REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-19

Subject: Health Plan Payment of Patient Cost-Sharing (Resolution 707-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 707, which was introduced by the California Delegation and assigned to the Council on Medical Service for study. Resolution 707-A-18 asked:

> That our American Medical Association (AMA) urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles.

This report provides an overview of patient cost-sharing obligations including the rise of high-deductible health plans, highlights patient collection management practices by insurers, summarizes relevant AMA policy, provides a summary of relevant AMA advocacy activities, and recommends policy.

BACKGROUND

Despite coverage gains in recent years, the health care system continues to struggle with decreasing the number of uninsured patients and, even for the insured population, utilizing health care services is often unaffordable. For the insured, the trend of rising health insurance deductibles has been altering health insurance from more comprehensive coverage to insurance with higher out-of-pocket costs.[1] Deductibles have gradually risen for decades and contribute to the changing nature of health insurance. One rationale behind high deductible health plans (HDHPs) is that they moderate the cost of health care and health insurance by shifting the rising cost of health care from insurers and employers to patients. Health plans with higher levels of cost-sharing generally have lower premiums and put a financial obligation of higher out-of-pocket costs on patients when services are used.[2]

The prevalence of HDHPs is not limited to the Affordable Care Act (ACA) Exchanges but also widespread in employer-sponsored coverage. Notably, the growth in HDHP enrollment has been fastest among those with employer-based coverage. About 40 percent of companies that offer health insurance make HDHPs the only choice for their employees.[3] About half of people with employer coverage have a deductible of at least $1,000.[4] Moreover, the shift to plans with rising deductibles began before the ACA was passed.[5] The average general annual deductible for employees has increased 49 percent over the last five years.[6] Overall, in 2018, 29 percent of workers with employer-based coverage were enrolled in a HDHP. Although the Council believes that health insurance should balance patient responsibility and patient choice; increasingly employees do not have a choice of coverage options.[7]

The impact of cost-sharing imposed by HDHPs is an ongoing concern for patients and physicians. HDHPs with tax-preferred savings accounts may not be a good fit for some patients, particularly low-income patients who may struggle to fund their health savings accounts (HSAs).[8] For example, there is evidence that exposing patients to increased cost-sharing has unintended and negative consequences. Overall, HDHPs can be a good option for people who are in relatively good health, but they may expose people who have more modest incomes to out-of-pocket costs that can be a barrier to care and a risk to their financial security. HDHPs also make beneficiaries increasingly vulnerable to sharp increases in drug prices. Cost-sharing, even when tied with available information on the price of services, generally does not induce patients to shop for lower-priced services. Instead, patients more often reduce their use of health services, potentially delaying needed care and exacerbating health issues. The burden of higher cost-sharing has a disproportionate impact on patients with lower incomes whose deductible may exceed available liquid assets.

The shift in financial responsibility toward patients may contribute to physicians' concerns about collecting cost-sharing from patients. However, if physicians do not collect these cost-sharing amounts, they sustain bad debt that adversely affects the financial sustainability of their practices.[9]

Bad debt typically is the difference between what providers billed patients and the amount those patients ultimately paid, and the phenomenon of bad debt has become an industry-wide issue for health care practitioners. Patient payments are an increasing share of expected revenues.[10] According to the American Hospital Association, this uncompensated care reached $38.3 billion in 2016. Bad debt may affect the financial viability of practices, and collecting on bad debt takes practice time and resources, and the additional time physician offices spend on collection of bad debt is not reflected in the cost of providing care. Moreover, the significant time used to collect on such debt may cause disruptions to the patient-physician relationship.

EXAMPLE OF INSURER PROGRAM COLLECTING COST-SHARING

To mitigate bad debt, major national health plans, including UnitedHealthcare and Anthem, have patient payment programs through InstaMed, which allow insurers to manage patient collections for the physician practice; however, there are caveats to this model. First, practices do not have a choice of if they want to receive patient payments in this manner. Therefore, if a patient signs up for InstaMed, the practice will get paid through InstaMed. Moreover, these programs typically only issue electronic payments to the practice. If the practice does not sign up for the program and receive standard electronic fund transfers, the practice will be issued a virtual credit card for the patient's payment. Importantly, such credit cards are associated with fees that tend to be 2-5 percent of the overall payment. Furthermore, practices may have reasons for wishing to manage patient payments themselves. For instance, the practice may have worked out a payment plan with the patient or there may be secondary or tertiary payers. The solution sought by Resolution 707-A-18 may negatively impact such business autonomy by precluding such arrangements. Advocating for patient payment programs may appear as an endorsement of such programs, which may be problematic for physicians and provider representatives of plans impacted by these patient collection methods. Accordingly, such action may adversely affect physician payment levels and processes, and could have unintended consequences within some physician practices.

AMA POLICY

Long-standing AMA policy and advocacy efforts acknowledge and support the business freedom of physician practices (Policies H-165.985 and H-165.838). Some physicians prefer the flexibility afforded to payment operations and do not want to cede patient collections to health plans.

Physicians currently have the ability to offer discounts or payment plans to patients to facilitate goodwill, which is an arrangement supported by long-standing Policy H-165.849. Moreover, Policy H-165.849 states that our AMA will engage in a dialogue with health plan representatives (e.g., America's Health Insurance Plans and Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in HDHPs.

Policy D-190.974 demonstrates the AMA's commitment to administrative simplification. Among numerous actions, it directs the AMA to continue its strong leadership role in automating, standardizing, and simplifying all administrative revenue cycle transactions between physicians in all specialties and modes of practice and all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses. Moreover, it directs the AMA to prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.

The AMA remains committed to health insurance affordability. Policy H-165.828 specifically encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Moreover, Policy H-165.828 supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

AMA ACTIVITY

The AMA has developed a comprehensive point-of-care pricing toolkit to help practices with patient collections (https://www.ama-assn.org/practice-management/claims-processing/managing-patient-payments). The toolkit recognizes concerns about uncollected patient financial responsibility that can result in physician practices taking on debt and contains varied resources to help mitigate the problem. This toolkit addresses point-of-care and post-visit collections and includes:

- Step-by-step guidance toward providing point-of-care pricing and collecting from patients at the time of service;
- Guidance on calculating the price of treatment at the point-of-care;
- Sample scripts to help practices collect patient payment;
- Letter templates to ask health insurers and other payers about terms and conditions of insurance contracts regarding physicians' rights to provide point-of-care pricing and collect payments at the time of care;
- Webinars designed for practices to help patients understand their financial responsibility;
- Resource providing information on how practices can implement an effective strategy for collection of payment after a patient has left the office; and
- Guidance on the steps to take when a patient fails to pay for treatment in full.

In addition to the AMA's point-of-care pricing toolkit, the AMA has repeatedly voiced its concern about virtual credit card payments and the fact that it may cause physicians to lose a significant amount of contractual payments to high interchange fees charged by the credit card companies. The AMA continuously advocates for transparency in virtual credit card payments including advanced disclosure of transaction fees and any rebates or incentives awarded to payers for using this payment method.

Furthermore, pursuant to Policy H-165.849, the AMA continues to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. The AMA continues to hold such meetings with insurers to address this issue as well as other issues relating to physician burden and practice sustainability.

DISCUSSION

Bad debt can affect the financial viability of practices, and collecting on this debt takes practice time and expense. Nonetheless, the Council is concerned about the unintended consequences of adopting Resolution 707-A-18. In particular, if insurance companies collect patient co-payments and deductibles, they would likely charge administrative fees to practices or lower physician payment levels. Nonetheless, the Council believes that the issues raised by Resolution 707-A-18 are compelling and warrant action, particularly for small physician practices that may be most impacted by an increase in bad debt brought about by some patients not fulfilling their cost-sharing obligations.

First, the Council recommends reaffirming long-standing policy illustrating the AMA's commitment to the business freedom of physician practices (Policies H-165.985 and H-165.838). Additionally, because the evidence suggests that it is not the HDHP itself that is necessarily problematic but rather the inability to meaningfully fund a corresponding HSA, the Council recommends reaffirming Policy H-165.828 encouraging the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Due to the trend of increasing use of HDHPs, the Council also recommends encouraging states and other stakeholders to monitor the growth of HDHPs and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability.

The Council believes that a factor contributing to uncompensated care is the lack of patient education on their health plans. Importantly, Policy H-165.828 also supports education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. Although the Council remains steadfast in its belief that patient education will help solve the problem of uncompensated care, it notes that the Emergency Medicine Treatment and Labor Act forbids emergency care providers from discussing with the patient any potential costs of care or details of their insurance coverage until the patient is screened and stabilized. The Council agrees with and respects this prohibition. Therefore, while the Council strongly supports patient education of costs not only at the time of enrollment but also at the time of care, the Council recognizes that this discussion is precluded at the point-of-care in the case of emergencies.

To further patient education efforts, the Council recommends amending Policy D-190.974 by updating part four by addition such that our AMA will prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in HDHPs. Following from this, the Council also believes that more sophisticated IT systems are critical to help enable physicians and empower patients to better understand financial obligations. Additionally, the Council recommends taking this opportunity to amend part six of Policy D-190.974 to reflect the ending of the Heal the Claims campaign and

instead recommends calling attention to the AMA's continued efforts to ensure that physicians are aware of automating their claims cycle.

As previously noted, the prevalence of HDHPs is not isolated to the ACA Exchanges, but is also widespread in employer-sponsored coverage. The Council believes that health insurance should balance patient responsibility and patient choice; however, increasingly patients do not have a choice of coverage options. Therefore, the Council recommends reaffirming Policy H-165.849 urging the AMA to continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasingly difficulty of practices in collecting co-payments and deductibles and the underlying issue of affordability.

The Council firmly believes that there are no easy solutions to the problem of patient collections and remains unconvinced that giving insurers additional control over the process is the best solution. Instead, the Council believes that the AMA should remain committed to addressing the concerns of its members and seeking solutions to the major issue underlying Resolution 707-A-18, which is greater affordability of health insurance premiums and cost-sharing responsibilities. Accordingly, the Council suggests a set of recommendations intended to address the root of the problem.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 707-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policies H-165.985 and H-165.838 illustrating the AMA's commitment to the business freedom of physician practices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.849 stating that the AMA will continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.828 encouraging the development of demonstration projects to allow individuals who forego cost-sharing subsidies by enrolling in a bronze plan to have access to a partially-funded health savings account and supporting additional education regarding deductibles and cost-sharing at the time of health plan enrollment. (Reaffirm HOD Policy)

4. That our AMA amend Policy D-190.974 by addition and deletion as follows:

   Administrative Simplification in the Physician Practice
   1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
   2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
   3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice

with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts ~~expand its Heal the Claims process(TM) campaign as necessary~~ to ensure that physicians are aware of the value of automating their claims cycle. (Modify Current HOD Policy)

5. That our AMA support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations. (New HOD Policy)

6. That our AMA encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. (New HOD Policy)

Fiscal Note: Less than $500

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