



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 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.

5. Medical Necessity *continued*

- 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-assn.org/go/codeofconduct to
pledge and access supplemental resources.**