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CHANGING COURSE IN TURBULENT TIMES: AN INTERVIEW WITH DAVID LAWRENCE

by John K. Iglehart

Prologue: The Kaiser Permanente Medical Care Program is a unique enterprise in the American health care system. Founded by industrialist Henry J. Kaiser as a way to provide medical services to workers in remote locations, the nonprofit program opened its doors to the public after World War II. Now, despite its rank as the nation’s largest managed care plan (6.6 million members), Kaiser Permanente faces challenges that are unprecedented in its illustrious history. Aggressive competitors are gaining larger market shares in some of its regions, while the program suffered its first-ever loss of total membership in 1993. Employers are becoming more aggressive in their pursuit of cost containment, a development that forced all of California’s major health plans to cut their premiums this year. And many more fee-for-service doctors are contracting at discounted rates with competing plans, undercutting Kaiser's dominant market position. In this interview David M. Lawrence, who joined the program as a practicing physician and rose in a meteoric fashion to become chairman and chief executive officer of the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals (its management side), discusses his future plans. He underscores the program’s strengths: its many years of experience as an integrated plan, its available capital for growth, its strong emphasis on quality, and a nonprofit culture that enables it to reinvest profits in the plan. Before joining the program, Lawrence served as a county health officer, an academic physician, and a Peace Corps doctor. Lawrence’s ambitious agenda of change, if embraced, could energize a program that is used to setting the industry’s standard. In any event, the result will say a lot about the man, his message, and Kaiser Permanente's future.
Background On Kaiser Permanente

Q: The Kaiser Permanente Medical Care Program has been in operation for fifty years, and it remains the largest health maintenance organization (HMO) in the nation. What does the program look like today, in terms of enrollment, geographic spread, physicians and employees, and its bottom line?

A: The year 1995 marks the fiftieth anniversary of making our plan available to the public. Today we serve 6.6 million people—put another way, one in thirty-seven Americans is a Kaiser Permanente member. We have health plans in sixteen states and the District of Columbia. While we have a national presence, our health plans and physicians are community based, and they respond to local members and local community needs. There are 9,200 doctors and 75,000 employees in our program. To give you an idea of the volume of service we provide, last year we provided forty million outpatient visits. And 92,000 babies were born to Kaiser Permanente members.

Our net income for 1993 was $848 million, on revenues of $12 billion. The net income we generate is used solely for the benefit of members—to provide facilities, purchase medical technology, and fund health care research and innovations. This amount is planned, based on capital needs, and we make no attempt to maximize earnings.

Q: What are the program’s future plans for growth?

A: We have very aggressive plans for growth in all of our regions. We need to be a major player in all of our markets.

Q: In an era in which the integration of hospitals, physicians, and other health care facilities has come into vogue, Kaiser Permanente has operated for decades with delivery and financing functions that are almost fully integrated. Could you envision a future in which Kaiser Permanente becomes less integrated, contracting more with community hospitals and physicians, to take advantage of the system’s excess capacity?

A: Our integration is central to our identity. Many people don’t understand the basis of our integration and assume that we own our own medical centers, in which there are a hospital, doctors’ offices, and other health care services. That model, however, exists in only four of our twelve regions—Southern and Northern California, Hawaii, and Portland, Oregon.

The keys to our integration are the way in which the program is paid, our comprehensive benefits, and how we operate. We receive a prepaid, capitated payment that covers a full range of services, whether provided in a hospital, a doctor’s office, or the patient’s home. Kaiser Foundation Health Plan and Hospitals and the Permanente Medical Group in each region together plan and provide, or arrange for, members’ health care, organizing it in a manner that makes the most sense for the patient and uses resources
appropriately.
Contrast this with the typical individual practice association (IPA) HMO. It also receives a capitated payment and has reasonably comprehensive benefits. But payments are made to individual physicians, hospitals, and home health agencies whose planning is only indirectly related to the HMO. In fact, their planning may be tied to five or six HMOs in the area. The providers have no real idea of how many patients they will get from their various affiliations or what the patients’ needs are.

**Economic Incentives In Managed Care Plans**

**Q:** Do you see the not-for-profit, prepaid group-model HMO as a dying breed? Since the federal government stopped providing subsidies for the creation of new HMOs, there really have not been, as far as I know, new not-for-profit HMOs. In addition, many of the formerly not-for-profit plans have converted to for-profit organizations in an effort to generate more capital and provide a return to investors.

**A:** We believe that nonprofit, group-practice HMOs will continue to play the vital role of setting the standard for American health care organization and delivery. Recently, the major expansion in HMO membership has come from for-profit IPA networks. But these still have fee-for-service elements and fragmented delivery systems. A number of companies—CIGNA and Prudential are two—are moving aggressively toward creating group-practice HMOs, but within a for-profit construct. I believe, as do these organizations, that you can take nonintegrated systems only so far. The economic arrangements, the kinds of tents that people are throwing over the current delivery system, are limited in terms of their performance on measures of quality, cost, utilization, and physician commitment.

I believe that we are entering an era in which much of the nongroup, contractual activity we have seen between physicians and health plans in the past five or ten years will begin to convert to staff- or group-model HMOs, or new forms of managed care that may emerge. There is great potential for the emergence of a large number of nonprofit organized systems through the development of physician/hospital organizations (PHOs). The vast majority of hospitals in America are nonprofit, and PHOs give such hospitals and their medical staffs the opportunity to develop integrated organizations similar to Kaiser Permanente. This potential is certainly causing great worry for for-profit HMOs that have no health care delivery responsibility but that are really just brokers taking advantage of the system’s excess capacity.

**Q:** What has been the political impact of the flowing trend that managed care plans are organized on a for-profit basis, particularly in the Sun Belt?
A: There have been a number of responses, and not just in the Sun Belt. One has been to assure adequate compensation to the public when nonprofit health plans convert or restructure into a for-profit mode. A second has focused on setting tight limits on administrative costs, including profit in health plans. There have been efforts to enact “any-willing-provider” requirements and variations of that model. And some providers have begun to look more favorably at single-payer models. Our challenge is to continue to provide policymakers with factual information on the benefits of non-profit group-practice HMOs.

Q: The economic incentives under which managed care operates are the reverse of those that propel fee-for-service. Given that, how would you characterize the potential risk that managed care plans will stint on the amount of care they provide to their members because plans benefit financially when they render less care?

A: There are some risks, particularly in organizations in which the profit motive is dominant and understanding of health care delivery is minimal. However, the opportunities in prepayment are great, not only in the rational organization of health care delivery, but also in the incentives to provide preventive services and early intervention in the disease process.

Your question seems to imply that the well-documented provision of unnecessary services by the fee-for-service world is benign, when in fact, it is not. Hospitals are not good places to be when one is healthy. Unnecessary surgery carries clear risks. The science of medicine is not fully developed, so there can be some disagreement about the appropriateness of specific services. We do need to rely upon the integrity of health care professionals, but we also need government regulation to assure that the more egregious abuses are detected and their practitioners barred from practice.

Q: Given the competitive nature of health care today, is Kaiser Permanente really any different than a for-profit managed care plan that is driven by its bottom-line considerations?

A: Absolutely. We are different in several ways. We operate on the social insurance, not the commercial insurance, side of the spectrum. We do not underwrite groups and have no preexisting condition exclusions for groups. We have always offered to convert to an individual membership, without medical review, members who have lost their group coverage. We were forced by the market to abandon community rating and adopt adjusted community rating, which charges groups based on their past use and demographics. Even so, we placed an upper cap on the amount we charge small groups and individuals under adjusted community rating, and we established a dues subsidy program to subsidize the coverage of low-income persons. For-profit commercial insurers have not historically done these things, and
that is one of the reasons there is so much pressure for systemwide health insurance reform.

I see a huge difference between Kaiser Permanente and for-profit plans based on the incentives that are structured into for-profit plans. Most for-profit plans bundle physicians and hospitals together by contracts that exploit the system’s excess capacity. They have not yet begun to address the issue of how to integrate care for the benefit of the patient.

Q: But I take it from the challenge that Kaiser Permanente faces with the growth of for-profit managed care plans that the marketplace really has not differentiated between these two forms. In other words, Kaiser Permanente looks no different to the average Fortune 500 company than does, say, Humana, U.S. Healthcare, or Aetna.

A: With knowledgeable group purchasers such as Xerox or GTE, for example, we are viewed differently. Xerox selected us as a network coordinator because they wanted us to lead a group of similar not-for-profit organizations. We are almost fifty years ahead of many plans on the learning curve of integrated care and joint management by physicians and managers.

Group-practice HMOs are not for everyone, and we have never tried to pretend otherwise. Many employers believe, however, that we have set and can continue to set the standard by which other HMOs are measured. Group-practice HMOs always have been distinguished from IPA/network-model plans and fee-for-service indemnity insurance. The way we provide services has considerable appeal to certain segments of the population, but often not to persons who have well-established physician relationships that they would have to break. However, employers have asked us to broaden our appeal to this group. As a result, we have introduced point-of-service products that cover services not provided or arranged by us, although with higher cost sharing.

The Competitive Marketplace

Q: Despite the differences between plans that you have outlined, I assume that Kaiser Permanente has had to adjust its operations to the more competitive environments in which it operates. Describe the nature of these changes and whether they have required Kaiser Permanente to change its basic mode of operation in any fundamental ways.

A: In response to our competitive environment, Kaiser Permanente has had to make a number of changes. Our basic mode of operation remains constant in the sense that we always will put the patient at the center of all decisions, making health the bottom line; we always will foster a deeply ingrained partnership between medicine and management and reinforce our group-practice ethic for delivering superior, cost-effective health care.
Our success in this competitive milieu, however, demands that we develop, share, and implement more effective and consistent medical management practices across the organization. It also means that we must take better advantage of our intellectual capital as we innovate and transfer best practices across regions. For example, physicians, health educators, and nurses have joined to create a support system that helps families to understand, predict, and control a child’s asthma. While the national average for repeat hospitalizations for children suffering from asthma is 20 to 30 percent, at several Kaiser Permanente facilities this figure is now down to just 5 percent. Hospital days for asthma treatment are down by 70 percent over a two-year period. Our premature-birth prevention programs include frequent prenatal visits, nutrition counseling, and having a nurse telephone the mother frequently to assess warning signs of premature labor. By putting the patient at the center of all decisions, we have prevented one in four premature deliveries. Neonatal intensive care days have been reduced 25 percent-days that cost more than ten times those of a full-term newborn nursery. The savings in hospital costs alone translate into more than $1 million a year in our Washington, D.C., region. By innovating and sharing in this way, we not only improve the health of our individual members, but we also set new standards for U.S. health care.

Q: What other changes has Kaiser Permanente instituted to thrive in this more competitive marketplace?

A: All of our regions are reorganizing to be more customer focused. Health care, of course, is a local issue, and our services must match local community needs in order to be effective. By decentralizing and restructuring the way we deliver health care, moving closer to our local markets, we are able to be a far more responsive and agile competitor. Northern California and Southern California, our largest regions, recently reorganized into customer service areas and member service areas, respectively, in an effort to be more responsive to the needs of our members.

Kaiser Permanente also is devoting significant effort and resources to quality improvement projects that, at heart, really are about changing the processes involved in delivering medical care. We have been national leaders in the development of performance measures, including HEDIS (Healthplan Employer Data and Information Set), and we are using these measures internally to improve our performance. We see these performance measures as a wonderful way to measure and improve our quality.

Q: As an organization that has integrated its delivery and financing functions for a long time, Kaiser Permanente, in my view, has never been granted its due
as a pioneer in marrying the interests of medicine and management on behalf of its enrollees. I might add, this is the direction in which the system is now moving generally, almost five decades after Kaiser Permanente embarked down this road. How does Kaiser Permanente manage the inevitable conflicts that arise between medical directors and plan managers concerning the allocation of its limited resources to members?

A: Kaiser Permanente’s hallmark for the past fifty years has been our ability to integrate the various elements of health care—physicians, hospitals, home health, support functions, and insurance—into a coherent whole. The greatest value of managed care, particularly HMOs, lies in its approach to organizing and coordinating care. For this reason, managed care has fueled the engine of reform in the marketplace. Our approach—so greatly misunderstood by critics— Involves changing the economics and delivery of health care so that it is possible to provide the right care at the right time and place. Management and medicine work together to achieve this kind of efficient, high-quality care with the appropriate consumption of resources. What happens when the quality of medical care is high? Costs go down. So managers and physicians have a common vision. While at times there may be dynamic negotiations between the medical directors and regional managers, this shared vision takes a lot of the unhealthy tension out of the relationship.

From the member’s point of view, being in a group-practice HMO means that physicians can truly be patient advocates, because individual clinical decisions do not directly affect physicians’ income. Knowing that patients will not be financially burdened also frees physicians to base clinical decisions on what is medically appropriate and to provide care in the setting that best meets the patient’s needs. An HMO’s financial incentives and rational structure ensure quality and contain costs.

Q: For the past several years, Kaiser Permanente has been working with McKinsey and Company, the management consulting firm, to improve its operations. What have been the results?

A: McKinsey’s impact has come through an approach, a mind-set, that has been very useful to us at this point in our history. They have helped us recognize the need for a much more vigorous, disciplined business planning process. They also have helped us analyze markets to determine how we can best compete.

Q: What you seem to be saying is that, after five decades of successful operation, Kaiser Permanente has reached a point in its history at which it must retool, reorganize in a fundamental fashion.

A: To remain a leader, we have to lead. Neither age, nor size, nor dominance is any guarantee of success—as so many American companies have come to realize. The world has changed, and Kaiser Permanente must change, too.
Many of the things employers and patients want are different today than they were even at the beginning of the decade. For example, until recently employers weren’t demanding performance measures such as HEDIS to help them make choices. The people we serve also have changed. Over the past decade, for instance, our country’s population has become more ethnically diverse, giving us new challenges in meeting the needs of these patients.

Q: Is it more difficult to manage change and persuade an organization to change when it is structured on a not-for-profit basis, when you do not have outside accountability through the stock market and other external forces that focus on the bottom line?

A: It is difficult to create a sense of urgency to compel change, no matter what the financial structure. There is no shortage of lessons on the importance of adaptability. Examples of for-profit companies failing to respond fast enough litter the landscape. Our size is both an advantage and a disadvantage when it comes to changing. On the down side, we have a huge ship to turn around. On the positive side, we have enormous resources in the people of Kaiser Permanente. We can move ideas and innovations within and across regions, so we don’t have to continually reinvent the wheel.

Health Care Reform

Q: Let’s turn to the health care reform debate. To me, the debate reflected a health care system that is increasingly driven by stakeholders whose chief concern is turning profits, rather than helping patients—protecting territory, rather than achieving universality. Perhaps that is too idealistic a view for our brand of entrepreneurial capitalism, but I would be interested in your own assessment.

A: President Clinton should get credit not only for raising the issue of universal coverage, but also for placing it in a moral context. Major social legislation, however, requires a degree of consensus around desired solutions that, in this case, did not exist. Congress came to a general agreement on the nature of the problems this country faces, but not on the solutions. While many interest groups wanted reform, their visions often conflicted. For many, doing nothing was the second-best option to achieving their preferred model of reform. I hope that consensus will come in the future.

Q: Many policymakers themselves seemed to possess an attitude of parochialism, perhaps because we’re in an era of anti-incumbency and many believed that their political futures were threatened. But there was precious little compassion for that large segment of the population that cannot afford health insurance. And not much leadership either.

A: I agree. The perceived crisis—a result of not having a system of universal
coverage and a means to finance it—was not serious enough to force people out of their parochial ways. While the mega-issue of universal coverage was fought and lost, a number of interest groups fought each other over turf and control.

What stood out was the extent to which some segments of the provider community sought to reverse the marketplace trend toward managed care by legislating requirements such as any-willing-provider and exclusive out-of-network requirements on health plans. We expect these battles to be played out again in many states. We’re concerned because these proposals would turn us into an insurance company rather than an organized delivery system and would adversely affect the cost and quality of care for our members.

It’s ironic that some of the traditionally conservative quarters of the health care establishment—surgeons, for example—are seriously considering a single-payer model, which is perceived as the most politically radical approach. In supporting single payer, they hope to preserve their status quo against the private-sector reform already going on. This should give one pause.

Q: One further result of the debate and all of the changes going on in the private sector has been to expose the divisions among companies, physicians, hospitals, and other interests that belong to national professional or trade associations. The most visible example was the Health Insurance Association of America (HIAA), which lost considerable authority when five of its largest members (Aetna, CIGNA, Metropolitan, Prudential, and The Travelers) abandoned the organization because their interests and those of small insurers that belonged to HIAA were antithetical. Could something akin to this occur within the Group Health Association of America (GHAA), given the diverse nature of its membership and the policy compromises that this diversity has compelled the association to make?

A: It is conceivable that something like that could happen in GHAA, but GHAA is working reasonably well thus far with its diverse constituency.

Changes In The Health Care Market

Q: As I understand it, effective January 1995, the San Francisco Bay Area Business Group on Health members—many of them large corporations like Pacific Telesis, Chevron, and Bank of America—will begin to see substantial reductions (5 to 15 percent) in the annual health insurance premiums that they pay to California’s major HMOs. What kind of an impact will revenue reductions of this magnitude have on Kaiser Permanente?

A: I think we may be entering a period of price stability and even price deflation in some health care markets. We are seeing a number of things that
will allow us to bring better prices to the marketplace. First of all, hospitalization rates are declining dramatically. There are labor/management settlements that reflect an understanding of the dramatic cost reductions necessary in HMO operations. There have been reductions in the size of our management staff and our patient care personnel. And there has been moderation in salary improvement for physicians.

Q: What about the actual practice of medicine? Are you achieving economies there?

A: Two of the major cost drivers across the system are the nonscientifically based variation in clinical practice patterns and the relative absence of information on the actual results (outcomes) of care. Contrary to popular rhetoric, the quality of care now provided in the United States is uneven at best and mediocre in many instances. Consequently, our nation is spending too much money for too much unnecessary or even harmful care. The Permanente Medical Groups are focusing considerable energy on improving quality and developing a science of health care, and we think this is why we are reducing hospital utilization rates and the inappropriate use of expensive technologies. Again, improving quality helps us to achieve economies.

There are three critical elements of quality, in my opinion. The first is what happens between a patient and his or her provider, usually a physician. That intimacy and special relationship are a critical part of the patient care experience, and quality of care has much to do with that relationship.

The second part of quality has to do with the impact of care on populations, which is the sum of individual encounters, as well as the application of what we know about prevention, health education, and early intervention. This is really the marker for whether the system—indeed, the entire health care sector—is achieving its goal. We measure impact in terms of death and morbidity rates by gender, age, and ethnicity.

The third component of quality has to do with cost. If we are wasting resources because of poor quality, that becomes an issue. Whether we are misusing those resources has a great deal to do with whether we will be able to meet the needs of various populations. For example, we have been able to show that women who have had their first child by cesarean section can, in most cases, subsequently have safe, normal vaginal deliveries.

The average number of women in the United States who have all subsequent deliveries by cesarean section is roughly 95 percent. In contrast, through very careful work in our Southern California region, Kaiser Permanente has demonstrated that upwards of 75 percent of women can deliver their babies by normal vaginal delivery after a prior cesarean section. That is a remarkable savings in terms of improved quality of care and cost.

Similarly, working with John Wennberg and others, we have demonstrated that by providing information in a timely way to men who suffer
from a normal condition of aging-benign prostatic hypertrophy-what was historically considered a routine operation can be avoided. We have reduced the surgery rate by 42 percent in our Colorado region by providing information to patients and by allowing patients the opportunity to make informed decisions.

The path to lower costs is better quality, and, conversely, one of the major factors contributing to the cost of care in the United States is poor or uneven quality. It is not, contrary to popular belief, fraud or abuse, administrative overhead, or malpractice.

Physicians And Managed Care

Q: You were trained as a physician and practiced as one before you joined the health plan management ranks at Kaiser Permanente. Does your calling remain a profession, or is its professionalism eroding in the face of relentless new pressures?

A: I continue to believe that the professionalism of medicine remains very high. The field has certainly changed, particularly as the cohort of physicians has grown so large. But I don’t believe doctors are any more or less willing to make compromises in their commitment to patients than they were, say, when I graduated from medical school, or during the twenty years before that. There is certainly a different set of expectations about workload and the relationship between a doctor’s practice and private life, but that shift is happening in a lot of fields. Having more women in the profession has changed things for the better. But the forces pressing change on physicians are unparalleled.

Q: How do the Permanente Medical Groups remunerate their members?

A: There are twelve medical groups, and each makes its own decisions regarding physician pay. That said, there are patterns; one is specialty specific, another is market specific. The base pay is a salary that is determined by the leadership of each medical group. On top of that, there may be limited-incentive compensation that relates to the financial performance of the region and, in some regions, to targets for patient satisfaction, improvements in the health status of the population served, and the overall care experience. There are no incentives that relate to the frequency with which specialty referrals take place. The Permanente Medical Groups do not apply the kinds of gatekeeping incentives that encourage primary care doctors to limit referrals of their patients to specialists.

Q: Are you concerned that health plans within the industry are applying those kinds of “gatekeeping” incentives to the physicians with whom they contact or whom they employ?

A: I am opposed to individual primary care physicians’ being given incen-
tives based on the frequency with which they refer patients to specialists—the withholding idea. Doing so places a terrible burden on the individual doctor. I am also troubled by having an insurance company or HMO determine what it will and will not pay for on the basis of rigid, non-individualized protocols administered by minimally trained clerks. Patients and their diseases do not fit into neat little boxes. Physicians end up torn between their clinical judgments and a utilization management system’s definition of what is covered, which leads to seemingly endless discussions with a nurse or medical consultant who is far removed from the circumstances. What is needed are scientific protocols based on outcomes research, which make distinctions among patients to the extent that this is demonstrated to be relevant. Overall, the health care system needs a more workable set of standards that better protects the interests of patients, payers, and providers alike.

Q: If more rigorous standards should be applied, who should set the standards? Is this a task for payers, for health plans, or for government?
A: We need a well-defined framework within which health plans are required to compete. Who should construct the framework? Certainly it could be built into federal or state regulation. It could be incorporated into the thinking of leading-edge employers, and into the purchasing process. It could be built into associations as a condition of membership. So the answer is plural, but it is not just who sets the standards but, once set, how they are enforced.

Q: How should the protocols apply to persons who enroll in health care plans?
A: The National Committee for Quality Assurance (NCQA) is the leading organization in accrediting organized health care systems. One area included in its reviews is an assessment of protections for health plan members. I would like to see the NCQA and other groups expand their reviews to include the ethics of decision making related to benefits and care decisions—who makes the decisions, and by what process and ethical standards.

Views On Managed Care

Q: I am of the opinion that the recent spate of rather negative, skeptical newspaper articles about HMOs reflects a belief on the part of some reporters, and also the people they are interviewing, that managed care and HMOs represent something of a “black box.” A lot of questions being asked go to the heart of the concepts upon which HMOs operate, and they need to be answered. Is that a fair description of current reality?
A: I think that’s a fair assessment. And I don’t think the situation is surprising. Here in California, there are four and five generations of families who have been HMO members. That isn’t the case in many parts of the
country, particularly on the East Coast, home to so much of our most influential media. As GHAA’s consumer research found, HMOs in general haven’t done a good job of telling their story over the years. We haven’t distinguished the successes of HMOs from the failed elements of the health care system.

Q: Are managed care organizations committed to providing services to low-income persons and persons with complex medical problems? Or should there be new government policies that encourage managed care organizations to be more responsive to vulnerable populations?

A: Let me address the second point first. I have already mentioned our commitment to a dues subsidy program for low-income persons. In addition, we are increasing our Medicaid enrollment in a number of regions and have always had a sizable Medicare enrollment. Extra costs are associated with this commitment because reimbursement is inadequate. Adjustments must be made for members who represent special financial and medical risks, or markets cannot be structured for competition. Plans can’t be expected to carry out a social good while jeopardizing their competitive position.

On the first point, Kaiser Permanente is committed to serving as broad a cross-section of society as we can and still survive. There is no ideological or philosophical reason for not being involved in caring for low-income populations. It is mainly a matter of economics. I want to provide a strong word of caution to states that are rushing to use HMOs as the way to lower costs and solve their current budget problems. Past efforts to do so, most notably in California, have met with mixed success. We believe that it is unwise to force people into HMOs against their wishes or to hand an entire area’s Medicaid population over to one organization. People—whether publicly or privately insured—will join an HMO if they believe that the plan they choose will provide the kind of care they need.