

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-19)
Addressing Financial Incentives to Shop for Lower-Cost Health Care
(Reference Committee J)

EXECUTIVE SUMMARY

The Council on Medical Service presents this report to examine the practice of employers and insurance companies increasingly implementing programs (ie, Financial Incentive Programs or FIPs) that offer patients financial incentives when they use shopping tools to compare prices on health care items and services and choose lower-cost options. This report examines the potential benefits and risks of FIPs, analyzes examples of current FIPs, and offers guidance on how FIPs could be improved.

Virtues of FIPs include promoting price transparency, empowering patients to pursue health care that minimizes financial burden and reducing societal health care costs. At the same time, it is critical that patients be empowered to make fully informed decisions about their health care, that they are never coerced into accepting lower-cost care if it could jeopardize their health, and that programs that influence patient decision-making be equally transparent about quality and cost. To protect patient access to high-quality care, the Council recommends a set of guiding principles that it encourages health care payers (employers, insurance companies, etc.) and third-party vendors to incorporate into the design and implementation of FIPs. These guiding principles focus on protecting physician involvement in FIPs, the patient-physician relationship, quality assurance and transparency, and patient choice. To further promote these ideals, the Council recommends that the American Medical Association (AMA) encourage state medical associations and national medical specialty societies to seek opportunities to collaborate in the design and implementation of FIPs to empower physicians and patients to make high-value referral choices, and to encourage objective studies of the impact of FIPs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-19

Subject: Addressing Financial Incentives to Shop for Lower-Cost Health Care

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Referred to: Reference Committee J
(_____, MD, Chair)

1 While encouraging patients to pursue lower-cost health care, employers and insurance companies
2 are increasingly implementing programs (ie, Financial Incentive Programs or FIPs) that offer
3 patients financial incentives when they use shopping tools to compare prices on health care items
4 and services and choose lower-cost options.¹ The Council on Medical Service presents this
5 Council-initiated report to examine the emergence and impact of FIPs, as well as the potential
6 benefits and risks of FIPs, and to offer guidance on how FIPs could be improved.

7 8 BACKGROUND

9
10 Care can be deemed “shoppable” when it is a common service that can be researched in advance,
11 multiple providers of that service are available in a market, and sufficient data about the prices and
12 quality of services are available.² Estimates vary as to what proportion of health care spending can
13 be deemed “shoppable,” with some estimates at 10 percent,³ and others as high as 33 to 43
14 percent.⁴

15
16 FIPs appeal to employers and insurers because they encourage patients to price shop without
17 exposing them to increased out-of-pocket costs.⁵ Additional virtues of FIPs include promoting
18 price transparency, empowering patients to pursue health care that minimizes financial burden and
19 reducing societal health care costs. While considering these potential benefits of FIPs, it is critical
20 to ensure that patients are empowered to make fully informed decisions about their health care, that
21 they are never coerced into accepting lower-cost care if it could jeopardize their health, and that
22 programs that influence patient decision-making be equally transparent about quality and cost.

23
24 FIPs in the private sector can be used by employers as part of employee benefit packages, or health
25 insurance companies can implement FIPs for their enrollees. In the public sector, some states have
26 implemented FIPs as part of state employees’ benefits. The Council discusses various models that
27 have emerged to encourage and assist patients shopping for lower-cost health care. The models
28 vary with respect to the level of voluntary versus potentially coercive impact on patients. With this
29 report, the Council emphasizes the protection of patients and the patient/physician relationship; and
30 recommends a series of principles to address the potential of FIPs to further fragment patient care.

31 32 POTENTIAL BENEFITS AND RISKS OF FIPs

33 34 *Potential Benefits*

35
36 FIPs could benefit patients, payers, and the health care system in several ways. Both
37 underinsurance and cost-related non-adherence pose significant challenges to patients and

1 providers. Even when a service is covered by a health plan, patients may incur significant costs in
2 the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting
3 their deductible. Such costs have been shown to cause people, especially those in low-income and
4 vulnerable populations, to forgo necessary care.⁶ Similarly, cost-related non-adherence refers to a
5 state in which patients are unable to pursue recommended medical care due to financial barriers.⁷
6 For example, greater out-of-pocket costs for medication to treat certain chronic conditions have
7 been found to reduce initiation and adherence, lower the likelihood of achieving desired health
8 outcomes, and sometimes, increase utilization of acute care services.⁸ In contrast, studies have
9 demonstrated that reducing or eliminating cost-sharing leads to improvements in medication
10 adherence⁹ and reductions in socioeconomic and racial disparities.¹⁰ Accordingly, FIPs could
11 potentially increase patients' access to medical care that may have been financially out-of-reach for
12 them. Additionally, when patients make cost-effective treatment choices, those savings can benefit
13 payers and the health care system. Moreover, even if patients do not alter their treatment plans,
14 having information about the cost of planned medical care provides much needed transparency.
15 Finally, if the care being incentivized by FIPs is, in fact, high-quality care, these programs could be
16 consistent with longstanding American Medical Association (AMA) policy supporting value-based
17 insurance design, as an opportunity to align clinical and financial incentives for patients to pursue
18 high-value care.

19
20 FIPs could also be significantly enhanced by including referring/prescribing physicians in the
21 "shopping" experience at the point of care. Treating physicians' referral recommendations play a
22 critical role in patients' choices regarding follow-up care. FIPs that embrace the importance of
23 physician referrals could benefit patients, physicians and other elements of the health care system.
24 If patients' FIP benefits could be made available to treating physicians in real time during patient
25 consultations, patients and their trusted physicians could work together to choose the best referral
26 and/or prescription option, considering both quality and cost of care. Such fully informed referrals
27 could enhance efficiency, quality, and cost of care.

28 29 *Potential Risks*

30
31 FIPs raise many questions that must be answered to determine whether they are truly in patients'
32 best interests. As an initial matter, FIPs raise several administrative questions. Health care is
33 uniquely complex and cannot simply be shopped like retail goods. Key limits on shopping for
34 health care include:

35
36 Patient Limits: Even if a service is shoppable for some patients, for other patients, shopping for that
37 service may not be convenient, practical or advisable.¹¹ Similarly, prescription drugs can be
38 shoppable in some cases, but not in others. Some patients find less expensive drugs just as
39 efficacious as more expensive alternatives, but specific formulations are required by others. While
40 some patients may find that a lower-priced prescription drug could be appropriate, it might require
41 additional burden for the patient (such as more frequent dosing) and/or the provider (such as
42 required monitoring and/or testing). In such cases, patients must fully understand and be willing to
43 accept the additional burden.

44
45 Care Coordination and Quality of Care: If shopping for lower-cost care leads patients to obtain care
46 from a variety of physicians and facilities, absent an integrated records system, there is a potential
47 for fragmentation of care, which creates additional challenges for patients and physicians in
48 receiving and providing quality care.

49
50 Administrative Burden: If, after receiving a referral or prescription from their physicians, patients
51 shop for and choose to pursue lower-cost care, both the patients and their physicians may face

1 time-consuming administrative burdens. Patients may need to reach out to their referring
 2 physicians for new prescriptions and/or new referrals, and they may have to seek copies of their
 3 medical records to facilitate care coordination.

4
 5 FIPs also raise concerns about quality of care and unintended consequences, and these become
 6 especially fraught when working with already vulnerable patient populations, such as those with
 7 low incomes and/or costly chronic conditions, who may be unduly persuaded by enticing financial
 8 incentives. Here the question of whether patients are truly presented with meaningful choices
 9 versus the extent to which they are somewhat coerced into accepting a non-preferred care option
 10 becomes more complicated. Key considerations include continuity of care and the tradeoff between
 11 quality and cost.

12
 13 Continuity of Care: It is unclear whether FIPs will interfere in patient-physician relationships
 14 and/or attempt to substitute for medical advice. Patients should be empowered to reach out to
 15 whomever they would like in researching their care options. However, if patients have received
 16 referrals or prescriptions from their physicians and have not made efforts to shop for alternative
 17 options, programs that proactively reach out to such patients to suggest alternative courses of
 18 treatment risk harming the trust built between patients and their physicians and risk substituting
 19 their judgement for medical advice. Additionally, it is not clear how the “health professionals”
 20 providing patient assistance through some FIPs are trained, but even if providing referrals is within
 21 their scope of practice, these “health professionals” could disrupt existing patient-physician
 22 relationships.

23
 24 Quality/Cost Tradeoffs: Any program that encourages physicians or patients to make quality trade-
 25 offs to reduce cost raises significant questions about unintended consequences. While some care,
 26 even if that care is of less than ideal quality, could be better than cost-related non-adherence, the
 27 obvious preference is to direct patients to appropriate care while minimizing financial burden. For
 28 patients experiencing significant financial burden, either due to expensive medical conditions or
 29 due to other social determinants of health, it is especially important to acknowledge and safeguard
 30 against crossing the fine line between an optional financial incentive and implicit coercion to
 31 accept the least expensive care.

32
 33 While the FIPs described in this report claim to base their decisions on care quality, it is not clear
 34 what metrics or data are used to evaluate quality, nor is it clear if their metrics align with well-
 35 established, evidence-based quality criteria developed by national medical specialty societies.
 36 Accordingly, it is possible that these programs could steer patients to care that is of lesser quality
 37 than the original physician referral. Transparency regarding FIPs quality data and analyses is
 38 essential.

39
 40 INTRODUCTION TO CURRENT FIPs

41
 42 Generally, shopping programs are available through preferred provider organization (PPO)-style
 43 plans that offer patients broader choices of providers from whom they can receive care. Patients
 44 enrolled in Health Maintenance Organizations (HMOs) and/or narrow-network plans are restricted
 45 to a smaller set of medical providers and may be unable to access higher quality and lower cost
 46 health care.¹² Additionally, patient cost-sharing varies significantly based on insurance benefit
 47 design, and some design features will provide greater or lesser incentives for patients to shop for
 48 lower-cost care.¹³

49
 50 The decision to implement an FIP can come from the private and/or public sector. In the private
 51 sector, employers can choose to implement FIPs as part of their employees’ benefits packages, or

1 health insurance companies can implement FIPs for their enrollees. In the public sector, some
 2 states have chosen to implement FIPs as part of state employees' benefits packages (eg, New
 3 Hampshire) or via legislation that requires some private insurers to offer pay-to-shop incentives
 4 (eg, Maine).¹⁴ Multiple tools have emerged to encourage and assist patients shopping for a broad
 5 spectrum of care.

6
 7 Sapphire Digital: More than 350 health plans and employers, representing over 95 million
 8 members, use the Sapphire Digital platform to incentivize patients to shop for care.¹⁵ Sapphire
 9 Digital's SmartShopper program works by integrating directly with an employer's benefit
 10 program.¹⁶ SmartShopper reaches patients through several channels: call centers, web chat
 11 assistants, direct mail campaigns, and an online platform where patients can compare prices.
 12 SmartShopper is aimed at patients, but it requires partnerships with local providers, employers, and
 13 payers.¹⁷ The FIP provides cash incentives to encourage patients to shop for what the company
 14 describes as "routine care" including, imaging services, labs, specialty drugs, preventive exams and
 15 outpatient surgeries. The extent to which these services are truly routine, however, is subjective.
 16 Approximately 200 procedures can be shopped through the SmartShopper program, with about 50
 17 services being responsible for the bulk of the savings.¹⁸ After comparing prices, if patients choose
 18 to receive care from one of the identified lower-cost providers, they will be mailed a check, with
 19 incentives on average ranging from \$25 to \$500 per individual service. In 2018, the most shopped
 20 medical procedures were lab/blood work, mammogram, magnetic resonance imaging (MRI),
 21 colonoscopy, and computerized tomography (CT) scan.¹⁹

22
 23 Critically, it is unclear what quality metrics Sapphire Digital uses to determine whether the lower-
 24 cost services it incentivizes are in fact "better value" and "high-quality."²⁰ Sapphire Digital
 25 provides shoppers with quality data from Quantros which has been described as, "a patent pending
 26 proprietary composite scoring system which integrates outcome quality measures, such as
 27 readmission, complication and mortality rates, into a single, multidimensional composite quality
 28 score. The data are risk-adjusted and rendered as an easy-to-understand rating for individual
 29 physicians, hospitals and health systems."²¹ Previously, Sapphire Digital had described its quality
 30 data as incorporating "structure" and "patient experience" measures.²²

31
 32 Sapphire Digital recently took health care shopping a step further when it launched its Medical
 33 Expertise Guide (MEG) in late 2018.²³ MEG builds upon the SmartShopper tool in two critical
 34 ways: first, it focuses specifically on influencing patients' choices for surgical procedures; and
 35 second, rather than relying on patients to engage with the tool because they are interested in
 36 shopping for care, MEG enables Sapphire Digital to predict which patients might need care and
 37 proactively reaches out to those patients. The program's engagement strategy is based on predictive
 38 analytics and modeling, used to identify patients on a clinical path that could lead to expensive
 39 surgery. In describing their methods for identifying high-quality care, Sapphire Digital explains
 40 that MEG applies quality measures such as infection and complication rates, patient reviews,
 41 predictive analytics, and "proprietary confidence measures." MEG also provides assistance from
 42 "highly-trained health care professionals."²⁴ This novel technology has the potential for both
 43 significant benefits and risks.

44
 45 UnitedHealthcare (UHC): In addition to incentivizing patients to shop for lower-cost health care
 46 services, FIPs can incentivize patients to choose lower-cost prescription drugs. UHC recently
 47 launched its My ScriptRewards program that allows patients to earn up to \$500 in prepaid debit
 48 cards that can be used to pay medical expenses when they choose "doctor-approved, guideline-
 49 recommended and cost-effective medications" to treat HIV.²⁵ UHC explains that the Department
 50 of Health and Human Services (HHS) has recommended several HIV treatment regimens, and the
 51 cost among these regimens can vary significantly. UHC has selected two regimens (Cimduo® +

1 Tivicay® (two-pill regimen) and Cimduo + Isentress®/Isentress HD® (three-pill regimen)) and
2 incentivizes patients to choose one of these lower-cost regimens by offering these regimens with no
3 patient cost-sharing, plus the prepaid debit card rewards.
4

5 With the lower cost of UHC's preferred regimens, however, come some key distinctions between
6 UHC's preferred HIV treatments and other options. Critically, HHS guidelines issued in late 2018
7 selected Biktarvy, a treatment that is not eligible for the UHC incentive, as a preferred regimen,
8 whereas UHC's preferred regimens do not appear on the list of HHS recommended initial
9 treatments.²⁶ Moreover, UHC's preferred regimens require patients to take two or three pills a day,
10 whereas Biktarvy is a once-a-day pill regimen. UHC does not explicitly force patients to accept one
11 of the lower-cost prescription options and stresses the importance of patients working with their
12 physicians to determine whether one of the lower-cost treatment regimens is right for them.
13 However, if the lower-cost regimens are not appropriate, the only recourse is to reach out to UHC
14 to determine which alternative regimens are covered under patients' pharmacy benefits,²⁷ and
15 patients or providers may be forced to explicitly opt out of the My ScriptRewards program in order
16 to fill a non-preferred antiretroviral prescription.²⁸ UHC plans to expand its My ScriptRewards
17 program to additional high-cost specialty drug categories in the future.²⁹
18

19 Walmart: In contrast to FIPs focused on identifying lower-cost care, some payers are creating
20 financial incentives that preference demonstrated quality over cost. Concerned that employees were
21 being misdiagnosed, leading to unnecessary surgery and spending, Walmart Inc., the nation's
22 largest private employer, created a program to encourage patients to go to specific imaging centers
23 based on diagnostic accuracy, not price.³⁰ Walmart employees do not have to choose a preferred
24 imaging center, but if they do not, they pay additional cost-sharing. Walmart's imaging program is
25 aligned with its efforts over the past decade to create financial incentives for patients to obtain care
26 at designated hospitals where it believes patients will achieve better results. As part of its Centers
27 of Excellence program, Walmart has selected hospitals across the country that it believes have the
28 expertise and resources to provide its members with the highest-quality care for several medical
29 conditions, including various surgeries and cancer diagnoses.³¹ For many of these treatments,
30 patients travel to one of the designated Centers of Excellence, where their care is covered 100
31 percent and travel and lodging costs are covered for the patient and a companion caregiver.
32

33 Anthem/UHC: A similar but clearly distinguishable insurance benefit design feature imposes prior
34 authorization requirements and/or denies coverage when patients choose a higher-priced site of
35 service. Such benefit design features jeopardize physician and patient choice. Anthem and UHC
36 provide examples of this type of program. In addition to Anthem's preapproval process to review
37 the medical necessity of a non-emergency outpatient MRI or CT scan, an Anthem subsidiary also
38 evaluates where the scan should be performed, and provides the requesting physician with a list of
39 eligible imaging centers.³² Citing the "huge cost disparities for imaging services, depending on
40 where members receive their diagnostic tests," Anthem's program ultimately prevents many
41 patients from receiving MRIs and CT scans at hospital-owned, outpatient facilities, instead
42 requiring them to use independent imaging centers.³³ Similarly, starting in 2019, UHC began
43 conducting site of care reviews, in addition to their prior authorization reviews, when specific
44 advanced diagnostic imaging procedures are requested at an outpatient hospital setting (no
45 additional review is required if the test is to be performed at a freestanding diagnostic radiology
46 center or office setting).³⁴

1 IMPACT OF HEALTH CARE SHOPPING PROGRAMS

3 *Objective Data*

5 Despite the increasing popularity of FIPs, there is little objective evidence of their impact.³⁵ A
6 working paper from the National Bureau of Economic Research highlights the crucial role of the
7 referring physician. The study suggests that rather than focusing on patient cost-sharing, payers
8 could more effectively help patients pursue lower-cost health care services by providing price
9 information to physicians and incentivizing them to make cost-efficient referrals.³⁶ The study found
10 that patients did not “shop” for care, even when the care at issue was a non-invasive MRI scan,
11 when they were exposed to significant out-of-pocket costs, when they were provided ready access
12 to a price transparency tool, and when they had the opportunity to reduce the price they would pay
13 without traveling a long distance.³⁷ Instead, the study found that referring physicians influence
14 where patients will receive further care far more than patient exposure to out-of-pocket costs, with
15 referring physician influence accounting for 51 percent of variance, and out-of-pocket cost
16 exposure accounting for 2.4 percent of the variance.³⁸ The data studied were comprised of
17 insurance claims data provided by a large national insurer that covers tens of millions of lives
18 annually and is active in all 50 states. However, the main analysis uses data from 2013. The study
19 authors infer that given the weight patients ascribe to the advice of their referring physicians versus
20 the influence of out-of-pocket cost in the context of a lower-limb MRI scan, patients are even less
21 likely to actively price shop for more complex services. Supporting these conclusions, a 2016
22 analysis by the Health Care Cost Institute, which is funded in part by Aetna, Humana, Kaiser
23 Permanente, and UHC, found only “modest” potential gains from the consumer price shopping
24 aspect of price transparency efforts.³⁹

26 In another recent study, the Health Care Service Corporation (the fourth-largest health plan in the
27 United States) collaborated with academic researchers to analyze the impact of the SmartShopper
28 program.⁴⁰ Critically, this study did not examine any impacts on quality of care; rather, it was
29 focused on financial impacts and changes in utilization. While the study identified some cost
30 savings for employers and patients, the financial impact was limited.⁴¹ The study estimated a 5.2
31 percent reduction in annual spending on reward-eligible services, a savings of \$2.3 million per
32 year, or approximately \$8 per patient per year. The study authors noted that, to receive a reward,
33 patients may not be able to receive care from the provider their physician initially recommended,
34 and patients may feel more comfortable seeking a second referral for imaging services, rather than
35 invasive procedures. Moreover, switching providers is particularly complex for surgical
36 procedures, and patients may be more concerned about quality of surgical services. Additionally,
37 the study noted that the availability of lower priced providers may play a role in the results
38 observed. The study authors suggested that the small reduction in utilization among patients in
39 receipt of any reward eligible services could be due to patients using the price comparison tool,
40 becoming aware of the still high out-of-pocket cost of reward eligible services, and choosing not to
41 pursue care. The study concludes that while rewards programs are appealing to employers, they
42 may not be the most effective way to reduce spending.

44 Another recent study specifically focused on quality of care variations that exist among sites of
45 care providing MRIs.⁴² A first of its kind study analyzed MRI reports following complete lumbar
46 MRI examinations of the same patient, performed at 10 different regional imaging centers, over a
47 period of three weeks. All of the study centers had valid accreditation from the American College
48 of Radiology. The study found “marked variability” in the reported interpretive findings and “an
49 alarmingly high number” of interpretive errors in the MRI reports.⁴³ Specifically, no interpretive
50 findings were reported in all 10 MRI reports, and only 1 finding (out of 49 total findings) was
51 reported in 9 out of 10 reports. Moreover, the high average miss rate across the examinations

1 means that important pathologies are routinely under detected, and the high false positive rates for
2 specific pathologies indicate that some diagnostic findings may be routinely over detected. These
3 findings have clear and critical implications for appropriate diagnosis and treatment. Moreover,
4 since payers heavily rely on MRI reports during utilization and authorization review processes, an
5 inaccurate diagnosis on MRI can lead to significant delays in appropriate care.⁴⁴ In the context of
6 incentive programs, knowing that such significant variation exists among equally accredited
7 providers of a non-invasive imaging examination raises serious questions about the quality of care
8 evaluations FIPs perform before making referral recommendations that may differ from the
9 patient's treating clinician.

10 *Data from Sapphire Digital*

11
12
13 In contrast to the objective research studies that question the impact of patients shopping for lower-
14 cost health care, Sapphire Digital claims its tools have achieved more significant cost savings
15 across the continuum of care. As of 2018, Sapphire Digital claims that, over the course of four
16 years, its program saved employers over \$56 million, and employers paid \$6.7 million in cash
17 incentives to their employees.⁴⁵ Sapphire Digital stated that, on average, patients save \$606 per
18 procedure shopped on SmartShopper. In 2016, Sapphire Digital published an analysis that
19 extrapolated potential health care system wide savings of \$17.6 billion on colonoscopies alone.⁴⁶
20 Data provided by plans that have implemented SmartShopper can support Sapphire Digital's
21 claims. For example, HealthTrust, a non-profit organization that provides insurance benefits to
22 public employees and began using SmartShopper in 2014, saved \$1.5 million by the end of 2015,
23 \$2.8 million by the end of 2016, and \$2.75 million in the first 10 months of 2017.⁴⁷ However,
24 despite increases in engagement, as of 2018, only 10 percent of HealthTrust members regularly
25 used SmartShopper.

26 27 **AMA POLICY**

28
29 FIPs relate to a wide variety of AMA policy. Policy H-450.941 expresses the AMA's
30 uncompromising commitment to primacy of the patient-physician relationship free from intrusion
31 from third parties. The policy specifically supports initiatives that protect patient access and that do
32 not contain requirements that permit third party interference in the patient-physician relationship,
33 and it strongly opposes attempts to steer patients towards certain physicians primarily based on cost
34 of care factors. Policy H-450.947 sets forth extensive pay-for-performance principles and
35 guidelines. Especially relevant elements of Policy H-450.947 include a focus on patient-centered,
36 evidence-based care; allowances for variations in individual patient care based on a physician's
37 clinical judgement; providing proactive explanations of programs to the patients impacted; and
38 programs that do not create conditions that limit access to improved care or directly or indirectly
39 disadvantage patients and their physicians based on geographic, ethnic, cultural, or socioeconomic
40 groups, their medical conditions, or the setting where care is delivered.

41
42 AMA policy regarding drug pricing also informs discussion of FIPs. Policy H-110.997 supports
43 programs that contain the rising costs of prescription drugs, with caveats to ensure that physicians
44 have input into such programs, that all patients have access to all prescription drugs necessary to
45 treat their illnesses, and that physicians have the freedom to prescribe the most appropriate drug(s)
46 and method(s) of delivery for individual patients. Policy H-125.991 guides drug formularies and
47 therapeutic interchange, discouraging switching of therapeutic alternates in patients with chronic
48 diseases who are stabilized on a drug therapy regimen, while encouraging mechanisms such as
49 incentive-based formularies.

1 AMA policies on the patient-centered medical home underscore the patient/physician relationship
2 as essential for maintaining continuity of care (Policies H-160.919 and H-160.918). In addition, the
3 Council notes the relevance of AMA Policy H-450.937 regarding medical tourism, which
4 advocates that employers, insurance companies, and other entities that facilitate or incentivize
5 medical care outside the US adhere to several principles, including that such incentives must be
6 voluntary and ensure continuity of care and necessary follow-up care.

7
8 AMA policy strongly supports value-based care. Policy H-110.986 provides principles to guide
9 value-based pricing programs for pharmaceuticals, including: (a) value-based prices of
10 pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of
11 pharmaceuticals should be evidence-based and be the result of valid and reliable data; (c) processes
12 to determine value-based prices of pharmaceuticals must be transparent, easily accessible to
13 physicians and patients, and provide practicing physicians and researchers a central and significant
14 role; and (d) value-based pricing of pharmaceuticals should allow for patient variation and
15 physician discretion. Policy H-155.960 supports value-based decision-making and recognizes the
16 role of physician leadership and importance of collaboration among physicians, patients, insurers,
17 employers, unions, and government in successful cost-containment and quality-improvement
18 initiatives. Policy D-185.979 supports value-based insurance design plans and encourages national
19 medical specialty societies to collaborate with payers to promote alignment of patient financial
20 incentives with utilization of high-value services. Policy H-185.935 guides use of reference pricing
21 and supports consideration of reference pricing strategies for elective services for which there is
22 evidence of a significant variation in cost that does not correspond to a variation in quality of care.

23 24 DISCUSSION

25
26 Patients, physicians, and health care payers alike benefit when it is possible to identify high-quality
27 health care that minimizes patient financial burden and ensures continuity of care. With payers
28 increasingly looking to FIPs as an avenue for reducing patient costs, it is essential that health care
29 quality not be sacrificed in the process, and that fragmentation of care is minimized. To protect
30 these and other critical elements of high-quality care, the Council recommends a set of guiding
31 principles for use in the development and implementation of FIPs.

32
33 Physicians are committed to providing and helping their patients obtain evidence-based, high-
34 quality, cost-effective care. Accordingly, patients will benefit if physicians are involved in the
35 development and implementation of patient incentives. Physicians should also be consulted by FIPs
36 to identify high-value referral options. FIP benefit information should be integrated into health care
37 information technology with real-time access to empower patients and physicians to make optimal
38 referral and prescription choices efficiently, reduce subsequent administrative burden, and promote
39 improved quality and cost of care.

40
41 FIPs must avoid adding to the fragmentation of patient care by informing referring and/or primary
42 care physicians when their patients have selected an FIP service and by providing a full record of
43 the service encounter. In addition, it is critical that patient care plans are first developed and
44 discussed between patients and their physicians. FIPs should make it clear that only the treating
45 physician can determine whether a lower-cost option is appropriate. Patients should be encouraged
46 to consult with their physicians prior to deviating from established patient care plans.

47
48 It is also essential that FIPs remind patients that they can choose their physician or facility,
49 consistent with their health plan benefits. FIPs should provide transparency regarding the quality
50 data they use in making referral recommendations so that patients and physicians can be confident
51 that lower-cost care meets their quality expectations. Similarly, FIPs should provide transparency

1 of their quality ratings of participating physicians and facilities and provide physicians with
2 directions for appealing exclusion from lists of preferred lower-cost physicians. The Council also
3 recommends that patients and physicians should have access to a process for publicly reporting
4 unsatisfactory care with FIP options.

5
6 FIPs should provide meaningful transparency of both prices and vendors. Patients should fully
7 understand any cost-sharing, other burdens or trade-offs, and incentives associated with receiving
8 care from FIP-preferred physicians and facilities.

9
10 To further promote the ideals articulated in the principles, the Council recommends that health
11 insurers that contract with FIPs should indemnify patients for any additional medical expenses that
12 result as follow-up in cases where the FIP service is inadequate, such as a scan that is not useful to
13 the referring physician. The insurer should cover the follow-up scan with no patient cost-sharing.
14 The Council also recommends that state and medical associations and national medical specialty
15 societies apply these principles and seek opportunities to collaborate in the design and
16 implementation of FIPs to empower physicians and patients to make high-value referral choices
17 and recommends objective studies of the impact of FIPs. With FIPs at the intersections of local
18 health care and nation-wide large employer benefit plans, as well primary care referrals to
19 specialists, the AMA and the Federation of Medicine have complementary roles to play in
20 promoting optimal patient care.

21
22 Finally, given the lack of data on the impact of current FIPs, the Council recommends objective
23 studies on various aspects of FIPs.

24 25 RECOMMENDATIONS

26
27 The Council on Medical Service recommends that the following be adopted and that the remainder
28 of the report be filed.

- 29
30 1. That our American Medical Association (AMA) support the following continuity of care
31 principles for any financial incentive program (FIP):
32
- 33 a) Collaborate with the physician community in the development and implementation of
34 patient incentives.
 - 35 b) Collaborate with the physician community to identify high-value referral options based on
36 both quality and cost of care.
 - 37 c) Provide treating physicians with access to patients' FIP benefits information in real-time
38 during patient consultations, allowing patients and physicians to work together to select
39 appropriate referral options.
 - 40 d) Inform referring and/or primary care physicians when their patients have selected an FIP
41 service prior to the provision of that service.
 - 42 e) Provide referring and/or primary care physicians with the full record of the service
43 encounter.
 - 44 f) Never interfere with a patient-physician relationship (eg, by proactively suggesting health
45 care items or services that may or may not become part of a future care plan).
 - 46 g) Inform patients that only treating physicians can determine whether a lower-cost care
47 option is medically appropriate in their case and encourage patients to consult with their
48 physicians prior to making changes to established care plans. (New HOD Policy)

- 1 2. That our AMA support the following quality and cost principles for any FIP:
 - 2 a) Remind patients that they can receive care from the physician or facility of their choice
 - 3 consistent with their health plan benefits.
 - 4 b) Provide publicly available information regarding the metrics used to identify, and quality
 - 5 scores associated with, lower and higher-cost health care items, services, physicians and
 - 6 facilities.
 - 7 c) Provide patients and physicians with the quality scores associated with both lower and
 - 8 higher-cost physicians and facilities, as well as information regarding the methods used to
 - 9 determine quality scores. Differences in cost due to specialty or sub-specialty focus should
 - 10 be explicitly stated and clearly explained if data is made public.
 - 11 d) Respond within a reasonable timeframe to inquiries of whether the physician is among the
 - 12 preferred lower-cost physicians; the physician's quality scores and those of lower-cost
 - 13 physicians; and directions for how to appeal exclusion from lists of preferred lower-cost
 - 14 physicians.
 - 15 e) Provide a process through which patients and physicians can report unsatisfactory care
 - 16 experiences when referred to lower-cost physicians or facilities. The reporting process
 - 17 should be easily accessible by patients and physicians participating in the program.
 - 18 f) Provide meaningful transparency of prices and vendors.
 - 19 g) Inform patients of the health plan cost-sharing and any financial incentives associated with
 - 20 receiving care from FIP-preferred, other in-network, and out-of-network physicians and
 - 21 facilities.
 - 22 h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives,
 - 23 may require them to undertake some burden, such as traveling to a lower-cost site of
 - 24 service or complying with a more complex dosing regimen for lower-cost prescription
 - 25 drugs.
 - 26 i) Methods of cost attribution to a physician or facility must be transparent, and the
 - 27 assumptions underlying cost attributions must be publicly available if cost is a factor used
 - 28 to stratify physicians or facilities. (New HOD Policy)
 - 29
- 30 3. That our AMA support requiring health insurers to indemnify patients for any additional
- 31 medical expenses resulting from needed services following inadequate FIP-recommended
- 32 services. (New HOD Policy)
- 33
- 34 4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other
- 35 than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively
- 36 must choose the FIP choice. (New HOD Policy)
- 37
- 38 5. That our AMA encourage state medical associations and national medical specialty societies to
- 39 apply these principles in seeking opportunities to collaborate in the design and implementation
- 40 of FIPs, with the goal of empowering physicians and patients to make high-value referral
- 41 choices. (New HOD Policy)
- 42
- 43 6. That our AMA encourage objective studies of the impact of FIPs that include data collection
- 44 on dimensions such as:
 - 45 a) Patient outcomes/the quality of care provided with shopped services;
 - 46 b) Patient utilization of shopped services;
 - 47 c) Patient satisfaction with care for shopped services;
 - 48 d) Patient choice of health care provider;
 - 49 e) Impact on physician administrative burden; and
 - 50 f) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy)

Fiscal Note: Less than \$500.

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