AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(JUN-21)

Introduced by: American College of Rheumatology, American Gastroenterological Association, American Academy of Ophthalmology, American College of Gastroenterology, American Academy of Dermatology, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology

Subject: Financial Incentives for Patients to Switch Treatments

Referred to: Reference Committee G

Whereas, All patients should have access to the medications they and their provider feel are most appropriate; and

Whereas, Biologic drugs are highly effective and have the potential to reduce long-term disability; however, they are not without certain risks. All classes of biologics used in autoimmune diseases may cause serious adverse events. The decision to choose one biologic over another requires careful clinical evaluation and consideration by a physician and patient. Factors such as an individual patient's age, gender, diagnosis, medications, specific organ manifestations, antibody status, disease severity, comorbid conditions, and ability to tolerate the route of administration strongly influence the specific biologic choice; and

Whereas, Due to these highly individual characteristics among patients, the journey to finding an effective treatment is often long and challenging. The complex medical decision making, and subsequent risks associated with these medications, fall on the physician and the patient, so these decisions should not be curtailed by a health plan's coverage policies; and

Whereas, In March of 2021, Cigna notified patients that they could be eligible for a $500 pre-paid medical debit card if they agree to stop taking Cosentyx (secukinumab) and switch to a payer-preferred alternative medication; and

Whereas, Incentivizing patients who are stable on an effective therapy to abandon treatment for non-medical reasons needlessly puts them at risk for significant long-term consequences including irreversible damage and disability. Patients who are switched to another treatment may experience serious disease flares, as even drugs with similar mechanisms of action have widely variable patient to patient effectiveness; and

Whereas, Using money to persuade patients to make a choice against their own health raises ethical concerns and is highly irresponsible, especially when so many have suffered financially due to the ongoing pandemic and may be swayed by financial incentive to make a decision contrary to their health interests; and

Whereas, This initiative jeopardizes patients' health, interferes with medical decision making, and undermines the doctor-patient relationship by possibly obliging physicians to counsel patients to forgo the $500 payment in order to safeguard their health; and

Whereas, This program will disproportionately affect patients of lower socio-economic status, who may have less ability to refuse such a payment despite their health interests; and

Whereas, Other large national insurers are contemplating adopting or expanding similar policies financially incentivizing patients to switch treatments, and these policies could quickly become common across multiple disease states if not checked; and

Whereas, It is of the highest urgency during this time of economic uncertainty and public health emergency that payers avoid policies that would take advantage of financial instability and jeopardize patient health; therefore be it

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Especially during the PHE, ensuring patients stay on their medication is urgent and of the highest priority. However, new tactics by insurance companies to financially incentivize patients who are stable on effective therapy to abandon that treatment for non-medical reasons needlessly put patients at risk.

This year, Cigna notified patients they could receive $500 debit cards if they agreed to stop taking a non-preferred medication and switch to the payer-preferred alternative. There are indications this policy is planned to be expanded and other large payers including UHC have signaled desires to adopt or expand this type of program. Additionally, at least one piece of state legislation proposed this year would explicitly make these policies legal. Without action in opposition these tactics are likely to proliferate, affecting many physicians and patients.

Payer policies should not interfere with complex medical decisions about treatments. Using monetary incentives to persuade patients to make choices against their own health is particularly irresponsible when so many have suffered financially due to the COVID-19 pandemic, especially patients of lower socio-economic status who may have less ability to refuse a payment despite health interests.

It is of the highest priority during this time of economic uncertainty and public health emergency that payers do not take advantage of financial instability and jeopardize patient health. It is urgent that we have policy in opposition and take action protecting patients' health, medical decision making, and the physician-patient relationship.

RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
a. Collaborate with the physician community in the development and implementation of patient incentives.
b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
e. Provide referring and/or primary care physicians with the full record of the service encounter.
f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
f. Provide meaningful transparency of prices and vendors.
g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
a. Patient outcomes/the quality of care provided with shopped services;
b. Patient utilization of shopped services;
c. Patient satisfaction with care for shopped services;
d. Patient choice of health care provider;
e. Impact on physician administrative burden; and
f. Overall/systemic impact on health care costs and care fragmentation.
CMS Rep. 2, I-19

E-9.6.3 Incentives to Patients for Referrals
Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.
Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.
AMA Principles of Medical Ethics: I,II,VIII