WHEREAS, Insurers contract with physicians to provide medical care to patients at an agreed upon rate; and

WHEREAS, Insurers contract with patients to receive medical care from physicians at an agreed upon rate, subject to co-pay and deductible amounts; and

WHEREAS, Despite the contract between patient and insurer, the patient’s physician must collect the co-pay and deductible from the patient; and

WHEREAS, At times, this practice is misunderstood by patients; they believe their physician is attempting to gain additional payment for care; and

WHEREAS, To honor the respective contractual obligations between insurer and physician, and insurer and patient, insurers should be required to collect co-pays and deductibles from patients; therefore be it

RESOLVED, That our American Medical Association advocate for legislation and/or regulations to require insurers to collect co-pays and deductibles directly from patients with whom they are contractually engaged, and pay physicians the contracted rate, not subject to the physician’s collection of co-pay and deductible from the patient (Directive to Take Action).

Fiscal Note: Modest: Between $1,000 and $5,000 to implement

Received: 9/6/22
RELEVANT AMA POLICY

Payment by Health Insurance Plans of Medicare Deductibles and Copayments D-390.984

Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.

Citation: Res. 105 and 106, A-03; Reaffirmed: BOT Rep. 28, A-13; Modified: CCB/CLRPD Rep. 2, A-14

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies’ contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers’ pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare’s drug-pricing dashboard.


Patient’s Out-of-Pocket Contributions to Private Health Insurance H-185.983

(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients’ copayments are being computed on a different basis than the third party’s reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.

Managed Care Secondary Payers H-385.950

Our AMA:
(1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;
(2) will require that these co-insurance and deductible obligations cannot be waived contractually;
(3) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;
(4) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service;
(5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to “manage” the Medicare benefit, as if the secondary carrier were the primary carrier; and
(6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient’s primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer.