AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 12
(A-25)

Introduced by: Alex Shteynshlyuger, MD

Subject: State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA

Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

Whereas, AMA policy D-385.944, "ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers"[1] seeks to support states in implementation of state-based regulation of ERISA plans to the extent allowed by the U.S. Supreme Court decision in *Rutledge v. PCMA*; and

Whereas, the Texas Attorney General opined that non-preempted "non-central matters" of health plans and PBMs could be regulated at the state level under the U.S. Supreme Court precedent *Rutledge v. PCMA*[2,3]; and

Whereas, the Employee Retirement Income Security Act (ERISA) does not address interest payments on overdue "clean" health insurance claims and thus it is not pre-empted on that basis, interest payments do not relate to a "particular scheme of substantive coverage," and many states such as New York have laws in place that require health plans to pay interest[4]; and

Whereas, ERISA does not address prior authorizations and thus prior authorizations are not pre-empted on that basis; likewise timeliness of response to prior authorization requirements does not relate to a "particular scheme of coverage;" similarly duty to obtain data that is available to health plans from sources other than physicians that health plans may need for prior authorization (test results, list of current medications) do not relate to a "particular scheme of substantive coverage" and such legislation may decrease the administrative costs and burdens of prior authorization on physicians; and

Whereas, ERISA does not address payments for services based on the coordination of benefits when an ERISA plan is secondary to Medicare, thus regulation of payments as a plan secondary to Medicare is not pre-empted on that basis; payment for services that the plan already covers under in-network benefits does not relate to a "particular scheme of substantive coverage" so requiring a health plan to pay at the in-network level of benefits for covered services when it is secondary to Medicare and the provider is a Medicare-participating provider does not relate to a "particular scheme of substantive coverage;" thus paying for services does not relate to a "particular scheme of substantive coverage;" and secondary Medicare payments are not regulated under Medicare; and

Whereas, AMA policy D-320.978, "Fair Reimbursement for Administrative Burdens"[5] states that physicians should be fairly compensated for administrative work related to prior authorization, appeals of prior authorization denials, and appealing wrongful pre- and post-service denials for administrative work reflecting the actual time expended by physician practices and their billing vendors advocating on behalf of patients, complying with insurer requirements, and successfully appealing wrongful service denials; despite AMA policy, ERISA does not address prior

authorization or compensation for the administrative work associated with prior authorizations and as such the regulation of prior authorizations is not pre-empted on that basis; likewise compensation for various administrative burdens associated with prior authorizations does not relate to a "particular scheme of substantive coverage;" and

Whereas, ERISA does not address parity for telehealth-assisted services, which may also be delivered using virtual reality in the future, nor does it refer to the site of service or technology used for care delivery, thus regulation of telehealth is not pre-empted on that basis; likewise, compensation for treatment of conditions that are already covered does not relate to a "particular scheme of substantive coverage" and the same medical services for the same conditions are delivered when appropriate via telehealth and in-person; and

Whereas, ERISA requires a plan administrator to make a claims decision "within a reasonable period of time, but not later than 30 days after receipt of the claim," but there is no regulation of the timeliness of the payment for the claim, thus timely payments are not pre-empted by ERISA[6]; further, states like New York require[7] health plans to pay claims within 30 days "when the insurer's obligation to pay the claim is reasonably clear" and applying similar requirements to ERISA plans would significantly improve the sustainability and financial viability of physician practices; and

Whereas, evaluation & management code modifier 25, a part of the CPT code, is an adopted federal standard that allows for no exemptions to compliance and currently ERISA does not address proper processing and payment for claims that include the 25 modifier, thus regulation of the 25 modifier is not pre-empted on that basis; regulation of proper processing and payment for claims for covered services that include the 25 modifier code does not relate to a "particular scheme of substantive coverage;" additionally, modifier 25 arbitrary and capricious denials are pervasive and have been a major concern of physicians and opposition to them is reflected in AMA policy[8]; and

Whereas, ERISA does not address payment recovery or recoupment by health plans, thus it is not pre-empted on that basis nor does it relate to a "particular scheme of substantive coverage;" IRS regulations are separate from ERISA and allow recoupment from any third party (participant, another plan, etc.) or the plan must pay in for its own mistakes; additionally increased costs of collection are not prohibited under ERISA or U.S. Supreme Court precedent; and

Whereas, health plan recoupment or payment recovery is on the rise, often via arbitrary demands with little explanation or justification, which a reasonable due process would require that a detailed and comprehensible explanation for the payment recoupment/recovery is provided with details to perform a forensic accounting of the recoupment action, including a detailed explanation with reference to pan benefit design, applicable law, source of error, and the reason for recovery that provides sufficient information should physician practices independently evaluate the factual legitimacy of the recoupment action and challenge baseless recoupments which would allow for a fairer process; application and enforcement of such rules against ERISA plans would help address arbitrary and capricious recoupment actions that are rampant; therefore be it

RESOLVED, that our American Medical Association will study whether and how the following issues not currently addressed under the Employment Retirement Income Security Act (ERISA) and that do not relate to a "particular scheme of substantive coverage" may be reasonably regulated by states for self-insured ERISA plans pursuant to the U.S. Supreme Court holding in *Rutledge v. PCMA* with a report back at the Interim 2025 meeting on the feasibility and barriers

of implementing state-based regulation for these priority issues and an action plan, including sample legislative language, to support state based implementation of these priorities:

1. Interest payments on overdue "clean" health insurance claims not otherwise addressed by ERISA's statutory mandate;

2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources;

3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan;

4. Payment for the administrative burden of prior authorization and successful denial appeals;

5. Parity for telehealth-delivered services;

6. Timely payment of "clean claims" when the insurer's obligation to pay the claim is reasonably distinct from timely determination of claims;

7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies;

8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor;

(Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 3/2/2025

REFERENCES

1. ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (D-385.944), American Medical Association.
2. Bell, A. (2025). Texas can regulate self-insured plans' PBMs, its attorney general rules. *ALM Benefits Pro.* February 11, 2025. https://www.benefitspro.com/2025/02/11/texas-can-regulate-self-insured-plans-pbms-its-attorney-general-rules-/?slreturn=20250313134527
3. Attorney General of Texas. (2025, February 5). Opinion No. KP-0480. https://www.texasattorneygeneral.gov/sites/default/files/opinion-files/opinion/2025/kp-0480.pdf

4. Office of the General Counsel of the Department of Financial Services of New York State. (2001). Opinion re: health claims interest rate. https://www.dfs.ny.gov/insurance/ogco2001/rg110231.htm
5. Fair Reimbursement for Administrative Burdens (D-320.978). American Medical Association
6. Employee Benefits Security Administration. Benefits claims procedure regulation FAQs. US Department of Labor. Accessed March 13, 2025: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation
7. Department of Financial Services. (2021, March 15). Governor Cuomo announces new guidance for the Department of Financial Services for the fair and prompt payment of health insurance claims. State of New York. Accessed March 13, 2025: https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202103151
8. Opposition to Reduced Payment for the 25 Modifier (D-385.956). American Medical Association.

RELEVANT AMA POLICY

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944

Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.

Citation: Res. 224, I-23

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22

Opposition to Reduced Payment for the 25 Modifier D-385.956

Our American Medical Association will aggressively and immediately advocate through any legal means possible, including direct payer negotiations, regulations, legislation, or litigation, to ensure when an evaluation and management (E&M) code is appropriately reported with a modifier 25, that both the procedure and E&M codes are paid at the non-reduced, allowable payment rate.

Citation: Res. 808, I-17; Reaffirmed: CMS Rep. 07, A-23

Uses and Abuses of CPT Modifier -25 D-70.971

1. Our American Medical Association Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.
2. The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.
3. Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.
4. Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.
5. Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.
6. Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.
7. Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.
8. Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

Citation: BOT Rep. 10, I-03; Reaffirmed: A-10; Reaffirmed: A-19; Reaffirmed: CMS Rep. 07, A-23

Remuneration for Physician Services H-385.951

1. Our American Medical Association actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is our AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed; A-11; Reaffirmed in lieu of: Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed; 811, I-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 30, A-24; Reaffirmed: BOT I-24; Reaffirmed: Res. 801, I-24