HEALTH POLICY

From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy

Theodore Marmor, PhD¹ and Jonathan Oberlander, PhD^{2,3,4}

¹School of Management and Department of Political Science (emeritus), Yale University, New Haven, CT, USA; ²Department of Social Medicine, University of North Carolina School of Medicine, Chapel Hill, NC, USA; ³Department of Health Policy and Management, University of North Carolina Gillings Global School of Public Health, Department of Social Medicine, University of North Carolina School of Medicine, Chapel Hill, NC, USA; ⁴Visiting Scholar, Center for Health and Wellbeing, Princeton University, Princeton, NJ, USA.

The United States has been singularly unsuccessful at controlling health care spending. During the past four decades, American policymakers and analysts have embraced an ever changing array of panaceas to control costs, including managed care, consumer-directed health care, and most recently, delivery system reform and value-based purchasing. Past panaceas have gone through a cycle of excessive hope followed by disappointment at their failure to rein in medical care spending. We argue that accountable care organizations, medical homes, and similar ideas in vogue today could repeat this pattern. We explain why the United States persistently pursues health policy fads—despite their poor record—and how the promotion of panaceas obscures critical debate about controlling health care costs. Americans spend too much time on the quest for the “holy grail”—a reform that will decisively curtail spending while simultaneously improving quality of care—and too little time learning from the experiences of others. Reliable cost control does not, contrary to conventional wisdom, require fundamental delivery system reform or an end to fee-for-service payment. It does require the U. S. to emulate the lessons of other nations that have been more successful at limiting spending through budgeting, systemwide fee schedules, and concentrated purchasing.

KEY WORDS: health reform; accountable care organizations; cost control.

J Gen Intern Med 27(9):1215–8

DOI: 10.1007/s11606-012-2024-6

© Society of General Internal Medicine 2012

The United States has the most expensive medical care system in the world by a large margin, with per capita expenditures of \$7960 in 2009.¹ Moreover, despite a recent slowdown due largely to the recession’s impact, the U.S. is projected to spend over \$30 trillion on medical care in the coming decade.² Over four decades after President Richard Nixon declared a cost crisis, the United States has yet to get a firm grip on rising medical care costs.

The failure to control health care spending has been accompanied by a distinctive dynamic. Since the 1970s, American policymakers and policy analysts have relentlessly searched for the “the Big Fix,”³ a reform that will decisively rein in spending and simultaneously improve the coordination and quality of medical care. The combination of these ambitious goals and our dismal record of cost containment has not diminished the health policy community’s endless enthusiasm for the latest fad. We have run through a truly staggering list of proposed panaceas: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), managed care, capitation, integrated delivery systems, health savings accounts (HSAs) and consumer-directed care, pay for performance (P4P), health information technology (HIT), comparative effectiveness research (CER) and much more. Now, bundled payment, value-based purchasing, patient-centered medical homes, and accountable care organizations (ACOs) have emerged as the solutions of the day, propelled forward by the 2010 Patient Protection and Affordable Care Act (ACA) and by private sector initiatives.

Reforms aimed at slowing health care spending have encompassed (and often combined) a range of organizational (HMOs, ACOs), financial (bundling, HSAs, P4P, ACOs), and informational (HIT, CER) approaches. Some reforms have called for more patient cost-sharing, others for tighter control of medical services by health plans, and still others for more evidence to guide medical decision-making. Thus the U.S. has moved rhetorically from the era of managed care to consumer-directed health care and now into the era of value purchasing and delivery system reform. The range of available ideas is evidently narrow enough that we are now repeating fads—yesterday’s conviction that capitation held the key to stemming the tide of rising costs is reborn in today’s faith in bundling while integrated delivery systems and HMOs have morphed into ACOs.⁴

THE SEARCH FOR THE HOLY GRAIL

Fads in American health policy come and go so quickly that there is too little reflection about their origins, effects, and whether any are actually effective approaches to controlling

Received February 1, 2012

Accepted February 9, 2012

Published online March 13, 2012

health care spending. Why do American analysts keep searching for the Holy Grail in health policy and what impact has that quest had on our medical care? American health policy is dominated by the search for these policies largely because of their political appeal. Reform labels promise to modernize and rationalize the health care system. Who can oppose the march of progress to replace paper medical records or our ostensibly antiquated fee-for-service payment arrangements? How can anyone oppose reforms that promise to curb medical spending and yet improve health outcomes? Indeed, because panaceas promise to moderate spending by reducing ineffective care, improving coordination, and keeping people healthy, such policies offer the prospect of painless cost control.⁵

That is powerfully alluring for politicians who want to avoid the conflict associated with policies such as imposing budgetary caps, limiting payments, restricting the availability of services, or cutting benefits. Further, if new organizations can be created to handle the task of making the difficult choices, or if new payment tools can be adopted that automatically unleash the right incentives, politicians can avoid blame for unpopular decisions. Innovation and its promise to enhance efficiency is an appealing substitute for policy realism and political will.

Many of these reform ideas are framed in ways that makes rational criticism seem implausible. Few will defend “medical homelessness” or argue that the U.S. medical care system needs less coordinated care. Indeed, a key characteristic of many reforms is that their descriptive labels are not actually descriptive, but instead comprise persuasive definitions.⁶ We used to label health care organizations by their primary characteristics; Kaiser Permanente was accurately known as a “prepaid group practice.” But beginning with the Nixon administration’s campaign to promote Health Maintenance Organizations in the 1970s, policy-makers and analysts increasingly started to label organizations and policies more by their aspirations, rather than by their substantive characteristics. “Managed care” and “patient-centered medical homes” exemplify such marketing slogans, terms that imply success by their very use. Yet many so-called managed care plans actually don’t do much to manage care.⁷ And whether a health care institution is “patient centered” is an empirical question (assuming we could agree on a definition of what it means to be patient-centered). In other words, the language used to describe many health reforms is meant to convince rather than to describe and explain, and that obscures realistic assessments of their appeal and impact.

Another reason that Americans look for the “big fix” is the absence of a coherent national health system. In most industrialized democracies, health care spending is controlled “upstream” through budgeting, fee schedules, and systemwide limits on medical capacity. But adopting such measures in the U.S. political system has been and remains extraordinarily

difficult. Restraining spending requires reducing the income of health care providers who historically have been effective at resisting robust cost controls.⁸ In addition, government measures to reduce spending growth invite charges of rationing that tap into many Americans’ distrust of government—recall the hysteria over mythical “death panels” during the 2009-2010 health care reform debate. And America’s fragmented political institutions give opponents multiple chances to defeat or weaken proposals to limit spending.

In fact, the U.S. has not had a national health system at all and consequently, cost containment efforts often focus “downstream” to regulate the costs of individual medical encounters.⁹ These efforts are typically led by individual employers and health plans, actors that by definition cannot pursue systemwide solutions. Our enthusiasm for innovative and organizational solutions to cost containment is, then, partly a product of our political incapacity to produce universal health insurance. Belief in “American exceptionalism”—that as a nation we are too different culturally, socially, and politically to learn from other countries—has reinforced America’s tendency to look inward for solutions to control health care spending.

Problems with Panaceas

There are five major problems with the endless search for cost control panaceas. The first is that the yearning for a transcendent solution inevitably produces a cycle of exaggerated expectations, followed by deep disappointment. The problem, as Bruce Vladeck argues, begins when a “modestly successful innovation is hyped as the unique and unitary solution to some complex, persistent problem.”¹⁰ Thus many policy analysts celebrated the rise of managed care during the early to mid-1990s as the solution to America’s health care spending problem. But as health care costs started to accelerate again, analysts quickly turned to writing managed care’s obituary.

Similarly, it will be difficult for ACOs to meet the lofty expectations that now surround them. ACO euphoria is evident in Ezekiel Emanuel and Jeffrey Liebman’s foolhardy prediction that “By 2020, the American health insurance industry will be extinct,” replaced entirely by ACOs.¹¹ Given the hype about their transformational impact, it is worth remembering the Centers for Medicare and Medicaid Services (CMS) median estimate that the ACO Shared Savings Program will reduce federal government spending on Medicare by only a total of \$470 million during 2012-15, a tiny fraction of total program expenditures.¹² Moreover, a recent review by the Congressional Budget Office of disease management, care coordination, and value-based payment demonstrations—all ideas currently touted as solutions to Medicare’s financing challenges—found that “most programs have not reduced Medicare spending.”¹³

Second, because we invest so much hope and faith in new solutions, and because persuasive labels make these ideas appear self-evidently right, the real-world challenges in making policies work are commonly overlooked. Aspirations are undercut by implementation problems, unanticipated outcomes and political constraints. Managed care triggered backlash from providers and patients. Supposedly the least effective form of managed care—PPOs—surprisingly emerged as the victor in the market by the beginning of the 2000s.¹⁴ ACOs may enhance integration of some providers and foster better coordination of some care. But the incentives to create ACOs may also lead to greater consolidation of health care providers and to hospitals purchasing physician practices, both of which could raise overall health spending.¹⁵

A third problem is generalizability. The enthusiasm for particular reforms often stems from positive results in a particular geographic and institutional settings: Kaiser Permanente, the Palo Alto clinic and the Mayo Clinic were held up as exemplars in the past, today they are joined by the Veterans Administration, Geisinger, and Intermountain. These institutions have in many cases produced impressive results. But the success of any particular institution does not imply that its performance can be extrapolated to the whole of American medicine. The difficulties Kaiser has had in making its model work outside of its traditional regions illustrates this point.¹⁶ And the VA has a level of organizational centralization that is not found in most other areas of American medicine. Creating new types of organizations is extraordinarily difficult and replicating them across different institutional, political, economic and geographic settings is even more so.¹⁷

A fourth problem is that these reform ideas usually focus on reducing the utilization of medical services. There are, to be sure, many instances of low-value medical care in the U.S. worth reducing.^{18,19} And in the past decade, increases in Medicare expenditures on physician services have been driven mostly by growth in service volume and intensity.²⁰ But a predominant focus on utilization diverts us from other important sources of high health care spending.^{21–23} The difference between Canadian and American spending on hospital and physician care, according to a recent study, is mostly explained by prices and administrative expenses, reflecting the lower costs of Canada's single-payer system.²⁴ Only 14% of the difference is attributable to higher utilization of medical services in the U.S. Yet American policy analysts continue to focus on ways to limit excessive utilization, while giving comparatively short shrift to policies—such as all-payer reform—that could lower prices and administrative costs.

The final and most serious problem is that the American quest for cost control fads hasn't worked—which helps explain why the U.S. keeps searching for more panaceas. Medical care spending did slow for a time during the

managed care era but, emblematic of the issues described above, much of that slowdown was attributable to price restraints.²⁵ Still, the overall record of health care cost control in the U.S. is dismal. That doesn't mean that the latest fad of delivery system reform is a bad thing. Perhaps these and other reform ideas currently in vogue will produce some savings. But even if they don't reduce spending, reforms that encourage ACOs and medical homes will be worthwhile if they improve the delivery and quality of care, and patient outcomes. Cost savings should not be the only metric by which we judge the desirability of health care reforms.

Emulation, Not Innovation

We do not know how far ACOs will spread or what impact they, medical homes or other delivery system reforms will have on health care spending. But our history of failed cost control offers sobering lessons about exaggerated expectations, the limits of organizational reforms, and the recurring temptation to oversell reform ideas like ACOs as panaceas and the harbingers of a new, radically transformed, and vastly improved health care system. Such ideas should be seen as supplements, rather than the basis for a national strategy of health care cost control.

We believe that the U.S. needs less innovation and more emulation.²⁶ That is, in order to control costs effectively Americans should focus less on (re)inventing the latest delivery system or payment method, and instead pay more attention to what other countries do to slow health care spending.²⁷ Global budgets, fee schedules, systemwide payment rules, and concentrated purchasing power may not be modern, exciting or “transformational”. But they have the advantage of working.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

Corresponding Author: Jonathan Oberlander, PhD; Department of Social Medicine, University of North Carolina School of Medicine, CB# 7240, Chapel Hill, NC 27599-7240, USA (e-mail: oberland@med.unc.edu).

REFERENCES

1. Organisation for Economic Co-operation and Development (OECD). OECD Health Data 2011 - Frequently Requested Data. http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (Accessed 2/9/12).
2. Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2010-2020. <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf> (Accessed 2/9/12).
3. Vladeck BC. Managed care's fifteen minutes of fame. *J Health Polit Polic.* 1999;24:1207–1211.

4. **Oberlander J.** Throwing darts: Americans' elusive search for health care cost control. *J Health Polit Polic.* 2011;36:477-484.
5. **Marmor T, Oberlander J, White J.** The Obama administration's options for health care cost control: hope versus reality. *Ann Intern Med.* 2009;150:485-489.
6. **Marmor T.** Fads, fallacies, and foolishness in medical care management and policy. London: World Scientific Publishing; 2009.
7. **Marmor T.** Fads, fallacies, and foolishness in medical care management and policy. London: World Scientific Publishing; 2009.
8. **Marmor T, Oberlander J, White J.** The Obama administration's options for health care cost control: hope versus reality. *Ann Intern Med.* 2009;150:485-489.
9. **Reinhardt UE.** The predictable managed care kvetch on the rocky road from adolescence to adulthood. *J Health Polit Polic.* 1999;24:897-910.
10. **Vladeck BC.** Managed care's fifteen minutes of fame. *J Health Polit Polic.* 1999;24:1207-1211.
11. **Emanuel EJ, Liebman JB.** The end of health insurance companies. *New York Times Opinionator.* January 30, 2012. <http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/?scp=3&sq=health%20insurance&st=cse> (Accessed 2/13/12)
12. American College of Radiology. Table 1. Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings. <http://www.acr.org/SecondaryMainMenuCategories/NewsPublications/FeaturedCategories/CurrentACRNews/archive/ACO-Final-Rule-Tables.aspx> (Accessed 2/9/12).
13. Congressional Budget Office. Lessons from Medicare's demonstration projects on disease management, care coordination, and value-based payment. Washington: Congressional Budget Office; 2012.
14. **Hurley RE.** The puzzling popularity of the PPO. *Health Aff (Millwood).* 2004;23:56-68.
15. **Berenson RA, Burton RA.** Accountable care organizations in medicare and the private sector: a status update. Washington, DC: Robert Wood Johnson Foundation/Urban Institute, November 2011. <http://www.rwjf.org/files/research/73470.5470.aco.report.pdf> (Accessed 2/13/12).
16. **Gitterman DP, Weiner BJ, Domino ME, et al.** The rise and fall of a Kaiser Permanente expansion region. *Milbank Q.* 2003;81:567-601.
17. **Brown LD.** Politics & health care organizations: HMOs as federal policy. Washington: Brookings Institution; 1983.
18. **Redberg RF.** Squandering Medicare's money. *New York Times.* May 25, 2011.
19. **Korenstein D, Falk R, Howell EA, et al.** Overuse of health care services in the United States: an understudied problem. *Arch Intern Med.* 2012;172:171-178.
20. **Iglehart JK.** Medicare payment reform—proposals for paying for an SGR repeal. *N Engl J Med.* 2011;365:1859-1861.
21. **Vladeck BC, Rice T.** Market failure and the failure of discourse: facing up to the power of sellers. *Health Aff (Millwood).* 2009;28:1305-1315.
22. **Oberlander J, White J.** Public attitudes toward health care spending aren't the problem; prices are. *Health Aff (Millwood).* 2009;28:1285-1293.
23. **Anderson GF, Reinhardt UE, Hussey PS, et al.** It's the prices, stupid: why the United States is so different from other countries. *Health Aff (Millwood).* 2003;22(3):89-105.
24. **Pozen A, Cutler DM.** Medical spending differences in the United States and Canada: the role of prices, procedures, and administrative expenses. *Inquiry.* 2010;47:124-134.
25. **Cutler DM, McClellan M, Newhouse JP.** How does managed care do it? *RAND J Econ.* 2000;31:526-548.
26. **Oberlander J.** Throwing darts: Americans' elusive search for health care cost control. *J Health Polit Polic.* 2011;36:477-484.
27. **White J.** Competing solutions: American health care proposals and international experience. Washington: Brookings Institution; 1995.