PHSA Section 2706(a) – The ACA'S Provider Nondiscrimination Provision: Boosting Access to Care, Offering Consumers Greater Health Care Choices, Promoting Competition among Providers, and Lowering Overall Costs

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This report is delivered to the Secretary of the Department of Health and Human Services (HHS) as a response to comments submitted to the Departments of HHS, Treasury, and Labor regarding PHSA Section 2706(a) following the March 2014 Request for Information (CMS–9942–NC) issued by the Departments. Aside from providing supplemental information, this brief aims to address assertions made by commenters, including those submitted by America's Health Insurance Plans (AHIP), claiming in part that "Section 2706(a): (1) does not require plans or issuers to accept all types of providers; and (2) does not govern provider reimbursement rates, which may be subject to factors such as quality, performance, or market standards and considerations." This report was prepared by John E. Schneider, PhD and Cara M. Scheibling of Avalon Health Economics.[1]

1. INTRODUCTION

Section 2706(a) ("Nondiscrimination in Health Care") of the Public Health Service Act (42 U.S.C. §300gg-5(a)), as amended by Section 1201 of the Patient Protection and Affordable Care Act (ACA), is a patient-centered health insurance reform included in the 2010 health law that is aimed at ending decades of health plan discrimination against licensed and certified health care providers. By ending these types of discriminatory actions, Congress aimed to boost access to high-quality health care services, provide consumers with greater choices regarding their health care decisions, promote competition among the nation's health care providers, and help to lower overall health care costs for patients and payers. After making their intent for this provision clear during the legislative process, lawmakers have also since affirmed that the provision was enacted as a means "to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their state."[2]

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[2] Committee on Appropriations, "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2014," (2013).

Overall, Section 2706(a) aims to end certain discriminatory practices perpetrated by health plans, including those plans organized under the Employee Retirement Income Security Act (ERISA), which have made it policy to summarily deny participation and provide inequitable reimbursement to a range of licensed and certified health care providers, such as optometrists, chiropractors, podiatrists, nurse anesthetists, nurse practitioners, and others, merely because those providers took a different educational path to clinical expertise, quality, and licensure. In the past, offending health plans have utilized tactics such as plan coverage and design, services covered, benefit limits, and enrollee cost-sharing, as well as other schemes, to deny or severely limit patient access to specific types of providers, even though those providers would be acting within the bounds of their training and scope of practice as statutorily defined by state law. These past discriminatory actions along with others - which Congress and the President sought to end through the enactment of Section 2706(a) - have led to less patient access to needed care for millions of Americans, less of an ability for patients to seek care from the provider of their choice, reduced competition among the nation's health care providers, and higher overall costs for patients, payers, and the wider health care system.

Taken together, Section 2706(a) bars health insurers, including ERISA plans, from discriminating against health care providers acting under their state scope of practice when providing services covered by the health plan. Largely, this means that health plans must now include on their panels a reasonable number of every type of health care provider licensed to provide services covered by the plan. The plans must not, in general, impede the provision of covered services to enrollees by all categories of health care providers licensed to provide services covered by the plan. In addition, the plans must generally provide equal reimbursement to all categories of health care providers licensed to provide services covered by the plan.

2. PROVIDER PARTICIPATION

Specifically, Section 2706(a) emphasizes that a payer "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."[3] However, unlike "any willing provider" laws, Section 2706(a) explicitly states that the law does not require a payer to "contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer." Rather than creating a broad loophole that renders the rest of the statute meaningless, this clarification merely serves to explain that the nondiscrimination provision does not require plans to contract with every individual willing provider.Therefore, while exclusion of an entire group of providers is prohibited, a plan may nevertheless decide not to "contract" with any particular provider.

Section 2706(a) clearly demands that a health plan cannot categorically exclude specific types of providers from a network if those providers are authorized under state scope of practice laws to perform specific types of services covered by the health plan. Some commenters point

[3] U.S. Government, "Ordered to Be Printed as Passed" (2009).

to the "any willing provider" clause of section 2706(a) to make the case that exclusion of an entire category of licensed providers from plan participation is not discrimination against such provider groups since there is no requirement that the plan "contract" with any individual provider. However, this misguided interpretation ignores the plain meaning of the words "discrimination" and "participation" and misconstrues the sentence pertaining to the acceptance of any particular individual provider as a green light to discriminate against a whole category of providers. "Words that are not terms of art and that are not statutorily defined are customarily given their ordinary meanings, often derived from the dictionary."[4] The term "discrimination" is defined by dictionaries to mean: "the practice of unfairly treating a person or group of people differently from other people or groups of people." Similarly, "participation" is defined as: "the act of participating; the state of being related to a larger whole." To exclude an entire provider group from participation because of licensure is "discrimination" and therefore a precise violation of "provider nondiscrimination" under 2706(a).

In much the same fashion, the April 29, 2013 Frequently Asked Questions (FAQ) regarding Section 2706(a) issued by the Departments incorrectly states: "…this provision does not require plans or issuers to accept *all types of providers* into a network…"[5] Simply put, Section 2706(a) does not require plans or issuers to accept every *individual* provider but, contrary to the aforementioned FAQ statement, does clearly prohibit discrimination against provider types. Moreover, discrimination in terms of participation also violates the statute's prohibition of provider discrimination in terms of "coverage." Health insurance coverage is defined under the Public Health Service Act to mean: "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer."[6]

By excluding entire provider types from participation, a plan is excluding their ability to provide covered medical care within the scope of their state license and therefore is also discriminating against them in term of "coverage" in violation of 2706(a). The statute does not "mandate" the coverage of any service or of any provider; rather, it ensures nondiscrimination in terms of the provider groups that may provide the plan's existing covered services. Consider the case of optometrists: If a health plan covers medical eye care for patients and pays network ophthalmologists to provide those services, then the plan must now also include and pay optometrists in the network to provide medical eye care services within the optometrist's scope of practice and the plan must give patients a choice to see an optometrist or ophthalmologist.

Congress made its legislative intent clear throughout the legislative process and then again when it passed language attached to the omnibus spending law approved in 2014 which stated

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[4] *Statutory Interpretation: General Principles and Recent Trends*, Congressional Research Service, Aug. 31, 2018, p.6; In the absence of a statutory definition, "we construe a statutory term in accordance with its ordinary or natural meaning." FDIC v. Meyer, 510 U.S. 471, 476 (1994).

[5] Centers for Medicare & Medicaid Services, "Affordable Care Act Implementation Faqs - Set 15," (Accessed 2014).

[6] 42 USC 300gg-91(b) (1)

that Congress was concerned that the FAQ document issued by the Departments "advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. Section 2706 was intended to prohibit exactly these types of discrimination…The Committee directs HHS to work with 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."[7]

3. PROVIDER REIMBUSEMENT

The last sentence of Section 2706(a) states that the provision "shall not 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."[8] Commenters have pointed to this clause to support assertions that: "Neither this sentence, nor anything else in this section, indicates that plans are prohibited from varying reimbursement rates for any otherwise lawful reason." Unfortunately, this argument fails to take into consideration the overall definitions from the Public Health Service Act for "health insurance coverage," "group health plans," and "medical care" which contain repeated references to "paid for," "amounts paid for" and "reimbursement."[9]

The above terms are either contained in the exact language of 2706(a) or are directly connected by their definitions with terms within the provision. Reimbursement is part and parcel of the very nature of health care coverage as reflected in the repeated references to reimbursement and payment in the above statutory definitions. To suggest that somehow Section 2706(a) does not pertain to these basic coverage considerations demonstrates a fundamental misunderstanding of Section 2706(a) and the overall portion of the Public Health Service Act with which it is now a part. In essence, because Section 2706(a) allows for varying reimbursement based on quality or performance, it clearly asserts that, except in cases of differences in quality or performance, plans may not discriminate against providers in terms of reimbursement. As such, plans may not simply pay, in the case of qualified eye care providers, an optometrist acting within their state scope of practice less than an ophthalmologist for the *same service* simply because the provider holds a different type of license.

Commenters also cited the flawed reference to "market standards and considerations" used in the aforementioned FAQ issued by the Departments.[10] On the whole, Section 2706(a) is clear in its establishment of a singular exception to the overall prohibition against discrimination based on the licensure of the provider in terms or reimbursement by stating: "Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the

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[7] Committee on Appropriations, "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2014."

[8] Ibid.

[9] 42 USC 300gg-91(a) (1) and (2); 42 USC 300gg-91(b) (1)

[10] Committee on Appropriations, "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2014."

Secretary from establishing varying reimbursement rates based on quality or performance measures." The FAQ, however, improperly amends that language by adding the extraneous and very broad reference to "market standards and considerations." The FAQ currently provides: "This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, *or market standards and considerations*."

Importantly, this italicized language that the FAQ adds, seemingly out of thin air, is not found in the statute. Such language can and will be broadly interpreted to include almost anything a plan administrator, fiduciary or insurance executive may decide to implement in order to discriminate against a class or group of licensed providers. It is obvious that Congress, passing a law that prohibits discrimination in the market, would not actually intend that such discrimination continue to occur.

Congress made its legislative intent clear throughout the legislative process and then again when it passed language attached to the omnibus spending law approved in 2014 which stated that Congress was concerned that the FAQ document issued by the Departments notified "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 directs HHS to work with 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." [11]

4. PROVIDER COMPETITION, CONSUMER CHOICE & AFFORDABILITY

Commenters also argued that by permitting plans and health insurers to discriminate against a licensed provider type by limiting their participation and coverage, this somehow is pro-competitive and improves rather than hinders "provider competition, consumer choice and health care affordability." Commenters extensively cited the 2004 U.S Federal Trade Commission & U.S. Department of Justice report entitled *Improving Health Care: A Dose of Competition* in support of this contention.[12] However, this argument, on its face, runs counter to the basic economic concept of supply and demand and is a misrepresentation of the FTC/DOJ report.

The FTC/DOJ report provided a comprehensive overview of the many ways in which competition has improved health care outcomes and efficiency, summarizing a large body of research supporting the benefits of competition in health care markets.[13] The main overall

[11] Ibid.

[12] FTC, "Improving Health Care: A Dose of Competition," (Washington, D.C.: Federal Trade Commission & U.S. Department of Justice, 2004).

[13] For examples of supporting evidence on the benefits of competition, see generally Jean Abraham, Martin Gaynor, and William B. Vogt, "Entry and Competition in Local Hospital Markets," (Carnegie Mellon University, Graduate School of Industrial Administration, GSIA Working Papers: 1999-E32, 2000); A. Bamezai et al., "Price Competition and Hospital Cost Growth in the United States, 1989-

conclusion of the FTC/DOJ report was that in the past few decades, competition has profoundly altered the institutional and structural arrangements through which health care is financed and delivered, and that competition law and policy have played an important and beneficial role in this transformation.

The FTC/DOJ report, and the large literature upon which it is based, emphasizes the importance of prerequisites to realizing the full benefits of competition, including: (1) unimpeded access to health care markets; (2) large numbers of buyers and sellers. Section 2706(a) is precisely the type of "competition law" that seeks to expand, not restrict, access by plan participants to the broadest range of health care providers for the provision of covered services. In this regard it serves an "important and beneficial role" in today's health care environment. The access goals of Section 2706(a) simultaneously meet the two competition prerequisites singled out in the FTC/DOJ report by reducing barriers to entry and increasing the number of competing providers in the market. Thus, Congress was well aware of the FTC/DOJ views on competition, and enacted Section 2706(a) to increase competition, among other things.

The misinterpretation of Section 2706(a) as having negative effects on competition is potentially harmful because the legislation clearly would have the opposite effect by increasing the number of competitors in the market and decreasing barriers to entry in the marketplace. In the case of optometrists, Section 2706(a) would promote competition among optometrists and between optometrists and ophthalmologists for inclusion in health plan networks. Again, there is ample evidence supporting the positive impact of competition on efficiency, prices and quality in health care markets.

5. ACCESS TO CARE

Senator Tom Harkin (D-Iowa) and his Senate colleagues authored Section 2706(a), working with groups such as the American Optometric Association, the American Chiropractic Association, the American Association of Nurse Anesthetists, the American Podiatric Medical Association, and others.[14] An important intention of the legislation was to end health plan discrimination against a wide range of providers, thereby, among other benefits, helping to improve health care access in underserved areas, such as inner city and rural areas. Improving access to care—especially in rural and other underserved areas—is a critical public health

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1994," *Health Economics* 8(1999); Michael F. Cannon, "Real Competition Is the Cure for Health Care," *Employee Benefit News* 19, no. 13 (2005); FTC, "Health Care Competition Law and Policy," (Washington, D.C.: Federal Trade Commission & U.S. Department of Justice, 2003); M. Gaynor and D. Haas-Wilson, "Change, Consolidation, and Competition in Health Care Markets," *Journal of Economic Perspectives* 13, no. 1 (1999); M.A. Morrisey, "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda," *Health Services Research* 36, no. 1 (2001); M.V. Pauly, "Competition in Medical Services and the Quality of Care: Concepts and History," *International Journal of Health Care Finance and Economics* 4(2004); R.L. Ohsfeldt and J.E. Schneider, *The Business of Health* (Washington, DC: American Enterprise Institute, 2006); M.E. Porter and E.O. Teisberg, "Refining Competition in Health Care," *Harvard Business Review* 82, no. 6 (2004).

[14] Brian R. Bullard, "Letter to Leader Reid," ed. PARCA (October 2009).

objective and an important consideration in the implementation of the ACA, which adds a large number of "users" to the health system nationally.[15]

The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate that the insurance coverage provisions of the ACA will increase the proportion of the nonelderly population with insurance from roughly 80 percent in the absence of the ACA to about 84 percent in 2014 and close to 90 percent in 2016 and beyond. The CBO/JCT project that 12 million more nonelderly people will have health insurance in 2014 than would have had it in the absence of the ACA. They also project that 19 million more people will be insured in 2015, 25 million more will be insured in 2016, and 26 million more will be insured each year from 2017 through 2024 than would have been the case without the ACA.[16]

The expansion of covered lives under ACA will increase demand for all health services, but in particular it will increase demand for the specific services mandated under the law, including eye and vision care. The ACA names eye and vision care as an "essential health benefit" and requires coverage (in nearly all cases) of asymptomatic annual comprehensive eye exams for children up to age 19 in all states.[17] The rationale for this coverage is based on the well-established importance of comprehensive eye and vision care, particularly the improved outcomes and cost-savings associated with preventive eye care,[18] the provision of which optometrists play a crucial role.[19] In addition, many children and adults with health insurance coverage for the first time will have medical eye care coverage. Thus, under the ACA, many people will now be covered for eye and vision care that may be provided by optometrists as long as health plans aren't allowed to illegally exclude all optometrists from their networks.

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[15] See generally B. Bale, "Optimizing Hypertension Management in Underserved Rural Populations," *J Natl Med Assoc* 102, no. 1 (2010).; C. D. Bethell et al., "A National and State Profile of Leading Health Problems and Health Care Quality for Us Children: Key Insurance Disparities and across-State Variations," *Acad Pediatr* 11, no. 3 Suppl (2011).; H. C. Felix, E. B. Wootten, and M. K. Stewart, "The Arkansas Southern Rural Access Program: Strategies for Improving Health Care in Rural Areas of the State," *J Ark Med Soc* 101, no. 12 (2005).; E. M. Rygh and P. Hjortdahl, "Continuous and Integrated Health Care Services in Rural Areas. A Literature Study," *Rural Remote Health* 7, no. 3 (2007).; S. W. Utz, "Diabetes Care among Rural Americans," *Annu Rev Nurs Res* 26(2008).

[16] CBO, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," (2014).

[17] Centers for Medicare & Medicaid Services, "Additional Information on Proposed State Essential Health Benefits Benchmark Plans," (Baltimore, MD: CMS, Accessed 2014).

[18] See generally J. Karnon et al., "A Preliminary Model-Based Assessment of the Cost-Utility of a Screening Programme for Early Age-Related Macular Degeneration," *Health Technol Assess* 12, no. 27 (2008); P. Orr et al., "Eye Care Utilization by Older Americans: The See Project. Salisbury Eye Evaluation," *Ophthalmology* 106, no. 5 (1999); J. Schaneman et al., "The Role of Comprehensive Eye Exams in the Early Detection of Diabetes and Other Chronic Diseases in an Employed Population," *Popul Health Manag* 13, no. 4 (2010); P. Shin and B. Finnegan, "Assessing the Need for on-Site Eye Care Professionals in Community Health Centers," *Policy Brief George Wash Univ Cent Health Serv Res Policy* (2009).

[19] For example, see E. Hoppe and R. Frankel, "Optometrists as Key Providers in the Prevention and Early Detection of Malignancies," *Optometry* 77, no. 8 (2006).

The chief consequences of this infusion of ACA "covered lives" are that any existing shortages in the overall health care workforce will be made worse—concerns which have already been expressed in the medical literature.[20] Optometrists are a critical component of the overall health care workforce, particularly the primary care workforce.[21] Optometrists provide "front line" prevention, detection and treatment of a variety of eye conditions, including cataract, glaucoma, age-related macular degeneration, diabetes (which can lead to diabetic macular edema or retinopathy) and malignancies.[22] Three factors—the aging population, the ACA infusion of insured (many of whom will have improved eye-care coverage), and the retirement of baby-boom ophthalmologists—are expected to exacerbate the demand for eye care professionals nationally.[23]

Concern over access to eye and vision care is shared by all providers of eye care, including ophthalmologists. For example, the American Academy of Ophthalmology believes there is "little doubt" that ophthalmology could face a shortage of practitioners in the near future, citing the role of the "fixed pipeline" of ophthalmologists due to the fixed number of

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[20] Association of American Medical Colleges, "Recent Studies and Reports on Physician Shortages in the Us," *Center for Workforce Studies Association of American Medical Colleges* (2012).; S. Collins, "Primary Care Shortages: Strengthening This Sector Is Urgently Needed, Now and in Preparation for Healthcare Reform," *Am Health Drug Benefits* 5, no. 1 (2012).; A. Grover and L. M. Niecko-Najjum, "Physician Workforce Planning in an Era of Health Care Reform," *Acad Med* 88, no. 12 (2013).; D. G. Kirch, M. K. Henderson, and M. J. Dill, "Physician Workforce Projections in an Era of Health Care Reform," *Annu Rev Med* 63(2012).; R. R. Kulesher, "Health Reform's Impact on Federally Qualified Community Health Centers: The Unintended Consequence of Increased Medicaid Enrollment on the Primary Care Medical Home," *Health Care Manag (Frederick)* 32, no. 2 (2013).; Q. Meng et al., "Expanding Health Insurance Coverage in Vulnerable Groups: A Systematic Review of Options," *Health Policy Plan* 26, no. 2 (2011).; J. Cantlupe, "Alarming Physician Shortages Lie Ahead," *HealthLeaders Media* (2013).; K. Dageforde, "Impact of the Federal Insurance Exchange on the Growing Physician Shortage," *Tenn Med* 106, no. 2 (2013).

[21] See generally "Routine Eye Examinations for Persons 20-64 Years of Age: An Evidence-Based Analysis," *Ont Health Technol Assess Ser* 6, no. 15 (2006).; N. J. Ammary-Risch and S. S. Huang, "The Primary Care Physician's Role in Preventing Vision Loss and Blindness in Patients with Diabetes," *J Natl Med Assoc* 103, no. 3 (2011).; Hoppe and Frankel, "Optometrists as Key Providers in the Prevention and Early Detection of Malignancies."; N. S. Logan and B. Gilmartin, "School Vision Screening, Ages 5-16 Years: The Evidence-Base for Content, Provision and Efficacy," *Ophthalmic Physiol Opt* 24, no. 6 (2004).; Schaneman et al., "The Role of Comprehensive Eye Exams in the Early Detection of Diabetes and Other Chronic Diseases in an Employed Population."; Shin and Finnegan, "Assessing the Need for on-Site Eye Care Professionals in Community Health Centers."; M. Soroka, "The New York State Optometry Workforce Study," *J Community Health* 37, no. 2 (2012).; J. E. Winters et al., "Coordinating Eye and Primary Medical Care in a Low-Income and Uninsured Population: The Experience of the Vision of Hope Health Alliance," *Optometry* 79, no. 12 (2008).

[22] International Council of Opthalmology, "Number of Ophthalmologists in Practice and Training Worldwide," http://www.icoph.org/ophthalmologists-worldwide.html.

[23] Healio Ophthalmology, "Growing Demand for Eye Care Services May Highlight Shortage of Ophthalmologists," *Ocular Surgery News U.S. Edition* (2010).; P. Kegel-Flom, "The Rural Optometrist: Who and Why?," *J Am Optom Assoc* 47, no. 12 (1976)

ophthalmology residencies combined with the rapid growth in demand attributable to the aging population and the ACA infusion of insured.[24]

6. CONCLUSIONS

In sum, Section 2706(a) prohibits discrimination, including omission of entire types of providers licensed to provide covered services by health plans, impeding the provision of covered services to enrollees by all categories of health care providers licensed to provide services covered by plans, and forbids using alternate reimbursement schemes to accomplish the same discriminatory results. By prohibiting broad exclusions of entire types of providers and ensuring unfettered access to covered services from the provider of choice as well as equitable reimbursement for providers offering the same services, the legislation helps maintain and improve the competition and patient choice in the health care marketplace —a very important consideration in light of the infusion of new health care users resulting from the Affordable Care Act. In the case of optometrists, their ability to provide comprehensive eye and vision care (including medical eye care and ongoing vision eye care) with greater access and equivalent or better quality than ophthalmologists meets the needs of the nation under the Affordable Care Act. Finally, by keeping markets open, Section 2706(a) supports the kind of competition that has been shown to be highly beneficial to health care quality and costs.

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