IMPLEMENTING HEALTH REFORM

Health Insurance CO-OPs

As part of the Affordable Care Act, Congress created an alternative to traditional, for-profit private insurance plans. Consumer Operated and Oriented Plans, known as CO-Ops, are consumer-run, private health plans that use their profits to lower premiums, increase benefits, expand enrollment, and improve quality of care.

Unless repealed, CO-OPs will be available to individuals and small businesses through the state-based health insurance exchanges starting in 2014.

Economist Sara R. Collins, Ph.D., vice president of the affordable health insurance program at the Commonwealth Fund, explained what CO-OPs will need to do to succeed in the new insurance marketplace.

Cardiology News: What's the rationale behind creating a nonprofit alternative to private health insurance?

Dr. Collins: The intent is to encourage the development of plans that have a strong consumer focus, are accountable to their members, and will use their members' premiums and revenues to improve health care rather than increase profits. Toward this end, the law specifies that the governance of the CO-OPs must be subject to a majority vote of its members, and the organizations are required to operate with timeliness, responsiveness, and accountability to members.

Profits must be used to lower premiums, improve benefits, or finance programs aimed at improving the quality of care for members. The law specifies that the HHS department, in determining loan awards, would give preference to those plans that utilize integrated care models.

CN: What does the history of health cooperatives in the United States tell us about how these CO-OPs might perform?

Dr. Collins: The most successful existing examples of regional health cooperatives are those with strong links to high-performing integrated care systems, such as HealthPartners in Minneapolis–St. Paul and Group Health Cooperative in Seattle.

A significant challenge facing newly formed cooperatives will be their ability to gain market share.

DR. COLLINS

The keys to these organizations' success include a consumer-focused mission, accountability resulting from a consumer-elected board, close links with care systems and networks of providers, a regional focus integrating a broad range of services, commitment to evidence-based care and informed patient engagement, strategic use of electronic health records to support care redesign, patient-centered medical home model of primary care, efforts at care coordination, and greater accountability for the total care of patients.

Similar successful examples of nonprofit, integrated delivery systems with affiliated health plans, though not consumer governed, are Geisinger Health Systems in Pennsylvania, Intermountain Healthcare in Utah, and Kaiser Permanente.

CN: What will be the key ingredients for success for these plans?

Dr. Collins: The keys to success will be the ability to purchase care on favorable terms and the ability to offer high-quality networks of providers. One of the most significant challenges facing newly formed cooperatives will be their ability to gain market share in highly concentrated insurance markets. There are only three states in the country where the two largest health plans dominate less than 50% of the market.

In addition, extensive consolidation in hospital and other provider markets across the country has substantially reduced price competition in those markets. Consequently, large insurance carriers and large provider systems individually negotiate prices, with those prices ultimately reflecting discounts off list prices that physicians and hospitals charge patients without insurance. Prices vary widely, and the lowest rates are not available to all health plans.

Newly formed cooperatives will thus be at a considerable disadvantage in obtaining favorable provider rates in most local markets, which will in turn make them less competitive in insurance exchanges and in the individual and small group markets. The extent to which the new state insurance exchanges are able to encourage the participation of high-value health plans could increase the likelihood that cooperatives can gain a toehold in competitive markets.

CN: What will this program mean for physicians in large and small practices?

Dr. Collins: The emphasis of the program on integrated delivery systems will benefit several types of providers. While the law precludes existing plans such as the Geisinger Health Plan from serving on the boards of cooperatives receiving grants, it does not preclude the new cooperatives from contracting with Geisinger's integrated system of providers. In the absence of such an integrated delivery system, cooperatives might contract with multispecialty group practices, clinics, and hospitals, with a goal of integrating care systems.

One such example is the Marshfield Clinic, a nonprofit, physician-governed, multispecialty group practice serving residents of rural Wisconsin through a regional ambulatory care system, an affiliated health plan, and related foundations supporting health research and education. Newly formed cooperatives might also contract with community health centers as a dedicated set of primary care providers. Available in every state, community health centers are linked through a common mission, and formally through national organizations such as the National Association of Community Health Centers. Thus, they have the potential to become multistate networks. ■

U.S. Doctors' Administrative Costs Quadruple Canadians'

BY JANE ANDERSON

FROM HEALTH AFFAIRS

VITALS

Major Finding: Medical practices in the United States spend nearly $83,000 per year per physician to deal with health insurance plans; practices in Ontario spend about $22,200 per physician per year to interact with Canada's single-payer health care system.

Data Source: Surveys of physician practices in Ontario and in the United States, as well as 37 interviews with physicians, health plan executives, and practice administrators.

Disclosures: The authors reported no financial conflicts of interest for the study, which was funded by the Robert Wood Johnson Foundation and the Commonwealth Fund.

Physician practices in the United States spend four times as much money as do those in Ontario, Canada, to cope with paperwork and communications involving health insurers and payers, according to a study.

The investigators found that medical practices in the United States spend nearly $83,000 per year per physician to deal with health plans. In contrast, physician practices in Ontario spend about $22,200 to interact with Canada's single-payer health care system. The report adjusted the figures slightly to account for exchange rates and specialty mix.

"If U.S. physicians had similar administrative costs to Ontario physicians, the total savings would be approximately $27.6 billion per year," wrote Dr. Dante Morra, assistant professor of medicine at the University of Toronto, and his colleagues (Health Aff. August 2011 [doi:10.1377/hlthaff.2010.0893].

Most of the problems U.S. physicians face relate to the fact that they're trying to cope with multiple payers, while Canadian physicians must deal with only one, said Dr. Morra and his colleagues, who added that U.S. insurers could help by taking steps to improve the efficiency of transactions, such as implementing electronic transactions.

"The price of inefficiencies is not only the cost measured in this study," according to the authors. "When these inefficiencies result in frequent interruptions in the work of physicians and their staff, they are likely to interfere with patient care. Everyone – health plans, physicians and their staff, and patients – will be better off if inefficiencies in transactions between physicians and health plans can be reduced," they wrote.

The differences in staff time spent on insurance issues started with the physicians themselves. U.S. physicians spent an average of 3.4 hours per week interacting with multiple insurers, while Canadian physicians spent an average of 2.2 hours per week dealing with that country's single payer. The main difference in time is the 1 hour per week that U.S. physicians spent obtaining prior authorizations, which accounted for most of the difference in the results, the study said.

In addition, practice staff members in the United States spent far more time on insurance issues than did their Canadian peers, according to the study, which called the differences "striking." U.S. nursing staff, including medical assistants, spent 20.6 hours per physician in the practice per week interacting with payers, nearly 10 times the 2.5 hours per week spent by Ontario nursing staff.

The study found that the U.S. nursing staff members spent more time in every possible category, including prior authorizations, which cost them 13.1 hours per physician in the practice per week. In Canada, nursing staff members spent no time on prior authorizations.

Clerical staff members were found to work 53.1 hours per physician per week in the United States, mainly on billing issues and obtaining prior authorizations, the study said. Meanwhile, clerical staff members in Canada worked only 15.9 hours per week, and only on claims and billing issues.

"The major difference between the United States and Ontario is that nonphysician staff members in the United States spend large amounts of time obtaining prior authorizations and on billing," Dr. Morra said in a statement. ■