

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)

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

4
5 That our American Medical Association (AMA) urge health plans and insurers to bear the
6 responsibility of ensuring physicians promptly receive full payment for patient copayments,
7 coinsurance and deductibles.
8

9 This report provides an overview of patient cost-sharing obligations including the rise of high-
10 deductible health plans, highlights patient collection management practices by insurers,
11 summarizes relevant AMA policy, provides a summary of relevant AMA advocacy activities,
12 and recommends policy.
13

14 BACKGROUND

15
16 Despite coverage gains in recent years, the health care system continues to struggle with decreasing
17 the number of uninsured patients and, even for the insured population, utilizing health care services
18 is often unaffordable. For the insured, the trend of rising health insurance deductibles has been
19 altering health insurance from more comprehensive coverage to insurance with higher out-of-
20 pocket costs.¹ Deductibles have gradually risen for decades and contribute to the changing nature
21 of health insurance. One rationale behind high deductible health plans (HDHPs) is that they
22 moderate the cost of health care and health insurance by shifting the rising cost of health care from
23 insurers and employers to patients. Health plans with higher levels of cost-sharing generally have
24 lower premiums and put a financial obligation of higher out-of-pocket costs on patients when
25 services are used.²
26

27 The prevalence of HDHPs is not limited to the Affordable Care Act (ACA) Exchanges but also
28 widespread in employer-sponsored coverage. Notably, the growth in HDHP enrollment has been
29 fastest among those with employer-based coverage. About 40 percent of companies that offer
30 health insurance make HDHPs the only choice for their employees.³ About half of people with
31 employer coverage have a deductible of at least \$1,000.⁴ Moreover, the shift to plans with rising
32 deductibles began before the ACA was passed.⁵ The average general annual deductible for
33 employees has increased 49 percent over the last five years.⁶ Overall, in 2018, 29 percent of
34 workers with employer-based coverage were enrolled in a HDHP. Although the Council believes
35 that health insurance should balance patient responsibility and patient choice; increasingly
36 employees do not have a choice of coverage options.⁷

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

14
15 The shift in financial responsibility toward patients may contribute to physicians' concerns about
16 collecting cost-sharing from patients. However, if physicians do not collect these cost-sharing
17 amounts, they sustain bad debt that adversely affects the financial sustainability of their practices.⁹

18
19 Bad debt typically is the difference between what providers billed patients and the amount those
20 patients ultimately paid, and the phenomenon of bad debt has become an industry-wide issue for
21 health care practitioners. Patient payments are an increasing share of expected revenues.¹⁰
22 According to the American Hospital Association, this uncompensated care reached \$38.3 billion in
23 2016. Bad debt may affect the financial viability of practices, and collecting on bad debt takes
24 practice time and resources, and the additional time physician offices spend on collection of bad
25 debt is not reflected in the cost of providing care. Moreover, the significant time used to collect on
26 such debt may cause disruptions to the patient-physician relationship.

27 28 EXAMPLE OF INSURER PROGRAM COLLECTING COST-SHARING

29
30 To mitigate bad debt, major national health plans, including UnitedHealthcare and Anthem, have
31 patient payment programs through InstaMed, which allow insurers to manage patient collections
32 for the physician practice; however, there are caveats to this model. First, practices do not have a
33 choice of if they want to receive patient payments in this manner. Therefore, if a patient signs up
34 for InstaMed, the practice will get paid through InstaMed. Moreover, these programs typically
35 only issue electronic payments to the practice. If the practice does not sign up for the program and
36 receive standard electronic fund transfers, the practice will be issued a virtual credit card for the
37 patient's payment. Importantly, such credit cards are associated with fees that tend to be
38 2-5 percent of the overall payment. Furthermore, practices may have reasons for wishing to
39 manage patient payments themselves. For instance, the practice may have worked out a payment
40 plan with the patient or there may be secondary or tertiary payers. The solution sought by
41 Resolution 707-A-18 may negatively impact such business autonomy by precluding such
42 arrangements. Advocating for patient payment programs may appear as an endorsement of such
43 programs, which may be problematic for physicians and provider representatives of plans impacted
44 by these patient collection methods. Accordingly, such action may adversely affect physician
45 payment levels and processes, and could have unintended consequences within some physician
46 practices.

47 48 AMA POLICY

49
50 Long-standing AMA policy and advocacy efforts acknowledge and support the business freedom
51 of physician practices (Policies H-165.985 and H-165.838). Some physicians prefer the flexibility

1 afforded to payment operations and do not want to cede patient collections to health plans.
2 Physicians currently have the ability to offer discounts or payment plans to patients to facilitate
3 goodwill, which is an arrangement supported by long-standing Policy H-165.849. Moreover,
4 Policy H-165.849 states that our AMA will engage in a dialogue with health plan representatives
5 (e.g., America's Health Insurance Plans and Blue Cross and Blue Shield Association) about the
6 increasing difficulty faced by physician practices in collecting co-payments and deductibles from
7 patients enrolled in HDHPs.

8
9 Policy D-190.974 demonstrates the AMA's commitment to administrative simplification. Among
10 numerous actions, it directs the AMA to continue its strong leadership role in automating,
11 standardizing, and simplifying all administrative revenue cycle transactions between physicians in
12 all specialties and modes of practice and all their trading partners, including, but not limited to,
13 public and private payers, vendors, and clearinghouses. Moreover, it directs the AMA to prioritize
14 efforts to automate, standardize, and simplify the process for physicians to estimate patient and
15 payer financial responsibility before the service is provided, and determine patient and payer
16 financial responsibility at the point of care.

17
18 The AMA remains committed to health insurance affordability. Policy H-165.828 specifically
19 encourages the development of demonstration projects to allow individuals eligible for cost-sharing
20 subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA
21 partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Moreover,
22 Policy H-165.828 supports additional education regarding deductibles and cost-sharing at the time
23 of health plan enrollment, including the use of online prompts and the provision of examples of
24 patient cost-sharing responsibilities for common procedures and services.

25 26 AMA ACTIVITY

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28 The AMA has developed a comprehensive point-of-care pricing toolkit to help practices with
29 patient collections (<https://www.ama-assn.org/practice-management/claims-processing/managing-patient-payments>). The toolkit recognizes concerns about uncollected patient financial
30 responsibility that can result in physician practices taking on debt and contains varied resources to
31 help mitigate the problem. This toolkit addresses point-of-care and post-visit collections and
32 includes:
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- 34
35 • Step-by-step guidance toward providing point-of-care pricing and collecting from patients
36 at the time of service;
- 37 • Guidance on calculating the price of treatment at the point-of-care;
- 38 • Sample scripts to help practices collect patient payment;
- 39 • Letter templates to ask health insurers and other payers about terms and conditions of
40 insurance contracts regarding physicians' rights to provide point-of-care pricing and collect
41 payments at the time of care;
- 42 • Webinars designed for practices to help patients understand their financial responsibility;
- 43 • Resource providing information on how practices can implement an effective strategy for
44 collection of payment after a patient has left the office; and
- 45 • Guidance on the steps to take when a patient fails to pay for treatment in full.

46
47 In addition to the AMA's point-of-care pricing toolkit, the AMA has repeatedly voiced its concern
48 about virtual credit card payments and the fact that it may cause physicians to lose a significant
49 amount of contractual payments to high interchange fees charged by the credit card companies. The
50 AMA continuously advocates for transparency in virtual credit card payments including advanced

1 disclosure of transaction fees and any rebates or incentives awarded to payers for using this
2 payment method.

3
4 Furthermore, pursuant to Policy H-165.849, the AMA continues to engage in ongoing dialogue
5 with health insurers and health insurance representatives about the increasing difficulty of practices
6 in collecting co-payments and deductibles. The AMA continues to hold such meetings with
7 insurers to address this issue as well as other issues relating to physician burden and practice
8 sustainability.

9
10 **DISCUSSION**

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

20
21 First, the Council recommends reaffirming long-standing policy illustrating the AMA's
22 commitment to the business freedom of physician practices (Policies H-165.985 and H-165.838).
23 Additionally, because the evidence suggests that it is not the HDHP itself that is necessarily
24 problematic but rather the inability to meaningfully fund a corresponding HSA, the Council
25 recommends reaffirming Policy H-165.828 encouraging the development of demonstration projects
26 to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a
27 bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent
28 to the cost-sharing subsidy. Due to the trend of increasing use of HDHPs, the Council also
29 recommends encouraging states and other stakeholders to monitor the growth of HDHPs and other
30 forms of cost-sharing in health plans to assess the impact of such plans on access to care, health
31 outcomes, medical debt, and provider practice sustainability.

32
33 The Council believes that a factor contributing to uncompensated care is the lack of patient
34 education on their health plans. Importantly, Policy H-165.828 also supports education regarding
35 deductibles and cost-sharing at the time of health plan enrollment, including the use of online
36 prompts and the provision of examples of patient cost-sharing responsibilities for common
37 procedures and services. Although the Council remains steadfast in its belief that patient education
38 will help solve the problem of uncompensated care, it notes that the Emergency Medicine
39 Treatment and Labor Act forbids emergency care providers from discussing with the patient any
40 potential costs of care or details of their insurance coverage until the patient is screened and
41 stabilized. The Council agrees with and respects this prohibition. Therefore, while the Council
42 strongly supports patient education of costs not only at the time of enrollment but also at the time
43 of care, the Council recognizes that this discussion is precluded at the point-of-care in the case of
44 emergencies.

45
46 To further patient education efforts, the Council recommends amending Policy D-190.974 by
47 updating part four by addition such that our AMA will prioritize efforts to automate, standardize,
48 and simplify the process for physicians to estimate patient and payer financial responsibility before
49 the service is provided, and determine patient and payer financial responsibility at the point of care,
50 especially for patients in HDHPs. Following from this, the Council also believes that more
51 sophisticated IT systems are critical to help enable physicians and empower patients to better

1 understand financial obligations. Additionally, the Council recommends taking this opportunity to
2 amend part six of Policy D-190.974 to reflect the ending of the Heal the Claims campaign and
3 instead recommends calling attention to the AMA's continued efforts to ensure that physicians are
4 aware of automating their claims cycle.

5
6 As previously noted, the prevalence of HDHPs is not isolated to the ACA Exchanges, but is also
7 widespread in employer-sponsored coverage. The Council believes that health insurance should
8 balance patient responsibility and patient choice; however, increasingly patients do not have a
9 choice of coverage options. Therefore, the Council recommends reaffirming Policy H-165.849
10 urging the AMA to continue to engage in ongoing dialogue with health insurers and health
11 insurance representatives about the increasingly difficulty of practices in collecting co-payments
12 and deductibles and the underlying issue of affordability.

13
14 The Council firmly believes that there are no easy solutions to the problem of patient collections
15 and remains unconvinced that giving insurers additional control over the process is the best
16 solution. Instead, the Council believes that the AMA should remain committed to addressing the
17 concerns of its members and seeking solutions to the major issue underlying Resolution 707-A-18,
18 which is greater affordability of health insurance premiums and cost-sharing responsibilities.
19 Accordingly, the Council suggests a set of recommendations intended to address the root of the
20 problem.

21 22 RECOMMENDATIONS

23
24 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
25 707-A-18 and the remainder of the report be filed:

- 26
27 1. That our American Medical Association (AMA) reaffirm Policies H-165.985 and
28 H-165.838 illustrating the AMA's commitment to the business freedom of physician
29 practices. (Reaffirm HOD Policy)
- 30
31 2. That our AMA reaffirm Policy H-165.849 stating that the AMA will continue to engage in
32 ongoing dialogue with health insurers and health insurance representatives about the
33 increasing difficulty of practices in collecting co-payments and deductibles. (Reaffirm
34 HOD Policy)
- 35
36 3. That our AMA reaffirm Policy H-165.828 encouraging the development of demonstration
37 projects to allow individuals who forego cost-sharing subsidies by enrolling in a bronze
38 plan to have access to a partially-funded health savings account and supporting additional
39 education regarding deductibles and cost-sharing at the time of health plan enrollment.
40 (Reaffirm HOD Policy)
- 41
42 4. That our AMA amend Policy D-190.974 by addition and deletion as follows:

43 44 Administrative Simplification in the Physician Practice

- 45 1. Our AMA strongly encourages vendors to increase the functionality of their practice
46 management systems to allow physicians to send and receive electronic standard
47 transactions directly to payers and completely automate their claims management
48 revenue cycle and will continue to strongly encourage payers and their vendors to work
49 with the AMA and the Federation to streamline the prior authorization process.

- 1 2. Our AMA will continue its strong leadership role in automating, standardizing and
2 simplifying all administrative actions required for transactions between payers and
3 providers.
- 4 3. Our AMA will continue its strong leadership role in automating, standardizing, and
5 simplifying the claims revenue cycle for physicians in all specialties and modes of
6 practice with all their trading partners, including, but not limited to, public and private
7 payers, vendors, and clearinghouses.
- 8 4. Our AMA will prioritize efforts to automate, standardize and simplify the process
9 for physicians to estimate patient and payer financial responsibility before the service
10 is provided, and determine patient and payer financial responsibility at the point of
11 care, especially for patients in high-deductible health plans.
- 12 5. Our AMA will continue to use its strong leadership role to support state and
13 specialty society initiatives to simplify administrative functions.
- 14 6. Our AMA will continue its efforts ~~expand its Heal the Claims process(TM)~~
15 ~~campaign as necessary~~ to ensure that physicians are aware of the value of automating
16 their claims cycle. (Modify Current HOD Policy)
- 17
- 18 5. That our AMA support the development of sophisticated information technology systems
19 to help enable physicians and patients to better understand financial obligations. (New
20 HOD Policy)
- 21
- 22 6. That our AMA encourage states and other stakeholders to monitor the growth of high
23 deductible health plans and other forms of cost-sharing in health plans to assess the impact
24 of such plans on access to care, health outcomes, medical debt, and provider practice
25 sustainability. (New HOD Policy)
- 26
- 27 7. That our AMA advocate for the inclusion of health insurance contract provisions that
28 permit network physicians to collect patient cost-sharing financial obligations (eg,
29 deductibles, co-payments, and co-insurance) at the time of service. (Directive to Take
30 Action)
- 31
- 32 8. That our AMA monitor programs wherein health plans and insurers bear the responsibility
33 of collecting patient co-payments and deductibles. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

¹Altman, D. The Missing Debate Over Rising Health-Care Deductibles. Kaiser Family Foundation. Available at: <https://www.kff.org/health-costs/perspective/the-missing-debate-over-rising-health-care-deductibles/>

² Assessment of the Impact of High-Deductible Health Plans on Patient Health and the Financial Impact on Medical Practices. Massachusetts Medical Society. Available at: <http://www.massmed.org/news-and-publications/research-and-studies/high-deductible-white-paper-2017/>

³ <https://www.pwc.com/us/touchstone2016>

⁴Goodman, J. High-Deductible Health Insurance: The Good, The Bad, and The Ugly. Forbes. Available at: <https://www.forbes.com/sites/johngoodman/2018/05/11/high-deductible-health-insurance-the-good-the-bad-and-the-ugly/#72ccbac87b18>

⁵ *Supra* note 1.

⁶ 2016 Employer Health Benefits Survey. Kaiser Family Foundation. Available at: <https://www.kff.org/report-section/ehbs-2016-section-seven-employee-cost-sharing/>

⁷ 2018 Employer Health Benefits Survey. Kaiser Family Foundation. Available at: <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-8-high-deductible-health-plans-with-savings-option/>

⁸ *Supra* note 1.

⁹ *Supra* note 2.

¹⁰ Kacik, A. Growing Bad-Debt Problem Illustrates Broken Billing System. Modern Healthcare. Available at: <https://www.modernhealthcare.com/article/20180627/NEWS/180629916>