September 23, 2013

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Department of Consumer and Business Services
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RE: Response to DCBS's Draft Guidance on Section 2706(a) of the ACA Released September 20, 2013

The Oregon Chiropractic Association which represents thousands of chiropractic patients, chiropractic physicians, and chiropractic assistants, strongly disagree with DCBS's interpretation and draft guidance for Section 2706(a). The guidance provided by DCBS conflicts with federal law and clear unambiguous congressional intent. Specifically, the guidance violates two critical elements of Section 2706(a) of the Public Health Service Act, codified at 42 U.S.C. 300 gg-5, and set to take effect on January 1, 2014:

1. Section 2706(a) prohibits insurers from discriminating against an entire type or class of health care provider/profession. In other words Section 2706(a) prohibits insurers to not contract with **any** chiropractic physicians, naturopathic physicians, licensed acupuncturists, licensed massage therapists, etc. The guidance from DCBS is in conflict with this mandate.

2. Section 2706(a) prohibits insurers from discriminating against these same provider types by allowing insurers to base varying reimbursement rates solely on licensure rather than quality and performance measures. The guidance from DCBS is in conflict with this mandate.

We respectfully advise that DCBS reconsider the language in this draft guidance relative to these two very critical issues prior to issuing final guidance on Section 2706(a), thus avoiding a conflict with federal law and congressional intent.

To assist in eliminating any remaining confusion or ambiguity in Section 2706(a) we offer the following passage from the legislative text. We believe this section is vital to tens of thousands of Oregonians who need and deserve access to high quality health care services covered by their group or individual insurance.

We ask DCBS to focus on the plain meaning of the terms of the law and review it sentence by sentence. The first sentence of Section 2706(a) is the heart of the law.

"(a) Providers
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or

coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

The first sentence explains who is subject to the law, who is protected by the law, and what is prohibited. A "group health plan and a health insurance issuer offering group or individual health insurance coverage" are subject to this law. The terms a "group health plan," a "health insurance issuer," and "group or individual health insurance coverage" are defined elsewhere in The U.S. Public Health Service Act. This definition broadly includes nongrandfathered individual health insurance and group health insurance to self-insured employee benefit plans and the Federal Employees Health Benefits Program. The law protects "any health care provider" acting within the scope of that provider's license or certification under applicable state law. Section 2706(a) protects these health care professionals only when they are legally providing services that are within their Oregon license or certification. **The law specifically prohibits those entities subject to the law from discriminating against an entire provider class or type protected by the law with respect to participation under the plan or coverage**. The law states that group health plans and insurance issuers "**shall not discriminate**." To discriminate is to make a distinction. In this instance, the law prohibits making a distinction with respect to participation or coverage. "**Participation**" pertains to the ability of an individual provider to participate in a group health plan or health insurance issuer's network of providers, and "**coverage**" pertains to the payment for plan benefits, items, and services. Section 2706(a) unambiguously prohibits discrimination against health care providers in participation or coverage by group health plans and health insurance issuers.

The second sentence of Section 2706(a) clarifies that the broad protections granted by the first sentence of the section are not infinite by describing an interpretation that would not be consistent with the section:

"(a) Providers
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

insurance issuers subject to this law and to the same health care providers protected by this law. The second sentence clarifies that the first sentence shall not require plans and issuers to contract with any provider willing to meet the plan's or issuer's terms and conditions for provider participation. In other words, Section 2706(a) shall not be treated as "**any willing provider**" legislation. Plans and issuers retain some discretion to selectively contract with individual health care providers as long as that discretion does not discriminate against an entire type or class of health care providers protected by the law. There is no ambiguity in the second sentence: Section 2706(a) **is not** an "any willing provider" law.

The third sentence of Section 2706(a) clarifies the other limitation of the broad protections granted by the first sentence of the section.

"(a) Providers
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

In the third sentence, Section 2706(a) again refers to the same group health plans and issuers. The third sentence also mentions the Secretary for the first time. The Secretary of the U.S. Department of Health and Human Services (HHS) regulates the Public Health Service Act as within the jurisdiction of HHS. Elsewhere in the Affordable Care Act, Section 2706(a) is incorporated into section 715(a)(1) of the Employee Retiree Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (the Code). Thus, the U.S. Department of Labor and the U.S. Department of the Treasury have concurrent jurisdiction over the implementation of PHS Act section 2706(a). The third sentence of the law undoubtedly refers to the Secretary of HHS and incorporates the Secretary of Labor and the Secretary of the Treasury. Those subject to the law and HHS (along with her counterparts at Labor and Treasury) retain the ability to vary reimbursement rates based on **quality or performance measures**. This last sentence would be considered superfluous if it did not have any effect on the interpretation of the statute. Therefore, we believe that this clarification serves to strengthen the plain language interpretation that discrimination in "participation" and discrimination in "coverage" includes discrimination in payment for covered services. If the first sentence of Section 2706(a) did not address discrimination in reimbursement in any manner, then the third sentence would be irrelevant. A canon of statutory

interpretation is that **congress does not enact meaningless language in statute.** No other part of Section 2706(a) renders the third sentence meaningless. To the contrary, the third sentence unambiguously explains that group health plans and health

insurance issuers may discriminate in reimbursement when quality and performance measures create the distinction, but not when the distinction is based on **licensure** or certification.

In light of the wording of Section 2706(a), the "Center for Consumer Information & Insurance Oversight" (CCIIO), published informal agency advice, "Frequently Asked Questions" (FAQs), and answers, on April 29, 2013. We believe DCBS has inappropriately relied on the following informal advice from (CCIIO) which does not carry the force of law and in conflict with congressional intent resulting in interpretational error by the Division. Specifically from the FAQs of April 29, 2013:

"Provider Non-Discrimination

PHS Act section 2706(a), as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." PHS Act section 2706(a) does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act[4] and implementing HHS regulations.

Q2: Will the Departments be issuing regulations addressing PHS Act section 2706(a) prior to its effective date?

***No**. The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.*
*Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. **This provision does not require plans or issuers to accept all types of providers into a network**. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or **market standards and***

considerations.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider

nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272."

The FAQ begins with an accurate recitation of the law. Unfortunately the introductory paragraph also mentions a separate statute, Section 1852(b)(2) of the Social Security Act (SSA) and its regulations 42 CFR 422.205. Indeed, Section 1852(b)(2) includes some similar legislative language. However Title XVIII of the Social Security Act is the Medicare statute. In contrast to the SSA, Section 2706(a) is specifically **not** an any willing provider law. The Medicare program may not discriminate in participation nor in coverage against providers acting within their scope of state licensure. Section 1852(b)(2) specifically applies to Medicare + Choice organizations (now known as Medicare Advantage organizations). The managed care plans delivering Medicare benefits have the authority to restrict their provider networks. These restrictions give managed care plans some room to negotiate discounted reimbursement rates with health care providers. Under the law Medicare Advantage plans may not reimburse providers differently based solely on their license from other health care providers who are licensed to provide the same service. The regulations implemented by HHS should not stand in conflict of the law. As cited by CCIIO, 42 CFR 422.205 allows an MA plan to deny participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees. In other words, the regulation can be read to allow discrimination in participation when the number of professionals available exceeds the number necessary to meet the needs of the plan's patients. **This would conflict with the statutory language that MA plans "may not discriminate in terms of participation" only if the denial is not based on licensure or certification**.

Title XIX of the Social Security Act also includes a nondiscrimination provision for Medicaid managed care organizations. Section 1932(b)(7) prohibits Medicaid managed care plans from discrimination against health care providers based on their license. HHS implemented regulations 42 CFR 438.12 that like the Medicare Advantage rule, allow Medicaid managed care plan to cap the number of health care providers they contract with and allows some differential reimbursement. As with the Medicare Advantage program, the regulations should

not be read to allow for discrimination in violation of the statute. **Thus, any cap in participation in the Medicaid managed care plan or any difference in reimbursement by specialty should not be based on licensure or certification.**

It is understandable then, that HHS might find Section 2706(a) unclear if it intends to regulate third party payers in the same manner as Medicare and Medicaid managed care plans. While all three of these federal nondiscrimination provisions use similar language, they each apply to different payers under radically different statutory and regulatory schemes. The Medicare and Medicaid nondiscrimination provisions for private payers developed from any willing provider environments, statutory coverage requirements, and fee schedules set by law. Section 2706(a) of the PHSA addresses commercial health plans and health insurance that typically are not any willing provider plans that negotiate coverage including benefits and reimbursement.

The Affordable Care Act reforms the commercial insurance markets creating much more substantial federal oversight of group health plans and health insurance issuers. The "Frequently Asked Questions" did not require statutory interpretation by HHS. **The question** posed was whether the Departments would be issuing regulations on Section 2706(a) prior to its January 1, 2014, effective date. This question is answered in one sentence, one word: "**No**." The first paragraph of the response explains that Section 2706(a) is self-implementing and applicable to nongrandfathered group health plans and health insurance issuers. The Oregon Chiropractic Association agrees with the first paragraph of the response to the FAQ.

The second paragraph of the response is problematic. First, CCIIO writes that group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of Section 2706(a) "using a good faith, reasonable interpretation of the law." We assume that no other interpretation (such as a bad faith or unreasonable interpretation) would be proper for those subject to any law making this sentence unnecessary. In fact, with this language HHS suggests there is greater room for interpretation than the statute allows. The paragraph then mentions coverage may be consistent with "**reasonable medical management techniques**." Medical management techniques may be reasonable and appropriate, but they are not protected by, nor exempted from, the terms of Section 2706(a). The statute **does not** reference medical management techniques. The law states that group health plans and health insurance issuers may not discriminate with respect to coverage. There is no exception for medical management techniques. If medical management techniques discriminate in coverage against providers acting within their scope of licensure then those techniques are forbidden under the Affordable Care Act. In enacting PPACA, Congress prohibited discrimination in coverage. Congress in effect is saying that medical management techniques that discriminate in coverage based on the health care provider's licensure are in fact unreasonable and illegal. The FAQ may confuse those subject to following the law by suggesting that illegal discriminatory

medical management techniques may still be permissible as long as they are "reasonable." To the contrary, Congress acted to address discriminatory coverage including medical management techniques that discriminated in coverage based on the health care provider's licensure or certification.

The CCIIO FAQs then stray even further from the statute by stating, "This provision also does not govern provider reimbursement rates which may be subject to quality, performance, or market standards and considerations." This inappropriate language was then copied verbatim by DCBS. Unfortunately this sentence is flatly contradicted by the law itself in an attempt to assert that Section 2706(a) does not govern provider reimbursement rates. In fact Section 2706(a) plainly does have impact on provider reimbursement rates since the law states that it does not prevent group health plans or health insurance issuers from varying reimbursement rates **"based on quality or performance measures."** The entire third sentence of Section 2706(a) would be unnecessary if Section 2706(a) did not govern reimbursement rates. Section 2706(a) prohibits discrimination in coverage. Varying reimbursement rates is discrimination in coverage. /1

2706(a) allows varying reimbursement rates based on quality or performance measures.

Explicitly, **Section 2706(a) was enacted to prohibit discrimination in reimbursement based not on quality or performance measures, but on licensure or certification.** Which brings us to the final and most significant deviation from Section 2706(a). In the second paragraph of the CCIIO response to the FAQ which is copied by DCBS not only ignores the plain language reading of Section 2706(a) to find that it does not govern reimbursement, but descends further into the conflict 2706(a) asserting that health plans may continue to discriminate in reimbursement (and thus in coverage) based on **"market standards and considerations."** This conjures words that are not only missing from the statute, but contradict the purpose of enacting the law. **Section 2706(a) unambiguously creates no exception for discrimination based on "market standards and considerations."**

Congress enacted PPACA in the face of the existing private health insurance market to protect patients from the health insurance reform law that rejects certain market standards and considerations as of January 1, 2014. The ACA prohibits discrimination…discrimination that has been occurring in the market to the detriment of Oregon consumers and health care practitioners. Section 2706(a) protects patients and health care providers. It is incumbent upon any guidance from DCBS to honor that intent and further to refrain from obfuscation of the plain language understanding of the law. As written, the FAQ guidance renders the law passed by Congress impotent even more than the Medicare Advantage regulations at 42 CFR 422.205 and the Medicaid managed care regulations at 42 CFR 438.12. As the famed Judge Learned Hand once noted, "Statutes always have some purpose or object to accomplish." (Cabell v. Markham, 148 F.2d 737 (2d Cir. 1945).) In rejecting the posted informal agencies FAQs, we remind DCBS that to do otherwise is to contradict and thus deprive

Oregon citizens of what Congress intended to accomplish.

That **Congressional intent** for Section 2706(a) was once again clearly and unambiguously reiterated by the makers on **July 11, 2013**, Report 113-71, Calendar No. 128 (attached), page 126 which states:

"Provider Nondiscrimination.---Section 2706 of the ACA prohibits certain types of health plans and issuers from discriminating against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law, when determining networks of care eligible for reimbursement. The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State. The Committee is therefore concerned that the FAQ document issued by HHS, DOL, and the Department of Treasury on April 29, 2013, advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in reimbursement rates based on broad "market considerations" rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was intended to prohibit exactly these types of discrimination. The Committee believes that insurers should be made aware of their obligation under section 2706 before their health plans begin operating in 2014. The Committee directs HHS to work with the DOL and the Department of Treasury to correct the FAQ to reflect the law and congressional intent within 30 days of enactment of this act."

The remaining two paragraphs of the response to the FAQ are helpful for consumers and health care professionals. The Oregon Chiropractic Association agrees with this portion of the guidance which is consistent with previous suggestions by HHS that States and the Centers for Medicare & Medicaid Services (CMS) would usually enforce Section 2706(a).

We urge DCBS to keep in mind these provisions serve to protect Oregonian's access to high quality affordable health care. There are many provisions within PPACA that protect patients. **The Affordable Care Act is primarily health insurance reform, with the federal government stepping in to provide more legal protections for patients and their doctors.** We have learned that some parties might object to following the letter of the PHSA law. These parties may argue that following Section 2706(a) as written could cause health insurance rates to increase. We have heard this argument for decades and we believe there is no credible evidence that group health plans or health insurance issuers have raised their rates because of payment due to nondiscrimination laws. The Oregon

Chiropractic Association believes any money saved by group health plans and health insurance issuers by discriminating against health care providers and their patients was not used to significantly lower premiums.

To the contrary, if group health plans and health insurance issuers choose to save money by paying providers less, then they must comply with Section 2706(a) by paying all health care providers the same lower amount rather than violating the terms of the PPACA by discriminating against certain health care providers based on their licensure. This option enables the plans to abide by the law and prevents undermining the intent and purpose of Congress by ignoring or

misinterpreting the plain language reading of the statute.

We strongly recommend DCBS focus on the wording of the law. Section 2706(a) prohibits discrimination in participation and coverage. The law does not exempt discrimination in coverage based on medical management techniques, reasonable or otherwise. Section 2706(a) allows plans to vary reimbursement based on quality and performance measures, but does not exempt the very "market standards and considerations" in discriminatory reimbursement that the law addresses by forbidding discrimination in participation and coverage. We do not seek to increase insurance costs or to lower payments to providers, but to eliminate discrimination against chiropractic physicians (and by default others), who are providing needed health care to thousands of Oregonians.

In the short term we strongly urge DCBS to issue final guidance regarding Section 2706(a) that adheres to the unambiguous wording of the statute. Two key changes are needed. **First** and most importantly, **DCBS must ensure Oregon consumers have the right to access covered health services from the full range of providers licensed and certified by the State of Oregon by not allowing insurers to discriminate against an entire type or class of provider/profession.** This will be achieved by DCBS following federal law and the unambiguous Congressional intent of Section 2706(a) memorialized in the Committee's July 11, 2013, Report 113-71, Calendar No. 128, page 126. **Second**, **DCBS must eliminate any suggestion that the law does not regulate provider payment rates because rates may vary only when based on quality and performance measures.** Section 2706(a) prohibits group health plans and health insurance issuers from discriminating in participation and coverage. The Oregon Chiropractic Association is ready and willing to assist DCBS should administrative rules need to be promulgated in the future on Section 2706(a).

We would be happy to address this and any other questions you may have in more detail.

Sincerely,

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LAS/amj

/1 Reimbursement is an integral part of coverage. The term "health insurance coverage" means "benefits consisting of medical care" (42 USC 300gg-91(b) (1). The term "medical care" means amounts paid for—

(A)the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
(B)amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and
(C)amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B). 42 USC 300gg-91(a)(2)

CC: Governor John Kitzhaber, MD

Laura N. Cali (Insurance Commissioner)

Senator Laurie Monnes Anderson (Chair, Health Care and Human Services Committee)

Representative Mitch Greenlick (Chair, Health Care Committee)

Senator Jeff Kruse (Vice-Chair)

Senator Tim Knopp

Senator Chip Shields

Senator Elisabeth Steiner Hayward

Representative Alissa Keny Guyer (Vice-Chair)

Representative Jim Thompson (Vice-Chair)

Representative Brian Clem

Representative Jason Conger

Representative John Lively

Representative Jim Weidner

Representative Chris Harker