Curbing health bills brings different cost: High-deductible insurance cuts premiums, but some fear it leads consumers to

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Two years ago, Holly Calvillo signed up for a new type of health insurance that was just starting to get popular. It had a nice low premium but a high deductible. Calvillo and her husband were young and healthy. She figured that with her employer's contributions to a health savings account, they would save money.

One unexpected pregnancy and C-section later, her medical bills came to $7,000. From then on, every family doctor visit was preceded by this question: "Can we afford it?"

Once, Calvillo suffered weeks with a bladder infection before calling the doctor. "I drank a lot of cranberry juice," said Calvillo, 29, of Minneapolis. "We were just trying to make it."

Five years after their introduction, high-deductible insurance policies linked to health savings accounts have delivered on their promise. People are thinking twice before seeing a doctor. They're asking about prices and shopping around. As a result, growth in medical spending in Minnesota has slowed dramatically and, in some cases, stalled.

But one important question remains unanswered: Are people cutting essential care as well as unnecessary treatment?

If so, the idea of harnessing consumer choice to reform American health

care might backfire, pushing consumers into decisions that undermine their health and driving up costs in the long run.

Doctors say they see worrisome signs: patients skipping colonoscopies and other screenings, or not showing up for follow-ups. Because the policies are new, most of the evidence remains anecdotal.

"We know that cost-sharing works," said Roger Feldman, a health economist at the University of Minnesota. "What we don't know is exactly what is getting cut back and what the long-run implications are."

Minnesota is a leader in the national experiment known as consumer-directed health care. It is based on the premise that Americans overuse medical care because insurance insulates them from real costs.

In 2004, backed by the Bush administration, Congress introduced a new insurance product - a high-deductible plan paired with a health-savings account (HSA) - to combat medical inflation. Consumers could put pretax dollars into accounts and keep any savings they didn't use for care.

The high deductible was supposed to force people to find the best value in a marketplace notorious for big variations in price. Employers liked the idea of shifting some cost to employees, much as they warmed to 401(k) investment plans two decades ago.

In Minnesota, where every major health insurer now offers the product, high-deductible plans cover nearly half a million enrollees, or 10 percent of the insured population.

That's created an explosion in demand for price information - which used to be treated like industry secrets. Now, law requires clinics and hospitals to give an estimate whenever a patient asks for it.

Last year, overall medical spending in Minnesota grew at just 6 percent, the smallest increase in a decade, according to the Department of Health. At companies that switched to HSA-type plans, the slowdown was even more dramatic, with some reporting actual drops in medical spending. At the same time, consumers' out-of-pocket costs overall were up by 14 percent, the biggest increase since 2002.

So what are people giving up? Judith Hibbard, a health policy professor at the University of Oregon, studied the medical claims of one large Midwestern employer between 2004 and 2006, after the company began offering a high-deductible plan alongside traditional insurance. She found that those on high-deductible plans were more likely to stop taking their drugs after the switch. They also cut back on necessary services, such as diabetes medication, as often as they skipped unnecessary care, such as going to a doctor for a cold. "They didn't make good decisions," Hibbard said.

However, another large study, by Bloomington-based HealthPartners, produced different results. HealthPartners, which owns a hospital and clinic chain as well as a health-insurance business, examined the medical and pharmacy claims of its members in 2006. It found that those enrolled in the new plans spent 4.4 percent less than those in traditional plans. It also found no difference in preventive care and use of medications for high blood pressure, cholesterol and diabetes - findings which surprised HealthPartners chief executive Mary Brainerd.

Yet some worry that if people are making bad decisions, those will only multiply as the economy worsens - causing people's health to deteriorate.

"It's very hard to take people from later-stage chronic disease to an earlier stage," said Michael Scandrett, a consultant with Halleland Health Consulting who works with hospitals, clinics and state government. "The costs are just going to bubble up later in the system."

In clinics and hospitals around Minnesota, doctors are seeing lots of creative efforts by patients to save money. Some make an appointment for one child, then bring two, said Dr. Michael Severson, a pediatrician in Brainerd. Families ask for free drug samples. They haggle over price. Recently, a child came in with chest pain. Severson, suspecting pneumonia, urged an X-ray. The parents chose to wait and see if the symptoms went away.

The first thing to go, Severson said, is the follow-up visit. After all, the kid feels better, so why spend more? "These little barometers are showing up everywhere," he said.

The pattern reminds him of the 1970s, when, as a young doctor, Severson treated lots of patients who paid out of pocket for routine care. Then, a lot of kids with vomiting and diarrhea were coming in dehydrated because parents waited too long. "We'll begin to see that," he predicted.

Enough pediatricians are worried that the Minnesota chapter of the American Academy of Pediatrics is trying to set up a joint council of physicians and insurers. Topping the agenda: high-deductible plans and their effect on children.

Some, however, have embraced the new consumerism.

For Jeff Palumbo of Grant, Minn., the epiphany came this year when he took his son in for ringworm. Palumbo had just switched to his employer's high-deductible plan. Despite multiple phone calls to his clinic and his insurer to ask the price of a doctor visit, he kept getting the same maddening answer: It depends. Finally, someone told him it would cost at least $85. When Palumbo ended up getting billed $125 for the visit - "For seven minutes!" - he called to complain.

Next time, he said, he'll go to a MinuteClinic. (It charges $59 for ringworm.) Despite the frustrations, Palumbo likes his control over spending. "It makes you ask more questions," he said.

For others, planning for health care is akin to planning for retirement.

Janet Schuerman and her husband own Ursa Inc., a company in White Bear Lake that makes wagons for gardening. Like many small-business owners, they signed up for a high-deductible plan as a tradeoff for lower premiums.

An MBA and a former insurance executive, Schuerman now plans their medical spending on spreadsheets. The family is healthy. They watch their diets and exercise. Their son gets his immunizations.

But while they all get annual physicals, they sometimes skip the higher-cost screenings. Schuerman's husband, Jim Ehrler, is 46 and has a heart-valve defect that his doctor recommends monitoring with an annual echocardiogram. Instead, Ehrler gets them every other year. Once, he waited so long to get a follow-up heart CAT scan that his doctor threatened to fire him as a patient.

Schuerman, 51, gets a panel of blood tests done once every three years instead of yearly. "Am I getting a level of health care I feel comfortable with?" she said. "Absolutely not."

Some experts think it's too much to ask consumers to make the kind of medical judgments for which doctors have spent years in training.

"There needs to be an added incentive or better information or both," to ensure that consumers get the care they need, said the University of Minnesota's Feldman.

Insurers already are trying to figure out the next iteration of consumer-directed health care. Ironically, it might involve less consumer and more health system.

"I don't think (consumer-driven care) is going to be the silver bullet people think," said William Bluhm, a Minneapolis-based consultant with Milliman, a large actuarial firm. Bluhm thinks the key to cutting unnecessary care is to compel doctors to follow scientifically proven guidelines, not to rely on patients to figure what they need. "That's when we'll be able to hold costs down."

Dr. Mark Fendrick of the University of Michigan is espousing value-based design in which some drugs and treatments have high value because they keep people well. Those should be covered, even in high-deductible plans, he said. Minnetonka-based UnitedHealth Group is introducing such a plan, where diabetes care is fully covered.

Meanwhile, Minnesota is experimenting with yet another new model called the "medical home," in which primary-care doctors serve as patient advocates, recommending what care is and isn't necessary.

Industry veterans say they've seen such U-turns before. "It's a pendulum," said Scandrett of Halleland. "Now it's swinging back a little."

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