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 (CO-OPs) are to be 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Unless repealed, CO-OPs will be available to individuals and small businesses through the state-based health insurance exchanges starting in 2014. In July of this year, the Department of Health and Human Services 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 insurance marketplace.

Rheumatology News: What's the rationale behind creating a nonprofit alternative to traditional private insurance?
Dr. Collins: The intent is to encourage 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.

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

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DR. COLLINS

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, 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.

RN: 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, consolidation in hospital and other provider markets has substantially reduced price competition in those markets. Consequently, large insurance carriers and large provider systems individually negotiate prices that ultimately reflect 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.

RN: 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.

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, which are 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. ■

DR. COLLINS joined the Commonwealth Fund in 2002 and has led its national program on health insurance since 2005. She has conducted several national surveys on health insurance, authored numerous reports on the topic, and provided testimony to congressional committees.

Recession Kept Health Spending Growth Low in 2010

BY ALICIA AULT

FROM HEALTH AFFAIRS

Despite a huge increase in the number of Americans who will have insurance coverage when the main provisions of the Affordable Care Act take effect in 2014, the nation's overall health spending in that year is projected to rise only 2% above the expected yearly average increase for the rest of the decade, economists from the Centers for Medicare and Medicaid Services said.

The 8% growth in spending expected in 2014 is in line with the average 5.8% annual rise in health spending expected each year from 2010 to 2020 and is relatively small given that, by 2014, an estimated 23 million more Americans will have health insurance coverage under the Affordable Care Act (ACA), said Sean P. Keehan, an economist in the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS).

Over the next decade, the ACA is projected to add only a tenth of a percentage point to the nation's overall health spending, Mr. Keehan and his colleagues reported in the journal Health Affairs (August [doi:10.1377/hlthaff.2011.0662]).

The ACA is expected to drive a 20% increase in Medicaid costs and a 9% increase in private insurance spending in 2014. The economists said many of the newly insured will be younger and healthier than the existing populations covered by Medicaid and private insurance.

VITALS

Major Finding: The nation's health spending rose by 3.9% in 2010 to $2.6 trillion. It is projected to rise by about 6% each year over the next decade, with the exception of an 8% increase in 2014, when the Affordable Care Act is in full effect.

Data Source: An actuarial and econometric analysis of data from the 2011 Medicare Trustees Report, done under a current-law framework.

Disclosures: The authors are all employees of the Centers for Medicare and Medicaid Services.

With the new coverage, they are likely to use more physician services (a projected 9% increase in 2014) and pharmaceuticals (a projected 11% increase in 2014), the authors said.

The increases in spending will not be offset by Medicare cuts in the first year, according to the report, an actuarial and econometric analysis of data from the 2011 Medicare Trustees Report, done under a current-law framework.

The projections could be substantially affected by the outcome of the ongoing federal debt ceiling talks and, in a few years, by any potential changes in the Medicare Sustainable Growth Rate (SGR) formula.

In 2012, the SGR calls for an-almost 30% cut in Medicare physician payments. If that happens, Medicare spending would only grow by 1.7%, instead of by 5.9%, according to the study. If the Congress decides to try an alternative, such as tying fee increases to the Medicare Economic Index, Medicare spending would rise by 6.6%.

In 2010, growth in health spending was, for the second year in a row, near a historic low, driven largely by the recession. The $2.6 trillion represented almost 18% of the gross domestic product (GDP). That was about the same share as 2009, as both health spending and the GDP grew relatively slowly, according to the report.

Medicare spending growth slowed because of less spending on private Medicare Advantage plans. Private health insurance spending grew only 2.6% in 2010, as more people lost jobs and coverage. Americans for the second year in a row also spent less out-of-pocket.

Overall, spending on physician and clinical services grew only 2.4% in 2010. The economists said they expect that figure to rebound by 4% in 2011, but to slow again in 2012, largely because of the SGR cut. That year, physician spending may only rise by 0.8%.

With many major provisions of the ACA taking effect in 2014, physician spending is expected to grow by 8.9% that year, a $17.8 billion increase over what would have been expected without health reform, according to the report. ■