



# BENEFITS PERSPECTIVES

Current Issues in Employee Benefits

## Introduction to shared savings arrangements and ACOs

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For a self-funded group health benefit plan sponsor that seeks high value and cost-efficient healthcare, contracting with an “accountable care organization” (ACO) in a “shared savings arrangement” may be appealing, as doing so ensures the provider delivery system is financially vested in achieving the same goals as the employer. Critics of the traditional, volume-based fee-for-service (FFS) reimbursement model note the misalignment of incentives when only the plan sponsor benefits from a reduction in healthcare expenditures, whereas the providers’ revenue continues to grow from increases in healthcare expenditures.

While shared savings arrangements may offer plan sponsors a new opportunity to provide both high-quality and cost-efficient care to plan participants, such arrangements also introduce a host of new analytical and contractual challenges for human resource and finance professionals. This article provides an introduction to plan sponsors on such issues.

### ACOs, shared savings, and self-insured group health plans

Over the last five years, the healthcare industry in the United States has begun to experience a structural shift in the way private and public healthcare plans reimburse healthcare providers. Instead of the FFS model, plans are increasingly reimbursing providers based on value and quality measures. Many provider systems are willing to take on additional financial risk through these new alternative reimbursement arrangements, including ACOs. The Department of Health and Human Services’ Center for Medicare & Medicaid Services (CMS) defines ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.”

In ACO arrangements with self-insured group health benefit plans, the ACO contracts with the plan sponsor using a shared savings arrangement that defines the responsibilities for costs and outcomes of a specific population (typically all covered employees and dependents) for a specific time period (typically one plan year). The general aim of the arrangement is to pay more to the ACO when the population’s healthcare costs come in below an agreed-upon target amount. Conversely, depending on the stipulations of the agreement between the ACO and the plan sponsor, the ACO may pay the plan sponsor a penalty if healthcare costs are above the target amount. In effect, the plan sponsor transfers a portion of utilization management risk to the ACO.

From the healthcare providers’ perspective, joining or starting an ACO allows them to:

- diversify their revenue streams to be less dependent on service volumes and more focused on providing value to plan sponsors;
- increase their focus on population health management; and
- potentially increase their market shares by promising to improve healthcare cost efficiency for a plan sponsor.

Employers that self-insure their group health benefit plans and that are contemplating ACO arrangements will have many issues to consider, including:

- assessing the financial savings opportunities with shared savings arrangements;
- developing and implementing a shared savings arrangement with an ACO; and
- managing the relationship with an ACO.

## Opportunity for improvement

One way to view a plan sponsor's healthcare expenditures is as a simple function of healthcare utilization and unit cost. While a myriad of factors impacts these two items, the simple model suggests that plan sponsors will only achieve cost savings by reducing utilization, reducing unit cost, or a combination of the two factors. Traditionally, self-funded plan sponsors have focused on reducing unit cost by analyzing which network, insurer, or third-party administrator offers the lowest unit cost reimbursement to providers. Doing so will enable a plan sponsor to select or contract with the organization that provides the most cost-efficient reimbursement for healthcare services. However, this exercise does not address the utilization side of the healthcare cost equation.

A key indicator for plan sponsors to assess the potential opportunity for savings on both the utilization and unit cost sides of the equation is the variation of utilization and unit cost within a region. A high cost variance suggests that some providers are more efficient than others within a market.

For example, to assess the variance, we summarized costs for groups with at least 8,000 plan participant-months in the Chicago, Los Angeles, and New York City metropolitan statistical areas (MSAs). Population health variance between groups was normalized by applying the Milliman Advanced Risk Adjusters™ (MARA™) to the claims experience. This process allowed us to isolate the variance attributable to provider utilization efficiency or unit cost, with the belief that a high degree of variability in either measure would indicate an opportunity for better plan management. Figure 1 illustrates the percentage difference between groups ranked in the 25th and 75th percentiles within each MSA, in terms of utilization management and unit cost. The percentile statistics were developed on claims experience from more than 40 groups in each MSA.

Figure 1 indicates that while a unit cost variance of approximately 10% exists between the 25th and 75th percentiles, roughly twice the variance exists in terms of utilization efficiency within each MSA. While this analysis indicates that a portion of the utilization variance may be attributable to benefit design differences (i.e., higher cost sharing will dampen member utilization levels), we believe that it also reveals a prime opportunity for plans to employ “pay for value” methods to better manage utilization.

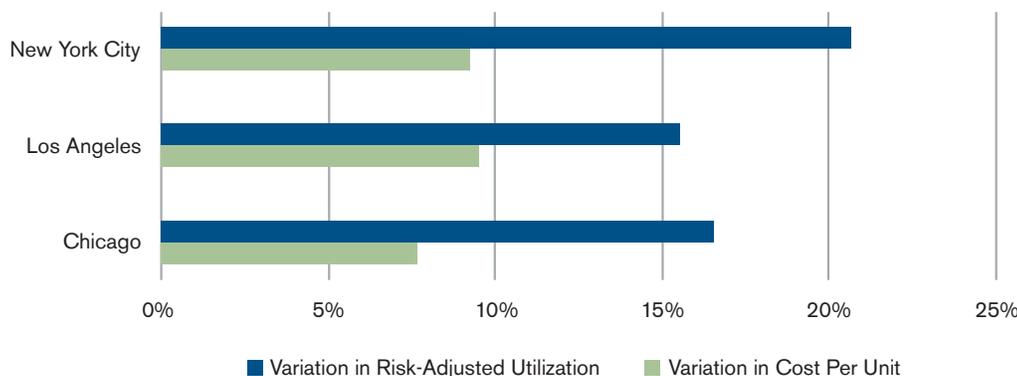
In these markets, plan sponsors have an opportunity to save costs and improve outcomes for their members by working with the more highly efficient provider systems. While a combination of wellness programs, value-based benefit design, and other programs may be geared toward decreasing utilization through employee behavioral changes and healthcare consumerism, a shared savings arrangement with an ACO may be a means to further optimize the efficiency of plan utilization.

## Will pay for value work for my plan?

For plan sponsors determining whether a shared savings arrangement is appropriate, the following are some of the key factors to consider:

- **Number of plan participants:** For plan sponsors with fewer than 2,000 plan employee participants, independently developing a shared savings arrangement with an ACO may be problematic as the plan may experience significant claims volatility from year to year. Additionally, the plan sponsor may not have the necessary leverage in terms of healthcare service volume to garner favorable terms with the ACO. For plan sponsors with limited size, exploring a shared savings arrangement as part of a purchasing coalition or through an insurer may be beneficial; however, the outcome of the shared savings calculation might not be shared directly with individual plan sponsors.

**FIGURE 1: PERCENTAGE DIFFERENCE BETWEEN RISK-ADJUSTED UTILIZATION AND COST PER UNIT AT 25TH AND 75TH PERCENTILES**



Notes:  
 1. To develop an aggregate measure of utilization across service categories for each employer group, we employed Milliman's GlobalRVUs™ to the claims experience for each group. By assigning a relative value unit (RVU) measure to each service, the GlobalRVUs allow us to develop a single measure of utilization and cost per unit for each employer group.  
 2. Variance measured based on allowed, rather than paid, expenses.

- **Geographic dispersion:** ACOs generally have a localized geographic focus. Therefore, for employers with employees dispersed across the country, having an ACO manage the majority of the employee population may be an impossible task. For such employers, they should evaluate how their third-party administrators are building networks on a regional basis. A benchmarking exercise (discussed in the next section) will allow the plan sponsor to determine if its plan is well managed at a regional level. If the network is built with a focus on high-quality, cost-efficient care, the employer may capture the same financial benefits of a shared savings arrangement. Additionally, to the extent a private exchange could contract with ACOs on a regional or local level, the private exchange may offer purchasing power that could not be created independently by a plan sponsor.
- **Current healthcare utilization and cost:** A plan sponsor that already enjoys partnering with a high-performing provider delivery system may have little financial incentive to deviate from its current arrangement. Employers with predominantly young adult employees also are unlikely to have the same financial savings opportunity from better utilization management as employers with a significant portion of employees with high-risk chronic conditions. Employees with high-risk chronic conditions create a larger variance in potential costs for a plan sponsor, as well as management opportunities for an ACO. As one of the first steps in evaluating whether a shared savings arrangement may be beneficial, plan sponsors should have their healthcare utilization and costs benchmarked relative to expected costs for their participants' demographics (including population health), plan designs, geographic location, and provider discount level. Such an analysis will identify utilization management opportunities for a shared savings arrangement.
- **Potential partners:** For a plan sponsor, success requires partnering with an ACO that is able to achieve the goals outlined in the shared savings arrangement. When assessing potential ACO partners, plan sponsors should consider the ACO's track record in meeting cost-savings goals for both public and private plans, as this may indicate its ability to manage a diverse group of members with varying degrees of clinical conditions. A plan sponsor should request information on the ACO's analytic tools, care management systems, and personnel that are deployed to improve utilization management. Additionally, understanding how the ACO's physician financial incentives are structured may allow for evaluating the likelihood of achieving cost savings. For example, if physician financial incentives are minimal or nonexistent, it may be less likely for the ACO to achieve meaningful efficiency improvements.

The plan sponsor that may be best matched for a shared savings arrangement will have a large number (the bigger the better) of geographically concentrated employees, have historical healthcare costs that indicate an opportunity for more efficient and higher-quality care, and be located in a highly competitive healthcare provider market.

## Getting started with an ACO arrangement

A plan sponsor will need to negotiate the framework of the shared savings arrangement with the ACO, considering such fundamentals as:

- **Contracting approaches:** Plan sponsors have a variety of means to engage in an ACO arrangement. Plan sponsors with significant size and plan management capabilities may negotiate a contract directly with an ACO. However, in many cases, the plan sponsor's third-party administrator (TPA) may have an existing relationship with ACOs and can negotiate on behalf of the employer. Plan sponsors may want to consider the TPA's capacity to negotiate these arrangements as part of their TPA procurement processes. As mentioned previously, insurance companies are establishing ACO networks as well, providing another option for employers to gain access to these organizations.
- **Target claims expense:** The plan sponsor and the ACO will have to settle on a methodology to project historical claims expense forward to the contract period of the shared savings arrangement. In addition to agreeing to a trend assumption, the two parties will need to establish the historical experience period, discuss the impact of any historical or future plan design changes, and determine if the agreement will be based on an allowed or paid claims basis. As discussed earlier, the initial target claims expense may be based on a benchmarking analysis of the plan sponsor's experience relative to expected costs for its population. The target claims expense also must be reset periodically to ensure it remains appropriate for the current employer population and the state of the healthcare environment. Resetting the target claims expense less frequently (e.g., every three years) will give the ACO more opportunity to impact trends and share in the savings, while resetting the target claims expense more frequently (e.g., each year) will consistently set a challenging bar for the ACO to attain.
- **Shared savings (losses) parameters:** To the extent actual experience does not match the projected claims expense, the plan sponsor and the ACO should have contractual language on how the cost variance is shared between the two parties. An ACO may pursue taking on only upside risk (i.e., receive payments from the plan sponsor if costs are below the target claims expense) or both upside and downside risks (i.e., introducing the possibility of paying a penalty if costs are above the target claims expense). The two parties may also negotiate a risk corridor, where unless the actual costs are greater or less than a certain percentage from the target claims expense, no payments are made between the two parties.

Benefit design considerations may also come into play when establishing a shared savings arrangement. While an ACO may not require that the plan sponsor's healthcare coverage is limited to the ACO network, it will likely prefer that members have a strong financial incentive to receive services within the ACO network. An ACO has no ability to manage care received outside its network of providers and may require that the benefit design be modified to

create more “steerage” toward its providers versus out-of-network options. Additionally, ACOs sponsored by hospital systems may want the decreases in utilization resulting from more efficient care delivery to be offset by being able to provide a greater proportion of the population’s healthcare services.

The above items are just a sample of initial considerations for designing and implementing a shared savings arrangement. A final shared savings arrangement between a plan sponsor and an ACO will require significant detail around cost calculations, payment timelines, and other factors. A plan sponsor may need additional contracting support from its legal counsel or others experienced with these arrangements.

## Managing the ACO relationship

Entering into a shared savings arrangement with an ACO is not a guarantee of cost savings for plan sponsors. For such agreements to be successful, there should be a transparent and collaborative relationship between the ACO and plan sponsor. A plan sponsor and the ACO should have regular meetings to discuss the status and emerging results of the shared savings arrangement. This will provide the opportunity for the two parties to discuss what has and has not been working.

For example, the ACO likely will be heavily focused on the care management of individuals with multiple chronic conditions. Initially, the ACO may have trouble engaging these individuals in care management programs. The plan sponsor may have to increase efforts to communicate to participants why it has contracted with an ACO and how high-risk members may leverage the new resources brought by the ACO to improve the management of their own health.

Implementing a shared savings arrangement does not replace existing cost management practices. An ACO is contracted to manage the utilization risk for a population with a certain level of clinical conditions. It is not a wellness vendor trying to prevent plan

participants from acquiring chronic diseases or illnesses. While some ACOs may offer such services, the target claims amount in shared savings calculation is typically adjusted for changes in population health status as measured through a risk adjustment process. To the extent that a plan sponsor believes its existing wellness programs have provided a positive return-on-investment, such programs should remain in place and coordinate with the ACO’s care management programs during the shared savings arrangement contract period.

## Conclusion

While they hold the promise of aligning the financial risks of plan sponsors and providers, ACOs and shared savings arrangements are still in their infancy. These agreements are likely to become much more common in the next five years in the commercial health insurance market. Plan sponsors should be prepared to adapt to changes in how shared savings arrangements are constructed as the market matures.



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