Health care deal could save money, but skeptics question how soon

By: ARIELLE LEVIN BECKER | May 20, 2011

The agreement between state employee unions and the Malloy administration counts on a nearly 10 percent savings in employee and retiree health care costs in the first year from changing the way the benefits plan is designed.

The concept behind it--structuring the plan to encourage workers to take care of their health--is already used widely in the private sector and among public employers in other states.

But some observers are skeptical about the prospect of achieving immediate savings on the scale assumed in the agreement. The plan counts on people using more preventive services, which can identify diseases early and potentially save money in the long run, but can themselves increase health care spending up front. And experts say wellness and prevention programs often don't save money for the first few years.

"One of the things that's hard about these programs, especially when you're in a political environment and facing the kind of financial pressures that governments are, it's hard to be patient," said Brooke Bascom, communications director for employee health and well-being in King County, Washington, which started a tiered benefits program in 2006. "You don't see cost savings from programs like this until five years out."

Similarly, several benefits consultants told researchers from the Center for Studying Health System Change that employers implementing wellness programs should be ready to lose money on health care costs in the first year or two, and not see reasonable returns until the fourth or fifth year.

And in its guide to value-based benefit plans--the kind the state employee agreement calls for--the National Business Coalition on Health warns that costs can increase in the short-term because of increased use of medical services. Reduced medical costs from improved health can take longer to materialize, it said.

The agreement assumes the state would save $121.7 million in the first year from changes to the health plan's design. Some is projected to come from more traditional changes like requiring prior authorization for services like MRIs, limiting the number of physical or occupational therapy sessions a person could have, and limiting orthotics to people with certain diseases, like diabetes. Mark Ojakian, Gov. Dannel P. Malloy's chief negotiator on the deal, said

those are projected to save about $20 million in the first year. The plan would also require members who go to the emergency room but do not get admitted to the hospital to pay $35; currently, they pay nothing. The savings figure also includes the increased premiums members who don't participate in the new plan design would pay.

But Ojakian said that Milliman, the consulting firm the state used to develop the savings targets, believed much of the savings could be achieved through the value-based plan design.

"They do believe that when people start to enroll in these programs, and start to do some of the things that they're supposed to do, some of the protocols, some of the diagnostic testing, that that will in the first year yield a good amount of savings," he said.

Republican leaders criticized the savings figures from the health plan changes, saying they were part of a series of "phantom savings" in the labor deal.

Senate Minority Leader John P. McKinney, R-Fairfield, said value-based benefits are good policy, and noted that he proposed tax credits to encourage them in 2008. But he and House Minority Leader Lawrence F. Cafero Jr., R-Norwalk, said such plans do not save money in the first two years and would instead cost money by requiring employees to get more care then many already get.

"Maybe as many as half the state employees don't even have a primary care physician. Many people don't go for an annual check-up. Under this proposal, you would be required to do that," McKinney said.

Supporters of the health plan changes have acknowledged that the projected savings are ambitious, but say they represents a structural shift that will bring long-term savings and improve workers' health. They say it's a better strategy than the way employers have traditionally cut health care spending, shifting more of the costs onto workers, which can lead them to put off care.

"It's obviously an ambitious number, but I have to believe that the actuaries would not [project] that savings unless they had strong confidence that we could get there," said state Comptroller Kevin P. Lembo, whose office administers the state employee and retiree health plan. "It will mean that we would have to get out of the gate quickly, that we'd have to educate folks about what this means and then start to put in place the program very rapidly, but we're ready."

Robert Krzys, the union chair of the statewide health care cost containment committee, called the first-year savings projection "fairly realistic." If the first-year target isn't met, he said, it could be made up in the second or third year. But he added that the projections aren't simple to quantify.

"Can anybody that was involved in this guarantee that we're going to do it? Well, they can't guarantee it, and if people want to jump on that, then let them jump on it, but that's been the

same in every actuarial projection that's ever happened," he said. "To me it's a red herring, really, because it's a change to a structure that's important."

Prevention or pay

The savings projection is based on the assumption that half of the people in the state employee and retiree plan will participate in a new "value-based" plan, Krzys said. The plan is voluntary; those who don't participate would receive the same benefits, but be charged $100 a month more in premiums and face a $350 deductible.

People in the value-based plan would have to meet certain conditions, including getting physicals and all screenings, like mammograms, colonoscopies and vision exams, recommended for them.

Those with certain conditions--diabetes, asthma or chronic obstructive pulmonary disease, high cholesterol and triglycerides, heart failure, or hypertension--would also have to participate in a disease management program run by the insurers that administer the plans. About a third of people in the state employee and retiree pool have one or more of the conditions, Krzys said, and their care represents about two thirds of the plan's costs.

The disease management programs include helplines and nurses who provide information about the conditions.

"You have to deal with them, you have to read the materials, call them back, take phone calls," Krzys said. "You don't have to get better. You don't have to lose weight, because obesity's not a part of this. You don't have to stop smoking, but you're going to be told [it's a] pretty good idea."

Copayments for drugs that treat the conditions would be reduced for patients in the disease management programs, and copays for doctor visits for the conditions would be waived.

Those who meet the value-based plan requirements for a year will get $100, Krzys said.

Other changes apply to all beneficiaries, including care coordination for people leaving the hospital, which is aimed at keeping patients from being readmitted. The plan would also encourage people getting bariatric or cardiac surgery to use "centers of excellence," designated by the insurers based on patient outcomes. Doctors who call for authorization will be told about the centers of excellence, although the doctor and patient could choose any hospital.

Lembo said the idea of the plan design is to remove barriers to receiving care and medication, coordinate care and emphasize prevention. State employees already face fewer barriers than many people in other types of plan, he said.

Still, many employees and retirees don't get screenings or physicals that are recommended, Krzys said.

How does he expect to get them to participate?

"We're going to charge them 100 bucks a month" if they don't, Krzys said. "I think that's a lot."

Part of national conversation

Lembo said the plan design reflects efforts that began before the concession negotiations.

"It really will synch us up with the national conversation around how do we spend our money in the most effective way, how do we really drive positive outcomes and how do we engage patients and their primary care providers... in a meaningful way?" he said.

The state will be "a bit of a laboratory," with a large insurance pool to see what works and what doesn't, and make changes accordingly, he said. But he added that the concept behind the plan design is not new and has improved outcomes and helped control costs in other places.

Ellen Andrews, executive director of the Connecticut Health Policy Project who is part of a Council of State Governments policy group looking at ways to link health care purchasing to quality, said she has gotten many questions about the plan, including about how it could save money. She said she understands that people can be suspicious of the incentives. Workers will need to buy into the plan's concept and feel that they have control over their care for it to work, she said.

"Honestly, I think it's the only way that we're going to save money," she said. "Because just raising premiums and copays on people isn't working."

Andrews said the projected first-year savings were "a little ambitious, but it's not out of the ballpark. Places that have done this have been surprised at how quickly they see savings."

Wellness and prevention programs vary widely, and experts caution that it's difficult to measure their effects on health care costs.

"There are so many factors in play that it's very difficult to measure accurately the actual savings by having a given program," said Richard Cauchi, program director for health for the National Conference of State Legislatures.

Stamford-based Pitney Bowes, which is often cited as a leader in employee wellness programs and benefit designs, says its per-employee health care costs are 15 percent to 20 percent below what similar companies spend. Its efforts began two decades ago. Administration and union officials involved in the agreement have cited Pitney Bowes as a model, but Cafero noted that Pitney Bowes did not save money from its program until the third year.

In Washington state, King County has spent $26 million less than projected since 2005, when it implemented a disease management program. In 2006, it began a three-tier health benefits program, with lower costs--up to $1,200--tied to health-related activities. Workers can lower their out-of-pocket costs by taking a health risk assessment, and can lower them further by doing 10 weeks of activity that targets a risk factor identified in the assessment.

Last year, only 10.7 percent of 19,000 workers and spouses or domestic partners in the plan took no action to lower their costs. Sixty-eight percent were in the lowest-cost tier. Body-mass index, blood pressure and cholesterol levels have fallen, as have smoking and medical claims for bronchitis and pneumonia, Bascom said.

Bascom cautioned that the savings took time to achieve. She credited an agreement between the county government and employee unions for keeping the program going before it started saving money.

"Anytime there was faltering support, the county and labor would come together and argue the case for staying the course and seeing how things would go," she said.