Past

Imagine a scenario: political wrangling over national health care policy, a general public concerned about rising health care costs and new models for delivering and paying for health care. Sound familiar? While this could describe the current public debate surrounding the Affordable Care Act (ACA), the same conditions held true in 1973 when the Nixon Administration passed the Health Maintenance Organization Act.

At the time, the HMO Act was hailed as “an experiment, an opportunity to evaluate what is hoped to be a major alternative health care delivery system”\(^1\). The Act, at its core, aimed to control health care spending and synchronize care delivery. To achieve these goals, the Act authorized $375 million in funding to promote the development of health maintenance organizations (HMOs). Additionally, the Act required many employers to offer HMO insurance options to their employees. Taken in aggregate, the Act marked a significant shift away from the fee-for-service model and introduced managed care to millions of Americans.

The basic HMO used an at-risk structure and provided comprehensive health coverage for a fixed monthly fee to the providers of that health care, also known as a “capitated payment plan.” Supporters of the HMO model argued that managed care would encourage a focus on preventative over curative care and provide quality results while containing costs. To be sure, HMOs achieved some level of financial success for a time: “in the early 1970s, fewer than four million Americans were enrolled in nearly 40 prepaid health plans, most of which were operating in California. By 1980, about nine million Americans were in HMOs. By 1990, that number more than quadrupled to 37 million\(^2\)”\(^2\). By the late 1990s, 85% of U.S. employees with health insurance were enrolled in an HMO or another managed-care plan. However, as competition grew and care costs rose, the capitated model often meant money losses for care providers, causing drop outs in participation and ultimately financial losses for the HMOs as well. HMO bureaucracies expanded to micromanage costs, often at the expense of the quality of the care provided. Patients eventually came to view HMOs as overly-bureaucratic institutions which managed costs but couldn’t properly manage care\(^3\).

Present

In 2010, with the passage of the ACA, a new managed care model is gaining momentum: Accountable Care Organizations ("ACOs"). While the term was coined in 2006, ACOs received a shot in the arm from the ACA, which introduced the concept to Medicare. The driving premise of the ACO model is to incentivize providers through a shared-savings plan that considers not only cost, but also quality of care.

ACOs are similar to HMOs in many regards; both take a “population health management” approach to delivering...
care and controlling costs. A key difference, however, is that the ACO model focuses on creating value as opposed to withholding service: in simpler terms, the ACO model uses more “carrot” and less “stick” with regards to incentivizing providers.

Under the HMO approach, providers were incentivized to simply keep costs below the capitated payment. Under the ACO model, providers are rewarded for meeting specific quality metrics under so-called “pay for performance” and “shared savings” contracts. Additionally, technological advancements including electronic health records and improved data analytics tools allow providers to understand trends and outcomes in a way that was previously not possible. Figure 1 illustrates how ACOs and managed care organizations differ.

**Future**

In June 2017, Health Affairs reported there were 923 active public and private ACOs across the United States, covering more than 32 million lives at the end of the first quarter of 2017 (Figure 2). Whether or not ACOs become the dominant health care model of the future remains to be seen. As we have learned from the rollout and evolution of the HMO, adoption of new models takes time.

**Figure 2: ACOs and Covered Lives**

![Figure 2: ACOs and Covered Lives](http://healthaffairs.org/blog/2017/06/28/growth-of-acos-and-alternative-payment-models-in-2017/)

Additionally, laws, policies, and public perception are bound to change going forward, and unintended consequences are a fact of life. The future of the Affordable Care Act, which provided the initial framework for the quality-based incentive payment program for health care providers, has recently been in jeopardy at the federal level. Whether or not the original legislation survives has left consumers and providers of health care anxious.