedHealthcare	Manhasset, NY	1
Total Commercial ACO Products		**40**

SOURCE: CHRT Analysis based on research from Oliver Wyman.

Commercial ACO products currently available through health plans tend to be based on existing PPO or HMO platforms (such as Health Net's HMO-ACO or Anthem Blue Cross' tiered PPO-ACO).[10] Narrow network HMO-ACOs often exclude higher-priced providers from reimbursement, while PPO-ACOs place certain higher-priced providers outside of the provider network. As in other PPOs, members can access these providers if they are willing to pay a higher share of the cost.

Narrow and tiered networks may both be used in ACO products. In narrow networks, providers are either in or out of the network. In tiered networks, providers may be in three or more different categories with a varying level of preference. For example, Tier 1 may be the most preferred provider tier while tiers 2 and 3 are less preferred.

FIGURE 3 provides an overview of the benefit design for several ACO products.

[10] J. Grossman, et al. September 2013. Arranged Marriages: The Evolution of ACO Partnerships in California. California Health Care Almanac. http://www.chcf.org/publications/2013/09/arranged-marriages-acos#ixzz2x1pgP0Xu (accessed 8/5/14).

Figure 3: Overview of ACO Product Benefit Design

Payer and ACO Product(s)	ACO Product Design
Aetna *Whole Health* *Aetna Whole HealthSM (California Only)* *Innovation Health Plan (Virginia Only)*	HMO- and PPO-based; tiered and narrow networks; varies by ACO agreement
Anthem Blue Cross *ACO Core*	PPO-based; narrow network
Anthem Blue Cross *ACO Flex*	PPO-based; tiered network
Anthem Blue Cross Blue Shield *Blue Priority*	HMO- and PPO-based; tiered and narrow networks
Blue Cross Blue Shield of Rhode Island *VantageBlue SelectRI* *VantageBlue* *LifeStyleBlue*	Patient center medical home-based; tiered network; varies by product option
Blue Shield of California *Basic Blue Groove* *Maine Blue Groove* *Care+ Blue Groove*	HMO- and PPO-based; 3-tiered and narrow networks; varies by product option
Health Net *Health Net ExcelCare*	HMO-based; tailored network
Tufts Health Plan *Blue Priority*	HMO-based; narrow network
UnitedHealthcare *UnitedHealthcare North Shore-LIJ Advantage Series*	2- and 3-tiered networks*
*2-tiered product options do not provide out-of-network benefits.	

SOURCE: Aetna, Anthem Blue Cross, Anthem Blue Cross Blue Shield, Blue Cross Blue Shield of Rhode Island, Blue Shield of California, Health Net, Tufts Health Plan, UnitedHealthcare**.**

Payers most active in establishing ACO products, such as Aetna, are heavily marketing their products to individuals and employers of all sizes. The individual and small group markets have the greatest projected interest in ACO products due to consumer price sensitivity.

Physician organizations and hospitals generally partner with health plans to provide ACO insurance products. However, there are some cases of physician and health system led ACOs contracting directly with employers (and a third party administrator for claims payment) to provide care for employees. For example, the Aurora Accountable Care Network (AACN) is directly contracting with self-insured groups of 250+ employees and at the same time is separately offering ACO-based products for fully insured groups through Aetna and Anthem Blue Cross Blue Shield.[11] As of April 2013, Aurora's ACO contracted directly with approximately 40 employers.[12] At this time, there is no publicly available data on the number of direct contracts between ACOs and self-insured employers.

[11] Aurora Accountable. Care Network 2014. Aurora Health Care. http://www.aurorahealthcare.org/services/aurora-accountable-care-network (accessed 8/5/14).
[12] R. Kirchen. April 26, 2013. Aurora ACO already has 40 employers. Milwaukee Business Journal. http://www.bizjournals.com/milwaukee/print-edition/2013/04/26/aurora-aco-already-has-40-employers.html?page=all (accessed 8/5/14).

ACO Products and Narrow Networks

Narrow networks are health plan options that feature a more constricted provider network and lower premiums than those in a PPO product. Narrow network products are prevalent options on the individual marketplace; nearly half (48 percent) of all marketplace plans in 2014 were narrow network plans.[13,14] Narrow networks are widespread due to the price sensitivity of individual health plan consumers and their willingness to accept network restrictions in exchange for lower premiums.[15] A Kaiser Family Foundation survey found that for consumers who are uninsured or are buying their own coverage (as opposed to employer coverage), 54 percent would rather save money and accept a narrower choice.[16] The Affordable Care Act requires plans sold on the health insurance marketplace to maintain an "adequate" provider network; however, states and insurers have the flexibility to interpret what it means to offer adequate access to services.[17,18] Some states have established more stringent or concrete adequacy standards than others.[19] Amid concerns over access to care and providers, federal regulators intend to more closely scrutinize plan networks for adequacy.

There are some inherent design differences between narrow networks and ACO products. Unlike ACO products, narrow networks do not incorporate the level of risk or partnership that an ACO entails. Nevertheless, commercial ACOs can use narrow networks as a tool to discourage their patients from seeking care outside of their ACO, and to incentivize consumers to stay within the ACO network via lower out-of-pocket costs.[20] In this regard, narrow networks are a potential stepping stone to ACOs. First, limiting the provider network could help control costs and manage referrals. Next, ACOs manage care and quality for their entire patient population. It remains to be seen if ACO products in practice will achieve clinical transformation beyond narrowing the provider network, or will emerge as a modified narrow network model.

[13] The McKinsey Center for U.S. Health System Reform defined a narrow network as a network that includes participation of between 31 and 70 percent of all hospitals in the rating area.
[14] McKinsey Center for U.S. Health System Reform. 2014. Hospital networks: Updated national review of configurations on the exchanges. http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf (accessed 6/16/14).
[15] M. Brodie, J. Firth, L. Hamel. February 2014. Kaiser Health Tracking Poll: February 2014. Kaiser Family Foundation. http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/ (accessed 5/30/2014)
[16] Ibid.
[17] S. Corlette, J. Volk, R. Berenson, and J. Feder. 2014. Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care. The Center on Health Insurance Reforms, Georgetown Health Policy Institute and the Urban Institute. http://www.urban.org/UploadedPDF/413135-New-Provider-Networks-in-New-Health-Plans.pdf (accessed 5/30/14).
[18] S. Corlette, K. Lucia, and S. Ahn. 2014. Implementation of the Affordable Care Act: Cross-Cutting Issues Six-State Case Study on Network Adequacy. The Urban Institute. http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649 (accessed 9/24/2014).
[19] S. McCarty and M. Farris. 2013. ACA Implications for State Network Adequacy Standards. State Health Reform Assistance Network, Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486 (accessed 6/25/14).
[20] M. Evans. March 12, 2014. Reform Update: Narrow networks bring equal parts controversy and savings. Modern Healthcare. http://www.modernhealthcare.com/article/20140312/NEWS/303129969 (accessed 6/16/14).

ACO Product Performance

There is no publically available data at this time to objectively evaluate commercial ACO product performance.[21] The following points summarize the currently available information on quality, health care costs, patient experience, and risk adjustment with regard to ACO products.

- **Quality measurement:** Payers and providers are generally relying on existing metrics developed by third-party organizations, particularly the Healthcare Effectiveness Data and Information Set (HEDIS) and the Physician Quality Reporting System (PQRS), to measure the quality and performance of commercial ACOs. Commercial ACO quality measures tend to overlap with Medicare ACO quality measures.[22,23]

- **Health care costs:** Most sources suggest that it is premature to measure actual cost savings of commercial ACO products. ACO products have projected goals of 5 to 15 percent cost savings (and corresponding premium savings). Achieving a sustained level of savings over the long term is likely to be increasingly difficult, as ACO product partners are expected to achieve the most accessible savings in the short term.[24] Over the long term, cost savings may result from efficiencies, such as improvements in care management and population health management.

- **Patient experience:** Payers and providers are generally using existing standardized measures to assess patient experience in ACO products, primarily Consumer Assessment of Healthcare Providers and Systems—Clinical and Group (CG-CAHPS). CG-CAHPS is a standardized survey that focuses on patient care experience, rather than satisfaction.[25] Similar to patients in standard HMOs, patients enrolled in an ACO product require more education and information than patients in a broader provider network on the features of the product (for example, the benefits of a medical home model) and advantages of staying within the ACO network.

- **Patient attribution:** Attribution, which defines which providers are held accountable for which patients, is fundamentally different in ACOs based on HMO versus PPO platforms. Notably, it is more feasible to manage member cost of care in an HMO-ACO, where the network is strictly limited and members can be attributed to a specific primary care provider. Depending on the attribution methods, providers in a PPO-ACO may not know which patients they are accountable for until after the fact (that is, after the performance period).

[21] M. Evans. March 12, 2014. Reform Update: Narrow networks bring equal parts controversy and savings.
[22] A. Higgins, G. Veselovskiy, and L. McKown, Provider Performance Measures In Private And Public Programs: Achieving Meaningful Alignment With Flexibility To Innovate. Health Affairs,32 (8): 1453–1461. http://content.healthaffairs.org/content/32/8/1453.full?sid=c67163cb-bec3-4485-9853-c9880f2eb7a1 (accessed 8/5/14).
[23] Z. Song, et al. 2012. The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending, and Improved Quality. Health Affairs 31(8): 1885–1894.
[24] J. Grossman, et al. September 2013. Arranged Marriages.
[25] Shaller Consulting Group. March 2013. Forces Driving Implementation of the CAHPS Clinical & Group Survey. Aligning Forces for Quality, Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf72668 (accessed 8/5/14).

Market Leaders

Aetna, Anthem Blue Cross, and Blue Shield of California are leading the development of commercial ACO products. Blue Cross Blue Shield of Massachusetts is also included as a market leader because of its longstanding Alternative Quality Contract (AQC) and the published research on its performance as an early commercial accountable care model. However, the AQC is not yet an insurance product offering. The following provides a brief overview of these four plans.

Aetna

Aetna, a national health plan, launched its first ACO product, *Aetna Whole Health*, in 2011 with Virginia-based Carilion Clinic. It has since developed similar co-branded products with established ACOs across the country, allowing the Aetna to increase its local presence by partnering with reputable health systems. By the end of 2013, Aetna had 32 ACO provider agreements covering 550,000 members. Aetna hopes to reach 60 ACOs serving 850,000 members by the end of 2014. If achieved, the health plan expects to earn 7 percent of its total revenue from these arrangements.[26]

Benefit designs for Aetna's ACO products differ with each agreement; however, all products use either a tiered or narrow network. FIGURE 4 provides an example of the three-tier benefit structure commonly found in its ACO products.

Figure 4: Example of Aetna ACO Product Tiers

Benefit Tier	Description of Tier
Tier 1	Offers members lower premiums and out-of-pocket costs when care is received within the ACO network
Tier 2	Offers members access to Aetna's network providers who are not in the ACO network at a higher cost than when care is received in the ACO network
Tier 3	Offers members access to out-of-network providers at an even higher cost than when care is rendered by a non-designated network provider

SOURCE: Aetna Accountable Care Solutions.

Target markets for Aetna's co-branded products also vary by ACO, but emphasis has been on the individual and small employer markets. The health plan is currently offering an ACO product on the health insurance marketplace in Virginia, with more expected in 2015, and is guaranteeing some small Wisconsin employers that they will experience claims costs up to 10 percent below their previous claims expenses if they sign a three-year contract.[27]

Little is available on the performance of Aetna's ACO products. The health plan predicts an 8 to 15 percent decrease in medical costs during each ACO's first year, with smaller decreases in later years.[28]

Anthem Blue Cross

In California, Kaiser Permanente's market dominance and a strong presence of physician organizations accustomed to risk sharing have driven commercial accountable care activity. Both payers and providers view commercial accountable care contracts as a strategy for competing with Kaiser Permanente. Furthermore, the California Public Employees Retirement System (CalPERS), the largest health purchaser in California, has prompted insurers to try to control spending and premium growth via accountable care arrangements.[29]

[26] J. Miller. February 1, 2014. Data Will Drive ACOs in the Real World. Managed Healthcare Executive. http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/aetna-ceo-accountable-care-real-world?contextCategoryId=21 (accessed 8/4/14).
[27] J. Anderson. September 2012. Aetna, Aurora Launch ACO Plan Featuring Premium Guarantee. AISHealth 3(9), reprinted from ACO Business News. http://aishealth.com/archive/nabn0912-04 (accessed 8/5/14).
[28] C. Williams. November 19, 2013. ACOs as private label insurance products. Western Pension Benefits Council. http://www.wpbcseattle.org/Resources/Presentations/2013-11-19%20Presentation%20-%20John%20Stockton.pdf (accessed 8/5/14).
[29] J. Grossman, et al. September 2013. Arranged Marriages.

In 2011, Anthem Blue Cross launched its first tiered network PPO-ACO with Sharp HealthCare, HealthCare Partners, and Santa Clara County IPA in San Diego. As of October 2013, Anthem Blue Cross has 11 provider partners across the state and expects to add more in 2014.[30,31] Anthem Blue Cross requires its potential provider partners meet several criteria before entering an accountable care product contract agreement, including:

- A minimum population eligible for membership of at least 15,000 members;
- An adequate network of ACO professionals to provide total care to the defined population;
- Defined relationships with hospitals and physicians; and
- A willingness to enter a five-year contractual relationship.

The payer offers two major categories of ACO products in its California market: ACO Core and ACO Flex, described in FIGURE 5. As of January 2013, Anthem paid providers a fee-for-service rate plus monthly incentive payments for managing care with an intention to move to partially capitated payments where providers are expected to provide and manage multiple (but not all) services for a pre-set rate. Eventually, Anthem expects to shift to global payments where provider organizations are paid a fee to cover a broader range of services for a patient population.

Figure 5: Overview of Anthem Blue Cross' ACO Flex and ACO Core Products

Anthem ACO Option	Description of Option
ACO Flex	A three-tier PPO-ACO offering: • *Tier 1*: ACO network providers, lowest out-of-pocket costs; • *Tier 2*: PPO network providers, middle out-of-pocket costs; • *Tier 3*: Non-contracting out-of-network providers, highest out-of-pocket costs. Aimed at large group employers.
ACO Core	A narrow network PPO with access only to ACO network providers, self-referral within ACO network; aimed at small group market and aggressively priced.

SOURCE: Anthem Blue Cross.

In 2013, Anthem Blue Cross, HealthCare Partners, Santa Clara County IPA, and Sharp HealthCare released limited performance outcomes from 2012, the first full year of operation. Anthem Blue Cross and partner providers reported a 35 percent increase in the number of mammograms performed and a 44 percent increase in appropriate prescribing of antibiotics for bronchitis.[32] In September 2014, Anthem Blue Cross announced a partnership with seven hospital systems to create, Anthem Blue Cross Vivity, an integrated health system in Los Angeles and Orange counties.[33] Vivity is similar to an HMO in structure, but will incorporate elements of ACOs, such as shared savings wherein Anthem Blue Cross and the providers will share in profits and losses.[34] Beginning in January 2015, Vivity will be offered to employers with 50 or more employees.

[30] Anthem Blue Cross. N.d. UCLA Joins Anthem Blue Cross ACO Network; Individuals Who Buy Insurance on Exchange May Be Able to Access UCLA's ACO. Anthem Blue Cross press release. https://www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2013/1473/ucla-joins-anthem-blue-cross-aco-network-individuals-who-buy-insurance-on-exchange-may-be-able-to-access-ucla-s-aco (accessed 8/5/14).
[31] Sansum Clinic Joins Anthem Blue Cross ACO Program, Signs on to Serve Anthem Members Purchasing through Covered CA. February 18, 2014. Market Watch. http://www.marketwatch.com/story/sansum-clinic-joins-anthem-blue-cross-aco-program-signs-on-to-serve-anthem-members-purchasing-through-covered-ca-2014-02-18 (accessed 8/5/14).
[32] Anthem Blue Cross. January 2014. Institutional Network Update. http://www.anthem.com/ca/provider/f5/s3/t3/pw_e211138.pdf (accessed 8/5/14).
[33] Introducing Anthem Blue Cross Vivity. Anthem Blue Cross. http://www.vivityhealth.com/ (accessed 9/24/2014).
[34] B. Herman. New Anthem network makes business case for HMO-ACO hybrid. Modern Healthcare. http://www.modernhealthcare.com/article/20140917/NEWS/309179964 (accessed 9/17/2014).

Blue Shield of California

Blue Shield of California, Dignity Health (a hospital system), and Hill Physicians Medical Group (a physician group) launched an ACO pilot project in January 2010 in Northern California, using a global budget payment model, to care for 41,000 individuals covered by the California Public Employees Retirement System (CalPERS). The three organizations worked together to identify initiatives to improve care and shared in both savings and losses.[35]

Analysis of the ACO's performance over four years found that:[36]

- Length of stay decreased by 15.4 percent
- Total inpatient days decreased by 16.2 percent
- Inpatient admission rate remained unchanged
- Emergency room visits increased by 17 percent
- Inpatient population risk score (a measure of patient complexity based on provider documentation) increased by 13 percent

Since 2010, the pilot has resulted in gross savings of $105 million: $10.36 million to providers as incentive payments and $95 million in net savings to CalPERS members.[37] In the first year, members of the pilot ACO had costs that were 10 percent lower than other Northern California members who were not in the ACO. Savings resulted from reductions in utilization and from a slowed rate of increase in the unit cost of provider reimbursement in the ACO pilot.[38] Over four years, the ACO was associated with a 3 percent increase in cost of health care growth, compared to a non-ACO annualized increase of 7.6 percent.[39]

This ACO network is now available to Northern California members beyond CalPERS via Blue Shield of California's Blue Groove product. The product allows members to choose a benefit model that best fits their health care needs and preferences. The three available options are described in FIGURE 6.

Figure 6: Overview of Blue Shield of California's Blue Groove Product Options

Blue Groove Options	Description of Options
Basic Blue Groove	A broad PPO-based network with out-of-network coverage for doctors, specialists, and hospitals at a higher cost.
Main Blue Groove	An HMO-based network with access to PPO and out-of-network providers for covered services. The product offers incentives, including reduced rates and cash rewards, for improving health.
Care+ Blue Groove	A primary care medical home model, with no access to the PPO network and no out-of-network coverage, for consumers with one or more qualifying chronic condition.

SOURCE: Blue Shield of California.

[35] J. Grossman, et al. September 2013. Arranged Marriages.
[36] G. Melnick and L. Green. April 2014. Four Years Into A Commercial ACO For CalPERS: Substantial Savings And Lessons Learned. Health Affairs Blog. http://healthaffairs.org/blog/2014/04/17/four-years-into-a-commercial-aco-for-calpers-substantial-savings-and-lessons-learned/ (accessed 8/5/14).
[37] Ibid.
[38] P. Markovich. 2012. A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years. Health Affairs 31(9): 1969–1976.
[39] G. Melnick and L. Green. April 2014. Four Years Into A Commercial ACO For CalPERS.

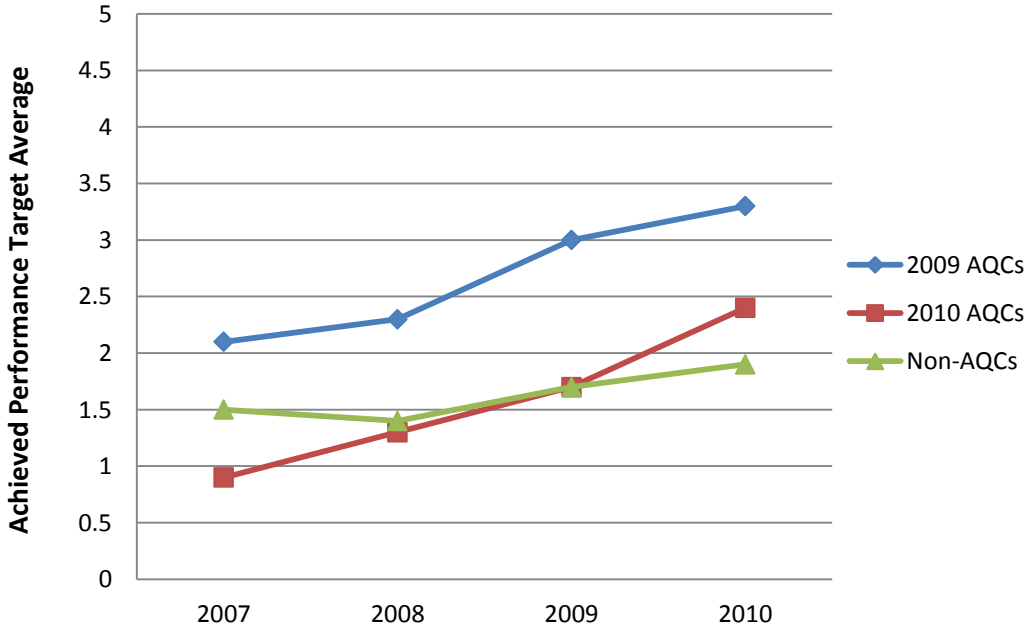
Blue Cross Blue Shield of Massachusetts (BCBSMA)

BCBSMA, unlike the other featured payers, does not offer an ACO product but has stated they will be designing products based on its Alternative Quality Contract (AQC).[40] The AQC is notably one of the few rigorously studied commercial accountable care arrangements—but it is not an insurance product that consumers can select as their health plan. BCBSMA introduced its AQC in 2009. This model is a five-year global budget accountable care agreement that applies mostly to HMO members and uses quality performance incentive payments.[41,42] Today, BCBSMA has 85 percent of HMO primary care physicians and 86 percent of specialists participating in the AQC, caring for approximately 85 percent of the health plan's HMO members.[43]

The AQC rewards provider groups based on their performance on 64 quality measures, many of which overlap with Medicare's 33 ACO program quality measures. Each quality measure used in the AQC includes a range of performance targets (1–5). The lowest target within a measure, Target 1, is set at the network median while the highest target, Target 5, is the best achievable performance.[44] Outcome measures are weighted more heavily than process and patient experience measures.

During the initial two years of the risk-sharing contracts, providers participating in the AQC demonstrated higher performance outcomes, on average, compared to non-AQC providers.[45] FIGURE 7 compares the quality improvements of the first and second cohorts, which began 2009 and 2010, to those of non-AQC providers.

Figure 7: Average Provider Performance by BCBSMA Contract Groups



SOURCE: Blue Cross Blue Shield of Massachusetts, 2012. Massachusetts Payment Reform Model: Results and Lessons. https://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf.

Overall, participation in the AQC was associated with 2.8 percent savings (a $22.58 decrease in average spending per enrollee per quarter) compared to non-participating control groups.[46] Self-selection of provider groups into the AQC was a concern in

[40] R. Mandel. N.d. An Alternative Quality Contract. Blue Cross Blue Shield of Massachusetts. http://www.genesys.org/GRMCWeb.nsf/HW_28.pdf (accessed 8/5/14).
[41] M. E. Chernew, R. E. Mechanic, B. E. Landon, and D. G. Safran. 2011. Private-Payer Innovation In Massachusetts: The 'Alternative Quality Contract'. Health Affairs, 30(1), 51–61. http://content.healthaffairs.org/content/30/1/51.full?sid=3ee4066a-14ec-4bb4-a664-ae34c1936c95 (accessed 8/5/14).
[42] Z. Song et al. 2012. The 'Alternative Quality Contract.'
[43] Blue Cross Blue Shield of Massachusetts. February 19, 2014. Blue Cross Blue Shield of Massachusetts President and CEO Andrew Dreyfus Outlines Ways to Address the Rising Cost of Health Care. https://www.bluecrossma.com/visitor/newsroom/press-releases/2014/2014-02-19.html (accessed 8/5/14).
[44] Ibid.
[45] Ibid.

the evaluation. The evaluation tested for differences in pre-AQC spending trends between AQC providers and non-AQC providers, which could indicate a self-selection bias, but did not find a difference.[47] Participating organizations achieved savings largely by shifting procedures to facilities with lower fees and, in some cases, lowering utilization of some services. Provider groups who entered the AQC contract after previously being reimbursed fee-for-service only (rather than any risk-based contract) reached substantially greater savings, averaging 8.2 percent savings over first two years. For these groups, lower use of certain healthcare services accounted for about half of the savings. The largest spending reductions were found among sicker, more complex enrollees found in the highest risk quartile.[48]

Summary

Following the inception of the Medicare ACO program, commercial accountable care products are becoming more widespread. While a few plans have shown early promising quality and cost improvements, overall it is too soon to fully assess the impact of commercial ACO products. Health insurers are using multiple models to offer ACO products, such as ACO products layered upon HMO or PPO platforms. Health insurers are not the only entities that offer commercial ACO offerings. Direct contracts between ACOs and employers and health systems with integrated insurance offerings are sources of competition for health insurers. Results over time will provide more information about the impact of ACO products on consumers, providers and insurers.

Authors: Erin Shigekawa, MPH and Kersten Lausch, MPP

[46] Z. Song et al. 2012. The 'Alternative Quality Contract.'
[47] Ibid.
[48] Ibid.