



AMERICAN BENEFITS
COUNCIL

June 10, 2014

Submitted electronically via <http://www.regulations.gov>

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9942-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Request for Information Regarding Provider Non-Discrimination

Sir or Madam:

I write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the Request for Information Regarding Provider Non-Discrimination (the “RFI”) published in the Federal Register on March 12, 2014, by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (collectively, the “Departments”). The RFI requests comments on all aspects of the interpretation of Section 2706(a) of the Public Health Service Act, which was added thereto by the Patient Protection and Affordable Care Act (“PPACA”).

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

The Council appreciates the opportunity to provide comments to the Departments regarding the provider non-discrimination provision. Section 2706(a) has significant implications for plan sponsors, as it directly impacts their ability to design and administer plans that best meet their needs and those of their employees. Employers face increased challenges designing and implementing affordable, high quality health benefits plans given other PPACA provisions that limit flexibility in plan design,

including limitations on cost sharing and the 40% excise tax on high cost health coverage (Internal Revenue Code Section 9000).

The Council believes the Departments' FAQ strikes an appropriate balance in implementing the provider non-discrimination provision while also ensuring employers retain flexibility to design and implement health plans that meet their diverse needs. While the Council does not believe that additional guidance is necessary at this time, we offer the following specific comments and recommendations in the event the Departments issue guidance in the future.

SECTION 2706(a) DOES NOT MANDATE COVERAGE OF BENEFITS OR SERVICES

We note at the outset that nothing in Section 2706(a) mandates that a plan or issuer cover specific benefits or services. The statutory text of Section 2706(a) merely provides that a plan or issuer "shall not discriminate with respect to participation" against any health care provider acting within the scope of his or her license or certification under applicable state law (emphasis added). This language reflects strong Congressional intent that insurers and self-funded plan sponsors not be required to cover specific benefits or services as a result of Section 2706(a). The FAQ correctly reflects this Congressional intent in stating that the non-discrimination provision applies "*to the extent an item or service is a covered benefit*" (emphasis added).

We further note that Section 2707(a) of PPACA requires that insured small group health plans cover the essential health benefits package required under PPACA Section 1302(a). Specifically, Section 2707(a) provides in relevant part that "[a] health insurance issuer ... in the individual or small group market *shall ensure that such coverage includes the essential health benefits package required under [PPACA Section 1302(a)]*" (emphasis added). The language in Section 2707(a) reflects clear Congressional intent that certain plans be required to offer certain benefits.

Similar directive language is not included in Section 2706(a), and the language in Section 2706(a) that provides that plans and issuers shall not discriminate with respect to "participation" indicates that the provision is intended only to apply to the providers that may "participate" in the plan or coverage and provide services, rather than to establish that certain benefits or services must be covered by the plan or coverage. Accordingly, Section 2706(a) should not be interpreted to impose further mandated benefits beyond those established by Section 2707(a).

From a policy perspective, reading Section 2706(a) to mandate coverage of certain benefits and services would increase costs of employer-sponsored health coverage, if plans and policies are required to cover benefits beyond even those mandated by Section 2707(a).

Finally, plans and issuers commonly exclude a benefit or a service that is performed by only one type of provider (e.g., acupuncture, massage therapy). Excluding a benefit or service that is performed by only one type of provider is not discriminatory in that the decision by the plan or issuer to exclude such benefit or service is made with respect to the benefit or service itself rather than who would be delivering such benefit or service. To read Section 2706(a) to require that a plan or policy include a specific benefit would unduly restrict plan design and innovation and detrimentally impact the affordability of health coverage for employers and consumers alike.

As a result, the Council requests that any future implementation guidance affirm that Section 2706(a) does not mandate any specific benefits or services be covered by a plan or policy.

SECTION 2706(a) DOES NOT REQUIRE CONTRACTING WITH ANY WILLING PROVIDER

Section 2706(a) specifically states that “[t]his 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.” This language is unequivocal in clarifying that Section 2706(a) should not be read to impose a requirement on plans and issuers to contract with any willing provider or with any specific category of providers. Selective contracting is vital to the ability of plan sponsors ability to offer affordable, high quality health coverage with a minimum of administrative burden.

The Council recommends that any future guidance affirm that Section 2706(a) does not impose an “any willing provider” requirement on plans and issuers and clarify that the prohibition on discrimination applies to participation as opposed to contracting. There is a significant difference between the two, in that a provider who has not contracted with a plan or issuer to be a part of the plan’s or issuer’s network may still receive payment for providing covered services on an out-of-network basis (and thus would still be “participating” in the plan or policy). The Council reads Section 2706(a) to prohibit discrimination in “participation” in this sense. (We note, however, that nothing in Section 2706(a) *requires* a plan or issuer to cover out-of-network benefits or services.)

SECTION 2706(a) DOES NOT RESTRICT THE USE OF REASONABLE MEDICAL MANAGEMENT TECHNIQUES

The FAQ provides that, “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” (emphasis added).

The Council believes the FAQ correctly and necessarily construes Section 2706(a) to allow plans and issuers to utilize reasonable medical management techniques in providing covered benefits and services without running afoul of the Section 2706(a) non-discrimination prohibition.

Reasonable medical management techniques are important tools for furthering quality improvement and containing costs. Permitting plans and issuers to apply reasonable medical management techniques is consistent with current practices that have been effective in furthering these goals. Among the techniques that plans and issuers use (and should be permitted to continue to use) are performance-based tiered networks and centers of excellence programs. The Council supports the provision in the FAQ permitting the use of reasonable medical management techniques and recommends that it be retained in any future implementation guidance.

SECTION 2706(a) ALLOWS THE ESTABLISHMENT OF VARYING REIMBURSEMENT RATES

Section 2706(a) provides that “[n]othing 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 further provides that “[t]his provision ... does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.”

The statutory provision clearly states that reimbursement rates may vary based on quality and performance measures. Section 2706(a) does not, however, *prohibit* plans and issuers from using measures other than those related to quality or performance in formulating reimbursement rates. The ability of plans and issuers to take into account a broad range of factors relevant to negotiating reimbursement rates, including market conditions, is vital to their ability to offer affordable health care coverage.

We believe the FAQ’s clarification (i.e., that Section 2706(a) does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations) is consistent with the statutory language and well within the bounds of the Departments’ interpretive authority. We recommend that the clarification be retained in any future guidance.

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Thank you for considering these comments submitted in response to the RFI. If you

have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

A handwritten signature in black ink that reads "Kathryn Wilber". The signature is written in a cursive, flowing style with a prominent dot over the 'i' in "Wilber".

Kathryn Wilber
Senior Counsel, Health Policy