



January 12, 2015

The Honorable Sandy Praeger  
Commissioner  
Kansas Department of Insurance  
420 SW 9th Street  
Topeka, Kansas 66612-1678

The Honorable Theodore K. Nickel  
Commissioner  
Office of the Commissioner of Insurance  
State of Wisconsin  
125 South Webster Street  
Madison, Wisconsin 53707-7873

Re: NAIC Health Benefit Plan Network Access and Adequacy Model Act

Dear Commissioners Praeger and Nickel:

On behalf of the 13,500 U.S. members of the American Academy of Dermatology Association (“Academy”), I appreciate the opportunity to comment on the National Association of Insurance Commissioners (NAIC) proposed health benefit plan network access and adequacy model act that would establish a model plan for states to address narrow networks. We support the NAIC decision to amend the model legislation to address the evolving healthcare environment. The model act has strong recommendations, many of which the AADA supports, and we would also offer the following recommendations and comments:

**Recommendation #1:** Section 3 defines numerous terms in order to ensure consistent interpretation throughout the document. The AADA recommends the NAIC include the following definitions in section 3:

**Board Certification:** Either;

- (i) certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association; or
- (ii) Requisite successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education or the American Osteopathic Association that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the American Board of Medical Specialties or American Osteopathic Association board for that training field and further successful completion of examination in the specialty or subspecialty certified.

**Material Change:** A change in network that could cause the coverage to fail to meet the actuarial value of a plan, due to a change in benefit design that modifies the recipient’s benefits, including but not limited to, physician network or drug coverages.

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**Narrow Network:** Health insurance plans that place limits on the doctors and hospitals available to their subscribers based solely on economic and subjective quality criteria to the detriment of patient access to needed care.

**Specialist:** A physician who has successfully completed a residency or fellowship training program which is accredited by the Accreditation Council of Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

**Subspecialist:** A physician whose scope of residency or fellowship training encompasses the treatments, conditions, or procedures for which subspecialization is being claimed.

**Recommendation #2:** Section 5.B. provides references a state could use to establish reasonable criteria.

The first criterion recommends a provider-to-covered-person ratio by specialty which appears consistent with the method the Centers for Medicare and Medicaid Services (CMS) uses to determine network adequacy for Medicare Advantage plans. However, physicians frequently practice part-time in multiple locations, thereby distorting the provider-to-covered-persons ratio. The AADA strongly recommends, as we have to CMS, that an insurer or regulator calculate the Full-Time Equivalent (FTE) of physicians when determining the provider-to-covered-person's ratio.

The sixth criterion recommends the evaluation of a practice's hours of operation. Similar to the provider-to-covered-person ratio concern, if a physician practices in multiple locations, the office of each location may still operate full-time to meet patient needs that can be met by other providers or administrative staff. The AADA recommends this criterion be amended to account for hours of operation a physician is available to see patients.

An additional criterion NAIC should consider is a provider-to-covered-persons ratio by sub-specialty, such as Mohs Micrographic Surgery or Pediatric Dermatology. The AADA believes that an adequate network provides patients access to both specialists and subspecialists that can meet their unique needs.

**Recommendation #3:** Section 5.F. details health plan processes and procedures for multiple situations the health plans should file.

As proposed, insurance carriers will file their access plans with the appropriate entity, but the model act does not indicate any active review by the insurance commissioner or appropriate regulator. The AADA urges NAIC to recommend that insurance commissioners play an active role in reviewing and approving access plans.

Among the information recommended for inclusion in the access plan is how the use of telemedicine or telehealth technology may be used to meet network access standards. While teledermatology is a viable option to deliver high quality care to patients in some circumstances, the AADA supports the preservation of a patient's choice to have access to in-person dermatology services (see attached Position Statement on Teledermatology) and does not believe a patient's choice to have access to in-person services should be replaced by telehealth technology.

Additionally, the NAIC recommends that a carrier describe its process for making available the criteria it has used to build its provider network, in a consumer-friendly language. This information must be made available through the health carrier's on-line and in-print provider directories. Unfortunately, insurance companies generally provide physicians with the criteria they must meet for inclusion in a network; however, even physicians who meet the criteria are frequently excluded to create narrow networks. The AADA strongly supports this NAIC

recommendation, and believes it could be strengthened by requiring plans to indicate how they determine which physicians to exclude from their networks if they meet the required criteria.

**Recommendation #4:** Sections 6.F. and G. provide multiple sets of criteria a plan should not be permitted to use when determining which providers to tier or exclude from network. NAIC recommends a plan should not be permitted to exclude providers because they specialize in treating populations presenting a risk of higher than average claims, losses, or healthcare services utilization.

Over the past year the AADA has seen numerous physicians terminated from Medicare Advantage plans with little protection for the frail elderly, a high cost segment of patients. The AADA recommends inclusion of a requirement that the plan or regulator conduct a “look-back” study to evaluate whether the beneficiaries, who transfer to other plans after a “network narrowing,” are disproportionately sicker than the general population. This study will be used to determine if these provisions were violated.

Additionally, the AADA recommends the NAIC differentiate between specialists who may have a subspecialty that focuses on sicker patient populations. For example, within dermatology a subspecialty is Mohs Micrographic Surgery, a procedural dermatology subspecialty that is ACGME approved but does not offer a discrete board certification. Mohs is the most effective and advanced treatment for skin cancer today and offers the highest potential for cure – even if the skin cancer has been previously treated by another method. Patients treated by a Mohs surgeon will require higher cost treatment and studies have shown that Mohs is cost effective especially when recurrence rates and costs of multiple treatments is taken into consideration. Despite the value of Mohs to a network many plans do not differentiate Mohs surgery from general dermatologists when determining their provider networks. In addition to Mohs surgeons, some dermatologists, for example, may primarily treat patients with psoriasis. There are higher costs associated with managing chronic conditions like psoriasis with biologic agents than with managing other conditions. Currently, plans do not account for the patient populations these physicians serve. As a result, physicians whose patient populations primarily include those who are critically ill, with costs that may far exceed average patient costs, lead to exclusion when a plan narrows its network.

**Recommendation #5:** Section 6.L. provides notification timelines the NAIC believes a carrier should follow when terminating a physician from network.

Over the past year the AADA has heard from numerous physicians that were terminated from a network, but were unaware until the insurance carrier began denying claims. The AADA has learned that this is typically a result of an insurance carrier mailing the termination notice to their billing department, often a different location from the physician’s practice and separate from the practice administrative staff. The AADA recommends the NAIC include a recommendation that notices of network termination or a change in network status be sent to the office(s) at which the physician is listed as practicing.

The first notification recommendation would require a health carrier provide a participating provider at least sixty (60) days written notice before terminating a contract “without cause.” CMS requires Medicare Advantage plans provide ninety (90) days written notice. This provides physicians time to appeal their termination from network and adjust their practices if the appeal is denied. The AADA recommends NAIC adjust the requirement to provide consistency with the current CMS requirements. In addition, patients, especially those with chronic conditions, frequently choose their network based on the provider network available to them during the plan selection period. The AADA believes that if a plan terminates a physician from its network “without cause” all subscribers should retain access to that physician until the next benefit year

when the subscriber has an ability to select a new plan with a provider network that meets their needs.

The second notification recommendation would require health carriers make a good faith effort to provide a written notice of a termination to all covered patients who have seen that provider on a regular basis. The AADA believes NAIC should remove the term “regular basis” and instead require notification of any patient who has seen that provider in the past one (1) year or in the time the patient has been with the insurer, whichever is shorter.

The third timeline recommended by the NAIC is to allow patients with chronic conditions receiving care from a provider who was terminated “without cause” an additional ninety (90) days to receive care, or until treatment concludes, whichever is less. As previously mentioned, patients with chronic conditions will frequently choose a plan based on the provider network including a physician the patient has an existing relationship with from previous appointments. The AADA would like to reinforce its position that patients should not lose access to a physician if a plan terminates the physician “without cause” during the benefit year, and believes this should be reflected in this model.

**Recommendation #6:** Sections 8.B. and C. detail provider directory information that the NAIC believes would provide greater transparency when a patient is selecting a plan. These efforts are consistent with the draft regulation released by CMS and would govern plans offered through the healthcare exchanges beginning in 2016. The AADA supports these requirements.

Sections 8.B.1.d. and 8.C.1.c. would require disclosure of specialties and board certification, respectively, in a network directory. The AADA supports this effort, but we recommend the inclusion of subspecialties practiced by the physician to increase transparency. A subspecialist may only accept patients who are diagnosed with a condition or referred by another physician, and as such, may not be truly available to the general population. Patients should be aware of this when reviewing a plan’s directory.

Section 8.C.1.e. would require office locations be listed in the network directory; however, this could present misinformation as not all physicians routinely practice in all locations that are listed for them, especially in academic hospitals. The AADA recommends this requirement be adjusted to require office locations in which a physician practices, on average, in excess of 25% of the time.

Section 8.C. drafting note recommends a requirement that health carriers develop an automated verification process, or some other means, to audit their networks when a provider has not submitted a claim in the past six months to ensure the physician is still providing services to the plans beneficiaries. The AADA would recommend an expansion of this recommendation to include an audit based on location. A plan’s directory frequently lists locations where a physician no longer practices; an audit based on location would provide greater clarity to the plan’s network.

**Recommendation 7:** The AADA recommends the NAIC include a provision in the model act that would give patients an opportunity to dis-enroll and enroll in a new plan should they enroll in a network based on incorrect directory information. As acknowledged through multiple studies recently conducted by academic physicians, the California Department of Insurance, and the Office of Inspector General (OIG), network directories are historically inaccurate and inadequate for patients to properly determine who is in network. The AADA requests if a patient determines that he or she selected a plan because a physician with whom they have an existing relationship was listed in-network errantly, that patient has an opportunity to select a new plan that includes their physician.

Re: NAIC Health Benefit Plan Network Access and Adequacy Model Act

## Conclusion

The AADA commends the NAIC for its efforts to update its network adequacy model act and encourages you to consider the AADA recommendations when reviewing and further updating this provision in the committee process. Should you have any questions, please contact David W. Brewster, Assistant Director for Practice Advocacy at 202-842-3555 or [dbrewster@aad.org](mailto:dbrewster@aad.org).

Sincerely,



Brett Coldiron, MD, FAAD  
President  
American Academy of Dermatology Association

### Attachments:

Position Statement on Teledermatology (<https://www.aad.org/Forms/Policies/Uploads/PS/PS-Teledermatology.pdf>)

### cc:

Elaine Weiss, JD, CEO, American Academy of Dermatology  
Barbara Greenan, Senior Director, Advocacy and Policy  
Leslie Stein Lloyd, JD, Regulatory and Payment Policy  
David W. Brewster, Assistant Director, Practice Advocacy  
David Pharis, MD



**Position Statement on Teledermatology**  
**(Approved by the Board of Directors February 22, 2002**  
**Amended by the Board of Directors May 22, 2004**  
**Amended by the Board of Directors November 9, 2013**  
**Amended by the Board of Directors August 9, 2014)**

Telemedicine is an innovative, rapidly evolving method of care delivery. The Academy supports the appropriate use of telemedicine as a means of improving access to the expertise of Board certified dermatologists to provide high-quality, high-value care. Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology.

The Academy strongly supports coverage and payment for telemedicine services provided by Board certified dermatologists when several important criteria are met (see details below in section III). These criteria are essential to ensure that dermatologic care provided by telemedicine is of high quality, contributes to care coordination (rather than fragmentation), meets state licensure and other legal requirements, maintains patient choice and transparency, and protects patient privacy.

While teledermatology is a viable option to deliver high-quality care to patients in some circumstances, the Academy supports the preservation of a patient's choice to have access to in-person dermatology services.

Teledermatology is the practice of medicine. Board certified dermatologists have extensive knowledge and expertise in cutaneous medicine, surgery, and pathology. Whether in-person or via teledermatology, the optimal delivery of dermatologic care involves board certified dermatologists.

Teledermatology providers choose between or combine two fundamentally different care delivery platforms (Store-and-Forward vs. Live Interactive), each of which has strengths and weaknesses.

## I. LIVE INTERACTIVE TELEDERMATOLOGY

### a. Definition

Live interactive teledermatology takes advantage of videoconferencing as its core technology. Participants are separated by distance, but interact in real time. By convention, the site where the patient is located is referred to as the originating site and the site where the consultant is located is referred to as the distant site.

### b. Technology

A high resolution video camera is required at the originating site, and a monitor with resolution matched to the camera resolution is required at the distant site. Videoconferencing systems work optimally when a connection speed of >384 kbps is used. Slower connection speeds may necessitate that the individual presenting the patient perform either still image capture or freeze frame to render a quality image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required, but higher resolution may increase diagnostic fidelity.

### c. Credentialing and Privileging

The Joint Commission (TJC) has implemented standards for telemedicine. Under the TJC telemedicine standards, practitioners who render care using live interactive systems are subject to credentialing and privileging at the distant site when they are providing direct care to the patient. The originating site may use the credentialing and privileging information from the distant site if all the following requirements are met: (i) the distant site is TJC-accredited; (ii) the practitioner is privileged at the distant site for those services that are provided at the originating site; and (iii) the originating site has evidence of an internal review of the

practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance management.

d. Privacy and Confidentiality

Practitioners who practice telemedicine should ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and its implementing regulations. While video or store-and-forward transmissions over ISDN infrastructure are thought to be secure, IP transmissions should be encrypted when transmitted over the public internet to ensure security. IP encryption in other settings such as private or semi-private networks is also highly recommended. The handling of records, faxes, and communications is subject to the same HIPAA standards as apply in a standard office environment.

e. Licensing

Interactive telemedicine requires the equivalent of direct patient contact. In the U.S., tele dermatology using interactive technologies is restricted to jurisdictions where the provider is permitted, by law, to practice. In other words, the provider using interactive technologies usually must be licensed to practice medicine in the jurisdiction where the patient is located.

f. Current Reimbursement

Medicare reimburses for live-interactive consultations, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system for patients located in non-metropolitan statistical areas (non-MSAs). This includes nearly all rural counties. A definition and listing of qualified areas is available via U.S. Census data at <http://www.census.gov/population/metro>. However, there is no limitation on the location of the health professional delivering the medical service. In some states, Medicaid reimburses for telemedicine services as well, but many have restrictions. Private insurers vary in their policies, but most will reimburse services provided to patients in rural areas. It is recommended that the provider write a letter of intent to the insurer informing them that the provider will be billing for telemedicine services. For the latest reimbursement information, see the American Telemedicine Association or CMS websites.

g. Responsibility / Liability

If a direct-patient-care-model (provider to patient) is used (no provider at the referring site), the consulting dermatologist bears full responsibility (and potential liability) for the patient's care. The diagnostic and therapeutic recommendations rendered are based solely on information provided by the patient. Therefore, any liability should be based on the information available at the time the consult was answered. In a consultative model (provide to provider), liability may be shared; however, the allocation of responsibilities will vary on a case-by case and state-by state basis. In either case, dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

## II. STORE-AND-FORWARD TELEDERMATOLOGY

a. Definitions

Store-and-forward tele dermatology refers to a method of providing asynchronous consultations to referring providers or patients. A dermatologic history and a set of images are collected at the point of care and transmitted for review by the dermatologist. In turn, the dermatologist provides a consultative report back to the referring provider or patient at the point of care.

Store-and-forward teledermatology is used in several settings:

1. Telerriage involves the review of patient cases transmitted by a referring provider to determine which patients need to be seen in-person by a dermatologist, which patients can be cared for by teleconsultation, and which patients may not need dermatologic referral.
2. Teleconsultation involves the review of patient cases transmitted by a referring provider and the provision of a consultative report back to the referring provider. Unless the patient's care is then transferred to the consulting dermatologist, the referring provider typically maintains responsibility for carrying out treatment recommendations.
3. Direct-to-patient telemedicine involves a patient originating his/her own consultation by transmitting a medical history and images to a dermatologist, who then receives some form of care from the dermatologist

b. Technology

A digital camera, whether integrated in a mobile handheld device or comprehensive telecommunications system or a stand-alone product, with a minimum of 800 x 600 pixel (480,000) resolution is required; however, higher resolutions may increase diagnostic fidelity. For systems that transmit over the Internet, a minimum 128-bit encryption and password-level authentication are recommended.

c. Credentialing and Privileging

Practitioners who render care using store-and-forward systems are viewed by TJC as "consultants" and may not be required to be credentialed at the originating site. However, standards can vary by state and organization.

d. Privacy and Confidentiality

In this case, HIPAA compliance is largely a matter of the originating site letting patients know that their information will be traveling by electronic means to another site for consultation. This should be noted in the consent form at the point of care, and the HIPAA notice of privacy practices. In addition, all electronic transmissions should be encrypted and reasonable care should be taken to authenticate those providers who have electronic access to the records.

e. Licensing

Most states require the physician to be licensed in the same state as where the patient resides, even when he or she acts only as a consultant. Providers who wish to provide store-and-forward consultations across state lines should limit such consultations to originating states in which they are permitted, by law, to provide care.

f. Current Reimbursement

As of 2014, CMS reimburses store-and-forward teledermatology only as a demonstration project in Hawaii and Alaska. However, several states are currently reimbursing store-and-forward teledermatology for Medicaid patients. There are also private insurers that are paying for store and forward modalities, including those that are part of a Medicare Advantage plan. Providers who wish to provide store-and-forward services should inquire with their payers regarding reimbursement.



g. Responsibility / Liability

In the teletriage and teleconsultation models (provider to provider), the referring provider ultimately manages the patient with the aid of the consultant's recommendations. The referring provider may accept the recommendations in part or whole or none at all, and the responsibility and potential liability in this scenario may be shared (between the referring provider and the consultant) based on the extent to which the recommendations were followed by the referring provider. If a direct-to-patient model (provider to patient) is used (no provider at the referring site), the responsibility and potential liability rests entirely on the tele dermatologist. In this case, the tele dermatologist would also be responsible to ensure proper follow up and to address any medication complications. Dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

**III. CRITERIA for HIGH QUALITY TELEDERMATOLOGY**

The Academy supports the use of telemedicine services provided by Board certified dermatologists, as well as coverage and payment for those services, when several important criteria are met:

- a. Physicians delivering tele dermatology services must be licensed in the state in which the patient receives services, and must abide by that state's licensure laws and medical practice laws and regulations. Emergency treatment and situations that arise when a dermatologist's existing patient is traveling to another state should be exceptions to this requirement, though existing laws and regulations may still apply. The Academy supports efforts by State Medical Boards to facilitate and lower burdens for physicians to obtain licenses in multiple states.
- b. Patients or referring physicians seeking tele dermatology services must have a choice of dermatologist, and must have access in advance to the licensure and board certification qualifications of the clinician providing care. The delivery of tele dermatology services must be consistent with state scope of practice laws. The Academy strongly believes that any use of non-physician clinicians in the delivery of tele dermatology should abide by the supervision requirements in the Academy's Position Statement on the Practice of Dermatology.
- c. The patient's relevant medical history must be collected as part of the provision of tele dermatology services. For teletriage and teleconsultation, appropriate medical records should be available to the consulting dermatologist prior to or at the time of the telemedicine encounter. Consulting dermatologists should have a good understanding of the culture, health care infrastructure, and patient resources available at the site from which consults are originating.
- d. The provision of tele dermatology services must be properly documented. These medical records should be available at the consultant site, and for teletriage and teleconsultation services, should also be available at the referral site.
- e. The provision of tele dermatology services should include care coordination with the patient's existing primary care physician or medical home, and existing dermatologist if one exists. This should include, at a minimum, identifying the patient's existing primary care physician and dermatologist in the tele dermatology record, and providing a copy of the medical record to those existing members of the treatment team who do not have electronic access to it. This is especially important so that information about diagnoses, test results, and medication changes are available to the existing care team.

- f. Organizations and clinicians participating in teledermatology should have an active training and quality assurance program for both the distant and receiving sites. In addition, those programs that are using teledermatology should have documentation of their training programs for any technician who is capturing clinical images and for any manager who is handling consults. Each organization should also maintain documentation on how the program protects patient privacy, promotes high quality clinical and image data, continuity of care, and care coordination for patients who may require subsequent in-person evaluations or procedures.
- g. Organizations and clinicians participating in teledermatology must have protocols for local referrals (in the patient's geographic area) for urgent and emergency services.
- h. The physician-patient relationship:
  - a. For teletriage and teleconsultation services where a referring provider ultimately manages the patient (including the prescription of medications), the consulting dermatologist is **not** required to have a pre-existing, valid patient-physician relationship. It is optimal, however, if the patient has available access to in-person follow-up with a local, board-certified dermatologist if needed.
  - b. For direct-to-patient teledermatology, the Academy believes that the consulting dermatologist must either:
    - i. Have an existing physician-patient relationship (having previously seen the patient in-person), or
    - ii. Create a physician-patient relationship through the use of a live-interactive face-to-face consultation before the use of store-and-forward technology, or
    - iii. Be a part of an integrated health delivery system where the patient already receives care, in which the consulting dermatologist has access to the patient's existing medical record and can coordinate follow-up care.
- i. The use of **direct-to-patient teledermatology** raises several additional issues (and all of the above criteria still apply):
  - a. Providers must exercise caution regarding direct prescribing for patients via electronic communications. Most states have regulations that discourage or prohibit practitioners from prescribing for patients that they have not seen face to face. In many cases, the wording of these regulations is such that a live interactive teleconsultation would meet the requirements for a "face to face exam." The Federation of State Medical Boards established a National Clearinghouse on Internet Prescribing located at [http://www.fsmb.org/ncip\\_overview.html](http://www.fsmb.org/ncip_overview.html). The Clearinghouse includes a state-by-state breakdown of jurisdiction, regulations, and actions related to the regulation of Internet prescribing.
  - b. Dermatologists providing direct-to-patient teledermatology must make every effort to collect accurate, complete, and quality clinical information. When appropriate, the dermatologist may wish to contact the primary care providers or other specialists to obtain additional corroborating information.

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- c. Photographs obtained by patients, their family members, or their friends outside of a clinical setting may not be of adequate quality, or may not include the appropriate lesions or areas, to make an accurate diagnosis.
- d. Mechanisms to facilitate continuity of care, follow-up care, and referrals for urgent and emergency services in the patient's geographic area must be in place. Any new medications prescribed or changes in existing medications must be communicated directly to the patient's existing care team (unless they have easy electronic access to the teledermatology record).
- e. The Academy does not support direct-to-patient teledermatology services designed **primarily** for profit, or direct-to-patient teledermatology services designed **primarily** to provide prescriptions to patients via electronic means.

### **Disclaimer**

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