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Shift to value-based health plan can cause worker anxiety

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With health care costs fast outpacing company earnings and workers' wages, Michelin North America assigned a team to find a new way to handle its health benefits.

The result was a plan that gave workers a greater stake in taking care of their health and paid them for taking risk assessments and addressing problems the tests identified. For the company, it meant no longer simply paying the bills and focusing on costs, but instead targeting their spending toward services to keep workers healthy.

In the two years since the plan was launched, it has gained acceptance. But the transition wasn't easy, said Martin Storey, the company's director of benefits.

"Anybody that wants to do this, they've got to have a very thick skin," he said. "It's a struggle. It's behavior change. And people don't like change."

What does it take to change workers' perceptions of the concept?

"It just takes them experiencing the program," Storey said.

Connecticut doesn't have that option. The concession agreement between state employee unions and the Malloy administration depends in part on the establishment of a new health plan with a focus on prevention and wellness, and that won't happen unless workers agree to it this month.

For union leaders trying to promote the agreement, the health plan changes have been the hardest piece to explain. Seventeen of the 29 web videos the union has produced to explain the deal address health care changes, and union leaders have been rebutting what they call myths and lies, including speculation that the changes are a plot to push the state employees into SustiNet, a proposed state-

run public insurance plan.

Under the tentative agreement, state workers and their families would have the option of joining a new "Health Enhancement Program." Participants would have to get all recommended screenings and preventive services, with no copays, and those with chronic conditions including diabetes, asthma and hypertension would have to participate in disease management programs. The cost of medications for the chronic conditions would be reduced, and medical visits to treat them would be free. People who meet all the requirements in a year would get $100.

Those who don't join the health enhancement plan would have the same benefits they have now, but would have to pay an additional $100 a month in premiums and have a $350 deductible.

Leo Canty, a vice president of the American Federation of Teachers-Connecticut who has taken to responding to questions and comments about the plan on the union coalition's Facebook page, said the plan will "nudge them into taking care of themselves, in particular so that we can start lowering the real cost of health care."

People who sign up for the Health Enhancement Program but don't comply with the requirements can be transfered to the more expensive plan, but only after getting a notice and a chance to improve. Workers can only be removed from the health enhancement plan if they refuse to get the required tests and screenings and, for those with chronic conditions, refuse to participate in the disease counseling and education programs, according to the tentative agreement.

"You have to deal with them, you have to read the materials, call them back, take phone calls," Robert Krzys, union chair of the statewide health care cost containment committee, said last month. "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."

In designing the plan, negotiators looked to companies that use "value-based" benefits--plans in which employers use the benefit design to encourage the use of effective care. They have become increasingly widespread in the business world as health costs rise.

It's long been known that the out-of-pocket costs people face for medical care affect how likely they are to use it. But traditionally, copayment and coinsurance levels have been blunt instruments, either encouraging or discouraging the use of care across the board, not tailored to steer workers to effective, preventive care and away from unnecessary or more costly services.

Value-based plans are meant to have a more precise influence on workers' choices. Any plan with three tiers of prescription drugs with varying copayments is a value-based plan, said Helen Darling,

president and CEO of the National Business Group on Health.

"Virtually everybody has something now that's value-based," she said. "It's a question of how extensive it is."

More extensive plans might set lower copayments for drugs that treat chronic conditions like hypertension, diabetes and asthma, encourage workers to take health risk assessments to gather baseline data and offer incentives for participating in wellness activities--or penalties for failing to do so. Some employers, including Stamford-based Pitney Bowes, give workers incentives--like lower out-of-pocket costs--to get their care from providers who are considered high-performing.

"For the most part, our value-based design is removing barriers, not putting barriers in place," said Andrew Gold, executive director of global benefits at Pitney Bowes. That means making preventive services free and reducing out-of-pocket costs for drugs that treat chronic conditions, giving workers one less reason to put off preventive care or managing chronic illnesses.

While Pitney Bowes uses incentives, many other companies are shifting to disincentives, Darling said, consistent with research suggesting that the prospect of losing something will make people act more dramatically than the chance of getting something. Doing so also puts more of the costs onto workers who don't take actions that could improve their health and keep health care costs down.

"Spreading the costs more back to them if they're not taking the steps... that would make a difference in their health is where we are today in the United States," Darling said. "There's much less tolerance, if you will, for letting people neglect their health and not do the things they're supposed to do."

"If the fact that this might prevent them from pain and suffering doesn't move them, which it clearly hasn't, then I guess the employer thinks they need to take a tougher line," she added.

Michelin North America began exploring changes to its health benefits in 2006, when health care costs were increasing by 10 to 12 percent per year and projections indicated that workers' pay increases would soon be eaten up by rising health care costs, Storey said. That prompted an examination of the company's approach to health care--including why it provided coverage to workers at all. Storey said the conclusion was that the company needs healthy workers. But at the time, the company's approach to health care was largely limited to paying the bills.

"If you look at most health care plans today, there's very little incentive... to do anything other than go to the doctor when you don't feel good, and then you get into that game of all you do is pay for services," Storey said. "So you've got to find a way to get people motivated to want to change

behaviors or to take advantage of programs that are there."

Beginning in 2009, the company, which is based in South Carolina, gave workers a choice of the existing health plan or a high-deductible plan with a lower monthly premium. Workers who took the high-deductible plan would get a health savings account to cover their costs, and the company contributed $600 for an individual and $1,200 for a couple. People who took a health risk assessment would get another $200 in the account, and those who agreed to participate in an activity to address their risks would get another $200.

In the first year, 53 percent of eligible workers participated in the high-deductible plan. It's now about 70 percent, and 80 percent of them take the risk assessment. Of those taking it, the proportion of workers considered "high risk" for health problems has dropped by 30 percent since 2009.

Storey said it's important to recognize that the company's role can only go so far; the health plan can't make workers want to change their behaviors.

"We will help them do that, we will provide programs to do that," he said. "But in the end, they've got to believe in that and do it."

He sees some acceptance at Michelin. Last year, the company had a voluntary program for employees to track their physical activity for two months. It happened during the hot South Carolina summer, but 40 percent of employees participated.

"That tells me that people are beginning to buy in," Storey said. "The only reward for that is a T-shirt."

Darling said the most important way to get employees to buy in is to "communicate and communicate and communicate," and to tie it to money.

Resistance to the health plan changes is nothing new, she said, and state employees' concerns are not surprising.

"I don't think anybody's ever comfortable when something's being taken away, and as long as they can basically stick the cost to the taxpayers without having to be accountable, they'll keep doing it," Darling said.

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