

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(A-26)

Introduced by: Private Practice Physicians Section

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

Referred to: Reference Committee (Assigned by HOD)

1 Whereas, AMA policy D-385.944, “ERISA Preemption of State Laws Regulating Pharmacy
2 Benefit Managers”¹ seeks to support states in implementation of state-based regulation of
3 ERISA plans to the extent allowed by the U.S. Supreme Court decision in *Rutledge v. PCMA*;
4 and; and
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6 Whereas, the Employee Retirement Income Security Act (ERISA) does not address interest
7 payments on overdue “clean” health insurance claims and many states such as New York have
8 laws in place that require health plans to pay interest²; and
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10 Whereas, ERISA does not address timeliness of response to prior authorization requirements,
11 duty to obtain data that is available to health plans from sources other than physicians that
12 health plans may need for prior authorization (test results, list of current medications); and
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14 Whereas, ERISA does not address payments for services based on the coordination of benefits,
15 requiring a health plan to pay at the in-network level of benefits for covered services when it is
16 secondary to Medicare and the provider is a Medicare-participating provider, and secondary
17 Medicare payments are not regulated under Medicare; and
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19 Whereas, AMA policy D-320.978, “Fair Reimbursement for Administrative Burdens”³ states that
20 physicians should be fairly compensated for administrative work related to prior authorization,
21 appeals of prior authorization denials, and appealing wrongful pre- and post-service denials for
22 administrative work reflecting the actual time expended by physician practices and their billing
23 vendors advocating on behalf of patients, complying with insurer requirements, and successfully
24 appealing wrongful service denials; despite AMA policy, ERISA does not address prior
25 authorization or compensation for the administrative work associated with prior authorizations or
26 compensation for various administrative burdens associated with prior authorizations; and
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28 Whereas, ERISA does not address parity for telehealth-assisted services, which may also be
29 delivered using virtual reality in the future, nor does it refer to the site of service or technology
30 used for care delivery, likewise, it does not address compensation for treatment of conditions
31 that are already covered and the same medical services for the same conditions are delivered
32 when appropriate via telehealth and in-person; and
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34 Whereas, ERISA requires a plan administrator to make a claims decision “within a reasonable
35 period of time, but not later than 30 days after receipt of the claim,” but there is no regulation of
36 the timeliness of the payment for the claim⁴; further, states like New York require⁵ health plans
37 to pay claims within 30 days “when the insurer’s obligation to pay the claim is reasonably clear”
38 and applying similar requirements to ERISA plans would significantly improve the sustainability
39 and financial viability of physician practices; and

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2 ERISA does not address payment recovery or recoupment by health plans and IRS regulations
3 are separate from ERISA and allow recoupment from any third party (participant, another plan,
4 etc.) or the plan must pay in for its own mistakes; therefore be it

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6 RESOLVED, that our American Medical Association will examine the strategic and operational
7 opportunities physicians should consider under the U.S. Supreme Court holding in *Rutledge v.*
8 *PCMA* as they pertain to the Employment Retirement Income Security Act (ERISA) with a report
9 back at the Annual 2027 meeting with recommendations for operational best practices (Directive
10 to Take Action); and be it further

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12 RESOLVED, that our AMA will explore and, as appropriate, provide related educational
13 programming at Interim and/or Annual Meetings and through other appropriate venues,
14 including potential educational modules, regarding ERISA and its practical implications for
15 private practice physicians (Directive to Take Action); and be it further

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17 RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of
18 amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways
19 that can eliminate problems that some independent physicians experience, including:

- 20 1. Interest payments on overdue “clean” health insurance claims not otherwise
21 addressed by ERISA’s statutory mandate;
- 22 2. Administrative issues surrounding prior authorization, including but not limited to
23 timeliness of responses and duty to obtain date records available from sources
24 other than the physician so as not to waste physician resources;
- 25 3. Payment for Medicare co-insurance and deductibles when Medicare is primary and
26 another plan is secondary and the physician is a Medicare-participating physician
27 but non-participating with the secondary plan;
- 28 4. Payment for the administrative burden of prior authorization and successful denial
29 appeals;
- 30 5. Parity for telehealth-delivered services;
- 31 6. Timely payment of “clean claims” when the insurer’s obligation to pay the claim is
32 reasonably distinct from timely determination of claims;
- 33 7. Enforcement of evaluation & management modifier code 25 use/payments as
34 articulated under AMA policies D-385.956 and D-70.971 as well as analogous state
35 medical society policies;
- 36 8. Requiring that when health plan payment recovery or recoupment is due to
37 coordination of benefit failure, the health plan shall seek recovery from the patient
38 and/or the correct payor;

39 (Directive to Take Action).

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Fiscal Note: (Assigned by HOD)

REFERENCES

1. ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers (D-385.944), American Medical Association.
2. 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>
3. Fair Reimbursement for Administrative Burdens (D-320.978). American Medical Association

4. 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>
5. 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
6. 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:

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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