

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 3
(A-26)

Introduced by: Alex Shteynshlyuger, MD

Subject: Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

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

1 Whereas, the United States healthcare system is complex with over 2.5 million ERISA-covered
2 group plans in 2021 according to the U.S. Department of Labor, plus over 4,000 Medicare
3 Advantage and Medicaid managed care plans and even more vendors connecting to more than
4 one million physician practices and other provider in 1-to-1 connections making automation
5 neither possible nor feasible; and
6

7 Whereas, health plan identifiers (HPID), a standardized national identifier for each of the greater
8 than 2.5 million health plans was mandated by HIPAA but never implemented causing
9 numerous administrative problems, including the inability of the Centers for Medicaid and
10 Medicare Services (CMS) to administer the No Surprises Act and confusion as to who is getting
11 healthcare claims and who is paying with a health plan such as Kaiser Permanente having up to
12 five different payer IDs for the same plan, pending on the clearinghouse used; and
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14 Whereas, true interoperability at scale is impossible with standardization and a unique health
15 plan ID; and
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17 Whereas, the AMA has existing policy (“Promoting Electronic Data Interchange” H-190.978) that
18 calls for a national electronic transaction clearinghouse that “continues to facilitate the rapid
19 development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange
20 electronic claims and eligibility information and remittance advice with payers and others in a
21 manner that protects confidentiality of medical information and to assist physicians in the
22 transition to electronic data interchange;” and
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24 Whereas, for the CMS Prior Authorization rule, CMS advised that healthcare providers pull out
25 their rotary phones to “connect electronically to health plans,” an insane idea for implementation
26 of a modern interconnectivity technology; therefore be it
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28 RESOLVED, that our American Medical Association advocate and adopt a policy supporting a
29 rational implementation of the standard national health plan identifier (HPID) to facilitate true
30 interoperability at scale, with overriding principle that all transactions must be communicated
31 directly with the health plan which must be a simple contact for all health plan communications
32 and transactions and it should be the health plan’s responsibility to build and maintain real-time
33 API connections to all its business associates and vendors, returning all information through a
34 single two-way connection to the physician practice and that the AMA ask the Centers for
35 Medicare and Medicaid Services to implement it properly (Directive to Take Action); and be it
36 further
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1 RESOLVED, that our AMA advocates for the implementation of a national centralized electronic
2 healthcare transaction clearinghouse that would allow physician practices, other providers,
3 health plans, clearinghouses, health IT vendors, state and federal regulators, digital health
4 products, and consumer apps to maintain only one standard direct connection through which all
5 electronic transactions can flow seamlessly, securely, and at low cost to any other participant
6 guided by a transaction ID and a standard identifier such as a health plan identifier (HPID)
7 and/or national provider identifier (NPI); such real-time application programming interface (API)-
8 based national electronic transaction clearinghouse should be built with redundancy to avoid
9 single-point failure and be modeled after the well-functioning automated clearing house (ACH)
10 network in the banking industry, specifically (1) the electronic transaction clearinghouse should
11 be created and maintained by the federal government with the option for a single,
12 interconnected, competing member-owned private entity similar to the National Automated
13 Clearing House Association-governed “The Clearing House” and 2) that such API-based
14 transactions have embedded functionality to file complaints to governing bodies about health
15 plan or vendor non-compliance that is seamless and easy to use (Directive to Take Action); and
16 be it further

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18 RESOLVED, that our AMA reports at the 2027 Annual Meeting on the status of implementation
19 of the national centralized electronic healthcare transaction clearinghouse and health plan ID
20 (Directive to Take Action).

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Fiscal Note: (Assigned by HOD)

Received: 4/5/2026

REFERENCES

1. Centers for Medicare and Medicaid Services. *HPID*. Department of Health and Human Services. <https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/unique-identifiers/hpid>. Accessed April 7, 2026.

RELEVANT AMA POLICY

Promoting Electronic Data Interchange H-190.978

1. Our American Medical Association:
 1. adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing:
 - a. Public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice.
 - b. Vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry).
 - c. Vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim.
 - d. All clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers).
 - e. Practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products.
 - f. States should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims.
 - g. Federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that:
 - i. any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations.
 - ii. that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services.
 2. continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing.
 3. continues to explore EDI-related business opportunities.
 4. continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange.
 5. continues its leadership roles in the NUCC and WEDI.

6. through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.

Citation: BOT Rep. 9, A-96, Amended: CMS Rep. TT, I-96; Appended: Sub. Res. 702, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: I-13; Reaffirmed: A-22

Administrative Simplification in the Physician Practice D-190.974

1. Our American Medical Association strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19; Reaffirmed: A-22