REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-23

Subject: Health Insurers and Collection of Patient Cost-Sharing (Resolution 823-I-22)

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee J

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 823, "Health Insurers and Collection of Co-pays and Deductibles," which was sponsored by the Private Practice Physicians Section and asked:

> That our American Medical Association (AMA) advocate for legislation and/or regulations to require insurers to collect co-pays and deductibles in fee-for-service arrangements directly from patients with whom the insurers are contractually engaged and pay physicians the full contracted rate unless physicians opt-out to collect on their own.

This report provides an overview of cost-sharing, highlights the impact of cost-sharing collection for physicians, including unique concerns for emergency physicians, explores alternatives to cost-sharing collections, and presents a policy recommendation consistent with Resolution 823-I-22.

DEDUCTIBLES AND OTHER COST-SHARING

Cost-sharing is a general term for the portion of annual health care costs that patients are responsible for paying "out-of-pocket" and may include deductibles, copays and/or coinsurance. Deductibles are paid before the full insurance coverage begins, while copays and coinsurance limit patient costs once the deductible is met.[1] Patients are responsible for all of these forms of cost-sharing and typically they are collected by the physician, practice, or hospital where the care was provided. Cost-sharing began in the United States in the mid-20th century as a response to patient desire for coverage beyond inpatient care and insurer concern that first-dollar comprehensive insurance could result in unsustainably high premiums. Since cost-sharing was collected at the point-of-service, physicians' offices and hospitals have traditionally been responsible for the collection of cost-sharing.[2]

A deductible is the amount that a patient must pay annually before the insurance plan covers the cost of care. Deductible amounts vary significantly by plan, but the average deductible for individual employer-provided coverage is just under $1,800.[3] High-deductible health plans (HDHPs) often have higher deductibles with individual health plans ranging between $1,500 and $7,500. Marketplace health plans range significantly by metal rating with "Bronze" plans annual deductible averaging just under $7,500 and "Platinum" plans averaging just $45. The Medicare Part B deductible is currently $226 annually. Plans with lower monthly premiums tend to have higher deductible amounts and those with higher monthly premiums tend to have lower deductible amounts. Often plans have both individual and family deductibles. Importantly, many plans cover certain services before the patient has met the deductible. For example, all Marketplace and many

private plans cover the full cost of certain preventive services before the beneficiary meets the deductible.[4] During the deductible phase, patient out-of-pocket charges are limited to the approved contracted rate of their health plan.

A copay is a fixed amount that patients pay for a covered health service once the deductible has been met.[5] Copays typically range from $15-$25 for a routine, in-network visit to the physician's office and are paid at the time of the visit. Patients who have not met their deductibles will pay the full allowable amount for the visit to the physician's office. The amount of a copay varies by plan and by the service rendered. As with deductibles, typically health insurance plans that have lower monthly premiums have higher copays and those with higher monthly premiums have lower copayments. Coinsurance is the percentage of costs paid by the patient for covered health care services after the deductible has been met. Coinsurance rates average approximately 20 percent for employer-sponsored insurance and is exactly 20 percent for Medicare Part B plans. Cost-sharing cannot be routinely waived or reduced by physicians/practices for either public or private plans, but payment plans may be acceptable in cases of financial hardship.

Cost-sharing may also vary by site of service (inpatient vs outpatient vs emergency). For patients who are receiving inpatient care, cost-sharing is typically based on length of stay, per-stay, or per-day basis once the patient has been formally admitted for inpatient care. All of the aforementioned specifics hinge on the patient receiving care from an in-network physician/provider. Should an out-of-network physician provide care, many insurance plans have additional/higher cost-sharing responsibilities for the patient.

PHYSICIAN IMPACT

While many physicians experience the adverse impact of collecting cost-sharing, private practices, especially small and rural practices, tend to face more extreme challenges. Net physician practice revenue is often reduced not only from unpaid cost-sharing, but also from the administrative overhead associated with billing and collection. These activities take staff away from more direct patient care activities and can be a drain on a practice's financial resources. Small private and rural practices often have smaller operating budgets and struggle more than larger practices to cover these increased administrative costs.

Uncompensated and partially paid care, such as when cost-sharing payments are not made, can stem from a number of factors with uninsured or underinsured patients often having the largest impact.[6] Regardless of the root cause of uncompensated care, it is estimated that the lost revenue can reach billions annually.[7] Patients with HDHPs, which typically have higher deductibles have significantly contributed to the growth in uncompensated care.[8]

Another factor behind uncompensated care in the United States is the lack of affordability of health care nationally.[9] Not only are these costs high, but they are also on the rise. For example, in 2021, health care costs accounted for 18 percent of the U.S. Gross Domestic Product, up from five percent in 1960.[18] As a result, many Americans have experienced medical debt. Twenty-three million American adults, about 9 percent, hold medical debt with about half of those reporting owing more than $2,000.[10] The lack of affordability of American health care is a contributor to the issues that many physicians face when seeking to collect co-pays and deductibles from patients.

COST-SHARING AND EMTALA

While the collection of cost-sharing is not prohibited by the Emergency Medical Treatment and Labor Act (EMTALA), any collection done during an emergency department (ED) visit cannot

interfere, impede, or delay the medical screening exam (MSE) or stabilizing care. The collection of patient cost-sharing in EDs is complicated and, in some situations, nearly impossible to pursue. As a result, many EDs determine that the collection of cost-sharing is not worth the investment that is needed to ensure that collection is done in a legal and respectful manner.

The regulation around ED copay collection, combined with Medicaid underfunding, Medicare's lack of an inflation adjustment, and uninsured patients seeking care, lead to emergency physicians providing uncompensated care about 55 percent of the time.[11] While the collection of copays and coinsurance are complicated in an emergency setting, the principles remain the same. A copay is still a set amount, typically between $50-$200 for an ED visit, and coinsurance is still a set percentage that the patient pays, usually ranging from 10-50 percent, as long as the deductible has been met. The collection of cost-sharing can be difficult enough in non-emergency settings, and the regulations around prevention of delay to MSE/stabilizing care further complicate the issue making it even harder to collect in emergency settings.

ALTERNATIVE COST-SHARING COLLECTIONS STRATEGIES AND OPTIONS

Some physician practices routinely use collections services. While this alternative still involves physician responsibility in collecting the cost-sharing, the onus of the specific collections actions falls on the agency. Collections agencies are contracted with the physician practice to collect on past-due or delinquent accounts.[12] Typically, agencies are paid via a contingency fee, which is only collected after the overdue account is settled. For physicians who are experiencing considerable financial challenges due to writing off accounts receivable as bad debt, or the difference between what patients are billed and what is actually paid, collections agencies may provide a viable alternative.

However, it is important that physicians are careful to ensure that selected agencies represent practices in a responsible manner and will not engage in undue patient harassment. Concerns surrounding the impact of overly aggressive collections agencies on not only patient financials, but also on the patient-physician relationship, are widespread and unfortunately founded.[19] Additionally, it is not uncommon for physicians to see minimal returns on collections sent to agencies as these agencies can charge significant fees to collect debts. On average, collections agencies charge a fee between 20 percent and 40 percent of what is collected. However, in certain situations, like when a debt is older, the collections agency may charge a higher percentage. When charging a percentage of the debt, agencies will only be paid if the debt is collected. Some agencies use a flat fee system where they charge between $15-$25 per account regardless of if the debt is actually collected.[13] Finally, collections agencies are utilized only after the physician/office has made attempts to collect payment, meaning that the physician/practice has already accrued costs to attempt collections. Due to the lack of return and the potential harms to patient financials, physician and practice reputation, and the patient-physician relationship collections agencies may not be the best alternative method for many physicians/practices to collect cost-sharing.

Another potential solution to physicians' collection of cost-sharing is the use of insurance-controlled collection systems. Collections systems like InstaMed, Flywire, Zelis, and MedPilot are patient payment programs that work to collect payments from patients for physicians, primarily through electronic means. These systems, utilized by companies like UnitedHealthcare, Blue Cross Blue Shield, and other major insurance companies, allow physicians to avoid the potential for bad debt.

Although these types of systems may help physicians and their practices in collecting cost-sharing, they can result in unintentional adverse impacts. For example, physicians may find that there is a

loss of business autonomy in turning over control of collections to insurers. Physicians often do not have a choice in if they want to receive payments in this manner, which further limits physician autonomy. Additionally, while there is little price transparency as to the specific cost to the practice, these services do come at an additional cost to the provider. Finally, as mentioned in CMS Report 9-A-19 physicians utilizing these programs are often pressured to sign up to receive costs via standard electronic fund transfers (EFTs). Should a physician choose not to sign up for EFTs, payments will be issued through a virtual credit card, which often comes with a substantial fee, often between 2-5 percent of the total payment. Due to the potential impacts on physician autonomy, this may not be the best solution to the collection of cost-sharing for most practices. More detailed information about this business model and its impacts can be found in CMS Report 9-A-19.

RELEVANT AMA POLICY AND RESOURCES

The AMA has a number of policies that work to ensure that care is affordable and patients are able to maintain affordable insurance coverage. Policy H-165.838 works to reform health systems to ensure that all Americans have coverage that is affordable and minimizes unnecessary costs and administrative burden. Additionally, Policy H-165.828 focuses more specifically on ensuring the affordability of health insurance for all Americans. This policy outlines the AMA's support for the ACA and suggests modifications to ensure that Americans are both educated about insurance choices and have access to coverage. Each of these policies work to ensure that coverage is expanded and help to reduce the cost of health care to patients as well as uncompensated care.

AMA policy also supports physician autonomy in practice type. Policy H-385.926 encourages physician practice autonomy through the growth of the patient-physician contract, support for physician choice in method of earning (fee-for-service, salary, capitation, etc.), and physician choice over charged fees. Finally, the AMA has policy that specifically addresses HDHPs and the complications that physicians face when collecting cost-sharing from patients covered by these plans. Policy H-165.849 outlines the AMA's opposition to plans that require physicians to bill patients, instead of more efficient methods, and outlines plans to engage with HDHP representatives to discuss the increasing difficulty for physicians to collect cost-sharing.

The AMA also has developed a variety of resources to help physicians navigate the complicated world of collecting cost-sharing. First, the AMA has a set of tools that are designed to help physicians manage patient payments, including a point-of-care pricing toolkit, resources on maximizing post-visit collections, and a how-to-guide for selecting a practice management system. Second, the AMA has developed a resource to support physicians in contracting with payers, Contracting 101 and hosted two webinars related to payer contracting, Payor and Contracting 101 Webinar and Payor and Contracting 201 Webinar. Each of these contracting resources are a part of the AMA's larger Private Practice Playbook: Resources.

DISCUSSION

The collection of cost-sharing is an extremely complicated and taxing process that physicians are required to navigate in order to receive full contracted compensation for services rendered. The Council believes that requiring physicians to engage in collecting cost-sharing negatively impacts physicians, with a particularly strong impact on those working in smaller private and rural practices. Accordingly, the Council concurs with the sentiment of Resolution 823-I-22.

AMA efforts to support physicians practicing in the current system of cost-sharing have included a series of resources, which were created to guide physicians in the steps of not only collecting cost-

sharing, but also in establishing fair and manageable contracts with payers. In addition to the guidance on payer contracting, the AMA has also established relatively extensive resources to assist physicians in navigating the collection of cost-sharing from patients. For example, these resources outline methods of point-of-care collections that have been shown to increase cash flow while also reducing billing and overhead costs, administrative burdens, and bad debt. In addition to the point-of-care collection resources, the AMA also provides information on how to maximize collections post-visit and how to select a practice management system. All of these resources are designed to assist physicians in navigating the complex and taxing process of collecting cost-sharing. However, it is clear that physicians still struggle with cost-sharing collection.

While cost-sharing seems to be a permanent fixture in health care payments, there are potential methods of collection that could ease the burden placed on physicians. As mentioned in this report, physicians are able to utilize collections agencies as a means to collect cost-sharing from patients. However, this may not be a method that all physicians are comfortable utilizing due to the potential negative impacts on patients and the physician-patient relationship. Another existing alternative to the traditional physician-collected cost-sharing system is insurance-controlled systems. These aforementioned systems are run by insurers, which may limit physician autonomy and may increase cost, but may be advantageous for physicians who struggle to collect cost-sharing. The Council specifically believes that alternative methods of collecting cost-sharing in which the onus is placed on insurers is likely to be advantageous for physicians and their practices.

Therefore, the Council recommends the adoption of an amended resolution 823-I-22. Specifically, the Council's recommended amendment allows for enduring policy to support insurers collecting patient cost-sharing, rather than physicians. The Council agrees that physicians should have the ability to opt-out of insurer collection.

Finally, in order to ensure that there are no unexpected adverse impacts on the health insurance coverage status of Americans, the Council recommends the reaffirmation of Policy H-165.838 which outlines the AMA's commitment to enact health insurance coverage for all Americans in a manner that is both affordable and accessible. The reaffirmation of this policy will reiterate the AMA's support to ensure that all Americans have access to affordable health insurance and that this would not be negated by the implementation of an insurance-controlled cost-sharing collections system.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 823-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full allowable amount for the health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy)

2. That our AMA reaffirm Policy H-165.838, which details the AMA's ongoing support for affordable and accessible insurance coverage. (Reaffirm HOD Policy)

3. That our AMA work with interested state medical associations and national medical specialty societies to support the adoption of policies requiring insurers to collect patient cost-sharing

and pay physicians their full allowable amount for the health care services provided, unless the physician should opt out. (New HOD Policy)

Fiscal Note: Less than $500.

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