

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-14

Subject: Health Insurer Code of Conduct Principles  
(Resolution 122-A-13)

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee G  
(Craig A. Backs, MD, Chair)

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1 At the 2013 Annual Meeting, the House of Delegates referred Resolution 122, “Health Insurer  
2 Code of Conduct Principles,” which was sponsored by the Organized Medical Staff Section and  
3 asks that our American Medical Association (AMA) update the principles of the AMA Health  
4 Insurer Code of Conduct, and report back to the House.

5  
6 Reference committee testimony highlighted the fact that the Code was developed before the  
7 Affordable Care Act (ACA) was passed and likely contains sections that are no longer relevant.  
8 Both the sponsor of Resolution 122-A-13 and a member of the Board of Trustees suggested that the  
9 resolution be referred for consideration of appropriate updates to the Code.

10  
11 **BACKGROUND**

12  
13 The AMA Health Insurer Code of Conduct (Appendix A) consists of 10 principles developed to  
14 encourage health insurers to commit to full transparency and accountability in all of their clinical  
15 and administrative processes. The Code covers each of the following areas:

- 16  
17 1. Health insurance cancellation and rescission  
18 2. Premiums and spending on medical services  
19 3. Access to medical care  
20 4. Respectful relations  
21 5. Medical necessity  
22 6. Benefit management  
23 7. Administrative simplification  
24 8. Physician profiling  
25 9. Corporate integrity  
26 10. Claims processing

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28 The principles were developed based on input from a Federation staff advisory work group and are  
29 grounded in policies that were part of the AMA Policy Database at the time the Code was prepared.  
30 The Code was endorsed by 68 state medical associations and national specialty medical societies.

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32 To facilitate efforts to monitor insurer compliance with the Code, our AMA developed a  
33 comprehensive companion resource, “AMA Health Insurer Code of Conduct Principles:  
34 Explanations and Strategies for Enforcement.” This resource provides information to help  
35 physicians understand AMA policy and advocacy related to each of the principles, and to help

1 physicians keep health insurers accountable. The 138-page document is available at [ama-](http://ama-assn.org/resources/doc/psa/code-of-conduct.pdf)  
2 [assn.org/resources/doc/psa/code-of-conduct.pdf](http://ama-assn.org/resources/doc/psa/code-of-conduct.pdf).

3  
4 The Code was intended to be a tool that third party payers would voluntarily use to guide their  
5 business practices. When the Code was released in May 2010, the AMA sent letters to the eight  
6 largest health insurers, the Blue Cross Blue Shield Association, and America’s Health Insurance  
7 Plans urging them to pledge to conduct their business in adherence with the principles in the Code.  
8 In addition, our AMA routinely encouraged insurers and other third party payers to adopt the Code  
9 in discussions about improving relations with physicians. Although the Code was a useful  
10 reference for speaking with insurers about important issues to help promote consistency, fairness  
11 and transparency, none of the major insurance companies formally adopted the Code.  
12

### 13 THE CODE AND THE AFFORDABLE CARE ACT

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15 The Code was under development prior to passage of the ACA, and there was overlap between the  
16 insurance provisions in the ACA and the principles in the Code. Accordingly, our AMA developed  
17 a resource that identified major provisions in the ACA and their relevance to principles of the  
18 Code. The 51-page document, which is available at [ama-assn.org/resources/doc/psa/ppaca-coc-](http://ama-assn.org/resources/doc/psa/ppaca-coc-relevance.pdf)  
19 [relevance.pdf](http://ama-assn.org/resources/doc/psa/ppaca-coc-relevance.pdf), cross-references individual components of the Code with the applicable sections of  
20 the ACA. Provisions in the ACA directly address nine of the 10 principles of the Code (the  
21 exception is physician profiling, which is discussed below).  
22

23 The AMA encouraged the Department of Health and Human Services (HHS) to require compliance  
24 with the Code for all qualified health plans operating in the state and federal exchanges. Although  
25 the final rules issued by HHS did not include this requirement, our AMA continues to encourage  
26 states and the federal government to promote compliance with the Code in order to facilitate an  
27 efficient, patient-centered health care system.  
28

### 29 AMA POLICY

30  
31 The AMA policy database includes over 200 polices and directives related to health insurance or  
32 managed care. The individual provisions of the Code are firmly grounded in these policies, and the  
33 House continues to debate and adopt new policies that address health insurer practices with respect  
34 to coverage and benefits, physician contracting, quality reporting, and administrative  
35 simplification. Many of these policies are identified in the aforementioned “AMA Health Insurer  
36 Code of Conduct Principles: Explanations and Strategies for Enforcement.” Our AMA continually  
37 uses these policies to shape and implement its advocacy efforts in ways that can be most effective  
38 in influencing key stakeholders, including health insurers.  
39

40 As noted, the ACA did not address AMA concerns with respect to physician profiling. Policy  
41 H-406.991, Work of the Task Force on the Release of Physician Data (Appendix B), is a  
42 comprehensive statement of our AMA’s commitment to ensuring that physician data are used to  
43 benefit both patients and physicians, and to improve the quality of patient care and the efficient use  
44 of resources in the delivery of health care services. Policy H-406.991 cross-references numerous  
45 other policies that support principles for the public release and accurate use of physician data,  
46 many of which are also reflected in the Code principle related to physician profiling.  
47

### 48 DISCUSSION

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50 The ACA has fundamentally changed the health care landscape, especially with respect to the role  
51 of private health insurers. As noted in Resolution 122-A-13, key elements of the Code—such as

1 those addressing health insurance cancellation and rescission; premium rate setting and spending  
2 on medical services; and transparency of covered benefits and provider networks—were addressed  
3 by the ACA. Nevertheless, it is important that our AMA continue to monitor these important issues  
4 to ensure that the standards and requirements established by the ACA are being upheld by the  
5 health insurance industry.

6  
7 ACA implementation has brought several additional issues to the forefront of our AMA’s advocacy  
8 efforts related to health insurers and health insurance contracting. Rather than updating or  
9 redesigning the AMA Health Insurer Code of Conduct at this time, the Council believes the AMA  
10 should continue its efforts to address emerging issues in more strategic ways. Consistent with the  
11 AMA’s new imperative to pursue a more focused agenda and undertake projects with the potential  
12 to achieve high impact results, the AMA is prioritizing the development of tools and materials that  
13 will help practices address the ongoing and emerging issues associated with expanding health  
14 insurance coverage for millions of Americans under the ACA. AMA work in this area includes:

- 15  
16 • The “Medical Practice Checklist for 2014 ACA Exchange Implementation,” developed in  
17 collaboration with the Medical Group Management Association ([ama-](http://ama-assn.org/resources/doc/washington/aca_checklist.pdf)  
18 [assn.org/resources/doc/washington/aca\\_checklist.pdf](http://ama-assn.org/resources/doc/washington/aca_checklist.pdf)).
- 19 • An ACA state implementation toolkit, which includes model state legislation related to  
20 tiered and narrow networks, the 90-day grace period for premium payments, and fair  
21 contracting practices ([ama-assn.org/go/stateaca](http://ama-assn.org/go/stateaca)).
- 22 • A campaign to assist state medical associations in advocating for transparency and fair  
23 contracting with insurers operating exchange plans. The Advocacy Resource Center  
24 continues to seek input from states to assemble a library of contract examples, which, if  
25 sufficient examples are received, will be used to identify and provide guidance for  
26 combating potentially unfair practices ([ama-assn.org/resources/doc/arc/hix-transparency-](http://ama-assn.org/resources/doc/arc/hix-transparency-summary.pdf)  
27 [summary.pdf](http://ama-assn.org/resources/doc/arc/hix-transparency-summary.pdf)).
- 28 • A toolkit to help practices navigate the 90-day premium payment grace period. Resources  
29 include a best practices checklist that helps physicians effectively communicate with  
30 insurers and patients regarding patient status, and materials to help physicians establish  
31 processes and policies in their offices related to the grace period ([ama-](http://ama-assn.org/go/graceperiod)  
32 [assn.org/go/graceperiod](http://ama-assn.org/go/graceperiod)).
- 33 • A dedicated mailbox ([exchangeplans@ama-assn.org](mailto:exchangeplans@ama-assn.org)) that allows physicians to report  
34 exchange issues to help our AMA identify trends and target advocacy efforts.

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36 The Council notes that advocacy efforts to address physician profiling concerns are also ongoing,  
37 particularly in the context of advocacy related to criteria for network inclusion or tiering placement.  
38 As noted, Policy H-406.991 provides detailed guidance to support AMA advocacy efforts in this  
39 area.

#### 40 41 RECOMMENDATION

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43 The Council recommends that the following be adopted in lieu of Resolution 122-A-13, and that  
44 the remainder of the report be filed:

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46 That our American Medical Association continue to develop resources to help physician  
47 practices address the ongoing and emerging issues associated with expanding health insurance  
48 coverage under the Affordable Care Act. (Directive to Take Action)

Fiscal Note: Less than \$500

## Appendix A

# American Medical Association's Health Insurer Code of Conduct Principles

## Standards for health insurers' administrative and clinical processes

The Code of Conduct is not intended to, and does not convey legal advice. Users of the Code of Conduct should always consult their own legal counsel when considering a legal arrangement.

### 1. Health Insurance Cancellation and Rescission

- Health insurer decisions to cancel a person's coverage must be subject to independent, outside review.
- Rescission of coverage should not be permitted for innocent mistakes on applications, nor after significant delay.
- Health insurers must not cancel policies of patients who become injured or severely ill after the policy is issued.
- Paying employees or contractors bonuses or rewards for rescinding the policies of sick consumers, our patients, must be prohibited.

### 2. Health Insurance Premiums and Spending on Medical Services

- Health insurers must calculate health insurance premiums fairly, and different products must be priced proportionate to their actuarial value.
- Health insurers must spend the substantial bulk of the premium dollar on direct medical care.
- Health insurer expenditures on profit and on administrative, non-medical costs (salaries and bonuses, advertising, utilization review, etc.) must be transparent to the public, based on a single standard definition and reporting mechanism.
- Clear information on covered benefits, including co-payments, co-insurance and other information affecting patient financial responsibility must be readily available to patients and their physicians.
- Consumers must receive written justification for premium quotes or renewal increases, and be provided with a fair opportunity and forum to seek redress.

### 3. Access to Medical Care

- Health insurance benefits, including all medically necessary and emergency care, must be available to all enrollees on a timely and geographically accessible basis at the preferred, in-network rate.
- Provider directories must be easily accessible in paper and electronic formats and clearly and accurately provide consumers with all information relevant to fulfilling the medical needs of themselves and their families. This includes which physicians (including hospital-based physicians), hospitals, and other health care providers are in-network and accepting new patients.
- Directories which include listings for providers who are not freely accessible, such as providers who are in a restricted "tier" or "out of network," must clearly and conspicuously disclose the specific terms of any financial or other access limitations which may apply, such as increased co-payment, co-insurance or other patient financial responsibility.

### 4. Respectful Relations

- Health insurers must treat all enrollees, physicians and other trading partners respectfully.
- Health insurers must protect the confidentiality of each enrollee's medical information, and must give appropriate deference to the treating physician's skill and professional judgment.
- Patients must be confident that the physicians and other health care professionals in the network may talk freely, without fear of retaliation.

- Health insurers must cease such unfair practices with physicians as demanding

#### **4. Respectful Relations (cont'd)**

- unreasonable contract terms, improperly applying contractual discounts, unilaterally amending contracts or refusing to acknowledge contract terminations.

#### **5. Medical Necessity**

- Medical care is “necessary” when a prudent physician would provide it to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- All emergency screening and treatment services (as defined by the prudent layperson standard) provided by physicians and hospitals to patients must be covered without regard to prior authorization or the treating physician’s or other health care provider’s contractual relationship with the payer.
- Health insurers must not use financial incentives that discourage the rendering, recommending, prescribing of, or referral for medically necessary care.
- No care may be denied on the grounds it is not “medically necessary” except by a physician qualified by education, training and expertise to evaluate the specific clinical issues.
- Patients and their physicians must have the right to a transparent appeal process and obtain a free, timely, external review of any adverse benefit decision based on “medical necessity” or a claim the service is “investigational” or “experimental.”

#### **6. Benefit Management**

- Clear information on benefit restrictions must be readily available to patients and physicians.

- Decisions based on formularies or other benefit management tools must be consistent with clinically appropriate medical guidelines, and physicians must have a simple, fast way to get exceptions when warranted by their patients’ medical needs.

- Adverse changes to formularies or other benefits must not be made during the plan coverage year, and physicians who have stabilized a patient on a particular medication or other treatment regime must not be forced to change those medications or other treatments, nor should these patients be required to incur additional costs based upon such changes.
- Financial incentives must not corrupt benefit decisions, and all financial incentives potentially impacting benefit decisions must be fully disclosed.

#### **7. Administrative Simplification**

- Health insurers must eliminate complexity and confusion from their processes and communications.
- Health insurers must comply with all laws governing the use of electronic transactions, and should participate in efforts to improve these transactions.
- Health insurers must provide clear, timely, and accurate eligibility and benefit information on request.
- Requirements imposed on patients, physicians and other health care providers to obtain approvals and respond to information requests must be minimized and streamlined, and health insurers must maintain sufficient staff and infrastructure to respond promptly.

#### **8. Physician Profiling**

- Physician profiling systems must be focused primarily on improving the provision of quality care—not on reducing the cost of care.
- Profiling systems must use good and relevant data and produce accurate, statistically valid results reflecting matters within the physician’s control.
- Profiling systems must be appropriately risk-adjusted to account for patient

variation for co-morbidities, severity of illness, racial/ethnic factors, compliance and other mitigating factors.

- Physicians must be given a meaningful opportunity to review their data, challenge the insurers' profiles and be afforded due process to remedy incorrect profiles prior to their publication or use in determining incentives or network placement.

#### **9. Corporate Integrity**

- Health insurers must conduct their business in compliance with the highest levels of corporate citizenship, consistent with their fiduciary obligations to their enrollees.
- Health insurers must comply with the letter and spirit of all laws that protect the clinical and business integrity of their dealings with their enrollees and their dealings with physicians and other health care providers.
- Policies prohibiting conflicts of interest, retaliation against whistleblowers and sharp business practices must be established and aggressively enforced.

- The corporate compliance officer must be adequately funded and staffed, and be given direct and open access to the health insurer's Board of Directors.

#### **10. Claims Processing**

- Health insurers must pay claims accurately and timely, and provide clear and comprehensive explanations of how each claim was handled, including the specific reason for any denial of, or reduction in payment.
- All fee schedules, claim edits and payment policies which may affect payment for a service or a patient's financial responsibility must be disclosed in a reasonably understandable, downloadable format.
- Requests for refunds after payment must occur rarely, and then only within a reasonable time after making the initial payment.
- Patients and their physicians must have a fair, fast and cost-effective right to appeal any contested claim.

**Pledge your organization's commitment to abide by or support the American Medical Association's Health Insurer Code of Conduct. Visit [www.ama-ssn.org/go/codeofconduct](http://www.ama-ssn.org/go/codeofconduct) to pledge and access supplemental resources**

## Appendix B

### H-406.991 Work of the Task Force on the Release of Physician Data

#### Principles for the Public Release and Accurate Use of Physician Data

*The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:*

##### 1. Patient Privacy Safeguards

- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).

##### 2. Data Accuracy and Security Safeguards

- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

##### 3. Transparency Requirements

- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).

#### 4. Review and Appeal Requirements

- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).

#### 5. Physician Profiling Requirements

- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (450.951).
- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists).
- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services (no current policy exists).
- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes (no current policy exists).

#### 6. Quality Measurement Requirements

- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data (no current policy exists).

#### 7. Patient Satisfaction Measurement Requirements

- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
- Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms (no current policy exists).



- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication (no current policy exists).
- (BOT Rep. 18, A-09; Reaffirmation A-10; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmation A-11; Reaffirmed: BOT Rep. 17, A-13; Reaffirmed: Res. 806, I-13)