

**To:** Vern Saboe, D.C., ACA Oregon Delegate  
**From:** Thomas R. Daly, ACA General Counsel  
**Date:** May 21, 2015  
**Re:** "force of law" of CCIIO 2706(a) FAQ and benefits template



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**In the following memo, "FAQ" refers to the Centers for Consumer Information and Insurance Oversight (CCIIO) Frequently Asked Question Regarding Provider Non-Discrimination, and "Template" refers to the CCIIO Quality Health Plan - Plans & Benefits Template.**

**I. The FAQ and Template are informal agency guidance made without following notice and comments procedures. Such informal guidance does not have the "force of law" and should not be given legal deference.**

Agencies may issue interpretive rules without a delegation of rulemaking authority and without following notice-and-comment procedure. Such interpretive rules do not have the "force of law". Courts have considered a number of factors in determining how much weight to give to informal interpretations of statutes. The leading case in this area is Skidmore v Swift & Co., 323 U.S. 134, 140 (1944), in which the United States Supreme Court recognized that "the Administrator's policies are made in pursuance of official duty, based upon more specialized experience and broader investigations and information than is likely to come to a judge in particular case. They do determine the policy which will guide applications for enforcement by injunction on behalf of the Government." Accordingly, the Court held: "the rulings, interpretations and opinions of the Administrator under this Act, while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." Skidmore, 323 U.S. at 140, 65 S.Ct. at 163 (emphasis added).

**II. The FAQ is inconsistent with a number of the provisions of the statute and its reasoning is invalid.**

The FAQ takes it upon itself to incorporate contrary meanings, concepts and language not found in Section 2706(a) of the Public Health Service Act ("Section 2706(a)")

"Market standards and considerations"

Section 2706(a) is quite clear in its establishment of an exception to the overall prohibition against discrimination based on 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 Secretary from establishing varying reimbursement rates based on quality or performance measures."

The FAQ however, restates that language by adding the extraneous and very broad reference to "market standard 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."

Setting aside for a moment the erroneous claim contained in the FAQ that Section 2706(a) does not "govern provider reimbursement rates", one can see by the above underscored language that the FAQ adds language not found in the statute. This new language can 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 axiomatic that while agencies may interpret the language of the statute, they may not create new legislative language or amend existing language.

As to the erroneous contention that 2706(a) "does not govern provider reimbursement rates", Section 2706(a) contains the terms "group health plan" and "health insurance coverage" and both of these terms reference "medical care" in their definitions. All of these terms contain repeated references to "items and services paid for", "amounts paid for" and "reimbursement" in their respective statutory definitions (see below).

"42 USC 300gg-91

(a) Group health plan

(1) Definition

The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

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).

(b) Definitions relating to health insurance

(1) Health insurance coverage

The term "health insurance coverage" means 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. "

Therefore, CCIIO's contention that Section 2706(a) does not "govern provider reimbursement rates" utilizes invalid reasoning and flies directly in the face of the statutory definitions which clearly and repeatedly incorporate payment and reimbursement considerations into the law.

"All types of providers"

Another erroneous and completely invalid concept added by the FAQ is that "This provision does not require plans or issuers to accept all types of providers into a network." Simply put, Section 2706(a) does not require plans or issuers to accept every individual provider but, contrary to the FAQ statement, it clearly prohibits discrimination against provider types.

Section 2706(a) first provides 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."

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:

"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.

The second sentence of Section 2706(a) refers to the same group health plans and health 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. The introduction of the notion in the FAQ that plans or insurers may somehow discriminate in terms of participation against "all types of providers" is completely inconsistent with very language and intent of the statute.

## "Medical management techniques"

The FAQ introduces the notion that in terms whether an "item or service is a covered benefit under the plan or coverage", insurers and plans may base such determinations upon the rather broad concept of "medical management techniques". The FAQ does not define what these techniques may entail, but it does say that they are to be "reasonable". That is small comfort given the history of litigation involving insurance companies and ERISA plans on what is and what is not a reasonable limitation on covered care. As in the instance with the creative inclusion of the term " market standards and considerations " as described above, the inclusion of the term " medical management techniques" into the FAQ gives a green light to insurance companies and plans to develop criteria which they will describe as "medical management techniques" to serve as nothing more than a subterfuge to discriminate against doctors of chiropractic and other providers. In short, this term is overly broad, vague, not found in the statute and provides a convenient means to circumvent the protections of Section 2706(a).

## Congressional expression on the invalid reasoning contained in the FAQ

The Senate Committee on Appropriations has added its voice and stated that the FAQ was and is defective, invalid and counter to the very intent of the law. The Senate Committee in its Report dated July 11, 2013 (113-71, to accompany S. 1284) stated:

*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 a 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 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.*

Therefore, for all the clear examples listed above of the erroneous and invalid reasoning contained in the agency FAQ, there should be no legal deference given to it in any setting under the standard established by the U.S. Supreme Court in the Skidmore decision.

## **III. The Template is inconsistent with a number of the provisions of the statute and its reasoning is invalid.**

The Template singles out "Chiropractic care" for special treatment. The Template specifically excludes "Chiropractic care" from plan coverage by identifying such care as "not covered in standard plan". "Chiropractic care" is the only type of care offered by licensed providers specifically identified as "not required" to be covered by all carriers, including health maintenance organizations, selling health insurance coverage. There are no other health care

provider types singled out for this blatant discrimination and broad exclusion from coverage. For the reasons detailed below, such exclusion from coverage violates Section 2706(a).

Section 2706(a) directly and specifically prohibits group health plans or health insurance issuers from discriminating against licensed health care providers and the services they provide in terms of "coverage". The language of Section 2706(a) is as follows:

“(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 term "coverage" is further defined to specifically pertain to and include "services" as follows:

"42 USC 300gg-91

"(b) Definitions relating to health insurance:

(1) Health insurance coverage

The term “health insurance coverage” means 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.”(emphasis added)

The term “medical care” is also defined as follows:

(2) Medical care

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).”(emphasis added)

Doctors of chiropractic along with medical doctors and other health care providers are licensed in all jurisdictions to provide services in the diagnosis, cure, mitigation, treatment or prevention of disease and for the purpose of treatment affecting the structure and function of the body within the requirements and limitations of the various state scopes of practice. The various services provided by doctors of chiropractic may not be singled out for coverage discrimination by labeling such services with the generic description of “Chiropractic care”. If nothing else, the

non-discrimination provision of Section 2706(a) means that a plan may not exclude from coverage the services of a licensed health care provider based only upon the nature of that providers license. Echoing that point, Jonathan Blum, former Principal Deputy Administrator at the Centers for Medicare & Medicaid Services, commented that “The law [Section 2706(a)] also provides that a health plan or health insurance issuer 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.” (emphasis added)[1]

Therefore, for reasons listed above, the listing of “Chiropractic care” as an uncovered service for a plan in the Template is based on the agency’s erroneous and invalid reasoning and there should be no legal deference given to it in any setting under the standard established by the U.S. Supreme Court in the Skidmore decision.

[1] Official CENTERS FOR MEDICARE & MEDICAID SERVICES Response to Include Licensed Naturopathic Physicians as primary care providers in the Federal Healthcare Law (Obamacare).

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