POLICY & PRACTICE

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With Weight, Asthma Misdiagnosed

Obese people presenting with breathlessness and other symptoms may be misdiagnosed with asthma, according to a small study published in CHEST. Of 91 overweight people previously diagnosed with asthma and using inhalants, 36.3% did not have bronchial hyperresponsiveness, the researchers found. Obesity increases a person's doctor visits, "where patients have the opportunity to report respiratory symptoms and each visit can potentially lead to mis-classification of asthma diagnosis," the authors said. They suggested further research on the impact of weight loss on obese patients and their health-related quality of life.

E-Records Improve Care

When it comes to treating adults with diabetes, primary care practices that use electronic health records achieve better outcomes than do those using paper-based systems, according to a study published in the New England Journal of Medicine. The research included more than 27,000 patients with various types of insurance or no insurance. More than half the patients in practices with electronic records received diabetes care that met standards. In contrast, 7% of patients in paper-based practices achieved that level of care. Given the incentives for the adoption of health information technology, the authors said the study's findings support the value of community-based partnerships to encourage the adoption of electronic health records and increases in care quality.

Dieting Outpaces Exercise

Weight loss with or without exercise significantly improved insulin resistance in a study of 439 postmenopausal women who were inactive and overweight at the beginning of the trial. The participants' insulin resistance improved significantly on regimens of diet or diet plus exercise, but not with exercise alone or no change. Reported in the American Journal of Preventive Medicine, the study supports previous findings that weight loss of 5%-10% of body weight is associated with improved insulin sensitivity and glucose tolerance, the authors said. Despite the relative failure of exercise alone, the authors said that "regular physical activity has the potential for health benefits among women with impaired fasting glucose."

Calorie Counts Help Some

One in six lunchtime diners at fast food restaurants in New York City read the calorie counts posted alongside the menu items and ordered something lower in calories as a result, according to a study of the impact of the 2008 law that requires city restaurants to post calorie information. The 15% of customers who said they used the calorie information bought food containing an average of 106 fewer calories than the food that others purchased. Diners at three restaurant chains – McDonald's, Au Bon Pain, and KFC – ordered significantly fewer calories following implementation of the law, the study found. Customers at Subway actually increased their calories following the law's implementation. The study was jointly funded by New York City and the Robert Wood Johnson Foundation.

Physicians Seek Solid Data

Physicians should be able to review and challenge data on their individual performances before that information is released to the public, the American Medical Association and more than 80 other medical groups said in a letter. The organizations were commenting on a proposed federal rule allowing access to Medicare claims data for entities creating reports for patients on providers' care quality and efficiency. "Physicians and other providers must have the opportunity for prior review and comment, along with the right to appeal, with regard to any data or its use that is part of the public review process," the groups said. "This is necessary to give an accurate and complete picture of what is otherwise only a snapshot, and possibly skewed or outdated view of the patient care provided by physicians and other professionals and providers." In addition, the CMS needs a campaign to educate the public about the data and its limitations, the groups said in their letter.

Insurance Costs Vary Widely

Health insurance costs vary up to threefold state to state, with the average monthly, per-person price tag ranging from $136 in Alabama and $157 in California to more than $400 in Vermont and Massachusetts, according to an analysis by the Kaiser Family Foundation. Nationally, each insured person – including children and adults – pays an average of $215 a month for health insurance. Reasons for varying premiums include cost-of-living differences, health care costs, average age of state residents, plans' effectiveness at controlling costs, the benefits offered by plans, and patient cost-sharing required, the report said. Since people in low-premium states might have to pay higher copayments and deductibles, the monthly prices don't necessarily reflect value, the analysts added.

–Naseem S. Miller

IMPLEMENTING HEALTH REFORM

Health Insurance CO-OPs

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

Unless repealed, CO-OPs will be available to individuals and small businesses through state-based insurance exchanges in 2014. The Department of Health and Human Services has proposed how CO-OPs should be structured and how they can become eligible for federal loans.

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 marketplace.

Clinical Endocrinology News: What's the rationale behind a nonprofit alternative to conventional private insurance?

Dr. Collins: The intent is to encourage the development of health plans with a strong consumer focus, that are accountable to their members, and that 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 to finance programs aimed at improving the quality of care for members. In addition, the law specifies that HHS, in determining loan awards, would give preference to those plans that utilize integrated care models.

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

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.

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.

> **The ability to purchase care on favorable terms and to offer high-quality provider networks will be key.**
>
> DR. COLLINS

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.

CEN: 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. ■

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