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Non-Discrimination and the Role of Complementary and Alternative Medicine

By John D. Blum

Section 2706(a) of the Affordable Care Act is a non-discrimination provision that requires group health insurers and individual health plans not to arbitrarily exclude a health provider from participation if that individual is acting within the scope of his/her license or certification.[1] This non-discrimination provision, known as the Harkin Amendment, was incorporated into the ACA and most recently revisited in the Consolidated Appropriations Act of 2014.

The Big Picture

Section 2706(a) has become a cause celeb for a wide range of non-physician providers, many falling into the ranks of complementary and alternative health practitioners, who view it as a significant step forward in achieving parity with allopathic medicine.[2] Proponents of Section 2706(a) argue that the non-discrimination clause is a matter of consumer choice, guaranteeing access to an array of services that, at best, have received spotty coverage. Other affected parties, including organized medicine, insurers and regulators, have greeted the prospects of CAM expansion with either a less than ringing endorsement, or active opposition.[3]

This article explores this curious snippet of the ACA, Section 2706(a), first focusing on the provision and its implications, and second, proposing an alternative way forward for expansion of licensed CAM, calling for its integration with allopathic medicine in the area of manual medicine. Although Section 2706(a) affects an array of providers (psychologists and other mental health professionals, as well as nurses and optometrists), the focus here centers on the impact on those licensed professionals who can be classified as CAM practitioners.[4]

Debate about the expansion of CAM services is part of a long, ongoing tale in American health care that dates back to the early days of the 20th century.[5] While acceptance of the myriad of unconventional practices that populate this arena has been achieved in fits and starts, it seems reasonable to conclude that licensed CAM practitioners, particularly in manipulative therapies, have become an established part of the fabric of health care.[6] It is, thus, no surprise that the better-

[1] 42 U.S.C. § 300gg-5.

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[2] This article is focused on CAM providers, but other non-physician providers, such as psychologists, optometrists and midwives are equally impacted by this law and have been quite vigilant in their lobbying efforts in the area. See, Steven Salzberg Alternative Medicine Providers Show Greedy Side available at http://www.forbes.com/sites/stevensalzberg/2013/08/26/alternative-medicine-providers-show-their-greedy-side/.

[3] American Medical Association, Board of Trustees, 8-I-12, available at http://newsfromaoa.files.wordpress.com/2012/10/i12-bot-report-08.pdf.

[4] Complementary and alternative medicine has been defined by the National Center for Complementary and Alternative Medicine. The definition is available at http://nccam.nih.gov/health/whatiscam.

[5] Erland Pettman, "A History of Manipulative Therapy" J. Man Manip Ther. 2007; 15(3): 165-174.

[6] Manipulative therapies include an array of providers who range from conventional to unconventional, covering osteopaths, chiropractors, physical therapists, naturopaths, napraopaths, massage therapists and acupuncturists.

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organized CAM groups were able to exert sufficient influence to have Section 2706(a) placed into the Senate amendments to ACA, with sponsorship from Iowa Senator Tom Harkin, a strong proponent of alternative medicine.

Although not a focal point of the ACA, given that so many Americans use some form of CAM services, and that in many places, integrative medicine is well established, it is no surprise that health reform did touch on this area. In fact, it is somewhat striking that, in lieu of challenges in cost control, chronic illness, prescription drug addiction and provider shortages, more emphasis wasn't placed on complementary and alternative health care. While the ACA non-discrimination provision is the most visible measure relating to CAM, the reform law opens other possibilities for a deliberate expansion of non-traditional medicine.[7]

Turning specifically to Section 2706(a), the provision provides a general directive against practitioner discrimination, covering licensed/certified providers who are acting within the bounds of state law. The goal of the provision, as noted by the Senate Committee on Appropriations, is to afford patients access to the services of health practitioners functioning within their scopes of practice.[8] While the section is not a coverage mandate, it is inextricably linked to insurance plan offerings, and, as such, rests on the framework of federal essential benefits and state mandates that underpin this area.

Grandfathered health plans are excluded from the reach of Section 2706, but the provision encompasses individual and group health insurance, and reaches ERISA plans, as well as insurance products offered on state marketplace exchanges. The most obvious conditional element is that groups seeking anti-discrimination protection must be licensed or certified in a given state. While more established CAM providers, such as chiropractors and acupuncturists, are licensed in all 50 states, other types of providers, such as naturopaths and naprapaths are licensed in only a handful of jurisdictions, and still other CAM groups are simply not subject to any state law requirements, thus completely falling outside the scope of Section 2706(a).[9]

While Section 2706(a) may prohibit discrimination of a category of licensed professionals, it allows for discretion in contracting, and thus, is not an open door for any provider agreeing to a given plan's terms and conditions. A further qualification is added as the statute specifies that the rates of reimbursement under the provision provided by plans, insurers and the DHHS Secretary may vary based on performance and quality measures.

Like most pieces of legislation, Section 2706(a) was not cut out of whole cloth, but rests on prior initiatives. Both Medicaid managed care law, and Medicare Part C regulations contain non-discrimination sections that are similar, although not identical, to the ACA provision.[10] In addition, provider non-discrimination provisions are encountered in many state insurance laws.[11] For example, in Washington state, a law was enacted in 1996 that prevents health plans from limiting or excluding health care or services delivered by whole categories of health professionals.[12] The Washington State Insurance Commissioner interpretation of its provider non-discrimination section included ''alternative health providers,'' a harbinger of Section 2706(a).[13]

FAQ Stance

No legislative history exists to ascertain the meaning and scope of Section 2706(a). Federal regulators determined that the non-discrimination provision was self-executing, and thus no rule making on the Harkin provision took place. Rather, what was developed was a three-agency (Health and Human Services, Treasury and Labor) FAQ that offered a conditioned reiteration of Section 2706(a), as enforceable law, as of Jan. 1, 2014.[14] The interagency policy was short on guidance; it urged insurers to work in ''good faith'' to achieve a reasonable interpretation of the section. The directive was quite clear in its affirmation that licensed or certified providers should not be discriminated against in offering items and services within their scope of practice. The FAQ reinforces the plain meaning of the provision, noting that the section is not any-willing-provider provision. Further, the directive reiterates that non-discrimination doesn't prohibit plans and insurers from offering variable reimbursement, based on quality and performance measures, and adds a third variable, market consideration, as a reimbursement qualifier, not contained in the language of Section 2706(a).

In essence, the inter-agency interpretation of Section 2706(a) takes a rather hard stance on the provision. The FAQ cedes considerable discretion to plans and insurers to determine the methods, items and settings of treatment in which covered services are offered, consistent with medical management. But whether CAM providers are licensed or appropriately used, the FAQ position can be read in such a way that allows regulated parties to circumvent this provision by excluding whole classes of providers from participation.. Not only is market consideration an added qualifier, but also the notion of medical management as a litmus test for assessing appropriate items and services, is vague and open ended.

The context in which the FAQ was released is one characterized by extensive political activities on both sides of the non-discrimination issue, reminiscent of long standing battles between allopathic medicine, and

[7] For example, 42 U.S.C. § 256a-1; ACA § 3502(2014) opens the opportunity for CAM providers to be part of multidisciplinary teams.

[8] S. Rep. No. 113-71, at 126 (2013).

[9] While many CAM providers fall outside the bounds of formal licensure, they are certainly impacted by restrictions prohibiting the unlicensed practice of medicine.

[10] See Medicaid law, 42 U.S.C. § 1932(b)(7); Medicare Advantage plan regulations, 42 C.F.R. § 422.205.

[11] *See, for example*, Utah Code Ann. § 31A-22-618.

[12] Wash. Rev. Code § 48.43.045. The Washington Supreme Court, in an ERISA class action challenge against Regence Blue Shield upheld an Insurance Commissioner interpretation that health insurers (with some exceptions) must cover services offered by ''alternative health providers.'' *See* Hoffman v. Regence Blue Shield, 991 P.2d 77 (Wash. 2000).

[13] Commissioner Deborah Senn, AANP Memo On Implementation of ACA 2706(a) (2013).

[14] United States Department of Labor, FAQs about the Affordable Care Implementation Part XV, April 29, 2013, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html.

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''non-traditional'' providers.[15] The AMA position is that Section 2706(a) should be repealed, as the association sees it as an inappropriate expansion of non-physician scopes of practice, infringing on the purview of state regulators, as well as a policy that impedes the development of physician-led medical practice teams.[16] A number of medical specialty groups have taken up the anti-non-discrimination mantle and adopted positions similar to the AMA.[17] In support of the organized medicine policy, Rep. Andy Harris, M.D. (R-Md.) has introduced H.R. 2817, which calls for repeal of Section 2706(a).[18]

On the other side of the ledger a wide, and eclectic array of provider groups have been very vocal in their support of Section 2706(a) and expressed considerable dismay about the narrow interpretation of the section in the noted FAQ.[19] Concerns that the additional qualifying elements in the guidance diminish the impact of provider non-discrimination and consumer choice resulted in calls for the revision of the FAQ. During a Budget Reconciliation Hearing conducted by the House Energy and Commerce Committee, Rep. Peter Welch (D-Vt.) took CMS to task for its failure to issue Section 2706(a) guidance in keeping with the terms of the provision.[20] With the support of Welch and Harkin, language was inserted into the final report of the Consolidated Appropriations Act of 2014 requiring correction of the Section 2706(a) guidance, within 30 days of passage of the Act.[21]

The three agencies (HHS, Labor and Treasury) have acknowledged the Senate directive by issuing a request for information (RFI) , which calls for public comment on their interpretation of Section 2706(a), ensuring that there won't be quick closure on this matter.[22] It is speculation as to where the agencies will come out on Section 2706(a), but even a new interpretation, more closely tied to the statutory language, will not be easy to enforce.

CAM Benefits as Essential Health Benefits

As noted, Section 2706(a) is not a coverage provision, but it is closely tied to benefits provided within the context of an ACA covered insurance plan. Prior to the ACA, some CAM coverage was offered through certain insurance products as a matter of state law, or resulted from distinct market pressures impacting specific offerings.[23] In reference to the ACA, coverage policy needs to be evaluated in conjunction with the law's 10 essential benefits areas. In this regard, CAM services may be applicable in outpatient, maternity/newborn, rehabilitation, pediatric coverage, but are mostly rooted in prevention, wellness and chronic disease care. At first blush these mandated coverage areas appear to spark opportunities for more CAM services in light of the non-discrimination provision. But in reviewing the actual implementation of the essential health benefit (EHB) mandates in state benchmark plans, there is no evidence that these product offerings present dramatic expansion of non-traditional health services. In fact, it should be noted that the initial EHB benchmark plans were selected without reference to provider mandates, and specifically excluded requirements that licensed professionals be reimbursed if acting within their scope of practice.[24]

What is striking is the inconsistency in CAM coverage represented by state benchmark plans. For example, the California benchmark plan, based on the Kaiser Foundation Health Plan, covers acupuncture (limiting it to treatment for nausea or as part of a comprehensive pain management program), but does not cover chiropractic. New York State, covers chiropractic in its Oxford Health Plan-based benchmark plan, but does not provide coverage for acupuncture. In Washington state, the Regence Blue Shield benchmark plans offers 12 visit coverage for both acupuncture and chiropractic. The federally facilitated marketplace plans, as well as Small Business Health Options Program exchange plans, are based on state insurance products, thus coverage of CAM is likely to be variable there as well, and largely specific to only one jurisdiction.

Some CAM services, particularly chiropractic and acupuncture, appear to fare better under the Federal Employees Health Benefits (FEHB) program as their plans offer consistent coverage for those two areas. In January 2014, the FEHB, BCBS Benefit Plan announced that, in compliance with Section 2706(a), it would cover any licensed medical practitioner for offered services within the scope of the provider's license. Specific to chiropractic, BCBS announced that it would remove prior restrictions of one visit and one set of X rays per year.[25] Coverage in FEHB plans may be more generous than in state benchmark insurance, but here too the floodgates of non-traditional services have not been opened as certain services such as naturopathic medicine and massage therapy are specifically and categorically rejected.[26]

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[15] Barbara L. Atwell, *Mainstreaming Complementary and Alternative medicine in the Face of Uncertainty*, 72 UMKC L. Rev. 593 (2004).

[16] American Medical Association Board of Trustees Report 32-A-13 (2013). *See also* letter from James L. Madara, M.D., Executive Vice President, CEO, American Medical Association, July 13, 2013 to Hon. Andy Harris M.D.

[17] John Weeks, *Beltway Battle Over Patients' Rights to Integrative Medicine & Health*, available at http://www.huffingtonpost.com/john-weeks/integrative-medicine_b_3732460.html.

[18] Protect Patients' Access to Quality Health Professionals Act, 2013.

[19] Weeks, supra at 17.

[20] House Energy and Commerce Subcommittee on Oversight and Investigations, Seeking PPACA Answers, Jan. 16, 2014.

[21] American Optometric Association, *Congress Strengthens Harkin Law, Boosts Nondiscrimination*, available at http://www.aoa.org/news.

[22] 79 Fed. Reg. 14051. Comments are due by June 10, 2014.

[23] Chiropractic care is offered in some state Medicaid programs, see http://kff.org/medicaid/state-indicator/chiropractor-services/, a well as in Medicare, found at http://www.medicare.gov/coverage/chiropractic-services.html.

[24] Center for Consumer Information and Insurance Oversight, *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, available at http://www.cms.gov/cciio/resources/data-resources/ehb.html.

[25] Mark Sanna, *DC's Expansion of Coverage Under BCBS Federal Employees Plan*, Jan. 3, 2014, available at http://www.mybreak.com/dcs-expansion-of-coverage-under-bcbs-federal-employees-plan/.

[26] SAMBA Health Benefit Plan, High and Standard Options p. 46. *See* NASHO White Paper, Inclusion of Specialty Health on State Insurance Exchanges, March 22, 2011.

Scopes of Practice Battles and Challenges of Enforcement

Even if Section 2706(a) is reinterpreted in a plain meaning fashion, application of the section is still a major challenge in light of the fact that coverage rests on the item or service in question being provided within the non-traditional practitioner's scope of practice. Scopes of practice issues are the stock-in-trade of disputes across health professions, and none are more visible than those in areas involving non-traditional medicine. Generally, licensed health professionals have a defined scope of practice, rooted in state statutes and regulations. Scope-of-practice delineations, however, can be generic in nature and are not always dispositive about the propriety of a particular service, giving payers wide discretion in such matters. There is frequent push back from allopathic medicine concerning the efficacy of practice expansions by non-medical doctors, and boards of medicine are zealous stewards in defense of the boundaries of medical practice.[27]

In the wake of the ACA, there have been renewed efforts on the part of non-physician groups to expand their scopes of practice, and in particular, chiropractors and naturopaths have been seeking recognition as primary care providers.[28] Arguably there are parts of the country where both naturopathic doctors and doctors of chiropractic do serve as first line providers, and in lieu of shortages in primary care medicine, there is clearly a need for additional providers in the area.

The sticking point for scope of practice expansion, however, is not lack of need but rather the ongoing challenge of non-physician providers, especially those outside the umbrella of medical practice, to demonstrate the safety and efficacy of their services. There have been numerous efforts to develop a clinical foundation for CAM services, including a long-standing national research center, the National Center for Complementary and Alternative Medicine (NCCAM).[29] While some promising results have been achieved, the sum total of those efforts are not universally convincing and make practice expansion resting on a biomedical proof difficult.

One could look cynically at the universe of CAM services and conclude that it is not provider non-discrimination that fosters utilization, but rather the offering of services that constitute non-competitive supplements to conventional medical care. In essence non-physician providers are allowed to function in areas where they fill a void in services or provide care that may be similar but nonetheless distinct from what is offered by a medical doctor. [30]

Another Way Forward – Integration and PCMHs

The larger issue underlying Section 2706(a) goes beyond questions of non-discrimination and rests with broader considerations about the adequacy of the health-care workforce. While the ACA may not have paved the way for easy insurance coverage of non-traditional health care, it does provide a template for a cautious expansion of alternative health care practitioner services. The role of non-traditional health providers, not as physician competitors, but as licensed health professionals in their own right, needs to be assessed in the broader scheme of public health needs.

While Section 2706(a) may be a difficult foundation on which to build an expansion and normalization of non-traditional health services, the ACA presents other opportunities to do so, especially within its efforts to usher in innovations in the delivery system. Particularly noteworthy for CAM providers is the ACA support for the development of patient centered medical homes (PCMH), a physician lead interdisciplinary practice team which focuses on primary care services. Within the context of the PCMH the health reform law directs the Secretary of DHHS to fund Community Health Teams, which are multi–disciplinary provider groups that support medical homes and may include chiropractors and alternative medicine practitioners as team members.[31] PCMHs have broad Medicare and Medicaid applicability and are being expanded into the concept of a patient centered medical neighborhood (PCMN). The PCMN is a multi-institutional community collaborative model directed toward enhancement of the health care workforce, and offers potential for creative use of multiple provider groups.[32]

Community Health Teams, PCMH and PCMN models afford an opportunity for non-traditional practitioners to develop partnership relationships with traditional primary care professionals. Such collaborative models are not without precedent, as they rest on prior initiatives in integrative medicine, but hold the potential to be far broader and more focused on a wider array of patient needs. In addition, collaborative practices will allow for the development of a clinical experiential base that may be far more persuasive in garnering support from allopathic medicine than CAM medical efficacy studies to date.

An integrative patient centered medical home would not need to be generic in character but could be structured around particular treatment areas. As such a large percentage of non-traditional health providers are concentrated in the area of manipulative medicine, this would be an ideal area for interdisciplinary expansion. In particular, manipulative medicine collaboration

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[27] Atwell, supra at 15.

[28] *For example, see* The Connecticut Naturopathic Physicians Association Request for a Change in the Scope of Practice of Naturopathic Physicians Licensed in Connecticut, Aug. 14, 2013.

[29] NCCAM, supra at 4.

[30] For an excellent review of CAM integration, highlighting challenges see Douglas Mann, Susan Gaylord, Sally Norton, *Integrating Complementary and Alternative Medicine with Conventional Care*, available at http://www.med.unc.edu/phyrehab/pim/files/Integrating.pdf.

[31] 42 U.S.C. § 256a-1, ACA § 3502(b)(4)(2010).

[32] TransforMED leads patient centered medical neighborhood kickoff learning collaboratives with health care organizations in eight more neighborhoods found at http://www.pcmneighborhood.com/transformed-leads-patient-centered-medical-neighborhood-kickoff-learning-collaboratives-with-health-care-organizations-in-eight-more-u-s-communities/. For a discussion of the patient centered medical neighborhood as an evolving model, *see* Xiaoyan Huang, Meredith B. Rosenthal, Transforming Specialty Practice and the Patient Centered Medical Neighborhood, New Eng. J. Med. 2014:1376-1379.

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could concentrate on pain management, and this focus could be further directed to back pain, a long-standing, costly health problem.[33] Back pain is an area of health care where there is a history of interdisciplinary collaboration, and certainly is an area where conservative alternatives are a welcome option to more costly surgical and drug interventions.

No doubt those CAM providers who seek greater autonomy and expanded scopes of practice may view integrative PCMHs as a trap in which their professions are relegated to a diminished status. Non-discrimination akin to Section 2706(a) may ultimately be a more powerful lever to combat disparity, but meaningful acceptance of non-traditional health will only be garnered through ongoing collaborations among licensed health providers. Those who provide CAM services, particularly in areas such as pain management, should be judged on the present value they bring to the health system and not on their potential to assume roles that will put them into perennial battles with organized medicine. While Section 2706(a) may provide certain protections for non-traditional providers, the larger challenge is to integrate this workforce into the delivery system in ways that address broad public health challenges.

[33] NCCAM Low Back Pain available at http://nccam.nih.gov/health/pain/lowback.htm.

Conclusion

Section 2706(a) opens an avenue for expanded use of licensed/certified non-physician providers in a wide range of health plans and insurance products, as a result of its prohibition on non-discrimination. But Section 2706(a) is conditioned in such a way that its utility for many providers is quite constricted. In particular, CAM practitioners face serious challenges in using Section 2706(a) as a lever for coverage expansion; the section is linked to the idiosyncrasies of state scopes of practice laws and the biases of payers who are likely to see such expansions as costly and unnecessary. While CAM services are popular, they are subject to the vibrancy of clinical efficacy studies that have been tepid at best. Nonetheless, the ACA offers opportunities for CAM expansion and legitimacy beyond the limitations of Section 2706(a) through inclusion in emerging practice models. Major areas of population health needs such as those in the area of pain management offer opportunities to develop avenues to better utilize the alternative practitioners, not as reinvented primary care doctors but as licensed professionals within their current scopes of practice. The innovations ushered in by the ACA hold promise for more meaningful use of the large CAM workforce. Collaborative practice models such as PCMHs have the potential to promote non-traditional health providers in more ways that could be more expansive than Section 2706(a) and hold significant promise to assist in combating chronic illness.