

Virtual Mentor

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Clinical Case

“Can We Just Drop the Copay?”

Commentary by Alex Federman, MD

Once every 6 months for the past 15 years, Edgar Delmand has been taking a morning off from his job as construction foreman to visit Dr Robiel’s office. Over the years, Dr Robiel has diagnosed Edgar’s high blood pressure, high cholesterol, and type 2 diabetes and helped him manage these conditions.

As Edgar enters the examination room, Dr Robiel glances at his chart. Although he has written all the entries himself, he likes to remind herself what Edgar’s 3 children are doing these days and what concerns he had at the last visit. He also notes that Edgar had an HbA1C drawn last week; the levels had bounced up to 8 percent, despite 3 oral hypoglycemic medications.

As they chat, Dr Robiel learns that Edgar, now 53, is taking his medications daily but that he was recently seen in the ER for an infected foot blister that he “just hadn’t noticed.” He has been checking his blood glucose twice a day but doesn’t write down the numbers. Dr Robiel mentions to Edgar that their control of his diabetes had slipped a little; they had been quite successful for the past 8 years, but they might need to add insulin to his regimen if the current treatments were not working.

“Actually Doc,” Edgar interjects, “I feel like my diabetes is not the only thing I’m losing control over. The company is making changes in our health insurance; they want me to switch to a doctor on their preferred list. If I stick with you, they’re going to charge me 20 percent of your bill. With 2 of the girls in college, that 20 percent carries a noticeable punch for us. You understand...isn’t your oldest boy in college now?”

Dr Robiel nods. “I would hate to have you leave my practice, Edgar.” He sincerely enjoys visits with Edgar, and he feels that his dedication to this patient’s health has made a genuine difference. They have worked well as a team to avoid complications of Edgar’s hypertension and his diabetes. Dr Robiel appreciates how college tuition bills stress a family’s budget—he recently added an extra weekly evening session to his practice to ease the burden on his savings. “I understand your dilemma, but I’d love to convince you to stay.”

“Well Doc,” Edgar continued, “maybe we could find a balance that suits us both. You’re my doctor. I’m not anxious to switch to someone who doesn’t know me or my conditions. We’ve worked together for a long time. Would you consider forgiving the

extra 20 percent reimbursement—and just accepting what my insurance pays you—if I do stick with you?”

Commentary

This vignette illustrates the importance of openness between patients and doctors about health care costs, and it highlights the value of having a strong patient-doctor relationship when addressing the topic. In this commentary, I point out some aspects of the case that speak to the problem of cost for patients, the potentially deleterious effects it can have on accessing care, and the role of the patient-doctor relationship in mitigating these effects.

Beyond Medications—Health Care Services and Insurance Costs

Medication costs have captured the lion’s share of attention about the financial burden of health care for adults, and indeed they represent a major barrier to care for many patients. Yet, this case reminds us that insured patients can also bear significant costs—the cost of insurance coverage *and* the cost of services—a fact that is often overlooked in clinical and health policy discussions. Insured patients typically face a variety of out-of-pocket health care expenses including monthly premiums, deductibles, and copayments for visits and treatment. Medicare beneficiaries with traditional (fee-for-service) coverage pay an \$88 monthly premium, a \$124 annual deductible, and a copayment of 20 percent of the fee for most outpatient services, such as physician visits and radiological tests [1].

For individuals with modest incomes, such as Mr Delmand in this vignette, these insurance costs and copayments can cause financial hardship. As many as 20 percent of low- and middle-income working adults may drop their coverage or switch to a new plan when health insurance premiums increase by 10 percent [2]. Numerous studies, including the RAND Health Insurance Experiment, show that various levels of cost-sharing (eg, copayments) can lead to reduced use of appropriate and needed services [3]. As a result, patients’ health may suffer. Recent research has found that people with diabetes had worse glycemic control, and adults with coronary artery disease had higher rates of angina, when they skipped medications due to financial strain [4, 5].

Talking about Costs

Although patients are increasingly burdened by medication, health care, and health insurance costs, conversations about the problem are unusual in patient-doctor encounters; only about 16 percent to 27 percent of adults who have some problem paying for medications ever discuss this hardship with their doctors [6, 7]. Patients and physicians cite similar obstacles to discussing drug costs, chiefly discomfort about the issue, lack of time during the visit, and a paucity of solutions [8]. The literature also suggests that those who do talk about costs with their doctors are those who are more severely affected.

If so few patients ever discuss cost, why did it happen in our narrative? Several factors are likely to have pushed Mr Delmand to raise this uncomfortable topic: anxiety over a specific financial concern, his worsening diabetes, the risk of a switch to a new provider, and his commitment to continuity of care. But perhaps the most important factor in his

broaching the topic is his trust in Dr Robiel. The element of trust is suggested by the long duration of their relationship and the ease and familiarity of their encounters. Research on patient-doctor communication identifies trust as a singularly critical element for establishing effective communication [9-12]. Patients' trust in their physicians has also been shown to mitigate the effects of cost on medication adherence [13].

There is much that physicians can do to establish trust with their patients—most importantly, perhaps, engaging patients in their own care and using a psychosocial communication style in which the balance of speaking and setting priorities tips towards the patient [14]. This helps to create an environment in which the patient feels safe enough to discuss sensitive topics that might otherwise trigger embarrassment or shame. Patients whose physicians employ this psychosocial communication style tend to be more satisfied with their care and have better health outcomes than those who have physicians with more paternalistic communication styles [14-17].

In our case, Mr Delmand asks Dr Robiel to waive the portion of the bill that his insurance will not cover. This seemingly unusual request is a testament both to the financial stress that Mr Delmand is experiencing and to his comfort with and trust in his doctor. In a less trusting relationship, Mr Delmand might have simply started seeing a new doctor without informing Dr Robiel of the reasons for the switch, or might not have offered up his own solution to the problem. This is a request that Dr Robiel should consider very seriously, so let's look at his choices.

Dr Robiel's Choices

Dr Robiel has 3 obvious choices in this matter. First, and with some justification, he could refuse Mr Delmand's offer outright. The copayment may be a substantial portion of the physician's revenue from the visit because reimbursement rates to primary care physicians can be quite low, and Dr Robiel recently added hours to his schedule because of his own financial situation [18, 19]. Dr Robiel may also consider it unfair to charge this patient less than he charges everyone else for a visit.

A second option is to try to convince Mr Delmand that continuing their visits is worth the extra cost because discontinuity of care is often associated with worse health outcomes, and Mr Delmand's health has been generally well maintained under Dr Robiel's care.

Thirdly, Dr Robiel could choose to accept Mr Delmand's offer and waive the copayment. He clearly enjoys the relationship and does not want the patient to suffer any setbacks in his diabetes management by having to start with a new doctor. But there is another, less obvious option. Dr Robiel could consider cost-saving alternatives for Mr Delmand, such as replacing some office visits with telephone calls. This solution makes the most sense for the patient's well-being, would probably be the most satisfying option for the doctor, and would require only small sacrifices on both the doctor's and the patient's part.

The point here is that Dr Robiel *can* consider Mr Delmand's financial struggles by modifying the type of care he gives Mr Delmand. It may take an open mind and a bit of creative thinking to work around financial challenges, but the patient's health and the doctor's relationship with the patient are likely to be the better for it.

Lessons Learned

In summary, this vignette provides a simple illustration of how health care costs can threaten access to and continuity of care. It also shows how elements of the patient-doctor relationship, specifically trust, can aid in the communication process and offer the physician the opportunity to do something about the problem. Indeed, physicians and patients can often find reasonable solutions to financial obstacles to care.

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Alex Federman, MD, MPH, is an assistant professor of medicine in the Division of General Internal Medicine at Mount Sinai School of Medicine in New York. His research focuses on financial barriers to care for low-income seniors and physician-patient communication about healthcare costs.

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