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STATE OF OREGON
LEGISLATIVE COUNSEL COMMITTEE

November 15, 2012

Representative Bill Kennemer
900 Court Street NE H380
Salem OR 97301

Re: Discrimination Against Types of Providers in the Coverage of Essential Health Benefits

Dear Representative Kennemer:

You have asked for an opinion on the following questions in order to clarify how federal nondiscrimination language may apply to the benchmark plan that Oregon has adopted as its essential health benefit package:

1. If providing an essential health benefit/service is within the scope of a chiropractic physician's license e.g., primary care treatment of illness/injury, home health care, inpatient rehabilitation, lab tests, X-ray services, imaging/diagnostics (MRI, CT, PET etc.), preventative and wellness services and chronic disease management, smoking cessation, diabetes education, allergy testing, screening pap tests, prostate cancer screening, pediatric services, etc., can an insurer deny payment to a participating chiropractic physician who provided one of these essential health benefits/services based solely on that provider's license or discipline?

2. Put another way, would an Oregon insurer violate federal law if that insurer refuses to pay for an essential health benefit/service provided by a participating chiropractic physician when providing that service is within that provider's scope of practice to deliver because he or she is <u>not</u> a medical/osteopathic physician?

3. If a particular essential health benefit/service is within the scope of practice of a participating health care provider (e.g., chiropractic physicians, naturopathic physicians, nurse practitioners, acupuncturists, etc.) would an Oregon insurer violate [Section 2706 of the ACA] federal law if an insurer refused payment for that service because the participating provider was <u>not</u> considered a "primary care physician/provider?"

The short answers to your questions are a qualified no, yes and yes.

Here is a more detailed answer.

Statutory and regulatory framework

The federal Patient Protection and Affordable Care Act (PPACA) requires all health insurance policies to cover "essential health benefits" beginning in 2014. Section 1302 of the Act[1] defines essential health benefits as including services within the following benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. The United States Department of Health and Human Services (HHS) has not promulgated regulations to fine-tune the essential health benefits that must be covered, but has issued preliminary guidance to states.[2] Under this guidance, for 2014 and 2015, each state may establish its own definition of essential health benefits by selecting one of the following plans issued in the state:

(1) The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;

(2) Any of the largest three state employee health benefit plans by enrollment;

(3) Any of the largest three national Federal Employees Health Benefits Program plan options by enrollment; or

(4) The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

Each state was required to select one of the four plans as its benchmark for essential health benefits and report its decision to HHS by September 30, 2012. The Oregon Health Policy Board and the Oregon Health Insurance Exchange Corporation board of directors recommended to the Governor the largest small group insurance product in the state's small group market, which is PacificSource Preferred CoDeduct. Since this plan does not cover all of the 10 categories required by the PPACA, the boards recommended that the benchmark coverage provided in the PacificSource plan be supplemented with:

- The federal BlueVision "High Plan" coverage of pediatric vision; and
- The Healthy Kids dental package for pediatric dental.

The PacificSource plan that was selected did not, at the time, include coverage of services provided by chiropractic physicians. However, as described below, selection of the PacificSource plan as Oregon's benchmark for the essential health benefits means only that Oregon is adopting the package of services covered by the plan and not necessarily the plan's restrictions on which providers may be reimbursed for the services. Moreover, according to a rate filing decision of the Department of Consumer and Business Services,[3] PacificSource will be covering all chiropractic services, not just manipulation, in its "preferred" and "premiere" plans beginning January 1, 2013.

[1] Codified at 42 U.S.C. 18022.
[2] *Essential Health Benefits Bulletin*, Center for Consumer Information (December 16, 2011), available at <http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf>.
[3] Available at <http://www.oregonhealthrates.org/?fuseaction=home.show_filings&limit=30>. In the table, follow the link for PacificSource Health Plans, decision dated November 7, 2012.

On February 17, 2012, HHS issued additional guidance further clarifying its preliminary guidance to the states on selecting a benchmark plan for essential health benefits. In it, HHS states that any limitations on the scope of benefits covered in a benchmark plan would be subject to other requirements or prohibitions in the PPACA. For example, while a plan may impose annual and lifetime dollar limits on the benefits, section 2711 of the Public Health Service Act, as amended by section 1001 of the PPACA,[4] prohibits such limits. Therefore, if a benefit "within a State-selected [essential health benefit] benchmark plan was to have a dollar limit, that benefit would be incorporated into the [essential health benefit] definition without the dollar limit."[5]

Would a health insurer discriminate in violation of the PPACA by refusing to reimburse chiropractic physicians who provide essential health benefits?

Section 2706 of the PPACA 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. 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.[6]

HHS has not issued any proposed regulation or guidance to carry out section 2706 of the PPACA so it cannot be said with certainty how the agency will interpret those provisions. On its face, however, the language prohibits an insurer from discriminating "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." Just as the federal guidance stated that annual and lifetime dollar limits within a state-selected benchmark plan would be stripped from the essential health benefit package for that state, it would follow that a provision in a state-selected benchmark plan that discriminates against a provider acting within the scope of the provider's license would have to be stripped from the essential health benefit package for that state, as well.

In coming to this conclusion, we considered two issues. First, does a plan that excludes services provided by a chiropractic physician discriminate against a provider acting within the scope of the provider's license? As is relevant here, the dictionary defines "discriminate" as "to make a difference in treatment or favor on a class or categorical basis in disregard of individual merit." *Webster's Third New International Dictionary of the English Language* (unabridged ed., 2002). By reimbursing for primary care services provided by a medical or osteopathic physician, but not for the same services provided by a chiropractic physician, solely on the basis of the

[4] Codified at 42 U.S.C. 300gg-11.
[5] *Frequently Asked Questions on Essential Health Benefits Bulletin*, Centers for Medicare and Medicaid Services, at 4, available at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.
[6] Codified at 42 U.S.C. 300gg-5.

physician's license and even though both are licensed to provide the services, a plan is treating the two classes of physicians differently on a basis other than individual merit. Therefore, the inescapable conclusion on the first issue is that exclusion of all chiropractic physicians based only on their medical discipline would constitute discrimination against chiropractic physicians.

Second, an insurer may argue that refusing to reimburse chiropractic physicians is not discrimination because chiropractic services were not covered in the benchmark plan at the time it was selected by the state boards. However, based on the federal guidance and the language of the PPACA, chiropractic services are not a singular type of "health benefit" separate and distinct from the other essential health benefits. Both the federal guidance and the PPACA require coverage of *physician services*, without any regard to whether the physician is a chiropractic physician or an osteopathic or medical physician.

Therefore, based on the language of the federal Act and the guidance issued by HHS thus far, but without an express interpretation by HHS, we believe that an insurer would be discriminating in violation of section 2706 of the PPACA if the insurer excluded coverage of a service that was an essential health benefit and was within the scope of the provider's license only because the service was provided by a chiropractic physician.

The opinions written by the Legislative Counsel and the staff of the Legislative Counsel's office are prepared solely for the purpose of assisting members of the Legislative Assembly in the development and consideration of legislative matters. In performing their duties, the Legislative Counsel and the members of the staff of the Legislative Counsel's office have no authority to provide legal advice to any other person, group or entity. For this reason, this opinion should not be considered or used as legal advice by any person other than legislators in the conduct of legislative business. Public bodies and their officers and employees should seek and rely upon the advice and opinion of the Attorney General, district attorney, county counsel, city attorney or other retained counsel. Constituents and other private persons and entities should seek and rely upon the advice and opinion of private counsel.

Very truly yours,

Lorey H. Freeman
Senior Deputy Legislative Counsel