AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-23)

Introduced by: Medical Student Section

Subject: Reconsideration of the Birthday Rule

Referred to: Reference Committee G

Whereas, Self-insured coverage is either a self-administered process or a third party administrator where the employer collects premiums from enrollees and assumes responsibility of paying employees' and dependents' medical claims[1]; and

Whereas, The Health Insurance Portability And Accountability Act of 1996 (HIPAA), established protections for "self-insured" and "insured" coverage, whereby newborns, adopted children, and new parents not enrolled under a health plan could enroll under a period of "special enrollment" upon the birth, adoption, or placement for adoption of a new child[2]; and

Whereas, Under HIPAA, as long as enrollment occurs within 30 days of birth, health insurance coverage is effective as of the date of birth and cannot be subject to pre-existing condition exclusion[2]; and

Whereas, If a health plan's benefits are provided through an insurance company or Health Maintenance Organization (HMO), state laws may amend HIPAA requirements to allow for additional considerations; such as extending the enrollment period[2]; and

Whereas, The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting organization governed by the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories to coordinate regulation of multistate insurers[3]; and

Whereas, Coordination of Benefits (COB) as defined by the NAIC is the provision to eliminate over-insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan[1]; and

Whereas, State law permits insurers to follow a COB to determine insurers' responsibilities under an insurance claim in the event the "insured" is covered by more than one health plan, in the identification of a "primary" and "secondary" benefit payer[4]; and

Whereas, Newborns of parents with separate insurance policies are subjected to a COB at birth[2,4]; and

Whereas, The birthday rule is a COB model regulation set by the NAIC in which a newborn takes as primary coverage the plan of the parent whose birthday comes first in the calendar year[2,4]; and

Whereas, The recently publicized case of the Kjelshus family resulted in a $200,000 bill for a NICU stay because the parents were unaware of their coordination of benefits, specifically the birthday rule, that resulted in the father's inferior policy determining their child's insurance

coverage solely due to the fact of having a birthday only 2 weeks earlier than his spouse in the calendar year[5]; and

Whereas, The birthday rule has led to confusion and frustration of parents when a child is automatically enrolled under the parent with the earlier birthday in the calendar year without considering the quality of insurance coverage between both parents, showing that simple awareness is not enough to address the problem[5]; and

Whereas, H.R.4636l, known as the Empowering Parents' Healthcare Choices Act of 2021, currently in the House Subcommittee on Health, would give parents with dual policies 60 days before the birthday rule would take effect from the date of an infant's birth to choose which plan is primary and to notify the insurer of their choice effectively reclaiming parental choice[6]; therefore be it

RESOLVED, That our American Medical Association support evidence-based legislation that support a parent, or guardian's, choice of their dependent's health insurance plan under the event of multiple insurers (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition to read as follows:

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;

(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the

promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 3/27/23

REFERENCES

1. National Association of Insurance Commissioners'. Consumer Glossary. Accessed August 31, 2022. https://content.naic.org/consumer_glossary#C
2. U.S. Department of Labor, U.S. Department of Labor Employee Benefits Security Administration. Fact Sheet: Health Insurance Portability and Accountability Act (HIPAA). www.dol.gov. Accessed August 31, 2022. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/hipaa.pdf
3. National Association of Insurance Commissioners'. About. Accessed August 31, 2022. https://content.naic.org/about
4. National Association of Insurance Commissioners'. NAIC Model Laws, Regulations, Guidelines and Other Resource. content.naic.org. Published 2013. Accessed August 31, 2022. https://content.naic.org/sites/default/files/inline-files/MDL-120.pdf
5. Anthony C. Proposed Law Would End Health Insurance "Birthday Rule" That Snags New Parents. NPR. https://www.npr.org/sections/health-shots/2021/07/27/1016485053/proposed-law-would-end-health-insurance-birthday-rule-that-snags-new-parents. Published July 27, 2021. Accessed August 31, 2022.
6. Davids S. Text - H.R.4636 - 117th Congress (2021-2022): Empowering Parents' Healthcare Choices Act of 2021. Published July 23, 2021. Accessed August 31, 2022. http://www.congress.gov/

RELEVANT AMA POLICY

Delay in Payments Due to Disputes in Coordination of Benefits H-190.969

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;

(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness,

and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.
Citation: (CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)

Health Insurance for Children H-185.948
Our AMA supports requiring all children to have adequate health insurance as a strategic priority.
Citation: Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18;

Multiple Coverage in Voluntary Health Insurance H-185.999
(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.
Citation: CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. 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.
B. 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.
C. 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.
D. 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.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
Citation: CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19;

Increasing Coverage for Children H-165.877
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support

federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.
Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Mitigating the Negative Effects of High-Deductible Health Plans H-185.918
Our AMA: (1) encourages ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients; (2) encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year; and (3) encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.
Citation: CMS Rep. 2, I-20;