RESOLUTION 71-09A

Title: **Price Transparency in Health Care**

Introduced by: **Michael Oleyar for the Medical Student Section**

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Referred to: **Reference Committee A**

House Action: **Adopted as Amended**

Whereas, health care spending in the United States has grown to be the most expensive in the world among industrialized countries totaling $2.2 trillion in 2007, approaching 16.2 percent of Gross Domestic Product (GDP) and outpacing inflation [1], and

Whereas, 57 million Americans were part of families that had difficulty paying medical bills in 2007 with the majority of those possessing health insurance [2], and

Whereas, prices for investigations and treatments may not be readily accessible and may be desired by consumers, legislators, and payers [3], and

Whereas, patients are unlikely to know the total cost or percentage of physicians fees associated with interventions [4] or what drugs are included in their formularies and the co-payments associated with those drugs [5], and

Whereas, medical providers are unlikely to know the price charged for a particular investigation or therapy [6-10] and they are often unaware of the preferred medications on the formulary, the patients' co-payment amounts, or the price of the drugs prescribed [11], and

Whereas, different investigations (diagnostic services) and therapies with similar efficacy may vary in price, including pharmacological therapies, i.e., generic versus brand-name drugs [12], and

Whereas, providing reliable cost and quality information empowers consumer choice and consumer choice creates incentives at all levels and motivates the entire system to provide better care for less money [13]; therefore be it

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to explore and develop a system whereby the payment expected of patients can be known by the patient at the time of service and the patient can receive a general estimate of the overall cost of service provided, in the spirit of educating patients to the cost of their medical care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

References:

1. Hartman, M, et al., *National health spending in 2007: slower drug spending contributes to lowest rate of overall growth since 1998.* Health Aff (Millwood). 2009 Jan-Feb;28(1):246-61.

2. Cunningham, P.J., *Trade-offs getting tougher: problems paying medical bills increase for U.S. families, 2003-2007.* Track Rep, 2008(21): p. 1-5.

3. Greene, J., *Shining a light on hospital charges.* Trustee, 2006. 59(8): p. 8-11,

4. Smolders, J.M., et al., *Patients poorly estimate the overall costs of a total knee arthroplasty and strongly overestimate the surgeon's fee.* Acta Orthop Belg, 2007. 73(3): p. 339-44.

5. Benedetti, N.J., et al., *Office visit copayments: patient knowledge, response, and communication with providers.* Med Care, 2008. 46(4): p. 403-9.

6. Allan, G.M. and G. Innes, *Family practice residents' awareness of medical care costs in British Columbia.* Fam Med, 2002. 34(2): p. 104-9.

7. Allan, G.M. and G.D. Innes, *Do family physicians know the costs of medical care? Survey in British Columbia.* Can Fam Physician, 2004. 50: p. 263-70.

8. Allan, G.M. and J. Lexchin, *Physician awareness of diagnostic and nondrug therapeutic costs: a systematic review.* Int J Technol Assess Health Care, 2008. 24(2): p. 158-65.

9. Allan, G.M., J. Lexchin, and N. Wiebe, *Physician awareness of drug cost: a systematic review.* PLoS Med, 2007. 4(9): p. e283.

10. Shrank, W.H., et al., *Do the incentives in 3-tier pharmaceutical benefit plans operate as intended? Results from a physician leadership survey.* Am J Manag Care, 2005. 11(1): p. 16-22.

11. Khan, S., et al., *Physicians' opinions about responsibility for patient out-ofpocket costs and formulary prescribing in two Midwestern states.* J Manag Care Pharm, 2008. 14(8): p. 780-9.

12. Kesselheim, A.S., et al., *Clinical equivalence of generic and brand-name drugs used in cardiovascular disease: a systematic review and meta-analysis.* JAMA, 2008. 300(21): p. 2514-26.

13. Home, V.D.H.C. [cited; Available from: http://www.hhs.gov/valuedriven/.

Relevant AMA and MSS Policy:

H-155.963 Health System Expenditures

1. Our AMA supports the development and adoption of a consistent format for estimating and publicly reporting health care administrative costs, in order to facilitate unbiased comparisons across insurers, and from different sources. The format would: (a) Report all government expenditures for the administration of Medicare, Medicaid, and other public programs, including those incurred but not currently reported by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies (e.g., staff salaries, building costs, promotion of benefits to beneficiaries); (b) Report all government expenditures for administration of Medicare, Medicaid, and other public programs that are incurred by all government entities, including agencies other than the CMS and state Medicaid agencies, (e.g., Inspector General audits, Social Security Administration revenue collection); (c) Identify and report those overhead expenditures that can be defined as either administrative or non-administrative (e.g., profits and retained earnings); (d) Identify and report those overhead expenditures that arise from legislative or regulatory requirements (e.g., compliance expenses, premium taxes); (e) Express administrative expenditures in the following metrics: dollars per-member-per-month, dollars per claim, percentage of total expenditures, and percentage of total claims payments. (f) Serve as a model and template for private health plan reporting of administrative costs at the state level and to national databases. 2. Our AMA supports efforts to educate the medical profession and the public about health care costs, including administrative costs and the costs of defensive medicine. (CMS Rep. 1, A-06; Reaffirmation A-07; Res. 727, A-08;Reaffirmation I-08)

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA: (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for performance incentives; and medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to

impact compliance; and (8) supports ongoing investigation and cost effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08)

H-155.980 Patient and Public Education about Cost of Care The AMA, as a part of its program to strengthen the US health care system, supports (1) intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns; and (2) conducting a public education program that clearly identifies the elements of medical care expenditures and those factors that lead to unwarranted, unavoidable or unproductive expenses not subject to physician control (e.g., an aging population, high health insurance administrative costs, inappropriate applications of technology and unneeded hospital beds). (Res. 153, I-89; Sub. Res. 42, I-89; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05)

H-165.846 Adequacy of Health Insurance Coverage Options

Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: 1. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. 2. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. 3. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. 4. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. (CMS Rep. 7, A-07; Reaffirmation I-07)

D-180.985 Health Plan and Insurer Transparency Our AMA will: (1) continue to closely monitor any new "transparency" programs unveiled by health plans to determine the impact on physicians; (2) communicate to health plans, employers and patients our concerns about current "transparency" programs, and educate them about "true transparency"; and (3) continue to educate physicians about the complexities of claims adjudication and payment processes to enable them to more efficiently manage their practices. (BOT Rep. 19, A-06; Reaffirmation A-07) H-110.996 Cost of Prescription Drugs The AMA (1) supports entering into dialogue with pharmaceutical company representatives and other appropriate agencies to explore ways to reduce the costs of brand name drugs through such mechanisms as a more cost-effective research and development process, more modest promotional activities, product liability reform and streamlining the FDA requirements for new drug approval, and (2) supports increasing physician awareness about the cost of drugs prescribed for their patients. (Res. 173, A-91; Reaffirmed: Res. 520, A-99)

H-285.926 Clinical and Professional Impacts of Cost Containment Efforts

Our AMA encourages the Agency for Healthcare Research and Quality to study the effects of cost containment activities on clinical outcomes and patient safety. (Res. 714, I-99) D-450.986 Evidence-Based Medicine

Our AMA: (1) working with state medical associations, specialty societies, and other medical organizations, will educate the Centers for Medicare and Medicaid Services, state legislatures, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, will work with other medical organizations to develop model state legislation to protect the physician-patient relationship from cost-based medicine policies inappropriately characterized as "evidence-based medicine" and to disseminate the measure to state medical associations through the Advocacy Resource Center. (Res. 704, A-05)