

# Next-Generation Cost-Sharing Products— The Concerns, The Experience, The Future Part 1: The Concerns

## Introduction

On October 9, 2003, *The Permanente Journal (TPJ)* held a roundtable discussion with physician-leaders from six of the Permanente Medical Groups (PMGs) who were present at the National Products and Benefits Development and Implementation Group meeting in Atlanta, Georgia. People involved in this work from Health Plan and the PMGs had gathered there to hear the Georgia Region's experience implementing next-generation cost-sharing products.

Through reading this roundtable discussion, we hope that you will be able to join the dialogue about cost sharing you may be increasingly having in the next year or two. The Georgia and Colorado regions and Group Health Cooperative have all implemented cost-sharing products. In July, the Kaiser Permanente (KP) Northwest Region will implement these Health Plan benefits which include deductibles, higher co-pays and co-insurance. Members and employer groups will have purchased these plans to lower their monthly premiums to be able to afford KP health care.

There is understandably much concern and anxiety among us about what this will mean for our medical care of patients, our conversations with patients, and

how this will integrate with other changes occurring (eg, HealthConnect).

For now, the best we can do is to understand physicians' concerns, learn from the experiences of other regions, and educate ourselves to have expanded conversations with patients. The Interregional Clinician-Patient Communication Leadership Group (IRCPC) has been at work developing CME workshops on cost-sharing conversations. The Georgia region delivered a revised second version in February.

This roundtable discussion will be presented in two parts to make the information more understandable and accessible for you. The first part will address physician concerns; the second part will review the implementation experience in three regions, and will look to the Health Plan products, service delivery, and Permanente Medicine.

The moderators for this discussion will be **Jon Stewart**, Director of Communication for The Permanente Federation, and Communications Editor for *The Permanente Journal*; and myself, **Tom Janisse, MD**, Assistant Regional Medical Director, Health Plan and Human Resources, Northwest Permanente, anesthesiologist, and Editor-in-Chief of *The Permanente Journal*.

Participants
<b>Victor Collymore, MD</b> , Medical Director, Care Coordination, Integrated Group Practice, Group Health Cooperative and Medical Director, Group Health Options
<b>Harry Glauber, MD</b> , former Assistant Operations Medical Director for Specialty Care, and endocrinologist, Northwest Permanente
<b>Lee Jacobs, MD</b> , Associate Medical Director for Professional Development, and infectious disease internist, The Southeast Permanente Medical Group
<b>Michael Mustille, MD</b> , Associate Executive Director of External Relations, The Permanente Federation, and occupational medicine physician, The Permanente Medical Group
<b>Jeffrey Selevan, MD</b> , Associate Medical Director, Business Management, and emergency physician, Southern California Permanente Medical Group
<b>William Wright, MD</b> , Associate Medical Director of External Affairs, and former Operations Medical Director for Primary Care, family practice physician, Colorado Permanente Medical Group
<b>Les Zende, MD</b> , Associate Medical Director, SCPMG (1993-2003), currently internist and geriatrician at the Los Angeles Medical Center, Southern California Permanente Medical Group

## The Market Has Become Unaffordable

**Dr Wright:** Since the decision to implement these new products—and each region is on a timeline to do this, with Georgia first, and then Colorado—I have been talking with physician leaders and with chiefs of departments to understand their views. We have also held several group discussions at the departmental/facility level. In spite of the general sense of concern, I have been approached by physicians who are actually hearing from their patients concerns around affordability. When physicians hear that from their patients, they understand very clearly that we need to do something different; *the market has become unaffordable*. The physicians who are younger or newer in the group and who have a background in “private practice” are more

attuned to issues of affordability in the way of doing business. The physician who has been with Kaiser Permanente (KP) for many years would be a lot more apprehensive about breaking the mold and may be fearful: Once we crack the dam, what else is going to happen? We have to be sensitive to those fears.

**Dr Zandle:** There's an understanding of the business case for these products among the leadership—among the SCPMG Board of Directors and some of the Chiefs, but I don't think it has gotten to the frontline physician. One of the reasons that we're hearing anxiety is that we don't have a good track record in KP of planning for how new initiatives on the business side are going to affect clinical practice—preparing physicians, listening to their concerns, and helping them get through the transition. Whether it's about using encounter coding systems or HEDIS or pharmacy utilization or disability forms or whatever, we didn't think to work it through with the physicians. Therefore, our physicians are very suspicious that this is just about another change that is going to have an unclear effect on their clinical practice and that they're going to hear a message that says, "This is no big deal. The market's making us do this. You're overreacting." So I'm very pleased that this initiative seems to be occurring differently. We do appear to be listening to concerns of physicians, and we have an opportunity to teach them why and what and how we're going to help them and acknowledge that it's not going to be easy—that it is going to cause change and stress and that we're going to do everything we can to help them.

**Dr Selevan:** In general, the direct patient care providers—physician and nonphysician—that I've talked to about the high-deductible, cost-sharing products that we're bringing to market uniformly dislike them on first hearing about them and say, "*This is contrary to our genetic code.*" Then I go through the business case and explain the rationale and put it into the context of the membership losses we've experienced; by the end of the discussion, they get it. They understand why we're losing members to competitors who offer these products. And even though they don't like it at the end of the discussion any more than they did at the beginning, they've a better understanding of why we need to adapt to the market, at least to be able to compete with the hope that at some point this, too, will pass, and that we'll go back to the comprehensive type of care that we're used to giving.

**Dr Collymore:** My experience has been that certainly the leadership in Group Health Permanente un-

derstands the market forces—understands the whys—but is not enamored with this, doesn't like it, and regrets it. When you speak to the front line physicians, they will understand the business case after it's explained to them, but they also say that *it is not the Group Health they've come to know, love, and understand.* And what are we doing as an organization to change this, to change the business environment, so that the employers are not being driven to act in this fashion? That's the challenge that's coming back to us. Physicians understand the rationale once it's explained to them and are willing to adapt, but they're asking us not to be accepting of the status quo and to move to a different solution.

**Dr Wright:** There is an understanding that there's a crisis of affordability. There may be less understanding or less acceptance that these products are the right tool to solve that problem. With that being said, if this is not the right tool, and if *this is really a bridge to somewhere else,* that somewhere else is obviously the delivery of care and how we practice medicine. This leads us to the view being promulgated by folks like the Institute of Healthcare Improvement (IHI) thinkers, that getting rid of waste is ultimately the way to address the affordability problem. Physicians that have been hired recently, two thirds of whom have come from the private sector in the last five years, usually say: "Duh, what's the big deal?" And I agree that physicians who have been with Permanente longer have been more insulated from the market and from the actual cost of care. They will struggle more from a cultural point of view. We have to keep helping people understand the why, the context, and then allow physicians to have an opportunity for revisiting core values. We emphasize that we are trying to continue delivering our comprehensive benefit package but we are trying to create other doors to access that package. So, yes, we understand the affordability issue but is there agreement about the mechanism to solve the problem? No. Is this a microcosm of the larger issues going on in health care? Yes.

### Potential Membership Losses

**Dr Jacobs:** Our doctors don't have the long history that many other Permanente people do around the core value of prepayment, which is the one that's at stake with these new high-deductible products, and so they don't hold on to it quite so closely. Our physicians are aware of the market pressures, and they do not feel secure when they look at membership losses in the past year, so I think they definitely have a sense of

need. Their question is, *“Is this going to change our care even more in the future?”*

**Dr Mustille:** Part of the anxiety I’m hearing has to do with some misunderstanding of the “what,” as opposed to the “why.” What I hear from physicians is: “What!? We’re going to change the organization into Wellpoint? Or Cigna?” And I don’t think that’s the “what” that we’re actually doing. So let me relate an experience I had recently following a meeting of the Care Management Institute network, to which I invited an executive VP of Human Resources from a major national bank. He sat through the meeting and listened to presentations from

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Paul Wallace, MD, and Jay Crosson, MD, about changes in the insurance aspects of what we’re doing and how we need to adapt with these new products while continuing to pursue excellent quality outcomes and cost efficiency. At the end of the meeting, he leaned over to me and said, “You know, Mike, *we don’t want you guys to change what you do.*” He said, “What we are asking you to do is find a way to bring KP to more people, not change what you do.” In that context, if we can talk to physicians who are really anxious about changing the organization into something different, if we can talk to them about how what we are doing is not to change the organization into something new but rather to bring what we do well to a broader audience, then they’ll understand that. It sounds a little Pollyanna-ish, but that is actually what the purchasers are asking us to do. And, the way we respond to that, the way we design these products and new benefits, can certainly be a positive way of improving and changing KP, not to mention surviving economically. So I think part of the way we have to answer the concerns of the physicians—which we should not minimize and which are very real—is to show how we’re going to support them in doing what we need to do from the delivery system perspective and show how this can enable KP to actually advance rather than retreat. But we should not foster the concept that we’re going to eventually get back to the good ol’ days in some future glorious state. Rather, this is a part of a transition in which KP is taking its rightful place in American health care.

**Dr Zendle:** If I can just add to what Mike said, what’s also true is the inverse: If we do not change, if we keep having only the comprehensive products that we have, there will be fewer people who are able

to be part of KP or Group Health Cooperative. That gets physicians’ attention because physicians have this sort of ambivalence about growing membership, but they’re not ambivalent about losing members.

### My Relationship in the Exam Room

**Dr Glauber:** One of our values as Permanente physicians is to be evidence based in our clinical and scientific approach. And while we can understand the market forces that are making us make these changes—and to some extent we’re modeling our co-pays and our product design from what the market is doing—I find myself asking questions: We understand there will probably be impact on utilization and we would like to see less inappropriate utilization and, if anything, more appropriate utilization, but what does the literature tell us about the impact on utilization, in our kind of population, or membership, of the kinds of products we’re proposing? And there is scant literature. We need to bring it out and update it and look at it. Very clearly, the first question physicians ask is, *“What is this going to do to my relationship in the exam room?”* Am I going to need to have a fee schedule? Am I going to be negotiating costs with patients? Are they going to be venting their dollar issues, dollar depressions, to me? How am I going to deal with that? We focus a great deal on member satisfaction, the service aspect of care quality. Are we going to be shooting ourselves in the foot with member satisfaction by changing the way we organize our financing? And what impact is it going to have on individual health? Are people going to decline to take necessary treatments or tests that we prescribe? On an individual level in the exam room, when I say to a patient, you need to do this test and it’s going to cost you \$200, will the patient say, “Well, I can’t do it this month, Doc.” But, additionally, at the population level, I’ve spent a lot of energy over the years in population-

“What is this going to do to my relationship in the exam room?”

based care of chronic diseases, things such as diabetes, hypertension, osteoporosis. Much of our energy has been focused on outreach to people who are not seeking care. We’re calling people, saying, “You need to come in and do a hemoglobin A<sub>1c</sub> test.” Or “You need to go in and get your eye exams.” They don’t want to do it. They don’t perceive the need. We want them to do it for the sake of their health and perhaps for our HEDIS measures or for CMI measures. But now KP wants them to do something that they don’t want

to do, and they're going to have to pay more for it. It's going to be more of an uphill battle to get that to happen.

**Dr Wright:** I would agree with *the concerns* I've heard. But I would rephrase them as *time, relationships, and unintended consequences*; and, surprisingly, I've even heard docs expressing actuarial concerns. With regard to time, it's just that there's so many "initiatives" colliding in the exam room while we have this movement toward cost-sharing products and we've got all the implications of HIPAA, deployment of the automated medical record, more emphasis on correct coding, and, in our region, the launching of a new hospital and multispecialty facility. Somewhere in the middle of all that, you're supposed to actually deliver care and have a relationship with patients.

It's probably self-explanatory that this is our culture—folks want to come here and practice medicine without having to think about "that stuff"—unintended consequences—I've already begun to hear about the possible unintended consequences of short-term gain and long-term adverse impacts. For example, a patient tells you, "You'll have to put me in the hospital to do that test because I don't want to pay for it as an outpatient." The last category is the actuarial concerns. The concern has been around trying to understand the phenomenon called "profit by line of business." You know, basically, are we going to offer this product to the right people? You could err on both sides, both extremes. I'm not an insurance expert, but let's say you offer one of these lower-premium packages to people who aren't likely to leave the program anyway, and so now you're just getting less in premiums. On the flip side, there's that category of patients who are excessive utilizers, that 5% of the population using about 50% of the care. A lot of people I've talked to think those patients will blow through their out-of-pocket maximum by the middle of January, and then we're on the hook for the rest. So there's a lot of anxiety about whether we can actually do this successfully.

### Permanente Values

**Dr Jacobs:** The concern in Georgia has fallen into three areas. One is Permanente values, meaning, *does this go against who I am as a Permanente physician?* Does it go against my values? And collectively, as a medical group, is this really what we're in Permanente for? The second concern is introducing the cost barrier into patient communication. And the last theme that we heard about was the risk area—whether it's around adherence or just putting up another barrier to care. There's a fourth area that we've heard about

in Georgia that involves delivering great service, including compassionate care. There's a sense that maybe this is not such compassionate care, and that's a mindset we're going to have to deal with to make sure that there is a compassionate approach to administering these new products.

**Dr Collymore:** Another concern I hear is: *Are we part of the solution or part of the problem?* Is this phenomenon contributing to a societal problem by putting comprehensive care out of the reach of people who need it most? On the flip side, though, some physicians are also saying that this may offer a potential opportunity to align patients' behavior with our care management strategies or to make sure that the EDs are used appropriately or that appropriate pharmaceuticals are selected. So there may be some positives here that physicians are seeing.

**Dr Mustille:** I agree with that, Victor. There are some positive aspects to it. One other thing that has come out in conversations with physicians is the issue of medical/legal liability—physicians *being concerned that somehow they will be held responsible from a legal perspective* when outcomes don't match their expectations, because of care that was either refused or deferred. The solution is for everyone to know what the physicians need, as far as understanding their legal responsibilities and ethical responsibilities, to help defuse some of that concern.

**Dr Selevan:** There's another concern I've heard that's not related to clinical care but more to service. I'm fearful that when our members have a high deductible product and have to wait for what they perceive is an inordinate amount of time for a procedure like colonoscopy and have to pay for the full value of that procedure, they're going to confront the physician with, "Well, I could've gone across the street to a local doctor for the same amount of money; *What value am I getting from KP?*" It's going to put our physicians into a very awkward situation. They're going to have to deal with a different type of patient interaction than they have had to face in the past, when the patients' financial liability was limited to a modest co-pay.

### How PMGs Are Addressing Physicians' Concerns

**Dr Jacobs:** We are at the very early stages of addressing the needs that you all stated so well. It's certainly something that's not done overnight. What we've realized as a group is that we've got to start at the very basic cultural level, at the level of values, and what's not going to change. That's been a good exercise for us. We

talked about the role of the physician in the exam room with these new products, trying to be really explicit, really clear about what might happen. And we talked about the role of the people around the physician, such as the billing office staff and the changes taking place there. We try to emphasize that, in fact, the business office is going to be very different with an expanded role. So we're dealing *first with these cultural issues*. *Second, we've developed opportunities for physicians to participate in CME workshops* that can help them get a handle

... cannot stick their heads in the sand on this issue.

on some of the new patient communication barriers. We're giving people a lot of skills in how to handle the conversations and, at the same time, are making them aware of the business processes. But we have a long way to go, and we're going to need everyone's help. I think

it's going to require a Permanente-wide solution to do this; it's not a Georgia issue alone. We're trying to make it truly interregional by working with other regions.

**Dr Wright:** *The PMGs, as leaders and partners with the Health Plan, absolutely cannot stick their heads in the sand on this issue.* We need to be very clear to our medical groups that we are at the table and that we are fully functioning as partners with the Health Plan in looking at these issues and that we're committed to learning about these issues, what's going on in the market, etc. We also need to be very clear that we are committed advocates for the individual patient in the exam room, as well as for taking care of our community of patients. The other commitment we need to make to our physician groups is that we will be quick learners and that we will modify as we go and will give feedback. We in Colorado have consulted with two groups. As you know, most of the regions have these clinician-patient communication folks, and we're working with them in terms of creating scenarios that actually give people a chance to think through various scenarios. We've also discussed these products with our bioethics committee. Their feedback around potential members being fully informed about what they are purchasing was valuable. We're also trying to educate folks about the market and what drives the cost of care, because a lot of physicians have been very insulated from the cost of care.

**Dr Collymore:** Sometimes the environment you're working in affects how folks respond to these products. Washington State has the second highest unemployment, I think, just after Oregon. Given that environment, where membership losses have been forecast,

the receptivity to cost sharing is enhanced. In July, the Group Health Permanente *physicians for the first time had to start sharing in premium costs themselves*. This was not exactly greeted enthusiastically by the front-line physicians, but nevertheless the argument can be made: How can we offer products that are asking for cost sharing from major employer groups if we're not willing to participate in the same cost sharing. These types of examples have made it a little bit easier for our folks to understand the current realities.

### On Exam Room Conversations About Cost

**Dr Jacobs:** There will be a very different kind of conversation with patients in the exam room—conversations about cost. And the onus on the leadership of the medical groups is to support that conversation. Much of our care in Georgia is provided by nurse practitioners and physician assistants, so we want to make sure they have opportunities to really enhance that skill. And I believe it is a skill, and it's one that not all of us have. The physicians coming from the community clearly have the knack, but *many physicians choose to avoid the conversation*. It's like the traditional death-and-dying discussion—everybody agrees it's important, but we don't do it. So the onus is on the leadership of the medical groups to support the physicians' conversations, and some will have an easier time than others. Also, it's the responsibility of the entire organization to support that conversation in the exam room. It's going to be a major challenge for us because it is so huge and there are so many complexities to make it work right. But if it's done right, it shouldn't affect care, except possibly in a positive way. I honestly believe that the idea of involving the patients in decisions about their care, whether it's drugs, lab tests, or what-have-you, is positive. The more we engage the patient, the better we are. This is a major opportunity.

... many physicians choose to avoid the conversation ...

**Dr Zandle:** I agree with Lee, but I also think there are *certain conversations that aren't appropriate to take place in the doctor's office*. If we expect our physicians to become experts on benefits financing, then we haven't supported them like we need to do. Yes, it's going to change the conversation between doctor and patient, and we need to help our physicians with the skills to change it in a positive way. We also need to make sure that we're not leaving the physicians hanging in the wind by expecting them to have conversations that really

belong in a different place, like the business office.

**Dr Glauber:** Yes, we need to have a very explicit safety valve in the exam room for the clinician to be able to say, “I understand. Here’s who you can talk to in the office.” And they need to be available. And patients shouldn’t have to be on hold for an hour, getting angry, waiting to talk to them. We don’t have the next-generation products yet, but these conversations are already happening. Part of my strategy with patients with diabetes was to simplify the visit by asking them up front, “*Well, what’s your agenda today?*” So we’re not guessing. Just a few weeks ago, a patient pulled out an ad from *Parade* magazine, wanting the newest brand of insulin, which, unit for unit is about four times the cost of the alternative. Clinically, it was not unreasonable, so I was prepared to prescribe it for him. He went down to the pharmacy and came back up 10 minutes later very unhappy, saying he couldn’t pay for it. So I had to go back and rewrite my instructions.

**Dr Jacobs:** That’s a good example—the patient wanted the newest-brand insulin but then didn’t want to pay four times the cost of the alternative. Now the *patient’s prepared to engage with you and he’s going to be involved in the decision*. Was the incremental benefit of this new insulin really worth the additional expense to that member? That’s a joint decision you two can make.

**Dr Glauber:** It’s not all negative, because if it’s something that’s critically necessary, you say, “You have to take this treatment. There is no alternative. That’s the reality.” But for so many things that are patient-driven, there is a marginal incremental benefit. You get an added degree of certainty by doing the CT scan, even though it’s probably going to be normal. Once the patient realizes the cost of it, we won’t have to deal with a lot of what is discretionary—such as the very expensive antibiotic or the very expensive PPI instead of an over-the-counter H<sub>2</sub> blocker, which would work just about as well. *So, we will see some benefits in more rational care.*

**Dr Mustille:** We may actually see better care, because we’re taking the patient’s perspective on value into account in a way that we did not have to do so explicitly in the past. Let me give you an example of how, in my own practice, which is occupational medicine, we have a similar kind of challenge. A few years back, we realized that physicians were not managing disability very well in occupational health. The reason was that, just as with cost issues, disability wasn’t being discussed. *Physicians and patients were both avoiding*

*the conversation about disability.* We took the time to focus on that and to train physicians to make the disability conversation an integral part of care planning just as perhaps we ought to be making resource efficiency part of the value structure in which patients make decisions. And guess what? It turned out that not only do we manage disability better, we also got people better faster because the disability conversation was part of the treatment plan. People actually got healthier faster, went back to work, and ultimately had less permanent disability. Now, obviously the parallel doesn’t work perfectly, but it’s an opportunity for shared decision making that actually turned into a win-win situation. There’s the potential for this same kind of conversation to happen with resource efficiency.

**Dr Wright:** Interestingly, when we were looking at some data about employers’ concerns about health care costs, we noticed there had been a slight down tick from about 2000 to 2001; a little less anxiety. When I dug into that statistic a little bit more, I found that a lot of employers feel they have found an answer with cost sharing. There’s a belief, right or wrong, that now that patients are going to be a little more engaged about costs, *they’re going to be back in the exam room asking questions that perhaps they weren’t asking before.* I can’t say that that’s totally negative.

**Dr Collymore:** In the old way of doing things, if a physician decided not to give patients what they wanted for clinical reasons, the doctor was in the position of being the bad guy. Now it can be out in the open. When the doctor says, “I don’t really think you need this.” The patient says, “Well, it’s gonna cost me \$100. *If you don’t think I really need it, maybe we won’t have it, doc.*” And, the physician will be removed from being the bad guy.

**Dr Janisse:** Do you think that introducing new cost-sharing products can lead to preventive medicine, or self care, on the part of the patient?

**Dr Wright:** We are designing our benefits to still show our bias towards preventive care (for example, zero-dollar co-pays for some prevention visits). Other feedback from some physicians regarding cost sharing and the decisions in the exam room, show a sense that since *quality is often defined as choice in America*, we should provide options for patients to “buy up.” For example, a bone mineral density study, it may not be indicated, they’re not in a high-risk group but their neighbor got it, and they want one, and, for extra cash, can they have that? Or, screening colonoscopy might be another example. So, from a consumer-demand point

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of view, they would be able to purchase it, adding an aspect of choice in their care.

**Dr Zendle:** However, we've trained our physicians to think about medical necessity. *It's either necessary or it's not necessary.* And there are some problems with what you just suggested, especially within the regulatory environment we're in now, in that if it's necessary, why are you charging me more for it? And if it's not necessary, then why are you offering it?

**Dr Mustille:** There isn't too much literature on the relation of cost sharing to preventive care and necessary care. But as you know, the Rand studies have shown, unfortunately, that *when you put in financial barriers to care, necessary care suffers as well as unnecessary care, and almost equally*, so that patients defer or avoid care that is recommended or necessary just as they avoid care that is truly discretionary. When we think about why, maybe it's that patients don't know which is which. They don't know which care they really need (ie, that is worth paying for), versus that which appears to be just as important. But on a scientific basis, the care may truly be discretionary and not needed. One of the advantages that we may be able to find in this discussion of resource effectiveness is to be able to help patients

distinguish between what's worth spending money on and what is not worth spending money on and in a way, to help them know how not to defer care that is critically important to get the best outcomes.

**Dr Collymore:** Well, besides preventive care, one thing that will align the incentives, as we are doing in Group Health Permanente, is putting in an electronic medical record with secure messaging. With office visit co-pays going up and co-insurance coming in, and with the advantages of technology, patients may not have to come in for a URI, for example. *They can talk to their doctor electronically and have their needs met.* So this may be an advantage where, with technology and cost sharing, it will drive the member into the appropriate method and venue of care.

**Dr Glauber:** We are also introducing secure messaging right now, and the physicians are expressing the fear that we are going to do more and more of that. It's not in the base schedule. It's sort of between the cracks at lunchtime or at the end of the day. Physicians' worry, "I'm doing all this extra work that I'm not being paid for."

Thank you. The discussions about the implementation experience in three regions and thoughts about the future (Part II) will appear in the next issue of *The Permanente Journal*. ❖

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## How Much You Care

Patients don't care how much you know  
until they know how much you care.

—Jill Steinbruegge, MD, PMG Federation, and Robert Sachs, PhD, at the Advanced Leadership Program, University of North Carolina, 1998