KHN
KAISER HEALTH NEWS

Carrot-And-Stick Health Plans Aim To Cut Costs

By **Julie Appleby** | March 11, 2010

This story was produced in collaboration with USA TODAY

Workers at a Portland, Ore., steel mill soon will be able to pick a new type of insurance that offers free care for some illnesses, such as diabetes or depression, but requires hefty extra fees for treatments deemed overused, including knee replacements, hysterectomies and heart bypass surgery.

The insurance, which will be offered by five different insurers in Oregon, is the most far-reaching and potentially controversial step in an effort by employers nationally to rein in medical spending by redesigning health benefits.

“We’re trying to make people better consumers,” says John Worcester, head of benefits at Evraz Oregon Steel, the sole employer to sign up since the plans began coming on the market earlier this year.

Workers who choose the option over a more traditional plan next year could see their costs drop sharply if they have one of six chronic conditions but might pay hundreds more in deductibles and co-payments if they need a hip replacement or a heart stent.

The policies are among the first to apply financial incentives on both sides of one important factor driving up the nation’s health care tab: The underuse of proven treatments and overuse of certain surgeries and diagnostic tests that may be less valuable.

Proponents like Worcester say such efforts, dubbed “value-based insurance design,” help steer patients to high-quality treatments, which could improve health and possibly slow health costs over time.

But efforts to charge workers more for some treatments put employers in the position of “playing doctor” and are well into a “danger zone of limiting access to medical care,” says Jerry Flanagan of the Santa Monica, Calif.-based advocacy group Consumer Watchdog.

The new policies come as employers continue to grapple with health spending that’s rising faster than inflation. Jobs are the main way people in the U.S. get insurance, with employers generally picking up the majority of the tab, fueling their efforts to find ways to slow medical costs.

Already, many offer workers financial incentives to join wellness programs, stop smoking or lose weight. About 16% surveyed last year by the benefits firm Mercer have changed how they structure health benefits, mainly by reducing employee fees for drugs that treat chronic conditions such as heart disease, asthma or diabetes. Encouraging workers to take their medicines can prevent a costly worsening of their conditions, companies say.

The city of New Orleans in January, for example, joined more than a dozen other employers across the country in offering a UnitedHealth insurance plan that provides discounted drugs for workers with diabetes – so long as they take their medicines and have recommended medical tests. If they don't, the employees are compelled to return to a more traditional insurance plan.

The new effort in Oregon goes even further. It uses incentives to influence patients' behavior not only on prescription drugs, but also on health services and surgeries. The idea is to encourage workers to choose high-value care, defined as treatments backed by strong evidence that they work.

Such incentives are attracting both interest and caution, says Peter Lee, national health policy director at the Pacific Business Group on Health, a coalition of employers on the West Coast.

"There's nervousness about playing against the good old American culture of 'more is better,'. " says Lee. "The challenge is having a design that discourages overuse without impeding access to the right care. It's a hard balancing act."

How They Work

At Evraz, John Worcester expects only about 30 of the 450 workers at the plant will choose the new option over more conventional insurance – even though the company won't charge workers monthly premiums for the new type of policy. The policies, administered by Regence Blue Cross Blue Shield, will work like this:

Just as in more traditional insurance plans, workers would pay an annual deductible of about $250 before coverage kicks in. Doctor office visits would cost workers $10 to $20. Employees would pay 20% of the cost of hospital care, up to an annual maximum of $1,500 for individuals and $3,000 a year for family coverage.

But employees with certain conditions – asthma, congestive heart failure, diabetes, depression, heart disease, chronic bronchitis or emphysema – would get prescription drugs and visits with physicians free or at greatly reduced rates. High blood pressure, another common condition, would qualify for low-cost care if it was part of an overall diagnosis of heart disease.

Conversely, they'd pay much more if they have a treatment or test from a list of about 20 broad categories, including knee or hip replacement, cardiac bypass surgery, artery-opening stents, hysterectomies, high-tech-imaging exams or emergency room visits. In those cases, they'd pay double the annual deductible, double the amount they'd normally pay for an office visit and up to half the cost of hospital or ER visit, up to the $1,500/$3,000 maximums.

"We'll do a lot of educating, telling people it may or may not be the plan for them," says Worcester, whose company's recent

HEALTH CARE DESIGN

MANY EMPLOYERS USE FINANCIAL CARROTS AND STICKS AIMED AT ENCOURAGING WORKERS TO ADOPT HEALTHIER HABITS OR USE PROVEN MEDICAL TREATMENTS FOR CHRONIC DISEASES. AMONG LARGE EMPLOYERS WITH 500 OR MORE WORKERS:

21% OFFER INCENTIVES OR PENALTIES TO ENCOURAGE PARTICIPATION IN DISEASE OR HEALTH MANAGEMENT PROGRAMS

9% VARY THE PREMIUM CONTRIBUTION BASED ON EMPLOYEE SMOKER STATUS

16% USE SOME FORM OF VALUE-BASED DESIGN

SOURCE: MERCER 2009 NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS OF MORE THAN 2,900 EMPLOYERS, CONDUCTED IN JULY 2009 THROUGH MID-SEPTEMBER. MARGIN OF ERROR IS +/3 PERCENTAGE POINTS.

annual wellness testing program had a nearly 70% participation rate. “If you have a chronic disease, you’ll really be taken care of. But if you’re thinking of doing a knee replacement, it may not be the plan for you.”

Those specific treatments on the extra-fee list were chosen because research finds they’re overused or not more effective than alternatives, says Jack Friedman, chief executive of Providence Health Plans, one of the insurers that developed the model after business groups challenged them in 2008 to come up with new ways to slow health costs. The others are LifeWise, Regence, PacificSource and the ODS Cos.

But the effort is likely to spark controversy. For instance, studies show that many patients with stable heart disease can be treated effectively with drugs, rather than stents. But no one disagrees that some patients should have stents, including those suffering heart attacks. And while researchers say that, overall, too many hysterectomies are performed, women with uterine cancer have little choice.

Applying the same high fees to everyone is “too much of a blunt instrument,” says Kevin Volpp, director of the Center for Health Incentives at the University of Pennsylvania, who says the Oregon policies need to be more nuanced and provide exemptions. “There are relatively few procedures where you can say for everyone that ‘this is a low value.’. ”

Friedman says individual insurers, including Providence, may make exceptions in some cases. But, overall, he adds, the insurers intend to honor the philosophy behind the plans.

“What are the treatments that do the most good for the most people at the least amount of cost?” he says. “Frankly, that’s where I think our health care system will end up.”

Big Unknowns

One of the biggest unknowns about such programs is whether they will slow medical spending and save employers’ money.

Currently, patients failing to take needed medications cost the country about $100 billion a year, partly in hospitalizations that could have been avoided, says A. Mark Fendrick, a doctor and professor of medicine and health policy at the University of Michigan.

Lowering the cost of certain drugs for chronic medical conditions encourages patients to keep taking them, possibly preventing a costly worsening of their condition, says Fendrick, who has written extensively on the topic.

Many studies have found that raising the amount workers pay for drugs or other care leads people to reduce their use of medical treatments, both necessary and more elective services, says Volpp. But, he says, less is known about the effects of lowering costs on the behavior of people who aren’t taking their medications. “You’re trying to pull non-adherent people into the fold,” says Volpp. “That’s a fundamentally different population.”

Fendrick says there’s evidence that lowering workers’ payments for certain treatments will, over time, slow medical spending. But in the short run, such policies might raise employers’ costs, because employees are more likely to take their medications

and make use of other proven treatments and tests.

The Oregon insurers say the plans are priced 10% lower than more traditional coverage.

“It’s got to save money,” says Worcester at the steel plant. “If we know that 60% to 70% of cost stems from chronic diseases, and we can keep a diabetic on point so they don’t (fall ill) and go to the emergency department, there’s $10,000 we save. If we can avoid a heart attack or a long-term problem, there’s $35,000. But how you measure those (savings) in a reliable, valid way is hard to do.”

Fendrick says that while lowering costs for proven therapies is an important first step, “We need to make some decisions about not paying for things that don’t produce health.”

And that, admits insurance CEO Friedman, “is where there’s a little more controversy.”

jappleby@kff.org | **@Julie_Appleby**