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In New Insurance Model, Costs Are Based On Value Of The Treatment

By **Michelle Andrews** | November 29, 2010

What if, instead of making a $10 insurance copayment for your cholesterol lowering drug, your employer provided it and other drugs to manage chronic conditions for free? What if your company also paid for weight management and smoking cessation classes? You'd probably give your employer high marks for looking out for your health.

Now, what if your employer said that if you want certain procedures that it's determined are overused, like an MRI or knee surgery, you'll have to pay up to $500 extra, on top of your other coinsurance charges? Those employer decisions might not be nearly as welcome.

Both, however, are part of an approach to health care that shares a common perspective: The idea that consumers' out-of-pocket medical costs should be based on the value of a medical service to their health rather than its price.

Although still relatively rare, the model is garnering increasing attention among employers, insurers and policy experts. Mercer, a benefits consulting company, found in a 2008 survey that 19 percent of employers with at least 500 employees were charging workers less for services the companies considered to have a higher value for workers' health. In addition, more than 80 percent of employers with at least 10,000 workers surveyed by Mercer in 2007 said they were interested in adopting this model in the next five years, according to a paper published in the November issue of Health Affairs. It was one of several on value-based insurance design, as it's called, in the current issue.

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Some health law provisions also embrace value-based insurance principles, including the requirement that new insurance policies provide free recommended preventive services such as mammograms and colon cancer screenings starting in 2011. "It's all in keeping with the idea that some things are so valuable to health care that there should be no barriers to their use," says Dr. Niteesh Choudhry, an assistant professor at Harvard Medical School and lead author of two of the articles in this month's Health Affairs.

A landmark 1982 study showed that as out-of-pocket costs rise, consumers spend less on health care services. But they scrimp not just on care that's ineffective or unnecessary but also on care that they need, treatment that's highly effective at addressing their condition.

Mike Hardy had a heart attack during the lunch hour at his job at office products and services supplier Pitney Bowes nearly three years ago. The 65-year-old e-commerce manager says he was surprised to learn that the medications he needed post heart attack - including the statin Lipitor, blood clot preventer Plavix, a beta blocker and an ACE inhibitor to control his blood pressure - were all provided to him for free. Smoothing the way even further, staff at the medical clinic at the company's Stamford, Conn., headquarters wrote prescriptions for him and the onsite pharmacy delivered the drugs to his office. "Zero barriers does make a difference," he says.

Pitney Bowes is an old hand at value-based benefit design. Since 2001, the company has been providing drugs to treat employees' heart disease, asthma, diabetes and high blood pressure, among other things, for free or at reduced-cost. The pharmacy plan works in tandem with comprehensive disease management and wellness programs to help employees prevent and manage chronic conditions, says Dr. Brent Pawlecki, medical director for Pitney Bowes.

Indeed, experts agree that eliminating financial barriers alone isn't enough to ensure that people stick with their medication regimens, get necessary preventive screenings and high-value medical care. Health coaching and other support services are also critical, says Eric Grossman, a senior partner at Mercer.

Nearly all employers and insurers who have adopted value-based insurance benefits to date have done so by dangling the promise of free or reduced-cost benefits, often medications, before consumers. But such an approach is unlikely to reduce overall health care spending, say some experts. In fact, it may actually increase it, as employees get the care they might have otherwise skipped.

To reduce costs, some experts say employers and insurers should use a stick in addition to the carrot, with financial disincentives to discourage people from using medical services that are considered low value.

In October, 155,000 Oregon public education employees and their dependents began to experience this stick approach. Their plans already offer carrots: free preventive care and low-cost or free generic drugs for chronic conditions. But starting in October members will be charged an extra $500 if they get services that the state Educators Benefit Board has determined are overused or "preference sensitive" to patient choice, including spinal surgery, knee and shoulder arthroscopy, hip and knee replacement and upper endoscopy exams. Patients will pay an extra $100 for advanced imaging tests and sleep studies.

"We explained that the reason the rates were going up was because people were using the benefits a lot," says Joan Kapowich, administrator for the boards. The board showed employees for example, that nationwide the average amount spent on sleep studies was $0.37 per member per year. In the Oregon state plans, however, it was a whopping $7.36. "Everybody who snores was getting a sleep study," she says.

It's too soon to know whether the new approach will be successful at improving employees' health or bringing down health care spending. But one researcher says she thinks workers may be more open to the idea than might be expected.

People are willing to compromise, says Marge Ginsburg, executive director of the Center for Healthcare Decisions, a Sacramento-based nonprofit that studies how consumers make health care choices. They're open to "the idea that yes, it's still available to you, but it's going to cost you more," she says.

Outright denials, on the other hand, don't sit so well. "People are really unhappy if you draw a line in the sand."