

Next-Generation Cost-Sharing Products— The Concerns, The Experience, The Future

Part 2: The Experience; Part 3: The Future

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 & Benefits Development and Implementation Group meeting in Atlanta, Georgia. At the April 7, 2004 National Products and Benefits meeting we revisited the discussion and added new learnings to this roundtable. Part I of this roundtable, which addressed physician concerns, was published in the Spring 2004 issue of *TPJ*. Parts II and III, The Experience and The Future, are published here. The moderators for this discussion were **Jon Stewart**, Communications Practice Leader, Government Relations and Health Policy for Kaiser Foundation Health Plan, and Public Policy Editor for *TPJ*; and **Tom Janisse, MD**, Assistant Regional Medical Director, Health Plan and Human Resources, Northwest Permanente, anesthesiologist, and Editor-in-Chief of *TPJ*.

Part 2: The Experience “Don’t Change What You Do”

Dr Mustille: Now, this relates to prevention again, but I want to qualify my earlier comment on the major purchaser who said, “Don’t change what you do.” He’s talking about two things. Keep doing what the integrated care model does very well, which is to treat people with chronic illness, comorbidities, and complicated complex care; and don’t take your system apart and risk disrupting the wonderfully good results you get from integrated care. That’s number one. Number two: Don’t forget that you have a history and tradition of excellent prevention and wellness at Kaiser Permanente (KP). Look at the HEDIS measures; zero cost is not what they’re after. They would be willing to pay us to do those two things if we could better show that we are doing them well.

Dr Wright: When I’m out talking in the community, I find that a couple of things distinguish us. Our focus on population health is unique compared with the fee-for-service community. It is rare to talk to a private physician who can tell you, or even thinks about, what the incidence of disease is in their own patient population; for example, how well their diabetics are doing, how well their asthmatics are doing. This focus on population health within KP is a huge advantage for us. The huge disadvantage we still have is perception of quality. I heard Tom Peters, business guru and author, quoted at a talk: “Most people evaluate quality in that end-of-the-day, idiosyncratic way, How did it feel?” That’s still the gap that has to close. That is why I think cost sharing is going to move the relationship along that perception spectrum.

Dr Mustille: Who we are really is a key part of this. As we all go out and talk to physicians, it’s a great opportunity to step back and talk about how different Permanente practice is from other practices; these are things we take for granted. In simple terms, the quality of partnership at Health Plan-Medical Group is strong and powerful. If we had this across this country, we wouldn’t be in the crisis we’re in today. The interac-

Participants
Dave Briere , National Director, National Product Development and Management, Program Offices
Victor Collymore, MD , Medical Director, Care Coordination, Integrated Group Practice, Group Health Cooperative, and Medical Director, Group Health Options
Ruth Dunker , Director, Benefits Implementation, Georgia
Harry Glauber, MD , former Assistant Operations Medical Director for Specialty Care; and endocrinologist, Northwest Permanente
Margaret Herndon , Director of Market and Product Strategy, Kaiser Permanente Colorado
Brian Hudes , Business Line Director for National Accounts, Program Offices
Lee Jacobs, MD , Associate Medical Director for Professional Development; and infectious disease internist, Southeast Permanente Medical Group
Neal Miller , Director, Next-Generation Products, Program Offices
Michael Mustille, MD , Associate Executive Director of External Relations, The Permanente Federation; and occupational medicine physician, The Permanente Medical Group
Jeffrey Selevan, MD , Associate Medical Director, Business Management; and emergency physician, Southern California Permanente Medical Group
William Wright, MD , Associate Medical Director of External Affairs, former Operations Medical Director for Primary Care, and family practice physician, Colorado Permanente Medical Group
Les Zendle, MD , Associate Medical Director, SCPMG (1993-2003); and internist and geriatrician at the Los Angeles Medical Center, Southern California Permanente Medical Group

tion of professional physicians among themselves—the way they talk, the way they practice openly, the way their practice is demonstrable to others, helping each other improve, and looking for opportunities to improve—that’s uniquely Permanente. It’s important for us not to just have pride in our service and in our care but, as KP Georgia cited—and I think it’s earth-shaking—we need to have pride in affordability; to offer outstanding care that’s affordable and to have pride in that.

Experience of Patients Paying for What They Need

Dr Janisse: I have a question for our Georgia partners in Health Plan, in terms of the effect of cost sharing on patients’ behavior. One of the concerns for physicians is: If we have a higher copay for this test, the patients won’t get it—they won’t want to pay for it or can’t afford it. Or if we have a copay for a certain treatment, patients won’t follow it. In Georgia, what is your experience of patients paying for what they need, paying for what is recommended by their doctor?

Ms Dunker: The experience in Georgia in terms of copayment collection is that we collect about 98% to 99% of all the copayments due when the service is being provided: at check-in. However, this is our normal copayment structure. More to the point would be the example of a pregnant woman on a plan that requires a \$1000 copayment for professional obstetrical services. We have processes in place to collect that \$1000 prior to delivery, and we’re doing that about 94% of the time. This process includes our business office initiating an outreach program—notifying the member, in advance, what it’s going to cost them and that they need to bring payment with them when they come in. This applies to those people who have an individual plan product that has coinsurance and a deductible on outpatient surgery, which includes colonoscopy. We have been very successful in collecting that up front as well. One thing that’s key is that cost-of-care conversations are going to occur. We need to provide the physicians Health Plan resources to help them. For example, a physician may need to refer a patient who wants a more in-depth discussion of finances and financing a payment plan. In Georgia, we have expanded the role of our business office to do that, because it’s important for the physician to be able to say, “You need to talk with someone else in more detail.”

Dr Mustille: That goes back to something Dr Glauber called a “safety valve” for the physicians. The physicians are concerned that they’ll have to become experts

on fee schedules and on benefits schedules. We ought to firmly reassure them that that is not the expectation. In fact, that’s not a good use of physician time or expertise at all. Physicians need a general understanding of the relative costs of various kinds of procedures and interventions. What they don’t need is a detailed fee schedule in their mind. Nor should they be expected to be able to interpret that fee schedule in terms of specific benefits, because these may be quite different from one patient to the next. Physicians need confidence in knowing the general nature of one thing being more expensive than the other and of knowing that benefit coverages differ from patient to patient. But the financing arrangements, the actual fee arrangements, ought to be handled by someone outside the exam room.

Experience of Contract Physicians

Mr Briere: This is a question for the Colorado contingent. You’ve introduced the cost-sharing products now in the Colorado Springs market and that is a totally contracted delivery system; in other words, all of the physicians are on contracts with KP to provide care. What are some of the learnings you’ve gathered from that experience? That is, by physicians who are used to dealing with multiple payers, and multiple plan designs. How are they dealing with the KP cost-sharing products?

Ms Herndon: We’ve sold only a couple of groups there, but the reaction of the Colorado Springs network is what Dr Mustille had said: They do this all the time. It’s not a change for them. So, from the KP perspective, this is part of their standard operating model. They’re not worried about it at all. As we sell more and more of this product, we may have different experiences. We need to be committed to a really fast feedback and learning loop so that if something happens, we can make necessary adjustments.

Dr Collymore: At Group Health, we have about 160,000 members in the equivalent of the Colorado Springs network. We’ve also had deductibles, copays, and coinsurance for a fair period of time. From a HEDIS measurement outcome, our results are very good. The rest of the world has been on this pathway for a longer period of time. Unless we believe that, all of a sudden, health care has markedly deteriorated with all of our other competitors to the point where they are providing totally inadequate health care and their HEDIS data are no good, then we have to recognize that cost-sharing products alone may not have such a great effect on quality of care.

Dr Selevan: Within Southern California, there has

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been a substantial amount of effort by our internal communications staff within the medical group. Dr Zendle and I have designated local “champions” in each of the medical centers who will be carrying forward this message. Dr Pearl, TPMG Medical Director, and Dr Weisz, SCPMG Medical Director, have made videos along with their respective regional presidents Marianne Thode and Rich Cordova. There is a high degree of collaboration, facilitated by the program office and by the Federation, making this happen. But the national products and benefits meeting we are now attending is an excellent example of how the cutting edge (or the bleeding edge) of this implementation in Georgia, in Colorado, and in Group Health, is helping Dr Zendle and me in Southern California. I’ve learned a lot today that I will use back in Southern California.

Dr Zendle: Before I came to this meeting, I really thought that we had to do this *de novo* in California. Now I realize that we don’t have to do that. We can steal it from Georgia and Colorado and other places. We’ll improve upon it for our group, but we don’t have to start from the very beginning. And that is what KP is all about.

Experience of Next-Generation Products

Dr Glauber: Well, earlier I said that Permanente clinicians are evidence based and want to understand the science behind things; we’re also moved by anecdotes. So, I’d like to hear some anecdotes from clinicians in Georgia and Colorado. How has it been?

Dr Zendle: We just have to remember that the plural of anecdotes is not data.

Dr Wright: Since January, we have more than 3000 members total with approximately 400 visits per month in this segment. We’re tracking every patient. Every physician or staff person fills out a “*fast learning tool*,” from which we are getting quick feedback. We collect copays at the initial check-in, and we’ve had no problem with reminding patients to return for checkout to do balance payments if necessary. We have not had any pushback from the members. I will say, anecdotally, that physicians and staff have uniformly said that they do not believe that their treatment or their recommendations have been altered in any way for patients on this plan. The patients have not perceived any difference in the recommendations regarding their care. Interestingly, the biggest question we are seeing on the feedback forms are the number of patients who have said they’re unsure what their employer signed them up for. They have no resentment toward us as an organization; and if they do have anger, it is toward their employers. The issue of affordability

breaks down into two categories. The first category is those patients who are saying, “Okay doctor, I understand what it is you’re recommending, but I’m not sure how I am going to pay for it.” We, like KP Georgia, have resources available to provide options. The other group says that they’re not sure they want to pay for what the provider is recommending. They need to be convinced. There have been a few anecdotal experiences of patients declining tests. So far, we’ve been auditing and watching those carefully. And although it is early, we have not seen any problems.

Dr Zendle: Of course, the other part of evidence-based medicine is not anecdotes but data. We have several research programs throughout KP and Group Health Cooperative, and we ought to dedicate some resources of our research and evaluation units to actually answer some of the questions that are not answered yet as to the effect on health of many of these cost-sharing products.

Mr Stewart: Yes, that goes to one of the questions I had. What are we not doing that we need to be doing? What do we need to be looking at? And what resources do we have that we can deploy to meet these needs?

Dr Mustille: We have a wonderful tool at the Care Management Institute. It’s called Archimedes, a biomathematical modeling device for testing implementation of interventions. You use this model to predict outcomes, both clinical and cost outcomes, five to ten years into the future. With this tool, we would be able to answer some of those questions that physicians have about the impact on quality and resource efficiency.

Dr Wright: We are hearing different perspectives across the physician group. We are touching a cultural issue in our organization—that we have concern that people are going to make wrong choices and have adverse health outcomes. Certainly, a contingent among our physicians say members need to make their own choices and that sometimes they may make choices that we do not agree with. In terms of cost-sharing products, from a data point of view, there are so many confounding variables right now that it is hard to imagine how to tease out whether A led to B. So, as Dr Glauber said, I think our main data are going to be anecdotes. We need a clearinghouse of those kinds of conversations because a lot of this is tacit knowledge that does not come through the big presentations. I think we need to use some adult-learning theory and let folks talk through vignettes over a brown-bag lunch. We know that some of our physicians are excellent at these conversations in the exam room. They can teach the rest of us.

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Training

Dr Janisse: In terms of training for physicians and clinicians in Colorado, do you have any experience about that so far?

Dr Wright: Working with the regional Clinician-Patient Communication Team, we've produced a video that's available to check out and can be watched at department meetings. There are three or four clinical vignettes, and it's constructed so that you can pause the tape, talk among the group, and discuss how you might address the issue at hand. One of the unexpected learnings in those settings has been that many of the physicians in the room come from private practice experience and are skilled at these conversations. The peer-to-peer effect is elegant in that there's often someone who has already figured out how to help somebody who's saying, "I have a crisis in affordability." This can be helpful to some of the physicians who've been in our system for a long time.

Ms Dunker: In Georgia, we also put together a customer service training that was primarily targeted at departments that interact with our members. It had several objectives, one of which was just to reinforce good customer service skills that we should periodically address anyway. As part of that training there were examples and scenarios for people involved in these cost-sharing product discussions to help people develop how to have those conversations whether they occur at the front desk, with the nurse, at the business office, or in Member Services. So, there was a concerted effort for nonphysicians as well.

Part 3: The Future

Mr Stewart: Let's try to look ahead, say five or ten years down the road. Where is this product, and where's the strategy going to take us beyond the next-generation cost-sharing products?

Dr Wright: I believe that cost-sharing products are not the answer to health care. This is a bridge. This is keeping abreast with the market. I think it's important for our organization to stay viable and to stay large enough that we're at the table. When we are at critical mass, policymakers and legislators want to hear our opinion. We can then continue, with our health policy committees, to articulate our vision for the future of health care. What is the endpoint? There probably needs to be some sort of safety net for all who live in our country. There will be a lot of discussion as to what basic health care should be. I suspect, then, that fitting with the consumer model, there will be a need for some to "buy upward." I sense that many employers want out of the middle. Consumer-directed

health care may be that opportunity for them to say, "Here's your cash, here's the Web site, go figure it out." If this is the future direction, we will have to continue our excellence in quality and continue to improve our "perceived" quality.

Dr Zendle: It's very dependent not on what the government wants but really what the people of the United States decide they want to do about health care. I agree with Dr Wright: We need to be at the table. We need to be able to respond to several possibilities of things that can happen, because I don't think anyone can predict what's going to happen.

Dr Collymore: I concur with Dr Wright. Cost-sharing products are not *the* answer. I think we're playing for time. I would love to be that shining light on a hill that says we're different and that we will not go there, but I'm just concerned about survivability. And I think that inevitably, when the country does turn to some type of national solution, perhaps in our lifetime, the Kaiser Permanentes, the Group Healths, the Health Partners, the Alliance for Community Health Plans will be at that table where policymakers finally say, "Gosh, we can't take it anymore. We've got to do something, and you seem to have a solution." But we've got to be in existence to be at the table. And right now, cost-sharing products are a tool for survivability.

Dr Mustille: For a number of reasons, I don't think this kind of financial or insurance solution is the ultimate solution to the health care problem. Most notably, it does not solve the issue of what's really driving the cost in health care: the people who are sick, not the people who are well and having discretionary care. But beyond that, where we will end up in five years is the realization that the solution to the health care crisis lies in the delivery system, not in the insurance system. And we'll have to find financing mechanisms, and there may be an evolutionary change or a revolutionary change, but the true answer to the problem with health care lies in how you deliver care. What I foresee is that as the consumer becomes more and more of the decisionmaker, because he or she is paying a more significant part of the cost, that person, as the decisionmaker, is going to be selecting the kind of delivery system that he or she wants. We need to be preparing our delivery system for that eventuality. We need to be alive. We need to be well. And, particularly, we need to have a desirable and effective delivery system so that we can be successful there.

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Creating Health or Health Care

Dr Janisse: I'd like to extend the discussion along the lines that Dr Mustille was going. Maybe in the future, a solution is for us to be involved in creating health instead of creating health care. We currently talk about and feel like we deliver preventive service, which I feel is just early diagnosis. Our conventional assumption is that you're healthy if you're not sick. What about our being involved in creating health in our communities as part of our future in medicine?

Dr Mustille: I don't have the whole answer to that, but let me throw out one example. On everyone's mind these days, both for providers and purchasers, is the issue of obesity. And if you look at what obesity is, and how it comes about, and its impact on the health care system, we may have a model here to understand the larger solution to this issue about health, which is that it takes a coalition of people to really promote health and not just to avoid illness. There's very little you can actually do about obesity from the doctor's office. There are a few things you can do. Ultimately, you can operate, if everything else fails. So much of what happens with obesity relies on nonmedical interventions—interventions in the community, in the schools, in the fast-food industry, and, to some extent, in the legislative and health policy areas. One of the things that KP is discovering is that it has a role in the community approach to health. And just thinking about the example of obesity and extending that into other chronic conditions and other burdens of illness, one of the

things I see in the future is this recognition that we have to work with partners. The issue of community and community services and community benefit is going to become a much larger and more important part of what we do.

Dr Wright: I remember that tired quote about trains not realizing that they were in more than the train business. They were in the transportation business. We spend a lot of time thinking about the delivery of care, but are we actually in the business of health information? If there is a move toward consumerism with people making individual choices, we have to help navigate through the ocean of information coming at them over the Internet and through direct-to-consumer advertising as well as over the backyard fence. We have all had experiences of requests from patients about things they had learned from "chat rooms," some even disease-specific. The light bulb for me is this:

We have an incredible opportunity to be a trusted "good housekeeping seal of approval" source of information. This could be our hedgehog.

Mr Miller: What we're really talking about here is our ability to adapt. The question we have to answer is: How do we evolve our financing, insurance, and delivery system capabilities to catch up to the rapid changes taking place in the health care market? Current market intelligence tells us that our comprehensive benefits philosophy plus our care delivery system does not work for everyone in today's marketplace. Now, more than ever, the people who purchase our products and benefits have the option to buy from someone else, select their desired level of coverage, and even the level of benefit. What we're trying to do is make our care delivery system available to a wider segment of the population while at the same time preparing and enabling the organization to move toward consumerism. Among other things, consumerism will require us to provide a range of financing and benefits options for those who could not otherwise afford, or who choose not to afford, our traditional benefit options. I agree that our cost-sharing products represent a transitional state for our organization and that they're also allowing us to build the capabilities (systems, business, and human) and the muscle to be able to adapt in the future.

Dr Collymore: The offering of additional copays, coinsurance, and cost sharing with consumers may paradoxically limit the reduction in the number of insured patients in the small-group-employer product line. These groups may, in fact, not drop health care insurance entirely and continue to offer it to their employees because of lowered premiums through the use of cost-sharing products. That's a critical issue. This group may be one of the most vulnerable in terms of rising premiums. We actually may be doing a civic duty along these lines.

Our KP Tradition

Dr Mustille: There's a historical perspective that's important. This issue about cost and resource efficiency is not a new issue for KP. Since our beginning, one of our traditions is wise stewardship of our members' resources. That's a principle of Permanente Medicine; in fact, a principle of KP. We've been very successful at that as an organization. It's been one of the strongest reasons why we are in the marketplace now: We've been able to be efficient and cost effective. These new products are just part of our history. It's not a new concept suddenly being imposed by an unthinking employer on the public. KP has responded to

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this challenge in creative and successful ways. That's why I feel that we'll be able to do that again. It's our historical tradition to be able to manage the efficiency of care.

Mr Hudes: Over the past few weeks, I've spoken to about 15 of our key national account customers and consultants, and there was a feeling among all of them that, in the pursuit of these cost-sharing benefits, they don't want us to sacrifice our core ethics, our core model. Even though there is a feeling out there that managed care is dead, there is a stronger view that KP is the last great hope, absent a real solution, because the other models haven't been effective at really managing cost. They've created this temporary fix to shift cost because they can't manage it. So KP has the great opportunity to show that we do have a model that is set up to manage care appropriately. We just need to

manage to a point where the price point is right, and we'll have a great competitive advantage in the future to sustain the model that is working.

Dr Zandle: I think that now more than ever, it's time to differentiate ourselves. I'm ready to say that we're not an HMO anymore. That term was invented in 1972, and we were around long before 1972. What were we back then? Why don't we go back to our roots? We're an integrated delivery system. We do total medical management. We're a prepaid group practice. It's time to differentiate ourselves. My final comment is that we all need the risk pool. Every person in this room needs the risk pool. None of us can afford all the medical care that we could potentially need if something big were to happen to us. And I think that's true for our country at large. ❖

A US Health Care Payroll Deduction—Two Centuries Ago

With all of the current legislative and public debate on the funding of a health care system for the 21st Century, it is interesting to remember that one of the earliest Federal taxes ever levied by the US government was for health care. When, in 1798, the US Marine Hospital Service bill was signed into law by President John Adams, it created the first prepaid medical program in the nation. It offered comprehensive medical care to America's seamen in an attempt to control the spread of communicable diseases as they traveled from port to port. In the beginning, the program was funded by an obligatory monthly payroll deduction of 20 cents a month from the wages of each sailor on an American vessel. In 1912, the Marine Hospital Service became the US Public Health Service. It's still one of the uniformed branches of military service complete with uniformed officers. (Today the commanding officer is known by the military term "Surgeon General.")

— *This "Moment in History" quote collected by Steve Gilford, KP Historian*