



June 5, 2014
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 CMS-9942-NC

The Integrative Healthcare Policy Consortium (IHPC) thanks the Department of Health and Human Services (DHHS) for the opportunity to respond to your Request for Information dated March 12, 2014 regarding provider non-discrimination. The IHPC is a national nonprofit 501(c)(4) consortium composed of 13 organizations and institutions (“Partners for Health”) representing more than 400,000 licensed, and state and nationally certified healthcare professionals. Our mission is to advocate for an integrative healthcare system with equal access to the full range of health-oriented, person-centered, regulated healthcare professionals.

This response to the Request for Information covers the following key points:

1. Background on the intended interpretation of Section 2706(a), Title XXVII of the Public Service Act and examples of misinterpretation and contrary guidance
2. Examples of variable implementation
3. Examples of non-discrimination in healthcare preceding Section 2706
4. Results of an IHPC survey characterizing the present landscape
5. Key recommendations for DHHS to consider
6. Appendices: statements from IHPC Partners for Health representing licensed healthcare practitioners impacted by discrimination
7. Attachments

History of discrimination and unintended interpretation

Senator Tom Harkin was the author of Section 2706(a), which safeguards patient access to non-MD/DO state licensed or state certified providers, including (but not limited to) chiropractors, naturopathic physicians, acupuncturists, massage therapists, optometrists, nurse practitioners and licensed or direct entry midwives and podiatrists, and who are providing a covered benefit within that practitioner’s scope of practice. Section 2706 is understood to prohibit plans from covering a given service when offered by one type of licensed provider while denying coverage when the same service is provided by another type of licensed provider.

Discrimination against any provider group, as a whole, is harmful to patients and restricts their ability to select the provider of their choice. Health plan discrimination is not only wrong in principle, but is without justification based on the universal benchmarks of quality of health care. Section 2706 is a vital component of the Affordable Care Act (ACA), embodying the federal government's goals of better access, increased cost efficiency, and enhanced quality. The ability for patients to choose the licensed provider of their choice is integral to the intended implementation of the ACA. **If access, cost, and quality are indeed the pillars of health reform, Section 2706 should be considered a linchpin to the Act's success.**

Unfortunately, Congress's aim of non-discrimination in Section 2706 has been interpreted in a variety of unintended ways (see Attachment 1). DHHS, the Department of Labor (DoL), and the U.S. Treasury issued a sub-regulatory guidance FAQ which is misleading, inaccurate and a threat to the very foundation of this provision. In that guidance, the Departments have interpreted the law in a way that violates its express language. Health plan issuers are currently exploiting loopholes so that they may continue to perpetrate the very type of discriminatory practices that Section 2706 was designed to prevent. Two specific flaws in the guidance are as follows:

1. The guidance *correctly* states that, to the extent an item or service is covered, an insurer shall not discriminate against a provider as long as the provider is acting within the scope of his or her license under state law. However, the guidance also states, *incorrectly*, that insurers are not required to accept all types of providers into a network.
2. The guidance allows insurers to employ "medical management techniques" or "market standards and considerations" to discriminate against certain types of providers and the patients that seek their care. These allowances are inconsistent with the language and intent of 2706. High-level critique of this misleading, inaccurate guidance is illustrated in statements from the Senate Appropriations Committee, the Principal Deputy Administrator at the Centers for Medicare and Medicaid Services, and Representative Kurt Schrader in his open letter to Secretary Kathleen Sebelius.

The Senate Appropriations Committee took strong issue with the FAQ, characterizing this guidance as a misreading of the statutory language and issuing a rebuke. In specific response to the FAQ, the Senate Committee on Appropriations Report dated July 11, 2013 (113-71, to accompany S. 1284) included the following language:

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.²

¹ http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

² <http://www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf>

The Senate Committee on Health, Education, Labor and Pensions has also recently written a letter to the three agencies, dated April 28, 2014, again underscoring their concerns with the FAQ and the Committee's expectation that the FAQ be corrected expeditiously (see Attachment 4).

Furthermore, in response to the confusion already promulgated by the misleading Center for Consumer Information and Insurance Oversight (CCIIO) FAQ, Jonathan Blum, Principal Deputy Administrator at the Centers for Medicare and Medicaid Services, answered a petition to the White House regarding the role of naturopathic physicians in the ACA:

*The law [Section 2706] also provides that a health plan or 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 licensure or certification under applicable state law. The law does 'not require that a group health plan or health insurance issue contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer,' and does not prevent a 'group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.' **We also note that this requirement addresses the type of providers included in a network, not which services are covered.***

This final point (in bold) is a key point that needs to be clarified in new guidance for Section 2706. Otherwise, states and health plans issuers will be left with conflicting information on how to implement this provision.

Furthermore, Representative Schrader voiced his dissatisfaction with the FAQ document in a letter to Secretary Sebelius (see Attachment 3 for full text). He states that he is:

"concerned that in the FAQ document published on April 29, 2013, the Departments advise insurers that section 2706 "does not require plans or issuers to accept all types of providers into a network." By claiming that insurers may exclude whole categories of providers operating under a State license or certification, the Departments are interpreting the law contrary to Congressional intent. We are concerned that this may mislead insurers, state regulators, and providers. Furthermore, the FAQ advises that section 2706 allows reimbursement rates to be determined based on "market standards and considerations." On this point, once again the language of the Affordable Care Act is quite clear—reimbursement rates may be varied based on quality and performance measures, but the law does not allow insurers to vary rates based on broad and undefined "market considerations."

The congressional intent of Section 2706 is clear, as demonstrated by its plain language as well as the Senate Appropriations Committee Report. Senate Report 113-71 also clearly demonstrates that the FAQ is flawed and needs to be corrected to accurately reflect the intent of Section 2706. Mr. Blum interpreted Section 2706 correctly. Representative Schrader points out the flaws, and Mr. Blum's interpretation did not veer from the statute and did not add the puzzling, superfluous and extraneous language found in the FAQ. The FAQ needs to be revoked immediately and replaced by new guidance to avoid any further confusion.

Variable compliance with Section 2706

A balanced review of Section 2706 published in the Bureau of National Affairs Health Law Report provides examples of inconsistent compliance with Section 2706:³

“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.”⁴

One such example is the following:

- The Blue Cross Blue Shield Federal Plan is an example of a plan that has attempted to comply with Section 2706, but has omitted certain provider groups such as naturopathic physicians and massage therapists.⁵

Positive examples include:

- 2014 Blue Cross and Blue Shield Service Benefit Plan Section 2
“Changes to both our Standard and Basic Options: subject to the criteria appearing on page 18, we now cover any licensed medical practitioner for covered services performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act (PHSA). Previously, benefits for certain medical practitioners were limited to services performed in Medically Underserved Areas.”⁶
- University Health Alliance (UHA), a Hawaii-based insurance plan, is attempting to comply with Section 2706. UHA has long covered chiropractic and acupuncture, but not naturopathic medicine. The 2014 UHA participating provider agreement now states in Section 1:11: *“Physician” means a person who holds an M.D., D.O., or N.D. degree and has a valid, current and unrestricted license to practice medicine in the State of Hawaii.* Whether licensed midwives and massage therapists are covered by UHA remains yet unclear.

Further examples of discrimination contrary to the congressional intent of Section 2706 can be found in the Appendix documents submitted by IHPC’s Partners for Health.

³ Blum, John D. “Non-Discrimination and the Role of Complementary and Alternative Medicine.” BNA’s Health Law Reporter:23 HLR 574, 4/24/14. The Bureau of National Affairs, Inc. (800-372-1033) <http://www.bna.com>

⁴ <https://petitions.whitehouse.gov/response/naturopathic-physicians-and-affordable-care-act>

⁵ 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.)

⁶ <http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2013/brochures/71-005.pdf>

Examples of non-discrimination in healthcare preceding Section 2706

Several examples exist which could serve as models for consistent interpretation and enforcement of Section 2706 as intended by Congress:

1. CMS has a rule that prohibits discrimination against practitioners in Medicare Advantage. This rule requires insurers to “furnish written notice to the effected provider(s) of the reason” for declining to include a given provider or group of providers in its network.⁷ Language such as this would be helpful in achieving compliance with Section 2706.

§422.205 Provider antidiscrimination rules.

(a) General rule. Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under §422.204, and with the requirement under §422.100(c) that all Medicare-covered services be available to MA (Medicare Advantage) plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision.

(b) Construction. The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan’s enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).

(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

[65 FR 40324, June 29, 2000]

2. Washington State has had a law prohibiting discrimination in healthcare since July 28, 1999. This Act (WAC 284-43-205) has become known as the “every category of provider” law.⁸ It is in many respects a precedent for Section 2706:

“To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the carrier’s standards pursuant to RCW 48.43.045 (1)(b). For example, if the BHP provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) may not be excluded from the network.”

⁷ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c06.pdf>

⁸ <http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-205>

Due to the longstanding nature of this statute, Washington State serves as a laboratory for what the country can expect from correct interpretation and enforcement of Section 2706. Numerous research studies have been published on the costs and outcomes of this law since its implementation, and findings reveal highly favorable results:^{9,10}

- Median per-visit expenditures were \$39 for complementary and alternative care medicine (CAM) care and \$74.40 for conventional outpatient care in Washington.
- The total expenditures per enrollee were \$2,589, of which only \$75 (2.9%) was spent on CAM.
- A systematic review of cost/benefit analyses of CAM compared to conventional care revealed that 42% of the published studies demonstrated cost savings.
- CAM users averaged \$1,420 less in annual health care expenditures than non-users among patients with the heaviest disease burden.

HHS' FAQ on Section 2706 conflicts with this long-standing law in Washington State, stating as it does – *incorrectly* – that insurers are not required to accept all types of providers into a network. Fortunately, compliance in Washington State with Section 2706 is not problematic because of this pre-existing “every category of provider” law.

We recommend that HHS look to Washington State and the select list of compliant insurers as examples on which to model Section 2706 guidance and enforcement strategies. This will ensure that the statute has the intended effects on access, cost, and quality of healthcare across the United States.

Results of a survey of 5300 licensed healthcare providers

IHPC, through its 13 Partners for Health organizations, disseminated a survey questioning practitioners about their experience with implementation of Section 2706 within qualified health plans since the provision went into effect on January 1, 2014. The intent of the survey was to understand the national landscape in the early months of implementation.

A total of 5,345 practitioners practicing in 50 states and 3 territories completed the survey. The survey collected data from naturopathic physicians, licensed acupuncturists, chiropractors, licensed massage therapists, licensed midwives, medical doctors, osteopathic physicians, optometrists, clinical psychologists, registered nurses, physician assistants, advanced practice registered nurses, homeopaths, physical therapists, and occupational therapists.

⁹ Lafferty, W. et al. Insurance coverage and subsequent utilization of complementary and alternative medicine providers. *Am J Manag Care*. 2006;12:397-404.

¹⁰ Lind, BK. et al. Comparison of Health Care Expenditures Among Insured Users and Nonusers of Complementary and Alternative Medicine in Washington State: A Cost Minimization Analysis. *The Journal of Alternative and Complementary Medicine*. April 2010, 16(4): 411-417. doi:10.1089/acm.2009.0261.

Key findings reveal patients and their healthcare providers are trying to work within the insurance-based healthcare system, yet are experiencing challenges with Section 2706 implementation in almost every state. Here are select findings:

- Only 33% of surveyed healthcare practitioners have cash-only practices.
- Of those, 67% still provide their patients with appropriate documentation, such as superbills, to submit for reimbursement from their insurance companies.
- Despite these efforts, 85% (more than 3,600 respondents) said their patients were rarely, irregularly, or incompletely successful in obtaining reimbursement for the healthcare services they provided and coded on a superbill.
- Problems also exist among providers who contract with a third-party payer. Twenty one percent report that patient access to healthcare services has been denied since January 1st, 2014.
- The characteristics of discrimination that healthcare professionals have experienced are summarized below in Figure 1.

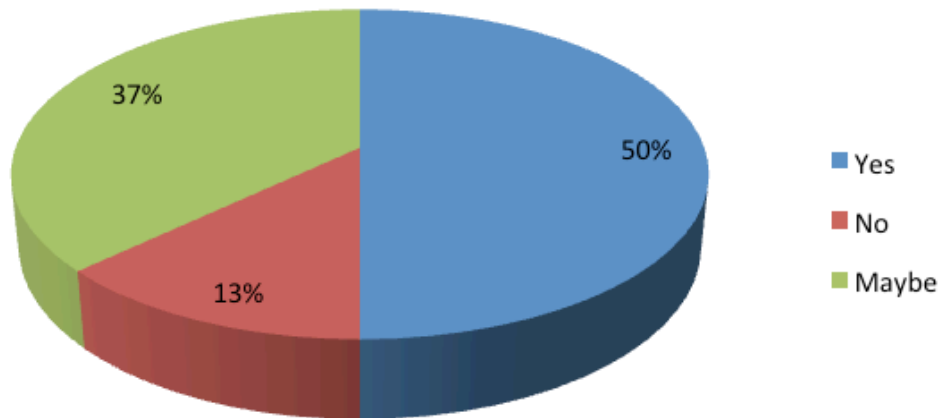
Figure 1: Frequency of responses to the types of issues CAM healthcare professionals have had when working with third-party insurance payers.

Type of Issue	Responses
Reimbursed for services, but at lower than the billed rate	64.06% n=2,408
Refused reimbursement when credentialed for a healthcare plan	25.41% n=955
Been unable to apply for healthcare plan credentialing	24.66% n=927
Had medical necessity of your treatment plan questioned/denied	51.56% n=1,938
Other	20.91% n=786
Total Respondents: 3,759	

More than 20% of surveyed healthcare practitioners were denied credentialing last year; in 2014, less than 10% (or approximately 400 providers) have been denied credentialing in circumstances that may reflect non-compliance with Section 2706. IHPC has detailed information about specific insurers throughout the country that can be made available if such data would be useful.

Despite these sobering statistics about the lack of success working with private insurers, members of IHPC’s Partners in Health overwhelmingly responded with openness toward future integration with the health insurance system (See Figure 2). More than 2,100 respondents are already working with PPO and HMO providers.

Figure 2: Survey responses to “If your services were reimbursed by a health insurance plan, would you pursue credentialing to become part of a health insurance payer network?” (n=5029)



As with any survey, there are limitations. Results may not be fully representative of the CAM healthcare practitioner community. IHPC received a higher frequency of responses from those states with the highest numbers of practitioners and with insurance plans covering a broader spectrum of services. While not exhaustive, the survey does capture objective data from the frontlines of CAM clinical practice regarding the extent of non-compliance with Section 2706.

Recommendations from the Integrative Health Policy Consortium

We respectfully urge that DHHS consider taking the following actions:

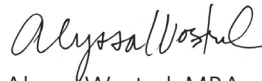
1. Revoke the FAQ issued April 29, 2013 and issue new, unambiguous guidance, as soon as possible **so that Section 2706 is understood to prohibit plans from covering a given service when offered by one type of licensed provider while denying coverage when the same service is provided by another type of licensed provider.**
2. Consider that model statutory language exists in Washington and Vermont – states with longstanding laws with the same intent as Section 2706.
3. Clearly provide, in the newly-issued guidance, that commercial insurers must allow all types of licensed providers to participate in their networks and to clearly define terms such as network adequacy.
4. The new guidance must not allude to “medical management techniques” or “market standards and considerations.” While Section 2706(a) does not prohibit insurers from varying reimbursement rates-based on quality and performance measures, the terms “medical management techniques” and “market standards and considerations” are arbitrary as well as completely contrary to the statutory intent.
5. Identify DHHS liaisons to serve as representatives/ombudsmen to the States in order to provide greater guidance to state insurance commissioners in the service of uniform and consistent implementation.
6. Ensure that each State display on its public website the appropriate Department and representative to serve as contact for consumers and healthcare practitioners related to 2706.
7. Encourage legislation that adds similar language to the Medicare statutes to ensure similar non-discrimination and equal access applicable to the full range of health-oriented, person-centered, regulated healthcare professionals.

Thank you for your attention to these comments in response to the Request for Information. IHPC and its Partners for Health will be pleased to serve as a resource should further information be desired, (202-505-4472; www.ihpc.org).

Sincerely,



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Appendix 1

Doctors of Chiropractic:

Through the restoration of spinal function, chiropractic service has served to optimize health and well being for all age groups. Chiropractic service has proven to provide the most cost-effective approach to managing conditions related to spinal dysfunction.

Doctors of Chiropractic provide cost effective management of health conditions for Americans of all age groups including many services deemed “essential” in the PPACA. Patients who choose a Doctor of Chiropractic as their primary care provider should not be discriminated against with reimbursement models that impose economic penalties for their choices.

A History of Provider Discrimination Against the Chiropractic Profession and Chiropractic Patients:

Self-insured plans have developed benefit structures wherein there is a chiropractic/spinal manipulation benefit; however, the benefit is only payable when the services are rendered by a Medical Doctor (MD) or Doctor of Osteopathy (DO), but not by a Doctor of Chiropractic (DC). This effectively creates an illusory benefit and drives patients away from choosing a DC for their care, and away from chiropractic treatment and spinal manipulation due to the scarcity of MD/DOs who will perform manipulation.

Section 2706 applies in the following situations:

- When there is evidence that doctors of chiropractic are being reimbursed at a different level than other providers for the same covered service and such discrimination is not based on quality or performance measures, but is based in whole or in part upon licensure and anticompetitive bias which perpetuates deleterious monopolistic practices;
- When there is evidence that an insurer or group health plan is, for example, applying caps on specific services provided by doctors of chiropractic, and such caps are not being applied to other providers based in whole or in part upon licensure;
- When there is evidence that the insurer or group health plan is denying specific forms of care otherwise covered under the plan on the basis that it is provided by a doctor of chiropractic, and the covered service is within the scope of practice of a doctor of chiropractic; and
- When there is evidence that doctors of chiropractic are being excluded as a group from participation in a network’s plan.
- When services provided by doctors of chiropractic are denied not based on training, competency and license to provide those services but rather on type of provider.

Appendix 2

Naturopathic Physicians:

The American Association of Naturopathic Physicians (AANP) is a partner organization of the IHPC. Naturopathic physicians (also known as naturopathic doctors or NDs) specialize in natural medicine, combining the wisdom of nature with the discipline of modern science. NDs are trained in a variety of natural approaches (such as diet and lifestyle modification, nutraceuticals, botanicals, homeopathy, and oriental medicine) with a focus on prevention and less invasive treatment, all of which have been shown to reduce costs and get to the root of one's health issues.

There are approximately 4,500 licensed NDs in the US. In order to become licensed to practice, an ND must graduate from a four-year graduate level program at an institution recognized through the U.S. Department of Education. Beyond the extensive classroom study and clinical training required, the ND must also pass an extensive postdoctoral exam and fulfill annual continuing education requirements. NDs are currently licensed in 20 states and territories.

Naturopathic physicians perform many of the services specified in the Affordable Care Act's "Essential Health Benefits." These include ambulatory care services, such as taking routine physical examinations and thorough health histories, performing cardiovascular screenings and Pap smears, referring for colonoscopies and mammograms and ordering lab tests, imaging procedures, and other diagnostic tests. Even prior to enactment of the Affordable Care Act, NDs were credentialed in-network in a number of states by such insurance plans as Blue Cross/Blue Shield and Cigna.

Challenges with Section 2706 Implementation

AANP strongly supports the legislative intent of Section 2706, which is to ensure that patients are able to choose the health care provider they believe is best suited to address their health care needs as long as the provider is licensed or certified under state law and is acting within the provider's permitted scope of practice. Implementation of Section 2706 according to its statutory intent will enable patients to realize greater choice among the types of health care providers they visit. Furthermore, proper implementation will improve the emphasis within our health care system on patient-centered, prevention-oriented, whole person care.

These aims, however, are confounded by the problematic FAQ issued April 29, 2013 by the Departments of Health and Human Services, Treasury, and Labor. Exacerbated by this FAQ, guidance at the state level is inconsistent and confusing; in many cases, there is no state guidance whatsoever for insurers or NDs. In just one state where NDs are licensed – Montana – has the insurance commissioner unambiguously stated that she is "admonishing all health insurers to offer provider contracts to naturopathic physicians" and that, if a patient's ND "provides a service that covered under [the given] health plan and is within the ND's scope of practice, it must be covered by the insurer."¹¹

Based on information furnished to AANP by its affiliated state associations (several of which are commenting separately in response to the Departments' Request for Information), insurers fall into one of three categories:

¹¹ Lundeen, Monica J. Commissioner of Securities & Insurance, Office of the Montana State Auditor. Letter to the Montana Association of Naturopathic Physicians and its patients. February 13, 2014.

- 1) The large majority is doing nothing to comply with Section 2706; e.g., these insurers have not changed their contracting procedures or processes for including providers in any way.
- 2) Some insurers are choosing to include covered services provided by NDs out-of-network, though they reject or ignore NDs' requests to be covered in network.
- 3) A very few insurers are acting in accordance with the statutory intent of Section 2706.¹²

The result of such inconsistent implementation is that patients are being denied access to the provider of their choice. Examples include:

- Routine doctor visits not being covered – despite the fact that ND bill patients using the same CPT codes as other provider types (88150, 99202, 99203, 99204, 99211, 99212, 99213, 99214, etc.)
- Lack of coverage for a mandated routine preventative screening ordered by an ND; for example, a well-child exam, annual preventive physical, Pap or mammogram that would be covered if ordered by another provider type
- Insurers' refusal to cover a pharmaceutical, lab, or diagnostic imaging that would be covered if ordered by another provider type
- Substantial difference in the reimbursement rates for services of the same quality and performance when done by an ND versus the reimbursement rates for other providers
- Insurers' refusal to credential an ND as an in-network provider
- Higher patient co-pays for services provided by an ND versus the co-pays applicable to identical services offered by another provider type
- Applying a \$1,000 or other annual cap for services that are identical to those of other providers not subject to that cap
- Applying labs and diagnostic imaging against a different 'alternative care' cap, instead of applying it to the plan's normal deductible
- Insurers disregarding NDs' requests for information for becoming a provider as well as applications for same

This widely varying range of coverage is to be found in virtually every other state in which NDs are licensed. (AANP's comments on the Request for Information, filed separately, will highlight those other examples.)

Remedy Requested

In order for Section 2706 to achieve its purpose, DHHS should revoke its FAQ of April 29, 2013 and issue new guidance to ensure that the statute is implemented in a manner true to its legislative intent. Without such action, private health insurers will continue the very types of discriminatory practices that the law aims to prevent.

¹² Lundeen, Monica J. Commissioner of Securities & Insurance, Office of the Montana State Auditor. Letter to the Montana Association of Naturopathic Physicians and its patients. February 13, 2014.

The Senate Appropriation Committee, Subcommittee on Labor, HHS, Education, and Related Agencies made clear that the FAQ was inconsistent with the intent and actual language of the law through its report on the 2014 HHS appropriations bill.¹³ Early in 2014, at a hearing of the House Energy and Commerce Committee’s Oversight and Investigations Subcommittee, Rep. Peter Welch (D-VT) took HHS to task for its FAQ that “could lead to discrimination against some providers by allowing health insurers to continue the very abuses that the statute aims to stop.”¹⁴ Furthermore, HHS will soon be receiving letters from members of both the House and Senate, authored by Rep. Kurt Schrader (D-OH) and Sen. Tom Harkin (D-IA), respectively, stating that the FAQ is “misleading, inaccurate, and a threat to the very foundation of the provision.” (See Attachment 3.)

The new guidance must be unambiguous so that Section 2706 is understood to require that all categories of licensed health providers who are acting within the scope of their license or certification under applicable State law be permitted to be included in-network.

Additionally, the new guidance must not allude to “medical management techniques” or “market standards and considerations.” While Section 2706 does not prohibit insurers from varying reimbursement rates based on quality and performance measures, the terms “medical management techniques” and “market standards and considerations” have no basis in the statute’s legislative history. In fact, those terms are completely contrary to the statutory intent.

We call upon the Departments to issue new guidance on Section 2706, superseding the April 29, 2013 FAQ, so that the promise of this law is fulfilled.

¹³ Report 113-71. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2014. July 11, 2013, p. 126. <http://www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf>

¹⁴ US House of Representatives. Energy and Commerce Committee – Oversight and Investigations Subcommittee. “2014: Seeking PPACA Answers.” Hearing held January 16, 2014. <http://energycommerce.house.gov/hearing/2014-seeking-ppaca-answers>

Appendix 3

Licensed Acupuncturists:

The American Association of Acupuncture and Oriental Medicine (AAAOM) is the national professional association representing over 32,000 AOM professionals, approximately 8,000 thousand current students, and millions of patients since 1981. The profession of acupuncture is a standardized, licensed, and regulated health care profession that conducts training in accredited institutions and provides safe low cost and comparatively effective evidence-based medical services. In a number of states, insurers will cover acupuncture services provided by an MD, but not a licensed acupuncturist.

Survey Results

From the professions surveyed (Medicine, Osteopathy, Chiropractic, Naturopathy, Acupuncture, etc.) a total of 5,345 practitioners responded. Over 66% of total respondents indicated that they do not have a cash-only practice and of those who do have cash practices, the majority are providing superbills for patients to get reimbursement for services – indicating that a large percentage of patients expect to be reimbursed for services by their insurer. More than half of providers are not credentialed as a preferred provider organization (PPO) in-network provider and/or a health maintenance organization (HMO) provider but more than 86% of respondents indicated they would become credentialed if their services were reimbursed by the third-party payer. Most importantly, there is a positive trend of reduced denials appearing for bills submitted on, or after January 1st 2014 – likely a direct result of the implementation of Section 2706.

More than 70% of total respondents provided details surrounding denial reasons given by insurers. The issues and denial reasons provided by insurers (i.e. medical necessity, inappropriate reimbursement rates, credentialing challenges, etc.) seem to indicate that there is a widespread lack of knowledge surrounding the overall utilization, effectiveness, and cost-effectiveness of these services. While these challenges and discrimination may persist at the insurer level, the data seem to indicate that the vast majority of respondents are coordinating care directly with (i.e. 25% consult with, 28% co-manage with, and 65% refer to) their local physicians.

Kaiser Family Foundation and Health Research and Educational Trust published a telephone survey of 3,017 companies in September 2004, which showed a 14% increase of employer coverage for acupuncture between 2002 and 2004. The survey found that 47% of all employers surveyed offered acupuncture as a covered health benefit, up from 33 percent in 2002. It also found that acupuncture services were covered more often in point-of-service (POS) plans (52%) than in PPO (47%), conventional (44%) or HMO (41%) plans, and that larger companies were more likely to provide acupuncture coverage.

Discrimination Persists

The acupuncture community had high hopes that the Affordable Care Act would end discrimination against licensed healthcare providers. Unfortunately, the guidance for the implementation of section 2706¹⁵ is both confusing and inconsistent with the intent of the law and instead of reducing discriminatory practices it encourages insurers to continue and/or increase discrimination against licensed providers. The AAAOM will continue to work to change this.

¹⁵ <http://www.dol.gov/ebsa/faqs/faq-aca15.html>

Appendix 4

Massage Therapists:

As of now, the implementation of the Affordable Care Act has had little impact on the massage profession. More than 80% of massage therapists are not credentialed with an insurance provider, although roughly 50% would be interested if they were able to get reimbursement. The path of integration between massage therapists and healthcare providers continues to be referral-based, accounting for more than 50% of the relationships massage therapists have with doctors. There is still little collaboration among massage therapists and hospitals, despite the fact that nearly 40% of hospitals utilize CAM therapies and that massage therapy is the most popular outpatient service of all CAM therapies. (http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Daily/2012/Jan/ananth012612-0180007602). As a patient-centered, prevention-oriented, whole-person care, massage therapy should be a critical component of preventative and rehabilitative services in a national healthcare system. With the recent implementation of the ACA and questions about coverage for massage therapy in certain instances, it is not surprising the numbers are where they are in terms of credentialing, reimbursement and relationships with healthcare providers. Despite research indicating effectiveness, massage therapists and the services they provide are discriminated against. A licensed massage therapist, acting within his or her scope of practice, should be accepted and reimbursed in the same manner as a physical therapist, doctor, or other healthcare provider providing the same service.

Appendix 5

Homeopaths

The ACA has limited effect so far in the emerging profession of homeopathy. ACA's Sec.2706 supports the individual patient's choice of practitioner, but for patients who choose homeopathy, reimbursement is currently very unlikely. As a multidisciplinary profession in which homeopathy itself is not individually licensed, approximately 30% of nationally certified homeopathic practitioners hold some other primary form of licensure (e.g. MD, DO, DC, PA, ND, FNP, CNM etc). Licensed practitioners with homeopathy in their scope of practice are restricted from billing for services. Adequate CPT codes for many integrative services, such as a homeopathic consult are not within the insurer allowable billing. For example, a chiropractor providing a homeopathic consult for a client who suffers recurrent muscular back pain, would not be able to bill for these services because the insurer specifies allowable CPT codes which are only for treatments related to diagnosis of spinal conditions. The remaining 70% of certified homeopathic practitioners are not credentialed with an insurance provider, although there is strong interest if reimbursement were possible. As an integrative healthcare discipline, homeopathy has much to offer: a patient centered approach for the whole person including prevention, promotion of health, and management of chronic disease. Implementation of Sec.2706 would ensure that insurers be required to cover services for licensed and nationally certified homeopathic practitioners who are working within their scope of practice.