REPORT 3 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (A-08)
The Role of Cash Payments in All Physician Practices
(Resolution 703, A-07 and Resolution 728, A-07)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2007 Annual Meeting, the House of Delegates referred Resolutions 703 and 728 to the Board of Trustees. Resolution 703 (A-07), introduced by the Illinois Delegation, asked that the AMA "study the advantages and disadvantages of cash-based practices," and "after completing a study of the advantages and disadvantages of cash-based practices…advise the physicians of this country of the advantages and disadvantages of cash-based practices." Resolution 728 (A-07), introduced by the Arizona Delegation, asked that the AMA "study the issue of direct patient payment to physicians and encourage free market forces." The Board of Trustees referred these items to the Council on Medical Service for a report back at the 2008 Annual Meeting.

In the current health care environment, virtually all medical practices receive a portion of their revenues directly from patients, regardless of the insurance status of the patient population. According to the most recent National Health Expenditure (NHE) data available from the Centers for Medicare and Medicaid Services, out-of-pocket spending accounted for 10% of health expenditures for physician and clinical services in 2006. Increasing cost-sharing requirements for insured patients, as well as payments made by uninsured patients, have resulted in increased levels of "direct patient payment" in all physician practices. In addition, as suggested by Resolution 703 (A-07), increasing numbers of physicians are exploring the implications of eschewing insurance contracts altogether and requiring patients to pay in full for their medical care. It is important to note that a cash-based practice is characterized by the physician's relationship with third-party payers, not whether or not the patient population has access to health insurance coverage.

This Council report describes the trends related to the increasing presence of cash-based transactions in medical practice; defines the various practice models and circumstances under which physicians receive cash payments from patients; and identifies issues that need to be considered when dealing with cash payments in a practice environment. The report also highlights the work of the AMA's Private Sector Advocacy group in providing educational materials and tools to help physicians manage cash in their practices. The Council recommends a series of guiding principles to help physicians who may be considering operating a cash-based practice.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-08

Subject: The Role of Cash Payments in All Physician Practices (Resolution 703, A-07 and Resolution 728, A-07)

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee G (H. Christopher Alexander, III, MD, Chair)

At the 2007 Annual Meeting, the House of Delegates referred Resolutions 703 and 728 to the Board of Trustees. Resolution 703 (A-07), introduced by the Illinois Delegation, asked that the AMA "study the advantages and disadvantages of cash-based practices," and "after completing [such] a study…advise the physicians of this country of the advantages and disadvantages of cash-based practices." Resolution 728 (A-07), introduced by the Arizona Delegation, asked that the AMA "study the issue of direct patient payment to physicians and encourage free market forces." The Board of Trustees referred these items to the Council on Medical Service for report back at the 2008 Annual Meeting.

In its consideration of these items, the reference committee at the 2007 Annual Meeting noted the likelihood of significant overlap in the requested studies, and recommended that the resolutions be referred together to allow for a comprehensive report back that would address a range of issues related to accepting cash payments. For the purposes of this report, the term "cash payment" will be used to refer to the amount of a medical bill that a patient – not a third-party payer – is obligated to pay directly to the practice.

In the current health care environment, virtually all medical practices receive a portion of their revenues directly from patients, regardless of the insurance status of the patient population. Increasing cost-sharing requirements for insured patients, as well as payments made by uninsured patients, have resulted in increased levels of direct patient payment in all physician practices. In addition, as suggested by Resolution 703 (A-07), increasing numbers of physicians are exploring the implications of eschewing insurance contracts and requiring patients to pay in full for their medical care. In light of these trends, the Council believes that a broad examination of issues associated with cash payments is warranted.

This report describes the trends related to the increasing presence of cash-based transactions in medical practice; defines the various practice models and circumstances under which physicians receive cash payments from patients; and identifies issues that need to be considered when dealing with cash payments in a practice environment. The report also highlights the work of the AMA's Private Sector Advocacy group in providing educational materials and tools to help physicians manage cash in their practices. The Council recommends a series of guiding principles to help physicians who may be considering operating a cash-based practice.

TRENDS IN CASH PAYMENTS TO PHYSICIANS

Despite the high numbers of uninsured in the United States, the majority of patients in a typical practice have health insurance, and third-party payments constitute the bulk of practice revenue. However, cash payments received from patients represent a growing source of revenue for physician practices. According to the most recent National Health Expenditure (NHE) data available from the Centers for Medicare and Medicaid Services, out-of-pocket spending accounted for 10% of health expenditures for physician and clinical services in 2006. NHE data defines out-of-pocket spending as "direct spending by consumers for all health care goods and services. Included in this estimate is the amount paid…for services not covered by insurance and the amount of coinsurance and deductibles required by private health insurance (including provider payments covered by Health Savings Accounts) and by public programs such as Medicare and Medicaid…." Premiums for private or public insurance are not included in the NHE out-of-pocket statistic, since those costs go to the third-party insurer, rather than directly for care.

Although some of this out-of-pocket spending reflects payments from uninsured patients, the vast majority of patients with health insurance coverage have cost-sharing obligations that contribute to this figure as well. According to the 2007 Employer Health Benefits Survey by the Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET), the majority of employment-based health plans require that patients meet an annual deductible before third-party coverage begins. The average annual deductible for PPO plans (the most common type of employer-sponsored plan) was $461 in 2007. Workers enrolled in high-deductible health plans combined with a health savings account had average annual deductibles of $1,729. Most insured patients are responsible for cash payments directly to their physician's office until they reach their annual deductible. Insured patients are also responsible for the full cost of uncovered services, which do not count toward meeting the deductible.

In addition to any plan deductible, approximately 95% of all covered workers are enrolled in plans that require copayments or coinsurance for physician office visits (KFF/HRET 2007). Once these patients meet their deductible, they are then responsible for a portion of their medical bill. In 2007, the average copayment for an in-network primary care visit was $19 for all plan types; the average coinsurance rate was 17%. Copayments or coinsurance are applied for each office visit, up to a maximum out-of-pocket spending limit, if applicable. Thus, at any given time, it is likely that most of a physician's insured patients are responsible for some level of cash payment.

CASH PAYMENTS IN DIFFERENT PRACTICE MODELS

Resolution 703 (A-07) states that some physicians are experimenting with operating so called "cash-based" practices in an attempt to eliminate the administrative hassles and practice restrictions imposed by insurance companies, including Medicare. Cash-based practices can be structured several ways, including charging patients a flat fee for a bundled set of services, or charging separate fees for each service provided. A cash-based practice is characterized by the physician's relationship with third-party payers, not whether or not the patient population has access to health insurance coverage. Physicians who operate cash-based practices do not have contracts with insurance companies, and do not accept third-party payment for their services. All patients are expected to pay the practice directly for any care received, and the practice does not perform any administrative functions related to insurance claims or payment. Patients with insurance may choose to seek reimbursement directly from their insurance company for out-of-network services,

which are documented on a standard, itemized receipt prepared by the practice for all patients. In the case of Medicare, a cash-based practice will typically have non-participating physicians (Medicare may reimburse the patient directly for unassigned claims), or may opt-out of Medicare entirely (no Medicare claims can be made for any services provided during a two-year period).

Resolution 728 (A-07) addresses practices that accept third-party payments, but may also see patients who pay directly out-of-pocket for services. Although some cash paying patients may be uninsured, as suggested in Resolution 728, insured patients – especially those with high-deductible health plans – commonly make cash payments for medical services as well. As described in the previous section, prior to reaching an annual deductible, the majority of insured patients pay out-of-pocket for the full cost of their medical care. Upon reaching the deductible, most insured patients continue to be directly responsible for a portion of their medical bill in the form of copayments or coinsurance. Traditional (i.e., non cash-based) practices may also see patients with out-of-network coverage. These patients may be expected to pay a portion or the full amount of their medical bills, and seek reimbursement directly from their insurance company, as they would in a cash-based practice arrangement.

While not directly relevant to this report, it should be noted that a "retainer" or "concierge" practice model is a hybrid cash-insurance model where patients pay some flat fee for a defined set of services or amenities (e.g., same day appointments or 24-hour direct physician access). Retainer models themselves can vary greatly in how they are structured, and what services are included as part of the fee. Retainer models generally operate in conjunction with insurance coverage, where the retainer fee covers services and benefits not included under an insurance plan. These hybrid models were the subject of Council on Medical Service Report 9-A-02.

Advantages and Disadvantages of Cash-Based Practices

In today's environment, third-party payers exert tremendous influence over all aspects of the physician-patient relationship. Often insurers, rather than patients and their physicians, set the rules for when and where patients seek care, and the preferred treatment options. These rules can sometimes be modified, but not without specific and often time-consuming efforts on the part of the patient and/or the physician. Physicians in cash-based practices liberate themselves from this third-party interference. Responsibility for decision-making is returned to the patient and physician. Physicians can spend more time helping individual patients make health care decisions based on the patient's individual needs and preferences, rather than having to work within the constraints set by insurance companies.

Operating a cash-based practice also allows physicians to avoid the administrative requirements associated with filing insurance claims, preauthorization requests, or appeals in the case of denied claims. Eliminating third-party payments is also likely to reduce the delay associated with waiting for claims payments, and will allow for more streamlined billing and payment tracking functions. Third-party administrative requirements cost practices time and money, often forcing physicians to work longer hours and see more patients in order to meet practice expenses. Some physicians who move to a cash-based environment find that eliminating the restrictions and responsibilities associated with processing third-party payments enables them to see fewer patients, and spend more time with each, and still meet the revenue goals for their practices.

Physicians should keep in mind that operating a cash-based practice generally involves a new set of administrative responsibilities that replace those formerly associated with dealing with third-party payers. Assuming direct responsibility for marketing, billing, and collection functions at the practice level often accentuates the "business" aspects of operating a medical practice, which may not appeal to some physicians. Although physicians may enjoy more autonomy by eschewing insurance participation, they will need to redirect their administrative focus to developing and maintaining a reliable and manageable patient base, and managing a cashflow that relies entirely on patients paying bills in a timely manner.

Designing an appropriate and transparent fee schedule is critical to operating a cash-based practice, so that patients are aware at the time of service exactly what their payment obligations are. Cash-based practices have more flexibility in setting a fee schedule than those that contract with one or more insurance carriers. AMA policy (e.g., H-385.990, AMA Policy Database) supports the right of physicians to set fair and equitable fee schedules, and strongly encourages physicians to base their fees on the practice's cost of providing goods and services and the value added by the physician's services. In the current environment, where a handful of health insurers may control payment rates in a given geographic location, it can be difficult for physicians who participate in managed care networks to develop an objective and comprehensive fee schedule that they feel reflects their true costs and value.

Physicians operating a cash-based practice should be prepared to provide extensive patient education regarding the rights and responsibilities associated with seeing a physician who does not accept insurance coverage. Because paying entirely out-of-pocket for physician visits is the exception rather than the rule, many patients with insurance may be confused about whether they are "eligible" to visit a cash-based practice, and how doing so might affect their insurance benefits. Some insured patients may be dissuaded from visiting a cash-based practice because of lack of information, rather than an unwillingness to pay directly for medical care. Especially when building a patient base, physicians in a cash-based practice will need to help patients understand their options regarding out-of-pocket payment responsibilities, and the decision to seek out-of-network reimbursement directly from an insurer.

The feasibility and success of operating a cash-based practice is heavily dependent on practice characteristics. Physicians need to consider whether their medical specialty and patient population are an appropriate "fit" for the model. Cash-based practices are typically most appropriate for primary care doctors, or doctors who want to limit their practice to more routine services. The income characteristics of the patient population also need to be carefully considered, especially when developing a fee schedule. The costs of complex treatments, specialist visits, or treatments for chronic or serious conditions can be substantial and it becomes virtually impossible for most people to afford this care without insurance coverage. Physicians who operate a cash-based practice should encourage patients without insurance to secure at least catastrophic coverage, in the event that they need additional treatments beyond the routine care provided at the cash-based practice.

<u>Cash Payments vs. Third-Party Payments</u>

Resolution 728 (A-07) raised the issue of whether cash payments should be treated differently than payments from third-party payers, specifically, whether billable amounts should be the same for different forms of payment. Media reports have suggested that uninsured patients typically face

higher fees for medical services than insured patients. The concern is that uninsured patients are being unfairly penalized for their lack of health insurance, an inequity made all the more troublesome because many uninsured may already have trouble paying medical bills.

Discounted fees for insured patients originate from managed care contracts that physicians have with insurers, and are available to patients insured by the contracting company. They represent a reduction of the physician's stated fee schedule, in exchange for several benefits an insurer offers participating physicians. The domination of health insurance markets by a relatively small number of insurance companies has unquestionably limited the leverage of physicians with respect to negotiating managed care contracts. However, among the benefits of being an in-network provider are the increased likelihood of a stable patient base, increased patient volume, and a relatively predictable revenue stream, in the form of payments from the insurance company. To the extent that insured patients pay up-front premiums for their insurance coverage, discounted fees associated with insurance coverage also reward enrollees for their participation.

Cash-paying patients without insurance coverage typically will not have access to the discounted fees insurers have negotiated with in-network physicians. However, cash-paying patients who do have insurance coverage – but are paying out-of-pocket because they have not yet met their deductible – typically will have access to the insurer's discounted fees. This also applies to patients paying from flexible spending accounts or health savings accounts paired with high deductible health plans. When considering charges for cash vs. third-party payments in these situations, the discrepancy in fees is not related to source of payment (i.e., individual or third-party), but rather to insurance status.

When patients pay directly for their medical services (as in the case of an uninsured patient, or a patient with a stand-alone catastrophic policy), practices avoid the paperwork and payment delays associated with filing a claim with an insurer. Some have suggested that bills paid in cash - instead of being processed through a third-party payer – result in lower administrative costs for the medical practice, and that patients should be offered a discounted rate if they pay directly for their services. Offering discounts to patients who make cash-payments for the primary purpose of bypassing administrative hassles associated with processing insurance claims could be problematic in practices that have contracts with either private or public insurers. A variety of legal, regulatory, and contractual factors are likely to restrict a practice's ability to create incentives for patients to pay in cash. Many managed care contracts include "most favored nation" clauses, which require physicians to offer their best "rate" to the contracting insurer. In addition, federal law prohibits doctors from billing Medicare and Medicaid "substantially in excess" of their usual charge, so offering special discounts to cash-paying patients could put physicians at risk of being barred from participation in Medicare and Medicaid.

It is also important to consider the true value of health insurance coverage as a protection against catastrophic events. Although the AMA favors limits on first-dollar coverage of routine medical care, the AMA believes everyone should have health insurance. Creating incentives for individuals to forgo insurance coverage, or to bypass the insurance system, would be in conflict with health system reform strategies and goals that seek affordable insurance coverage for everyone.

Out-of-Pocket Payments from Disadvantaged Patients

Creating incentives for patients to pay in cash is not the same as offering discounts or debt-forgiveness for reasons of economic hardship. It is not unusual for physicians to accept lower payments from financially disadvantaged patients on a case-by-case basis, and it is unlikely that doing so would be seen as a violation of any legal or contractual requirements. Several AMA policies encourage physicians to make accommodations for patients experiencing financial difficulties (e.g., H-380.990, H-380.994, H-385.990, H-385.989).

The trend toward increasing patient cost-sharing responsibilities among insured patients is creating a new set of difficulties for low-income patients and their physicians. Most third-party payer contracts require physicians to make a good-faith effort to collect deductible, coinsurance and copayment amounts from their patients, and many physicians are finding themselves in the awkward position of bill collector as well as caregiver. The Council is concerned about this unintended consequence of the increasing prevalence of "cash payments" in all physician practices, and is aware that it presents unique challenges. The suggestions outlined in the following section are intended to simplify the business aspects of the expanded role of cash in physician practices. They are not intended to address the ethical and professional issues associated with providing care to all individuals, regardless of ability to pay.

MANAGEMENT OF CASH PAYMENTS IN ALL PHYSICIAN PRACTICES

Given the large and increasing role of cash payments in physician practices, the Council believes it is important to highlight three key issues that should be considered with regard to cash management. These have been adapted from material developed by the AMA's Private Sector Advocacy group.

First, to the extent possible, patients should be made aware of their payment responsibilities before receiving services, and practices should collect payments – including copayments, coinsurance and deductible amounts - at the time of service. In a cash-based practice, presenting the patient with an easily understandable fee schedule that reflects a relatively straightforward set of medical services can help patients anticipate their costs. For practices that accept payment from third-party payers, practice staff should obtain current personal and health plan payer information when a patient schedules an appointment. This will allow time to verify a patient's eligibility, benefits, and cost-sharing requirements prior to the provision of care.

Second, the medical practice should have a clearly defined billing and collections policy, so that the office staff and patients understand when and how payment is expected. Practices should determine steps that will be taken in the event that patients have outstanding balances, and help patients understand their responsibilities and when it may be necessary to turn payment matters over to a collection agency. All patients – whether paying entirely out-of-pocket or fulfilling a cost-sharing requirement – should be aware that they are responsible for ensuring that the physician is paid in full for services received.

Third, practices must be aware of relevant contractual, legal and regulatory requirements that may affect the design of their fee schedule or implementation of their payment policies. State and federal debt collection laws may place limits on late fees or interest charges, or on the amount or type of contact collectors can have with patients. Physician practices may want to implement flexible payment plan options, or financial hardship policies, but private insurer contracts may impose limits on these types of policies. As noted, cash-based practices have more flexibility in developing their fee schedules and payment policies, but all physicians, regardless of practice structure, may want to seek legal advice prior to developing and communicating fee and collections procedures.

PRIVATE SECTOR ADVOCACY ACTIVITIES

The AMA's Private Sector Advocacy (PSA) group is committed to combating third-party interference with the physician-patient relationship and helping physicians navigate the rules established by health insurers. Within PSA, the Practice Management Center helps physicians manage the business side of their practices by developing and distributing educational resources and tools that help address private payer and practice management issues. A recent focus of the Center has been helping physicians and their practice staff understand how to maximize their revenue by helping patients understand their billing and payment responsibilities. The Center has produced an extensive library of "practice tips" on a variety of subjects, including "Collecting payment for services rendered," "Getting paid what you deserve for out-of-network treatment," and "Helping patients understand their payment responsibilities." These tips and links to more comprehensive educational resources are available online to AMA members at http://www.ama-assn.org/go/psa. As noted, the Council has drawn from these materials in developing this report, and appreciates the strong work of the Practice Management Center and the PSA group.

RELEVANT AMA POLICY

Resolution 728 (A-07) asked that the AMA "encourage free market forces." A pluralistic approach to health care delivery and financing is one of the cornerstones of the AMA's vision for health system reform, and several policies emphasize freedom of choice and encourage free market competition among all modes of health care delivery and financing (H-165.920, H-165.985, H-165.960).

Regarding physician fees and practice revenue options, several policies support the right of physicians to determine their own fees, and to choose the method of payment for their services (H-165.920, H-385.926, H-385.990, H-380.994, H-385.989). Policy H-380.989 also supports the right of patients to privately contract with a physician for health services and to pay directly for those services, regardless of insurance coverage. Physicians are also strongly encouraged to discuss their fees in advance with patients, and to make appropriate arrangements with patients in cases of financial need (H-380.994, H-385.990, H-385.989).

DISCUSSION

The expanded role of "cash" in virtually all physician practices offers challenges and opportunities for physicians. AMA policy supports the right of physicians to determine their choice of payment options, and the right of patients to contract privately with physicians and/or to choose a health care plan that meets their individual needs. Physicians who choose to operate cash-based practices

generally seek more autonomy and freedom from administrative hassles associated with filing claims with third-party payers. Patients who choose to visit cash-based practices are generally willing and able to pay up front for their medical costs. If applicable, insured patients may choose to seek reimbursement from their insurance carriers for out-of-network services.

The Council has identified a number of areas that physicians should be aware of when considering operating a cash-based practice. Physicians who eliminate health insurance contracts in favor of a cash-only practice assume increased responsibility for marketing, billing and collection processes, processes whose importance may have been diluted by the predictable - albeit frustrating - nature of participating in a health insurance network. Third party payments represent a relatively stable source of income for most practices, and that safety net disappears in a cash-based practice. Physicians operating a cash-based practice need to be especially vigilant about the "business" aspects of their practice, and ensure that policies and procedures are in place to help patients understand and fulfill their payment responsibilities.

The importance of good cash management practices is growing, as the vast majority of patients, including those with traditional health insurance coverage, are responsible for at least a portion of their medical bills, in the form of deductibles, copayment or coinsurance amounts. In traditional practices, the increase in patient cost-sharing obligations is translating into an increased volume of cash payments, which combine with third-party payments to comprise the physician's contracted rate.

Many patients who pay directly for medical services are simply meeting cost-sharing requirements associated with their insurance coverage. These patients generally have access to discounted fees negotiated by their insurance company, even though they are paying directly for the services. Patients who are uninsured, or otherwise pay for their care outside of the traditional managed care framework, generally do not have access to discounted fees that insurers negotiate with physicians for their covered patients. The defacto higher fees paid by uninsured, cash-paying patients reflect the absence of these discounted rates, rather than inflated rates.

The Council notes that there are numerous legal, regulatory and contractual factors that affect a physician's ability to offer discounts to patients who pay in cash. The Council is also reluctant to encourage physicians to create incentives for people to forgo or bypass health insurance coverage, since appropriately designed insurance coverage offers true value to patients and physicians. The Council emphasizes, however, that offering discounts in acknowledgement of financial hardship is different from offering discounts simply based on an individual's form of payment. Consistent with several longstanding AMA policies, the Council recognizes the need for physicians to be flexible in payment arrangements with patients who have financial limitations.

In response to Resolutions 703 (A-07) and 728 (A-07), the intent of the Council in this report has been to explore specific issues associated with cash payments to physicians. The information in this report is also intended to give physicians a broader perspective on how trends in the insurance industry are resulting in increasing cost-sharing responsibilities on the part of patients, and how these trends may affect physician business practices. The Council believes that the AMA has strong policy that supports and provides information on the issues raised in this report with regard to traditional practices, and is confident that the resources and tools being developed by the AMA Practice Management Center will help guide physicians in these new challenges.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendation be adopted in lieu of Resolutions 703 (A-07) and 728 (A-07), and that the remainder of the report be filed:

1. That the American Medical Association adopt the following as AMA policy:

   GUIDING PRINCIPLES FOR OPERATING A CASH-BASED PRACTICE

   (a) Prior to transitioning to or opening a cash-based practice, physicians should develop a business plan that includes the following:

      (i) An analysis of the target patient mix, and, if transitioning from a traditional practice, an analysis of how the target compares to the current patient population with respect to demographics such as age, income and health status.

      (ii) A description of the type(s) of care that will be offered by the practice.

      (iii) An evaluation of practice expenses to determine revenue requirements.

      (iv) A description of how the marketing, billing and collection needs of the practice will be met.

      (v) Consideration of the legal, regulatory and contractual implications of opening or transitioning to a cash-based practice.

   (b) Cash-based practices should develop and maintain an appropriate and transparent fee schedule that is understandable and easily accessible to patients.

   (c) Cash-based practices should have clearly defined payment policies that help patients understand their payment responsibilities. These policies should include guidance about how patients can coordinate health insurance benefits with cash-based physician services.

   (d) Cash-based practices should encourage patients to maintain health insurance coverage for more complex or catastrophic health care events. (New HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.