New York Times Article Challenges ACO Proponents Submitted to the Health Care Financing Task Force by the Board of Directors of the Minnesota Chapter of Physicians for a National Health Program December 18, 2015

MN PNHP's last letter to the Task Force presented evidence indicating ACOs do not cut health care expenditures, and may in fact raise them when the costs required to set up and run ACOs are taken into account. In this letter we call your attention to an article that ran on the front page of the *New York Times* on December 15. That article reinforced our conclusion that the task force should not recommend any policies that will encourage the spread of ACOs.

The *Times* article presented evidence indicating the endorsement of ACOs by President Obama and the Affordable Care Act has encouraged mergers among hospitals and clinics, and that this has in turn driven up health care costs. What makes the article particularly interesting is that it contradicts research authored by Elliot Fisher, the man who invented the phrase "accountable care organization" along with Glenn Hackbarth (former chair of the Medicare Payment Advisory Commission) in 2006.

The online version of the *Times* article http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html is entitled, "The Experts Were Wrong About the Best Places for Better and Cheaper Health Care." The "experts" referred to in the title include Elliot Fisher and other scholars at Dartmouth who produce the Dartmouth Atlas, and other experts who relied on the Dartmouth Atlas, including Atul Gawande, author of the famous 2009 *New Yorker* article that influenced President Obama's thinking about cost containment.

The Dartmouth Atlas divides the country into 306 "hospital referral regions" and compares per capita Medicare spending among regions. For the last two decades, Fisher and many others have claimed that the low Medicare costs in places like Grand Junction, CO and Rochester, MN were not only reflective of total per capita costs in those areas, but were due to the presence of large hospital-clinic systems in those areas. Both claims were dubious when they were made. Now it appears both claims are wrong.

According to the Times' article, many of the areas shown to be low-cost by Medicare data alone are high-cost areas when measured by expenditures by insurance companies. Moreover, it appears that the large "integrated systems" that Fisher et al. are so passionate about, now called ACOs, are raising costs because they are so big they can force even large insurers like UnitedHealthCare to pay them high rates.

The *New York Times* article is about a paper published by the National Bureau of Economic Research. The paper was written by Zack Cooper, an economist at Yale, and three others http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf

Cooper et al. examined the cost of health care spending for three large insurance companies by "hospital referral region." The Times article begins by placing two maps of the country side by side. One shows high- and low-cost regions according to the Dartmouth Atlas, and one shows high- and low-cost regions according to Cooper et al.'s data. There is some overlap but not much.

Here is the *Times'* summary of the findings by Cooper et al.

> Health care researchers who have seen the new findings say they are likely to force a rethinking of some conventional wisdom about health care. In particular, they cast doubt on the wisdom of encouraging mergers among hospitals, as parts of the 2010 health care law did.
> Larger, integrated hospital systems – like those in Grand Junction – can often spend less money in Medicare, by avoiding duplicative treatments. But those systems also tend to set higher prices in private markets, because they face relatively little local competition.
> "Price has been ignored in public policy," said Dr. Robert Berenson, ... former vice chairman of the Medicare Payment Advisory Commission, which recommends policies to Congress. "That has been counterproductive."

We agree with Dr. Berenson's remark. Public policy, in Minnesota and across the country, has followed conventional wisdom since the early 1970s. It has encouraged reducing volume of medical services by herding doctors into larger organizations – HMOs beginning in the 1970s, now ACOs – so that they can bear insurance risk. This policy has ignored the impact of higher administrative costs and consolidation (in both the provider and insurer sectors) on price.

We urge task force members to focus on price, not volume. After a half century of experimenting with HMOs, PPOs etc., it is clear that pushing doctors into "integrated systems," whether we call them HMOs or ACOs, cannot cut costs, and that the agglomeration of providers into these large entities is creating serious side effects, including concentrated market power.