AMERICAN CHIROPRACTIC ASSOCIATION

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ACA CHIROPRACTORS Hands down better™

June 4, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Richard E. Neal
Ranking Member
Committee on Ways and Means
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Vern Buchanan
Chairman
Committee on Ways and Means
Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking Member
Committee on Ways and Means
Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20515

Dear Chairmen Smith and Buchanan, Ranking Members Neal and Doggett:

The American Chiropractic Association (ACA) submits the following comments regarding the Subcommittee on Health hearing on May 23, 2024, titled, "The Collapse of Private Practice: Examining the Challenges Facing Independent Medicine." ACA thanks the Committee for facilitating the hearing and allowing us to provide a statement for the record. Our comments are directed specifically to access and participation issues facing both providers and patients.

ACA is the largest professional organization in the United States representing doctors of chiropractic (DCs). ACA members lead the chiropractic profession through collaborative relationships in public health, support for research and evidence-based practice, and the active reporting of functional outcome assessment measures to ensure the health and well-being of the estimated 35 million Americans who seek chiropractic services each year.

Regarding patient access, since the chiropractic benefit was first included in Medicare in 1972, beneficiaries have been limited in the services they can receive from their chiropractor. DCs are currently not allowed to furnish existing covered Medicare services that fall within their scopes of practice to their patients. This artificial limitation restricts chiropractors from providing their patients a continuity of care as they age into Medicare, putting beneficiaries at a distinct health disadvantage. This limitation has persisted for over 50 years with no scientific or valid policy basis.

Beneficiaries seeking to obtain chiropractic services face many obstacles in the Medicare system. These obstacles may require the beneficiary to experience delays, inconveniences, and the added expense (copays, time, travel, etc.) of seeing a second provider when such visits are unnecessary. For example, if a DC determines that the beneficiary needs an x-ray, laboratory test or other diagnostic procedure, current policy does not even allow DCs to "order" those covered services, and thus, in those instances further unnecessary visits and beneficiary expenses are required in order to obtain the needed "order" from a second Medicare provider who will often turn around (especially in the case of diagnostic imaging, for example) and order the service from a third Medicare provider.

Because Medicare's chiropractic policy is stuck in 1970-era health policy, patients are, in effect, channeled to other providers whose standard treatment regimen may involve the use of drugs, spinal injections, or surgery for a range of spinal conditions. Chiropractic services have been demonstrated through research to be a less costly and safer alternative in many of these situations and are routinely covered by private insurance and Medicaid. As policymakers seek to prevent the use of unnecessary drugs and surgery, DCs are poised to assist in the opioid effort by lowering the reliance on those drugs, especially in cases involving spinal-related pain. To the extent that current policy arbitrarily restricts access to chiropractic services, it exacerbates these problems.

Needed legislation would not add any new reimbursable services to Medicare that are not already covered services and delivered by existing providers. Legislation would simply seek a modification of existing statute to ensure that doctors of chiropractic are allowed to furnish and order "existing covered services" which they are currently permitted to do under state law.

Fortunately, to correct this disparity, the Chiropractic Medicare Coverage Modernization Act, legislation to allow Medicare beneficiaries full access to current services chiropractors are allowed to provide under their state licensure, has been introduced in both the House and the Senate in the 118th Congress. The House bill, H.R. 1610, was introduced earlier this session by your colleague Rep. Greg Steube (R-Fla.) and currently has over 160 bipartisan cosponsors, including a majority of Ways and Means Committee members. A Senate companion bill, S. 799, was introduced at the same time as the House bill and currently has 13 bipartisan cosponsors. In order to give Medicare beneficiaries access to the benefits they are authorized, we urge Congress to pass this vital legislation this session.

Regarding provider participation, in 2010, health care providers were promised a "balanced playing field" when Congress passed the Patient Protection and Affordable Care Act (PPACA), with the goal of improving the accessibility, quality, and affordability of health care. With the passage of the PPACA, Congress enacted first-of-its-kind provider nondiscrimination coverage requirements on health insurance issuers as well as group health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA).

Specifically, participants in ERISA-covered health benefit plans and other group health benefit and insurance plans are entitled to PPACA coverage requirements and may enforce those requirements by using the ERISA enforcement measures as well as enforcement by state agencies and HHS. PPACA amended the Public Health Service Act to prohibit discrimination based on provider license in terms of coverage and participation. (Section 2706(a)) of the Public Health Service Act, 42 U.S.C. § 300gg–5). This requirement prohibits health insurance issuers and group health benefit plans from discriminating against health care providers if those providers act within the scope of their license or certification.

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" and "participation." However, health care providers met nothing but resistance from major insurance companies, State insurance departments (which were obligated under PPACA to enforce 2706(a)) and even HHS itself.

In responding to a defective informal guidance issued by HHS and other federal agencies, which was subsequently withdrawn, the Senate Committee on Appropriations added its voice as to the statute's intent. The Senate Committee in its Report dated July 11, 2013 (113-71, to accompany S. 1284) stated, "Section 2706 of the PPACA prohibits certain types of health plans and issuers from discriminating against any health care 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."

More recently, Congress has made clear that federal implementation to date has not been sufficient. In December 2020, the *Consolidated Appropriations Act of 2021* was signed into law, which included the *No Surprises Act*. Section 108 of the *No Surprises Act* requires the Secretaries of the Departments of Health and Human Services, Labor, and Treasury to issue a proposed rule no later than January 1, 2022. Based on the regulatory timeline required under Section 108, a final rule should have already been promulgated to permanently implement these protections against provider discrimination.

In addition to the above, an August 2023 deadline was published in the Spring 2023 Unified Agenda of Regulatory and Deregulatory Actions. The need for prompt rulemaking is critical because many private health insurers continue to discriminate against health care providers based on their licensure. We are deeply concerned that it is now almost two years past the January 1, 2022, statutory deadline for rulemaking stated in the *No Surprises Act* as part of the *Consolidated Appropriations Act of 2021.* Without an enforceable rule, many non-MD/DO providers face undue barriers to providing care based on discriminatory policies from insurers. We are very concerned that numerous deadlines have passed to promulgate this rule and we encourage the agencies to release this rule in the very near future.

Despite the above, and after many years of seeking enforcement of the protections of 2706(a), health care providers have not been able to overcome the obstacles placed before them by big business to achieve the promises for a "level playing field" made to them under the PPACA. Without enforcement, health plans will continue to discriminate against providers, especially non-MD/DO providers who are working within their scope of practice to provide essential health care. A strong and enforceable rule is a critical element to ensuring that patients have access to the care they deserve from the provider of their choice. This will increase competition, drive down costs and benefit consumers. Now, however, many of those same companies are moving rapidly to consolidate their dominance through private equity ownership and consolidation of health care organizations.

ACA appreciates the opportunity to provide these comments to the committee. If you have any questions regarding our remarks, please contact John Falardeau, ACA Senior Vice President for Public Policy and Advocacy, at jfalardeau@acatoday.org or (703) 812-0214.

Sincerely,

Leo Bronston, DC, MAppSc
President