

# Benefit Insights

## **Most Americans Unwilling to Pay More for Better Care**

Americans have become more skeptical than fair and reliable ways exist to measure the quality of health care providers' services, and less ready to say that high-quality providers should be paid more. These findings from a Harris Interactive online survey of 2,123 U.S. adults conducted for the Wall Street Journal show shifting opinions on health care quality issues—and on the connection between quality and cost—from 2003 to 2006.

In 2003, 58% of respondents said they believed there were fair and reliable ways to measure and compare the quality of care provided by different hospitals and medical groups, but by 2006 this figure had dropped to 49%. Quality measurement methods identified as fair included patient satisfaction surveys (assessed as fair by 69% of the respondents); medical tests that measure how well doctors are managing patients with chronic medical conditions (61%); assessments by medical boards (58%); assessments by third-party organizations that monitor health care quality (57%); frequency of preventive screening tests (55%); the use of electronic medical records and other information tools (47%); and malpractice suits (41%).

While 33% of the respondents favor health insurance plans paying more to hospitals and physicians that have been shown to provide higher quality care (down from 44% in 2003), only 19% thought that patients should pay more (18% in 2003) and even fewer—14% (16% in 2003)—were personally willing to pay a significantly higher premium for a health care plan that covered access to providers that have been shown to render superior care.

Such data reinforces the importance of health plan members' understanding of the impact that the quality of care can have, on overall health and on costs. A 2003 report from the National Committee for Quality Assurance (NCQA) concluded that quality gaps that hindered best practices lead to more than 57,000 avoidable deaths, 41 million sick days and more than \$11 billion in lost productivity each year. This human and financial toll is a piece of the health care cost equation—along with the member premiums and insurance reimbursements—that should be considered when deciding the price that one is willing to “pay” for quality health care.

## **Cost Is Lesser Factor in Assessing Health Care Quality, But Increases Are Affecting Use, Survey Concludes**

Americans tend to consider factors other than cost when assessing health care quality, according to the results of the 2005 Health Confidence Survey (HCS) published by the Employee Benefit Research Institute (EBRI). However, insured Americans who have seen their costs go up are changing the way they use health care, the survey found.

The HCS examined what survey participants considered to be “quality” health care. In assessing a provider, topping the list were the skills, experience and training of the doctor (con-

sidered by 97% as very important), followed by the provider's willingness to listen and explain things to them (90%), and the provider's personal manner, sensitivity and respect shown for the patient (80%). Factors not directly related to the provider but considered important included the degree of control the individual has over health care decisions (90%), the timeliness (89%) and ease (85%) of getting care and treatment, and the ability of a doctor or hospital to access patient medical records (81%).

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## **Cost-Containment Strategies Needed for the Few Employees with the Highest Health Care Spending**

Conventional wisdom has it that 20% of health plan participants run up 80% of health plan costs. Now, an analysis of health plan expenditures paints an even starker picture, concluding that 4% of participants account for nearly half of health plan costs.

The analysis of health plan expenditures from Watson Wyatt Worldwide found—

- 4% of participants with serious health conditions—chronic or catastrophic conditions—account for 49% of health care costs. These individuals average more than \$10,000 in annual health care spending.
- 24% of participants—who Watson Wyatt characterized as being in the early stages of chronic conditions or having acute health episodes—account for 40% of spending. These individuals average \$1,500-\$9,999 in health care costs.
- The remaining 72% of participants—who are relatively healthy—account for only 11% of health care costs, and have less than \$1,500 in annual health care spending.

These statistics send a clear message that disease and case management programs are crucial elements in any plan's overall cost management strategy.

Disease management programs focus on a particular condition, usually a chronic one such as asthma, diabetes or hypertension. The program offers care monitoring and coordination, along with patient education and care strategies. The end goal is to enable the patient to manage the condition in a way that enhances quality of life and day-to-day functioning, while

providing appropriate care, avoiding complications, reducing hospitalizations and, hopefully, containing costs.

Case management programs usually focus on individuals who have suffered a catastrophic injury or have life-threatening—and sometime multiple—conditions (such as cancer, stroke or head trauma). As with disease management, care is coordinated, usually through a case management nurse with extensive knowledge of the condition. However, a catastrophic case manager also acts as a liaison between the patient and the health care professionals (in catastrophic cases, there usually are many) involved in the patient's care, coordinating the different health care resources and treatment plans that may be involved. Such attention minimizes redundancies and the risks of counterproductive and contra-indicated treatments, and enhances a patient's and family's understanding of the health care received. Again, contained costs are among the hoped-for goals.

Centers of excellence are health care facilities that have been determined to provide high quality, cost-effective care in one or more specialty areas. Directing individuals to these facilities when appropriate (for example, a cancer patient to hospital that has been identified as an oncology center of excellence) can aid in cost management, especially if the center is a provider in the plan's network.

The bottom line: For the few who have the most spending, strategies that focus on managing the needed care likely will be more effective tools.

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While 79% said that they consider the cost they pay for health care as a factor in judging quality, less than two-thirds—63%—thought cost information on alternative doctors, hospitals and treatments was very important. And, only 28% thought that the quality of the health care system would be better if they knew the full price of health care services and treatments and prescription drugs, compared to knowing only the cost they paid.

A majority of those surveyed have seen the cost of their health care coverage increase in the past year, through higher premiums (55%), prescription drug copayments or coinsurance (51%), office visit copayments or coinsurance (48%), deductibles (41%), or other out-of-pocket costs (50%). Consequently, the survey reports changes in the way that individuals are using health care. These changes include use of generic drugs (79%), attempts to take better care of oneself (71%), and talking with a doctor more carefully

about treatment options and costs (57%). However, some respondents said they have delayed going to a doctor on account of cost concerns (40%) or have limited their doctor visits to when they have more serious symptoms or conditions (54%).

Most Americans remain satisfied with their current health care plan (54% say they are extremely or very satisfied, and 35% are somewhat satisfied), a rating that has remained relatively constant over the eight years that the HCS has been conducted. Generally, satisfaction with health care quality is high, while complaints focus on health care costs. Respondents who saw their costs increase in the past year were more likely to voice dissatisfaction with their current health plan and with other aspects of health care.

*The 2005 Health Confidence Survey can be reviewed in full through a link on EBRI's Web site, [www.ebri.org](http://www.ebri.org).*

## What's the Financial Impact of Disease Management Programs?

Disease management (DM) is becoming increasingly commonplace in health plans of all sizes. In the large employer arena, 70% offer at least one DM program, according to Mercer Human Resource Consulting's National Survey of Employer-Sponsored Health Plans 2004. A separate survey by Aon Consulting of human resources executives found that 43% of the surveyed companies had formal disease management programs in place. And, a survey by Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRT) of public and private firms ranging in size from upwards of three employees reports that 56% of workers with health care coverage are in plans that have at least one DM program.

A disease management program focuses on a particular condition—usually a chronic one—and offers care monitoring and coordination, along with patient education and care strategies. The end goal is to enable the patient to manage the condition in a way that enhances quality of life and day-to-day functioning, while providing appropriate care, avoiding complications, reducing hospitalizations and, hopefully, containing costs.

Prevalent DM programs are for conditions such as diabetes (99% of the workers covered in the KFF/HRT survey who were enrolled in plans with a disease management component had access to a DM program for diabetes), asthma (86%), hypertension (82%) and high cholesterol (66%). Other conditions frequently subject to disease management include congestive heart failure, depression and multiple diseases.

On an intuitive level, DM programs would seem to offer the potential for substantial cost savings. Among the Mercer survey participants, 31% reported a positive return on the investment (ROI) they had made in a DM program, although a majority of these employers (59%) had not attempted to measure the program's financial impact.

A study from Cornell University and Thomson Medstat examined 44 separate studies on the ROI generated by disease management programs and came to the conclusion that "evidence of their economic impact is scant." The review revealed mixed results for programs targeting depression, diabetes and asthma, but positive ROI for programs targeting congestive heart failure or multiple diseases.

Specifically—

- Congestive heart failure DM programs cost an average of \$1,399 per participant, but generated medical savings of \$3,884, meaning that \$2.78 was saved for every dollar spent on the program.
- DM programs managing patients with multiple diseases produced \$4.37-\$10.87 in savings for every dollar spent on the program.
- The reviewed studies for diabetes DM programs were "too variable" to draw conclusions; only two of the reviewed studies for asthma DM programs showed enough savings to produce a positive ROI.
- DM programs targeting depression consistently cost more—about \$500 more a year—than they saved in direct medical costs.

While disease management programs may be implemented with the hope that they will have a positive financial impact on the employer's health care costs, a look at the health plan's bottom line alone shouldn't be the end of the cost-benefit analysis for these programs. By enhancing quality of life and reducing the risk of complications that can arise from a chronic condition, individuals who participate in such programs may have reduced absenteeism, be more productive on the job, have fewer instances of short- or long-term disability, and experience greater overall job satisfaction. In assessing the financial impact of a DM program in the workplace, these are important factors that should not be overlooked.

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by assessing surcharges for employees with an unhealthy behavior who fail to participate in an available program (for example, smokers who decline participation in a smoking cessation program). However, the attitude toward the use of negative incentives is split. In a survey of large U.S. companies from PricewaterhouseCoopers Health Research Institute, 48% said that employees who exhibit unhealthy behaviors should be responsible for paying a larger share of their health benefit costs, but only a slightly smaller percentage (42%) disagreed.

According to the Health Intelligence Network online survey, the behaviors that earned incentives most frequently were proper nutrition (44% of the employer and health plan respondents had incentives in place for this), smoking cessation (34%), and adequate exercise (20%). The

incentives used most were a reduced health care benefit cost for participants (43% of the employer and health plan respondents utilized this as an incentive), merchandise and certificates (24%), and cash (21%).

Employers considering healthy lifestyle incentives (or unhealthy lifestyle disincentives) need to be aware of any applicable laws governing benefit plans that might limit implementation of such initiatives. Consultation with a benefits professional or legal counsel can help ensure that provisions of the Health Insurance Portability and Accountability Act of 1996 (which prohibits discrimination on the basis of health status) and other applicable state or federal laws are not violated in designing and implementing healthy lifestyle incentives.

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## **Lifestyle Incentives Can Lead Employees Toward Healthier Habits**

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Though health care cost increases have moderated, they still are substantial, projected for employers at 9.9% in 2006, according to human resources consultant Hewitt Associates. Employees, too, have been stung by the rising cost of health care, seeing their contributions nearly double since 2002, according to Hewitt research. Along with premium contributions, employees have experienced increases in their out-of-pocket costs, in the form of higher copayments, coinsurance rates and deductibles. Overall, employees' total health care costs—including their premium contribution and out-of-pocket costs—will rise 12% to \$3,136 for 2006, Hewitt projects.



Such data should make employees more motivated to be open to ideas that have the potential to reduce their health care cost outlay. Most people understand intuitively—though their actions might not indicate it—that eating a nutritionally sound diet, exercising, not smoking, not drinking in excess, and undergoing preventive exams and screenings all

enhance one's chances of staying healthy and, in turn, the likelihood of having lower health care costs. And, if the fact that "it's good for you" isn't reason enough, financial incentives from an employer or health plan can provide an added push to encourage employees to develop healthier habits, and to get them into programs that help them to learn and live a healthier lifestyle.

Lifestyle incentive programs sweeten the pot for employees to take steps toward and engage in healthier habits. In an online survey of health care industry professionals—employers and health plans—conducted by the Health Intelligence Network, 43% had lifestyle incentive programs in place and of the remainder, 47% planned to implement such programs in the future.

What behaviors do lifestyle incentive programs encourage? Some of the most common include undergoing health risk assessments, participating in smoking cessation programs, joining fitness programs (nutritional counseling, weight loss, exercise), and participating in disease management programs for chronic conditions such as asthma, diabetes, hypertension or high cholesterol. The incentives that provide the added push to get employees into these programs might include cash, gift cards and reduced health care premiums. Or, some employers and health plans try to nudge employees toward healthier behaviors with a stick instead of a carrot, such as

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