

**DEPARTMENT OF LABOR,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
and DEPARTMENT OF THE TREASURY**

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**LISTENING SESSION REGARDING PROVIDER
NONDISCRIMINATION UNDER SECTION 2706(A) OF THE
PUBLIC HEALTH SERVICE ACT**

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**WEDNESDAY
JANUARY 19, 2022**

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**The Listening Session convened via
Videoconference, at 1:00 p.m. EST, Amber Rivers
and Elizabeth Schumacher, Co-Facilitators,
presiding.**

PRESENT

AMBER RIVERS, Co-Facilitator

ELIZABETH SCHUMACHER, Co-Facilitator

**ALI KHAWAR, Acting Assistant Secretary of Labor
for Employee Benefits Security**

1 P-R-O-C-E-E-D-I-N-G-S

2 1:03 p.m.

3 MS. RIVERS: So I just wanted to thank
4 everyone for joining us today for the tri-
5 department listening session on the provider
6 nondiscrimination provision. I think most folks
7 are aware that this provision was initially added
8 as part of the Affordable Care Act and then most
9 recently the Departments of Labor, HHS, and
10 Treasury were directed to undertake rulemaking on
11 this provision as part of the Consolidated
12 Appropriations Act. And I think it's great that
13 technology permits us to continue to convene
14 these sessions because they are just so helpful
15 in informing the department's implementation
16 efforts.

17 We do have quite a number of speakers
18 today representing a wide variety of
19 perspectives. And in the interest of reserving
20 as much time as possible for those remarks, we're
21 not going to do full introductions on the
22 government side. But I did want to acknowledge

1 our colleagues from the other departments.

2 From HHS, I believe we will have Ellen
3 Montz joining us and I think I see Jeff Wu as
4 well as a number of folks from their teams to
5 have joined. From Treasury and IRS, I see Carol
6 Weiser and Rachel Levy as well as a number of
7 members from their team. So thank you so much
8 everyone for joining. And before we get into the
9 stakeholder remarks, I did want to turn it over
10 to our Acting Assistance Secretary Ali Khawar to
11 give a few remarks.

12 MR. KHAWAR: Thanks, Amber, and
13 welcome, everyone. It is good to see all of you,
14 and thank you for participating and thanks to our
15 tri-department colleagues for joining us. We're
16 really looking forward to this conversation, and
17 it is an important part of our process as we move
18 towards the proposal that we're ultimately going
19 to issue in this space.

20 I'm very excited that have a pretty
21 diverse group of stakeholders because there are a
22 variety of different ways to look at these

1 issues. And we're looking forward to hearing
2 about the issues and concerns that all of you
3 have related 2706, the provider nondiscrimination
4 revision, and to begin the discussion about the
5 different ways that we should be thinking about
6 this as we move towards implementation. So there
7 are about a dozen, I think, different speakers
8 that we have, as well as a number of folks that
9 are registered to listen in on the conversation.

10 We're gathering information today. In
11 the interest of time and because of the number of
12 speaks that we have, we're probably not going to
13 be asking many questions. But you should rest
14 assured and apologies in advance.

15 We're probably following up with a
16 number of you with questions after the fact. And
17 we're really looking forward to this as the
18 beginning of a number of conversations that we're
19 going to have. But with that, why don't we get
20 started.

21 MS. RIVERS: Thanks so much, Ali. So
22 I'm going to actually turn it over to Elizabeth

1 Schumacher. She's going to help facilitate
2 today's session.

3 MS. SCHUMACHER: Thank you, Amber, and
4 thank you, everyone, for joining us today. I
5 just want to quickly remind our speakers that,
6 because we are limited on time, I ask that
7 everyone please try to keep your remarks to seven
8 minutes. And with that, our first speaker is
9 Jeanette Thornton from AHIP.

10 MS. THORNTON: All right. Can you
11 hear me okay? All right. Hi, everyone. Let me
12 get situated here. On behalf of AHIP, I'm
13 Jeanette Thornton. And we really appreciate all
14 the work the tri-departments have done on the
15 implementation of the No Surprises Act. And we
16 really look forward to the continued partnership
17 with all of you to ensure patients are protected
18 from surprise bills under the law.

19 We really appreciate the opportunity
20 to share our perspective with you today and are
21 really also pleased that you are seeking opinions
22 from a diverse set of stakeholders prior to

1 releasing any proposed rule. We certainly know -
2 - and I'll talk a little bit about it today --
3 there is a long history about this provision.

4 I think it goes with saying we want to
5 stress the importance of non-physician providers
6 to our healthcare system. They are such an
7 important part of plan design because they can
8 provide both appropriate and cost effective care.
9 And this is so important in a time when we have
10 rising healthcare costs as well as when we're all
11 facing both personally and professionally due to
12 the global COVID-19 pandemic.

13 So we're left with the three sentences
14 that were in the original Affordable Care Act
15 provision. And I'm sure you're going to hear a
16 lot of varying thoughts today about what these
17 three sentences mean and what they mean for the
18 departments' required regulations in this area.
19 I want to draw you all to the first sentence,
20 which is what I think foundationally this
21 provision is all about.

22 We, as in health insurance providers,

1 shall not discriminate with respect to
2 participation under the plan or coverage against
3 any healthcare provider who is acting within the
4 scope of that provider's license or certification
5 under applicable state law. In our view, this
6 provision is not about changing what benefits a
7 plan chooses to cover. It does not mandate a
8 certain provider reimbursement approach and does
9 not require us to contract with all providers.

10 Making these broad changes at this
11 time would really negatively impact both
12 affordability and the quality of our member
13 health insurance plan offerings. Now for our
14 perspective, we do support the departments'
15 original 2013 FAQ that really implemented the
16 statute by forbidding the discriminatory behavior
17 but left in place the ability for health
18 insurance providers to make coverage decisions,
19 administer benefits, and set competitive
20 reimbursement rates for providers. So, in
21 thinking about the departments' charge from
22 Congress, we originally believe the statute to be

1 self-implementing.

2 But we recognize that Congress really
3 threw us a curve ball and required the
4 departments to issue regulations. And so, in
5 drafting those, we really think it's important to
6 focus on three goals. One, keeping with the
7 statute, prohibiting discrimination and really
8 affirming state authority to regulate provider
9 licensure. Two, it's really critical that you
10 maintain the ability for plans to design benefits
11 and select providers based on both consumer and
12 employer demand and existing law and regulations.
13 And finally, it's also critical that you preserve
14 private market contracting between plans and
15 providers to set appropriate reimbursement rates
16 that reward efficient, high quality, and
17 performance outcomes.

18 So a couple of things that we think
19 are important in order to meet these three goals.

20 One, I think the regulations should
21 restate this goal of prohibiting certain types of
22 discrimination and really defer to the states for

1 oversight as is practiced with many of the tri-
2 department regulations. States continue to be
3 the primary regulator of license and
4 credentialing requirements for healthcare
5 providers in their states. States and also the
6 federal government also have network adequacy
7 requirements that exist to make sure consumers
8 have sufficient access to necessary care.

9 It's also important to note that
10 Section 2706 clearly states that it does not
11 mandate any willing provider contracting. Thus,
12 we think it's really important that your
13 regulations recognize the importance of plan
14 networks. They're really important. They help
15 improve affordability, promote quality, reflect
16 consumer preferences, and also drive a
17 competitive market across our industry.

18 In looking at benefit design, we
19 really think it's important the regulations
20 maintain the ability for plans to select covered
21 benefits that meet the needs of consumers and
22 employers, but also comply with any necessary

1 federal and state regulations. It is our view
2 that this section does not require plans to cover
3 additional benefits that would not otherwise be
4 covered under a plan. For example, plans in the
5 individual and small group market are required to
6 follow the essential health benefits requirements
7 by their respective states, and all plans are
8 required to offer preventive services consistent
9 with federal law.

10 It is so important that the
11 regulations do not impede plans' ability to
12 design benefits that respond to consumer demands
13 and balance affordability and high quality of our
14 offerings. Regarding provider reimbursement, as
15 I mentioned earlier, it's so important that -- I
16 emphasize the statute is not about changing the
17 decisions health plans make regarding
18 reimbursement. Plans and providers negotiate
19 private market rates for covered services for
20 reasons beyond just quality and performance
21 measures.

22 We partner with our contracted

1 providers to implement important strategies
2 related to efficiency, clinical effectiveness,
3 decreasing costs, and also ensuring we do have a
4 robust network of providers. Given the short
5 notice of presenting today, and I think we've
6 just begun the dialogue with our member plans on
7 this provision. But I do want to reiterate our
8 support for the role of non-physician healthcare
9 providers.

10 We look forward to coming back to the
11 tri-departments with more detailed
12 recommendations very soon. And I really look
13 forward to hearing the perspectives from all of
14 the speakers gathered online here today. So with
15 that, I'll turn it back to you, Elizabeth. Thank
16 you.

17 MS. SCHUMACHER: Thank you, Jeanette.
18 Next we have Ralph Kohl from the American
19 Association of Nurse Anesthesiologists.

20 MR. KOHL: Thank you, and good
21 morning. My name is Ralph Kohl. I'm the Senior
22 Director of Federal Government Affairs for the

1 American Association of Nurse Anesthesiology.

2 First off, I wanted to say thank you
3 to the hardworking staff at the Department of
4 Health and Human Services, Labor, and the
5 Treasury and to the Acting Assistant Secretary
6 for hosting this important conversation and for
7 all the work that you guys are doing in the face
8 of this unprecedented global pandemic.

9 I'm here today representing the AANA
10 and our over 60,000 certified registered nurse
11 anesthetist members nationwide. CRNAs are
12 advanced practice registered nurses who
13 personally administer more than 50 million
14 anesthetics to patients in all types of
15 healthcare settings.

16 Nurse anesthesia predominates in
17 veterans' hospitals and in the U.S. armed
18 services. CRNAs also play an essential role in
19 assuring that rural America, an underserved area,
20 have access to critical anesthesia services,
21 often serving as the sole anesthesia provider in
22 rural hospitals, affording these facilities the

1 capability to provide many necessary procedures.
2 CRNAs complete a rigorous clinical and didactic
3 education which prepares them to provide the
4 highest quality anesthesia care. All available
5 legitimate peer reviewed studies in evidence show
6 that CRNAs -- regardless of patient population,
7 regardless of the case -- achieve the same
8 quality outcomes as our physician
9 anesthesiologist colleagues.

10 CRNAs acting within the scope of their
11 state licensure have experienced denials for
12 coverage of procedures that are clearly in their
13 state scope of practice and have been outright
14 denied participation in certain insurance plan
15 networks solely based on their licensure. And
16 this is since 2706 was passed into law. These
17 practices in payer access to care and payer
18 consumer choice in competition impairs the
19 efforts to control healthcare costs' growth.

20 Further, this discrimination violates
21 the intent of the original provider
22 nondiscrimination provision, Section 2706 of the

1 Affordable Care Act. When Congress included
2 Section 2706 in the ACA, their intent was to
3 protect patient choice and access to a range of
4 benefit providers and prevent discrimination
5 against any entire class of healthcare
6 professionals solely based on their state
7 licensure.

8 It is to promote and expand patient
9 choice of providers, level the playing field
10 among providers, and regulate healthcare markets
11 by promoting choice and competition. We believe
12 this included preventing health insurers from
13 discriminating against qualified licensed
14 healthcare providers solely based on their
15 licensure. Unfortunately, no regulation has been
16 issued since this law took effect, and there's no
17 real way to enforce this important provision.

18 That is why Congress turned back to
19 it. That is why they're looking for the
20 departments to take regulatory action at this
21 time. Congress understands that addressing
22 discrimination against healthcare providers is an

1 important part of ending surprise billing and
2 ensuring network adequacy.

3 Each of the congressional committees
4 of jurisdiction signed off on including this
5 provision once again in the Appropriations Act.
6 And the departments have heard from members of
7 all the committees of jurisdiction clearly
8 outlining what they expect to see from
9 rulemaking. If implemented correctly, we believe
10 Section 2706 will go a long way to increasing
11 access to care for consumers, increasing network
12 adequacy to avoid problematic out of network
13 billing situations, and drive down healthcare
14 costs through increased competition between the
15 highest quality healthcare providers.

16 As the administration looks to build
17 on the ACA, we believe a regulation fully
18 implementing the congressional intent of this
19 provision will benefit consumers and will
20 strengthen the ACA's focus on rewarding outcomes
21 regardless of which qualified provider is
22 achieving those outcomes. CRNAs have been on the

1 front lines of this unprecedented pandemic in
2 surgical suites and on COVID teams, providing the
3 highest quality of care. The pandemic has seen
4 our members answer the call as one of the most
5 utilized specialties during the pandemic based on
6 Medicare data while also seeing an increase in QZ
7 billing which is the billing code for CRNAs
8 independently providing care.

9 Despite what some of our opponents
10 would have you believe, we have not seen a
11 significant increase in adverse outcomes related
12 to anesthesia care. In closing, AANA believes
13 that CRNAs, APRNs, and all nurses have earned the
14 right to be paid what they are worth with the
15 high quality services provided and to be
16 reimbursed for achieving those high quality
17 outcomes in their respective fields. Ultimately,
18 we know that CRNAs' education and training yields
19 the highest quality anesthesia providers which is
20 reinforced by peer reviewed studies, the
21 precipitous decline in CRNA liability insurance
22 premiums, and the continued use of CRNAs as full

1 practice authority providers in the Army, Navy,
2 Air Force, combat support hospitals, and forward
3 surgical teams.

4 As your departments move forward with
5 implementation of this important rule, we ask
6 that you move away from the position-centered
7 ethos which has far too long guided health policy
8 decisions and focused on the evidence and the
9 economics.

10 Thank you for your time and
11 consideration on this important matter. We will
12 remain a stakeholder and resource as you move
13 forward with the provider nondiscrimination rule,
14 and thank you all for your time and
15 consideration.

16 MS. SCHUMACHER: Thank you, Ralph.
17 Next we have Matthew Thackston, who is also from
18 the American Association of Nurse
19 Anesthesiologists.

20 MR. THACKSTON: Hello, and good
21 afternoon. I'm Matthew Thackston, the Associate
22 Director of Federal Government Affairs at the

1 American Association of Nurse Anesthesiology and
2 currently the Chair of the Patient Access to
3 Responsible Care Alliance, a coalition of more
4 than a dozen healthcare provider organizations
5 who collectively represent more than four million
6 healthcare providers. I wanted to first thank
7 you for all of your diligent work during this
8 pandemic as well as on this issue, and thank you
9 for the invitation to join you for today's
10 listening session.

11 Patient Access to Responsible Care
12 Alliance, known as PARCA, represents non-M.D. DO
13 Medicare-recognized healthcare providers, many of
14 whom face discrimination due to the lack of
15 enforcement of provider nondiscrimination rules.
16 Discrimination against non-M.D. DO healthcare
17 providers, including the refusal to negotiate in
18 good faith and to bring non-M.D. DO providers in
19 network, only serves to hurt patient access to
20 care. We have seen some payers have unnecessary
21 barriers to care provided by non-M.D. DO
22 providers or flat out refuse to reimburse for

1 medically necessary care provided by those
2 healthcare providers who are working within their
3 state scope of practice.

4 We believe that insurers adding
5 unnecessary barriers to non-M.D. DO care above
6 and beyond what is required by state laws as well
7 as state boards of nursing and medicine is a form
8 of discrimination that unfairly decreases access
9 to care, minimizes competition within the
10 healthcare space, and increased costs. The
11 members of PARCA represent not only many of the
12 non-M.D. DO Medicare recognized health and mental
13 health providers who often face discrimination.
14 But we are also the providers of choice for many
15 patients, particularly in rural and underserved
16 communities who are most adversely affected by
17 the lack of access to care when provider
18 discrimination occurs.

19 We believe that any effort to address
20 the underlying causes of surprise billing must
21 include a provider nondiscrimination rule with an
22 enforcement mechanism to help ensure compliance

1 and give healthcare providers a means to fight
2 discrimination. Additionally, as we continue to
3 see increasing difficulties with access to
4 healthcare more broadly and specifically with
5 underserved populations, it's imperative that
6 patients be allowed to access care from all
7 qualified and licensed healthcare professionals
8 without the barriers that provider discrimination
9 presents. The providers represented in our
10 coalition are all Medicare-recognized providers
11 and are among some of the most sought after
12 healthcare professionals who provide the highest
13 quality care to their patients.

14 While we urge your departments to
15 promulgate an enforceable rule, we are not
16 seeking to force a system of any willing provider
17 on insurers. But it is imperative that patients
18 have access to the providers of their choice when
19 those providers are working within their scope.
20 To that end, we support a strong provider
21 nondiscrimination rule that includes an
22 enforcement mechanism to address the issues of

1 discrimination that many of the healthcare
2 providers in our coalition face. We hope to be a
3 constructive partner with you as you continue
4 this important work. And I'd like to thank you
5 for your time and attention today.

6 MS. SCHUMACHER: Thank you, Matthew.
7 Next we have Frank Harrington from the American
8 Association of Nurse Practitioners.

9 MR. HARRINGTON: Good afternoon. And
10 I would like to reiterate everything my
11 colleagues have said so far. We really
12 appreciate the departments holding this session
13 and really look forward to working with the
14 departments and all the stakeholders on the
15 successful implementation of this rulemaking.

16 On behalf of the American Association
17 of Nurse Practitioners and more than 118,000
18 individual members, over 200 organization
19 members, and more than 325,000 nurse
20 practitioners across the nation, we appreciate
21 the opportunity to provide feedback during this
22 listening session and provider discrimination

1 under Section 2706(a) of the Public Health Act.
2 This is an important piece of legislation
3 necessary to address ongoing provider
4 discrimination, which limits access to care, and
5 deprives patients of their ability to select
6 their healthcare provider of choice. As you
7 know, nurse practitioners are advanced practice
8 registered nurses who are prepared at the
9 master's or doctoral level to provide care to
10 patients of all ages and backgrounds.

11 NPs practice in nearly every setting,
12 and daily practice includes assessment, ordering,
13 performing, supervising, and interpreting
14 diagnostic and laboratory tests, making
15 diagnoses, initiating and imagining treatment,
16 including prescribing medication and non-
17 pharmacologic treatments, coordinating care,
18 counseling, and educating patients and their
19 families and communities. Nurse practitioners
20 hold prescriptive authority in all 50 states and
21 the District of Columbia and complete more than
22 one billion patient visits annually. NPs have

1 long been recognized for providing high quality,
2 cost effective care in their communities.

3 The importance of removing barriers to
4 practice, including restrictive insurance
5 coverage and payment requirements on nurse
6 practitioners, has been recognized by independent
7 entities and government agencies, including the
8 National Academies of Science, Engineering, and
9 Medicine, the Brookings Institution, American
10 Enterprise Institute, and the Federal Trade
11 Commission. As an example, the National
12 Academies' Future of Nursing report, which was
13 released last year, called for payment reform
14 among public health agencies and private payers
15 that addressed these restrictive policies and
16 removed barriers that limit the ability of APRNs
17 and other nurses to improve healthcare access,
18 quality, and value and create more equitable
19 communities.

20 These regulations are an opportunity
21 to address these restrictive policies and help
22 achieve these goals. Approximately 70 percent of

1 all NP graduates deliver primary care, and the
2 percentage of patients receiving primary care
3 from NPs increases in rural and underserved
4 communities which are the most in need of stable
5 growing practices. Data presented at the recent
6 MedPAC meeting found that APRNs and PAs combined
7 comprise about a third of the primary care
8 workforce, with that percentage increasing to
9 approximately half in rural areas.

10 Despite the importance of nurse
11 practitioners and other clinicians in our
12 healthcare system, many clinicians continue to
13 experience discrimination by health plans. This
14 has a negative effect on the financial stability
15 of practices, limiting their ability to meet the
16 needs of their communities, an impact which has
17 only been exacerbated by the COVID-19 pandemic.
18 Section 2706 of the Patient Protection and
19 Affordable Care Act signed into law in 2010
20 prohibits private health plans from
21 discriminating against qualified licensed
22 healthcare professionals based on their

1 licensure.

2 However, since this provision was not
3 implemented through rulemaking -- only
4 subregulatory guidance -- it has not had its
5 intended effect. In December 2020, the
6 Consolidated Appropriations Act of 2021, which
7 included the No Surprises Act, was signed into
8 law. Section 108 of the No Surprises Act
9 requires the departments to implement Section
10 2706 by promulgating rules on provider
11 nondiscrimination by January 1st, 2022.

12 This reflects the strong congressional
13 intent to implement Section 2706 in a manner that
14 protects healthcare providers from ongoing
15 discrimination and reflects the reality that the
16 existing guidance has not been sufficient.
17 Despite the passage of the ACA in Section 2706,
18 NPs and other healthcare providers continue to
19 experience discrimination based solely on
20 licensure by insurers with respect to
21 participation in health plans, low reimbursement
22 rates, lack of coverage for procedures and

1 services within their state's scope of practice,
2 lack of inclusion of value-based contracts, and
3 denying patients the ability to choose an NP or
4 other qualified clinician as their primary care
5 provider. Such discrimination violates Section
6 2706 of the ACA and impairs access to immediate
7 healthcare services, increases patient cost
8 sharing, limits patient choice and healthcare
9 market competition, and inhibits efforts to
10 control healthcare cost growth.

11 As the departments undertake the
12 rulemaking process on provider nondiscrimination,
13 we make the following recommendations on
14 objectives to ensure that the final rule will
15 prevent provider discrimination.

16 One, clearly and comprehensively
17 define discrimination and the intent of the
18 provider nondiscrimination provision.

19 Two, ensure that the regulations
20 address reimbursement discrimination based on
21 licensure.

22 Three, prohibit health plans, health

1 insurance, and payer practices such as those that
2 deny clinicians access to insurance networks and
3 advanced payment model based on licensure which
4 impose requirements for supervision or additional
5 certification for training beyond state licensing
6 requirements, which deny coverage of services and
7 procedures within the clinicians' scope of
8 practice, which prevent patients from choosing
9 NPs and other primary care practitioners as their
10 PCPs, and which require geographic limitations on
11 provider network participation.

12 Four, we think it's extremely
13 important that the departments create a robust
14 enforcement and penalties mechanism to ensure
15 that all health plans, health insurers, and
16 payers comply with Section 2706.

17 And five, we strongly encourage the
18 departments to establish a streamlined notice and
19 complaint process for providers so that they can
20 obtain an independent resolution of their
21 complaint in a timely fashion.

22 In order to properly honor the intent

1 of Congress, the Consolidated Appropriations Act
2 of 2021 and Section 2706 of the ACA, these are
3 key provisions the rulemaking must address. NPs
4 and other clinicians provide a substantial share
5 of the high quality cost effective healthcare
6 that our nation requires, particularly in rural
7 and underserved communities. Preventing insurer
8 discrimination based on licensure is essential to
9 ensuring robust patient access to healthcare
10 services, promoting patient choice of healthcare
11 providers, and reducing out-of-pocket costs on
12 patients for select NPs and other qualified
13 clinicians as their healthcare practitioners of
14 choice.

15 Again, we strongly thank the
16 departments for holding this listening session
17 and providing AANP with the opportunity to
18 provide comment. Our members are committed to
19 providing the highest quality care to their
20 patients and communities, and we look forward to
21 working with all of you on this important issue.
22 Thank you very much.

1 MS. SCHUMACHER: Thank you. Next we
2 have Katy Johnson from the American Benefits
3 Council.

4 MS. JOHNSON: Thanks, Elizabeth. I
5 was so busy writing everything Frank was saying,
6 I've got to get all my papers together. Okay.
7 So hello, everybody. Thanks so much for the
8 opportunity to speak today. I'm Katy Johnson.
9 I'm the Senior Counsel for Health Policy at the
10 American Benefits Council.

11 Just as background, the American
12 Benefits Council is a national nonprofit
13 organization that's dedicated to protecting
14 employer sponsored benefit plans. So we
15 represent over 220 of the country's largest
16 employers on the full array of employee benefits
17 issues. We also include in our membership
18 organizations that support employers that sponsor
19 coverage. So collectively, our members directly
20 sponsor or support health and retirement coverage
21 for almost all Americans participating in
22 employer sponsored programs.

1 I wanted to note a few items for
2 context before I get into the specifics of the
3 provision today. First, I just wanted to note
4 that employers provide coverage to over 177
5 million Americans and make great efforts to
6 ensure that the coverage provided is high quality
7 and affordable. Also, I wanted to note that the
8 vast majority of our members are large employers
9 that sponsor self-insured coverage.

10 That's just something to note. I'll
11 kind of put a pin in it for the tri-agencies,
12 something I personally am thinking through as I'm
13 hearing all the remarks today to the extent that
14 we're talking about in my mind constructs that
15 sometimes apply specifically to insured coverage
16 subject to more extensive state regulations.

17 As we all know, self-insured plans
18 have more flexibility, and some of the things
19 we're talking about today do not apply to us in
20 the normal course.

21 And so I guess one high level ask is
22 that we all think through these issues and as you

1 all think through these issues that we keep in
2 mind the legal background for self-insured plans
3 to the extent that it's different than insured
4 coverage. That's something I'll personally be
5 doing. So I'm happy to talk about that with you
6 guys more in the future. I just note it's
7 something I'm kind of keeping in my brain to the
8 side.

9 I did want to note that this
10 flexibility that self-insured plans have they use
11 to provide benefits that are really tailored to
12 their workforce. And that includes working
13 really hard to provide the benefits that the
14 workforce wants and also to provide different
15 health plan options and to carefully manage their
16 provider networks.

17 I asked to speak today because the
18 provider nondiscrimination provision has really
19 significant implications for plan sponsors as I
20 mentioned, the employers that I work with every
21 day to help them provide employee benefits and
22 healthcare coverage to their employees. This is

1 because the provision covers several key issues
2 for employer-provided coverage that have already
3 come up today, like health plan networks, payment
4 rates that plans pay to providers, and the
5 methods that plans use to provide affordable,
6 high quality healthcare. Our members have worked
7 to implement the provision in good faith, and the
8 council has been engaged on these issues since
9 the provision was enacted, including responding
10 to the request for information back in 2014,
11 which to me feels recent but I guess was actually
12 kind of a long time ago at this point.

13 I also wanted to note and amplify what
14 Jeannette said and a thread that's kind of been
15 woven through everybody's discussion so far,
16 which is the importance of non-physician
17 providers and the importance of the full array of
18 healthcare providers. Employers greatly value the
19 ability to provide coverage through all different
20 healthcare providers, including to expand access,
21 to control costs, and to meet a lot of the goals
22 that folks have been already mentioning this

1 afternoon. So I did just want to note that,
2 while it's really important and we will be
3 continuing to work to ensure that the provision
4 is implemented in a way that's consistent with
5 Congress' intent, it will continue to be the case
6 that providing coverage through various
7 healthcare providers is really important to
8 employer plan sponsors and is really something
9 that we value.

10 So, with my remaining time today, I
11 wanted to emphasize three main issues that folks
12 have touched on somewhat already that are key
13 from the employer plan sponsor perspective. So
14 the first item, which I think some folks have
15 alluded to perhaps in different directions, is
16 just that nothing in this provision mandates that
17 a plan or issue cover specific benefits or
18 services. I think Jeanette helpfully read us all
19 the first sentence of the statute when she first
20 started, and so we all know it's framed as a
21 nondiscrimination provision.

22 As we know, Congress knows how to

1 impose a benefit mandate. It did so in the ACA a
2 few different ways. It imposed a requirement to
3 cover preventive services on non-grandfathered
4 group health plans. As some folks have alluded
5 to, it imposed a requirement to cover essential
6 health benefits for individual and small group
7 insured coverage. So we know what it looks like
8 when we see a benefit mandate.

9 This provision instead is a
10 nondiscrimination provision. And so nothing here
11 indicates an intent to require either issuers or
12 self-funded plan sponsors to cover specific
13 benefits or services as a result of this
14 provision. Moreover, I did want to note that
15 plans and issuers do sometimes exclude a benefit
16 or service that is performed by only one type of
17 provider, such as acupuncture or massage therapy.

18 And excluding a benefit or service
19 that is performed by only one type of provider is
20 not discriminatory against the provider in that
21 the decision by the plan or the issuer to exclude
22 the benefit or service is made with respect to

1 the benefit or service. It's not made with
2 respect to who will be delivering the benefit or
3 service. So to read the provision to require
4 that a plan or policy include a specific benefit
5 would not only be directly inconsistent with the
6 law, it would undermine employers' ability to
7 tailor the benefits that they offer to the needs
8 of their workforce and to ensure affordable
9 access to coverage.

10 And so, as the tri-agencies work to
11 develop regulations in response to the
12 Consolidated Appropriations Act, we ask that they
13 confirm that the provision applies only to the
14 extent that an item or service is a covered
15 benefit and does not require coverage of any
16 particular item or service, including items and
17 services that are provided by just one type of
18 provider.

19 Second, and this is something that
20 Matthew mentioned, I wanted to just confirm the
21 key point that the provision does not require
22 contracting with any willing provider. And we

1 can probably talk all afternoon about some of the
2 network issues that folks have brought up.

3 But I wanted to key in on one key base
4 point, which is that the provision states that
5 this section shall not require that a group
6 health plan or health insurance issuer contract
7 with any healthcare provider willing to abide by
8 the terms and conditions for participation
9 established by the plan or issuer. So this
10 language is unequivocal in clarifying that the
11 provision should not be read to impose a
12 requirement on plans or issuers to contract with
13 any willing provider. And I'm really looking
14 forward to listening throughout the discussion
15 today, because it sounds like folks might touch
16 on that in terms of whether everybody is in
17 agreement on that or where we might have
18 different views.

19 I did want to note that health plan
20 networks and selected contracting are vital to
21 plans to be able to offer affordable high quality
22 coverage. Selective contracting helps control

1 healthcare costs by incentivizing providers to
2 engage in competitive negotiations with plans.
3 Networks also help consumers by making clear
4 which providers meet the plan standards. And
5 networks can also be helpful to distinguish
6 between plans to the extent they might have
7 different network arrangements and different
8 costs.

9 There are also many reasons why a plan
10 may not contract with a provider, including that
11 the plan has sufficient numbers of providers in
12 its network of a sufficient quality already or if
13 the plan and a provider can't come to an
14 agreement on the contracted rate. So we ask that
15 the future regulations explicitly and clearly
16 reaffirm the congressional directive that plans
17 and issuers retain discretion and flexibility
18 with respect to determining which providers may
19 participate in a network and that the provision
20 does not impose any willing provider requirement
21 on plans or issuers.

22 The third issue I wanted to mention is

1 that it's important to note that this provision
2 does allow the establishment of varying
3 reimbursement rates.

4 I will spare you again me reading from
5 the statute. But, as we all know, there is a
6 sentence in there that notes that this provision
7 shouldn't be construed to prevent plans and
8 issuers from establishing varying reimbursement
9 rates based on quality or performance measures.
10 So the statute specifically addresses
11 reimbursement rate variation based on quality and
12 performance. And I note that quality and
13 performance are really important factors.

14 But it's our view -- and we've
15 asserted this in the past -- that the statute
16 doesn't preclude plans and issuers from varying
17 reimbursement rates on other legally permissible
18 factors as well. As I'm sure many of us know who
19 work in this space, reimbursement rates and the
20 amounts that providers bill account for myriad
21 factors. So that includes education, level of
22 experience, patient acuity, quality, performance,

1 geography, market standards, market power of the
2 provider, and the facility in which the item or
3 service is provided.

4 The ability of plans and issuers to
5 take into account this broad range of factors
6 relevant to negotiating reimbursement rates is
7 vital to the ability of plans to offer affordable
8 healthcare coverage. Our view is that a
9 suggestion that provider reimbursement be limited
10 to two factors would be a sweeping change. A
11 change that consequential does not seem to us
12 would be included in one clarifying sentence in a
13 nondiscrimination provision, especially in a
14 sentence that seems to emphasize the fact that
15 plans have the discretion with regard to setting
16 the reimbursement rates.

17 So our view is that the statute
18 doesn't explicitly or implicitly set provider
19 reimbursement rates and also does not delegate
20 authority or discretion to the tri-agencies to do
21 so. Moreover, a payment parity statute in this
22 context or an interpretation of this provision as

1 a payment parity statute would raise public
2 policy concerns that we should all think about as
3 well, including effectively setting a price floor
4 which could result in less competition, less
5 robust negotiation, and increased costs for plans
6 and consumers. So, on this topic, we ask that
7 the forthcoming regulations make clear that plans
8 may determine reimbursement rates on any relevant
9 measure, not just quality and performance
10 measures.

11 In conclusion, I want to thank the
12 tri-agencies for holding this listening session.
13 I think it sounds like we all agree on that.
14 Everybody is really glad you guys got us all
15 together.

16 I know this is a provision that has
17 been in effect for over eight years, but it's one
18 that I think is still worthwhile to talk about
19 and make sure we fully understand. As I noted,
20 it is kind of a unique posture here, in which
21 case we've had a statute which, like I said, our
22 members have been in compliance with for several

1 years. And so it's useful to hear what everybody
2 is raising today, and I think it's also really
3 important for the tri-agencies to fully
4 understand what all the stakeholders are thinking
5 here and making sure we all fully understand the
6 issues before new regulations are issued.

7 So, as Jeanette mentioned, we wanted
8 to make sure to chime in today. But we also are
9 kind of beginning our process of re-discussing
10 these issues with our members and really digging
11 in yet again. And I think, Ali, you mentioned
12 perhaps having additional conversations as we go
13 on, and we would love to do that with you. We
14 view this as the beginning of the dialogue and
15 would love to keep the dialogue going. And with
16 that, I will turn it back to Elizabeth.

17 MS. SCHUMACHER: Thank you, Katy.
18 Next we have Kara Webb from the American
19 Optometric Association.

20 MS. WEBB: Thank you so much. I'm
21 Kara Webb. I'm the Chief Strategy Officer at the
22 American Optometric Association and want to echo

1 the previous sentiment. We're really grateful
2 for the departments for holding this session, and
3 the comments today have been illuminating. And
4 really appreciate this opportunity.

5 The American Optometric Association --
6 we represent more than 33,000 doctors of
7 optometry across the nation. Our doctors are
8 essential healthcare providers and are recognized
9 as physicians under Medicare. Doctors of
10 optometry examine, diagnose, treat, and manage
11 diseases and disorders of the eye, and they also
12 detect systemic diseases and diagnose, treat, and
13 manage ocular manifestations associated with
14 those diseases.

15 We really greatly appreciated the
16 recognition of members of Congress for the need
17 to better implement the provider
18 nondiscrimination provision. We truly look
19 forward to working with the departments on this
20 rulemaking. And we believe that the need for
21 additional rulemaking related to provider
22 nondiscrimination is really very clear.

1 Over the past several years, our
2 members have been affected by the lack of
3 enforcement of provider nondiscrimination rules.
4 At times, health plans have imposed additional
5 requirements on our doctors before they are
6 authorized to join insurance panels. And these
7 requirements are often only placed on our doctors
8 and not enforced uniformly across provider types.

9 And, ultimately, these actions reduce
10 choice in the marketplace. So, as the agency
11 moves forward with the development of regulations
12 to implement the nondiscrimination provision, we
13 would recommend that you consider a few of the
14 following thoughts.

15 While we fully understand that
16 reimbursement variances are allowable based on
17 quality or performance programs, we believe that
18 variances in reimbursement based solely on
19 provider type should be prohibited.

20 Additionally, we believe rulemaking
21 should prohibit health plans from requiring
22 certain provider types to perform additional

1 certification of credentialing programs in order
2 to be allowed on a panel. These additional
3 requirements create inequities that hamper
4 patient choice of provider.

5 And we also believe it's critical that
6 an enforcement mechanism exists for these
7 regulations. We encourage the departments to
8 include an enforcement mechanism to hold those
9 who are not compliant accountable. And when
10 compliance issues are not adequately addressed,
11 we believe that financial penalties should also
12 be considered.

13 We definitely understand the
14 challenging work involved in development of these
15 regulations, and there are a lot of varying
16 opinions on how these rules should be
17 implemented. But we welcome the opportunity to
18 serve as a resource for the departments moving
19 forward. We welcome the opportunity to provide
20 specific examples and details of the issues that
21 our doctors have experienced. And, again, just
22 thank you for the opportunity to share these

1 recommendations.

2 MS. SCHUMACHER: Thank you, Kara.

3 Next we have Laura Pickard from the American
4 Podiatric Medical Association.

5 DR. PICKARD: Can everybody hear me
6 now?

7 MS. SCHUMACHER: Yes, we can hear you
8 now.

9 DR. PICKARD: Okay. I'm on my phone.
10 Good afternoon. My name is Dr. Laura Pickard.
11 I'm a practicing podiatrist from Chicago,
12 Illinois, as well as the incoming president of
13 the American Podiatric Medical Association.

14 APMA is the premier association
15 representing the vast majority of our nation's
16 doctors of podiatric medicine, also known as
17 podiatrists or podiatric physicians and surgeons.
18 On behalf of our member podiatrists, I thank the
19 Department of Labor, the HHS, and the Treasury
20 for holding this very important listening session
21 on the implementation of the provider
22 nondiscrimination provision under Section 2706(a)

1 of the Public Health Service Act. The
2 nondiscrimination provision was intended to
3 ensure patients are able to receive the services
4 they need from the providers they choose.

5 In order to achieve this goal, we urge
6 the departments to issue regulations in an
7 expedient manner. Such regulations must comply
8 with the congressional intent and prohibit health
9 plans from discriminating against providers
10 acting within their scope of licensure.

11 Specifically, the regulations should
12 prohibit health plans from limiting coverage of
13 services furnished by a specific provider type,
14 excluding specific types of providers from their
15 network, and prohibiting varying reimbursement
16 for the same services based solely on provider
17 type.

18 Regulations also should prohibit a
19 health plan's downstream entities from engaging
20 in such discriminatory action.

21 Finally, the departments must include
22 robust reporting and enforcement provisions.

1 Doctors of podiatric medicine receive comparable
2 education, training, and experience as M.D.s and
3 DOs, including four years of undergraduate
4 training, four years of podiatric medical school,
5 and at least three years of hospital-based
6 surgical residency.

7 With this training and experience, my
8 colleagues and perform and bill for the same
9 foot-and-ankle services as our M.D. and
10 counterparts do. However, we are too often
11 categorically discriminated against by health
12 plans solely based on our degree and licensure.
13 In many, if not most, instances, a podiatric
14 physician has more experience in furnishing the
15 very same foot-and-ankle services that some
16 insurers, through their discriminatory policies,
17 refuse to cover when furnished by a podiatrist.

18 Ultimately, such policies harm
19 patients who either have to find a new provider
20 less familiar with their foot-and-ankle care or
21 pay out of pocket. For example, a podiatrist's
22 longtime diabetic patient could develop a painful

1 hammer toe that despite conservative treatment
2 fails to relieve the pain and limits the
3 patient's mobility. If the patient's health plan
4 refuses to cover the arthroplasty surgery
5 required to restore the toe joint when furnished
6 by a podiatrist. The patient must then seek out
7 an M.D. or DO orthopedic surgeon with whom they
8 do not have a relationship.

9 This is despite the fact that
10 podiatrists perform over 70 percent of these
11 procedures, increasing the likelihood of a
12 successful surgical outcome. Such a
13 discriminatory coverage policy denies the patient
14 the choice of their trusted physician who has
15 more experience performing the procedure.
16 Unfortunately, this scenario reflects the actual
17 experiences APMA members face in the podiatric
18 practice.

19 In fact, APMA recently heard from a
20 podiatric physician whose request for prior
21 authorization of a hammer toe surgery were denied
22 under a Fortune 500 company's group health plan

1 which has a policy to only cover the procedure
2 when furnished by an M.D. and D.O. Another
3 Fortune 500 company's group health plan imposes a
4 dollar limit on coverage of services furnished by
5 podiatrists that is not imposed on M.D.s and D.Os.
6 As a practical matter, the limit or cap as it's
7 known as is so low that it effectively excludes
8 surgical procedure by podiatrists particularly if
9 they have billed for conservative care prior to
10 recommending surgery.

11 APMA believes this is precisely the
12 type of discrimination that Section 2106(a) was
13 intended to prohibit. But prohibiting
14 discrimination and coverage alone will not ensure
15 patient's choice of providers. Too often, claims
16 simply provide for disparate payment rates
17 between podiatrists and other types of
18 physicians.

19 This makes it economically challenging
20 or even infeasible for a podiatrist to furnish
21 covered service, even though they're technically
22 considered covered. Determining whether such

1 different differential payment rates are
2 discriminatory may be difficult. However, there
3 are situations in which it's simple to determine
4 if payment is discriminatory.

5 For example, some health plans
6 maintain a separate podiatry fee schedule under
7 which podiatrists are paid significantly less
8 than their M.D. and DO colleagues for identical
9 foot-and-ankle services billed under the same
10 procedural code. Or the fee schedule may be
11 negotiable for M.D.s and DOs, but podiatrists
12 must take or leave it. Congress restated its
13 intent that Section 2606(a) would prohibit this
14 type of discrimination in the 2014 Senate
15 Appropriations Committee report.

16 APMA recognizes that this section
17 explicitly permits health plans to vary
18 reimbursement based on quality and performance
19 and that there is a public interest in doing so.
20 However, APMA is concerned that such varying
21 reimbursement could be used to support
22 discriminatory reimbursement practices. To

1 preclude such actions and ensure that quality and
2 performance bonuses are applied as intended, the
3 APM recommends that the departments work with
4 stakeholders to implement guidelines on the use
5 of such payment incentives.

6 Finally, as previously stated, to
7 effectively ensure patient choice, APMA
8 recommends that the departments put into place
9 strong reporting and enforcement provisions. So
10 in conclusion, discrimination by health plans
11 limits consumer choice and increases consumer
12 costs. We urge the departments to implement
13 regulations that prohibit provider discrimination
14 and ensure that the healthcare consumers receive
15 is the care they need from their choice or
16 providers. Thank you again for holding this
17 listening session, and APMA welcomes the
18 opportunity to engage with you further on this
19 very important issues. Thank you.

20 MS. SCHUMACHER: Thank you, Laura.
21 Next we have Maureen Maguire from the American
22 Psychiatric Association.

1 MS. MAGUIRE: Hi, good afternoon. My
2 name is Maureen Maguire, and I'm an Associate
3 Director of payor relations and insurance
4 coverage at the American Psychiatric Association.
5 On behalf of our members, which are over 37,000
6 psychiatrists, we thank you for the opportunity
7 to make these comments.

8 Psychiatrists are medical doctors, and
9 they treat people who suffer from mental health
10 and substance use disorders. And these people
11 have historically faced significant
12 discrimination, stigma, and prejudice. This can
13 be subtle or it can be overt. And it can come
14 from members of the public, their employers,
15 their own families, and institutions like the
16 healthcare system.

17 APA is really grateful to have the
18 opportunity to talk about what it looks like in
19 terms of the medical healthcare system, and
20 specifically what psychiatric medical doctors
21 have to do to care for their patients while
22 navigating prejudicial barriers to that care.

1 The reality is that -- unfortunately -- people
2 who suffer from mental health and substance use
3 disorders are still not treated the same as
4 people who suffer from physical illnesses like
5 cardiac events or diabetes. What I'd like to do
6 now is mention several scenarios that we hear
7 repeatedly from our providers.

8 These are health plan issuer and
9 issuer practices that discourage our members from
10 participating in health plan networks. And, for
11 our members who do practice in-network, these
12 health plan practices interfere in how they care
13 for their patients and keep them fearful of
14 retaliation should they appeal denials of care or
15 complain about insurer or plan practices.
16 Continuing authorization for inpatient care.
17 Patients with mental health and substance use
18 disorder conditions who need hospitalization are
19 extremely acute and extremely fragile.

20 They're suicidal. They're having
21 psychosis, for example. And yet, once they are
22 hospitalized, every several days, our providers

1 have to go through a process with the insurers of
2 continuing to justify their care and the need for
3 them to stay hospitalized. This takes an
4 enormous amount of time.

5 And the question is, is this happening
6 for other admissions such as cardiac patients?

7 Secondly, continuing authorization for
8 medications, or a new requirement that the
9 patient try another medication. Some of our
10 patients have been stable for many, many years on
11 a particular medication, and then the doctor is
12 notified that they have to go through
13 authorization or try another medication. Not
14 only does this take time, but it disrupts the
15 treatment plan and the medical decisions that the
16 doctor with the patients' input have made. It's
17 enormously disruptive. Medications used to treat
18 mental health conditions can't be stopped or
19 started. It must be titrated over a period of
20 time which means that every change of a
21 medication requires weeks to see if the patient
22 is responding properly. And if the patient

1 doesn't respond well, then the process has to
2 start all over again. Sometimes these new
3 authorizations are not processed fast enough and
4 as a result the patient can go days without
5 medication, often resulting in decompensation
6 which results in a visit to the emergency room or
7 hospitalization.

8 Third, audits and clawbacks, these
9 happen on a fairly regular basis and they keep
10 our providers frightened about what the outcomes
11 will be. And the question is, how often is this
12 happening on the medical side? Network admission
13 standards, for psychiatric doctors who are
14 willing to join a network, it takes six to nine
15 months, sometimes longer to get admitted to a
16 network. And the question is, how does this make
17 sense when we have data showing Americans are
18 experiencing increased levels of anxiety,
19 depression. Suicides are rising as are
20 overdoses. And people can't find an in network
21 psychiatrist to care for them.

22 Lastly, I want to address

1 reimbursement rates. The nondiscrimination
2 provision in question does mention that
3 reimbursement rates may be varied based on
4 quality or other performance measures. However,
5 the Milliman study that was done in December of
6 2019 looked at how primary care reimbursements
7 compared to behavioral health reimbursements with
8 the same unit of care. And it was found that
9 primary care reimbursements were 24 percent --
10 approximately 24 percent -- higher than
11 behavioral health reimbursement with the same
12 unit of care. And this was based on two large
13 national databases. It just seems that cannot be
14 specifically dependent on provider quality and
15 performance measures.

16 In summary, these practices discourage
17 our providers from joining networks. And our
18 members who are in networks waste countless hours
19 on administrative tasks -- hours that could be
20 spent taking care of patients. And they're
21 fearful to appeal plan denials. The end result
22 is patients who need care for mental health and

1 substance use disorder conditions have a harder
2 time finding care and often go without care.

3 Thank you.

4 MS. SCHUMACHER: Thank you. Next we
5 have Kris Haltmeyer from the Blue Cross Blue
6 Shield Association.

7 MR. HALTMEYER: Good afternoon,
8 everyone. Thanks for the opportunity to speak
9 today. It's very nice to talk to you about
10 something other than over-the-counter COVID
11 testing today.

12 I'm Kris Haltmeyer, Vice President for
13 Policy Analysis with the Blue Cross Blue Shield
14 Association. BCBSA represents the 35 independent
15 Blue Cross Blue Shield Companies, which
16 collectively provide coverage for one in three
17 Americans. And, as the departments engage in
18 rulemaking on Section 2706(a), we believe it's
19 critical that departments recognize the
20 importance of maintaining the ability for health
21 plans to deliver high-quality affordable care at
22 this time of ever increasing healthcare costs.

1 I want to echo something that Jeanette
2 and Katy said earlier, that health plans want to
3 ensure their enrollees receive the healthcare
4 they need in the most appropriate cost effective
5 manner. Health plans routinely contract with a
6 wide array of healthcare professionals to provide
7 the services covered by their benefit programs
8 and recognize the contributions physician
9 practitioners make towards ensuring that
10 enrollees receive high quality care in the most
11 cost effective setting. As you go forward with
12 developing regulations here, we think it's
13 critical that the proposed rules closely follow
14 the statutory language of 2706(a).

15 This language is clear that health
16 plans may not discriminate against providers who
17 are acting within the scope of their license with
18 respect to their participation under the plan or
19 coverage. However, some providers have asked for
20 an expansion of the scope of this provision in
21 ways that we think would undermine the ability of
22 health plans to manage the care for enrollees and

1 their costs.

2 Jeanette and Katy talked a lot about
3 what health plans don't believe this provision
4 requires. I'm not going to repeat all that now.
5 I think Katy in particular did a much better,
6 more eloquent job that I could in kind of laying
7 that out. But I did want to just mention that we
8 think it really is important that this not be
9 considered to be a requirement to cover all
10 providers or even a percentage of providers in
11 any given area. The ability to selectively
12 contract with providers is one of the most
13 important tools that health plans have to provide
14 a high quality network and address the
15 affordability of care.

16 I also wanted to emphasize --
17 reemphasize -- the importance that this not be
18 viewed as a prohibition against varying
19 reimbursement. While the statute permits rates
20 to vary based on quality and performance
21 measures, it does not prohibit rate variation
22 based on other factors. If Congress wanted to

1 prohibit variation based on other factors, it
2 could've easily done so, as it did in Section
3 2701 of the very same title of the ACA, which
4 limits permissible rating factors. One point
5 that I don't think has been made earlier is that
6 Medicare has a more prescriptive provider
7 nondiscrimination provision, which has not been
8 interpreted as an any willing provider provision
9 or limited the ability of health plan to vary
10 reimbursement based on quality, performance,
11 specialty, or cost among other factors.

12 We believe the departments were
13 correct in how they crafted their initial 2013
14 FAQ on the Section 2706. And nothing in the
15 governing statute or market has changed since
16 that that would justify this approach.

17 Our recommendations for the
18 forthcoming rules are as follows. The department
19 should reiterate the statutory language of 2706
20 and not attempt to prescriptively define
21 discrimination or alter the difference in this
22 position to state rules around scope of practice,

1 healthcare markets, or the regulation of health
2 insurance issuers. The rule should also not
3 establish a complicated new regulatory framework
4 that would be costly and challenging for health
5 plans to comply with and result in increased
6 costs. Finally, the regulations should clearly
7 state that health plans can continue to establish
8 benefits, networks, medical management programs,
9 and reimbursement approaches that ensures that
10 members have access to high quality care at the
11 most affordable prices.

12 Thank you again for the opportunity to
13 present today. I will turn it back to you.

14 MS. SCHUMACHER: Thanks, Kris. Next
15 we have Darren Patz from the Mednax national
16 medical group.

17 MR. PATZ: Yes, thank you. Hello, I'm
18 Darren Patz with Mednax national medical group,
19 also known as Pediatrix Medical Group. And thank
20 you very much for the opportunity to speak.

21 Mednax is a national physician group
22 comprised of the nation's leading providers of

1 prenatal, neonatal, and pediatric services.
2 Mednax, through our affiliated professional
3 entities, provide services through a network of
4 more than 2,300 physicians, more than 1,400
5 advanced practice nurses in 39 states and Puerto
6 Rico. Yes, as you heard, we employ physicians
7 and advanced practice nurses, who work together
8 on a care team model to treat 25 percent of the
9 premature babies in the United States and our
10 NICUs as well as other sick and mentally complex
11 children.

12 In implementing the provider
13 nondiscrimination provision of the Public Health
14 Service Act, the department should direct that
15 plans reimburse all healthcare providers
16 regardless of license status for the valuable
17 service they deliver to our citizens. As I will
18 outline, our physicians and advanced practice
19 providers provide lifesaving services every day
20 to moms and babies, including resuscitating a
21 baby. Plans ought to reimburse APPs, advanced
22 practice providers, for the high value of

1 services they provide. They should not be
2 artificially reimbursed 75 percent or 85 percent
3 of what the plan would've paid a physician simply
4 because of their license.

5 That said, I do recognize that there
6 are complexities to payment policies. And
7 certain clinicians have a superior level of
8 training, expertise, and education that should
9 lead to elevated payment levels.

10 But we don't want to create an
11 artificial barrier to reimburse APPs for the
12 services they are provided.

13 Plans cannot discriminate against
14 advanced practice providers and need to design
15 plans and reimbursement policies that pay
16 practices for valuable services. For example, if
17 a neonatal nurse practitioner resuscitates a
18 baby, the payer ought to reimburse 100 percent of
19 the amount it would have paid had a physician
20 performed the lifesaving service. The APP is
21 licensed, trained, and qualified to do this work
22 and maybe has even performed the services more

1 often than a physician has. Furthermore, when a
2 patient has a co-pay for an office visit where
3 the APP provides service to the patient, it's the
4 same case. The patient co-pay is the same in the
5 case where the APP is the main clinician treating
6 a patient in the place of a physician.

7 Therefore, it's illogical for a plan
8 to reimburse the practice an artificially lower
9 rate. Plans should compensate both physicians
10 and advanced practice providers fairly and
11 generously for such lifesaving care.

12 Mednax Pediatrix is the largest
13 employer of neonatal, pediatric, family practice,
14 and maternal nurse practitioners in the United
15 States. Our APPs are men and women who dedicate
16 their lives to the care of infants and family and
17 contribute to the clinical excellence that our
18 organizations strive to achieve. I have worked
19 personally alongside our nurse practitioners on
20 difficult issues such as the care of babies who
21 are born addicted to opioids that mom has
22 ingested during pregnancy. Indeed, some of the

1 leading compassionate national leaders of the
2 national opioid epidemic are advanced practice
3 providers.

4 We are proud of the outstanding work
5 that our qualified APPs have delivered during
6 this difficult pandemic. Each advanced practice
7 provider holds a minimum of a master's degree in
8 nursing with clinical training focused on their
9 specialty. They must hold a national board
10 certification in the specialty, and many nurse
11 practitioner training programs have transitioned
12 to a doctorate level program.

13 Our APPs perform high level valuable
14 service to our fragile neonates and comply with
15 state hospital credentialing and education
16 requirements. Our neonatal nurse practitioners
17 can evaluate, manage, prescribe, dictate the care
18 of patients from birth to two years of age.
19 These NNPs can be privileged to perform a variety
20 of procedures as well as attend high risk
21 deliveries and participate in neonatal transports
22 from one hospital to another. They are

1 credentialed and privileged by hospitals to
2 perform services via the medical staff office and
3 they must obtain ongoing education for
4 maintenance of certification and state licensure.

5 We support the departments'
6 promulgated regulations in a timely manner to
7 establish APPs to furnish services up to the full
8 licensed scope of practice as permitted by state
9 law. The department should direct the plans and
10 state Medicaid programs to reimburse any
11 healthcare provider regardless of license status
12 for the value of the important services they
13 deliver to our citizens.

14 As the largest employers of pediatric,
15 maternal, and neonatal nurse practitioners, we
16 would like to offer our support to the
17 departments and their rulemaking endeavors by
18 serving as a technical advisor. Dozens of
19 dedicated and eager APPs working within our
20 organization are at your service when called
21 upon. Thank you so much for the opportunity to
22 speak.

1 MS. SCHUMACHER: Thank you, Darren.

2 Next we have Elizabeth McCaman Taylor from the
3 National Health Law Program.

4 MS. TAYLOR: Hello, everyone. Thank
5 you for the opportunity to speak today. My name
6 is Liz McCaman Taylor. And I am here with you on
7 behalf of the National Health Law Program, also
8 known as NHLP, which is a public interest law
9 firm working to advance access to quality
10 healthcare and protect the legal rights of low
11 income and underserved people.

12 NHLP provides technical support to
13 direct legal service programs, community-based
14 organizations, the private bar providers, and
15 individuals who work to preserve a healthcare
16 safety net for the millions of uninsured or
17 underinsured low income people. It is our
18 understanding and belief that Section 2706(a) is
19 intended to secure robust networks of providers
20 by ensuring that enrollees have access to covered
21 health services from the full range of providers
22 licensed and certified in the state. We look

1 forward to the promulgation of rules on this
2 provision and offer the following comments for
3 consideration.

4 NHELP urges the departments to ensure
5 effective monitoring and transparency in the
6 implementation of section 2706. Monitoring
7 health plans for nondiscrimination should be
8 ongoing and not dependent on annual compliance
9 reviews. To that end, regulations should require
10 that health plans provide written notice
11 explaining the reason a health plan denies
12 participation to a provider or groups of
13 providers. Such procedures are already
14 established for Medicare advantage plans. We
15 also strongly encourage the departments to
16 include a transparency provision in regulations
17 so that providers, enrollees, and potential
18 enrollees can effectively monitor provider
19 participation in health plans, network adequacy,
20 and can identify patterns of discrimination based
21 upon licensure and provider type.

22 Next, the regulation should include

1 both an investigative and adjudicative process to
2 ensure the enforcement of this provision. NHLP
3 recommends the departments authorize an
4 independent entity within HHS to investigate
5 complaints of provider discrimination. We
6 believe providers, consumers, and other
7 stakeholders should file complaints which would
8 merit investigation and potential remediation.
9 Final administrative decisions should be subject
10 to judicial review. This would provide a process
11 in which providers alleging discrimination can
12 directly apply provider denials and terminations
13 and bring claims for violations of Section 2706.

14 Next, the departments should ensure
15 that reasonable medical management standards do
16 not undermine Section 2706. Medical management
17 techniques should not deny and refuse access to
18 providers who are acting within the scope of
19 their license or certification under state law.
20 The departments should clearly explain that
21 health plans and issuers cannot use medical
22 management techniques to discriminate against

1 providers by excluding them from plan
2 participation.

3 And finally, Section 2706 regulations
4 must ensure robust networks. If networks do not
5 have sufficiently available and licensed
6 providers and release geographic access, ability
7 to see appropriate providers, and waiting times
8 are compromised. Indeed, federal rules recognize
9 the seriousness of this issue by requiring health
10 plans to ensure an adequate provider network.
11 These regulations, however, only apply to plans
12 in the marketplace. We recommended the
13 establishment of network adequacy protections in
14 the 2706 regulations to ensure consumers in all
15 health plans can obtain covered services from
16 available licensed providers in their states.

17 The departments' regulations should
18 prohibit health plans and issuers from excluding
19 otherwise qualified and licensed providers from
20 participation in health plans. Otherwise,
21 consumers will face barriers to obtaining
22 critical services from certain providers; for

1 example, providers of comprehensive reproductive
2 and sexual health services, particularly in areas
3 of the country facing provider shortages and
4 budgetary restrictions of services.

5 Thank you so much for the opportunity
6 to provide these remarks. We look forward to
7 being an ongoing stakeholder partner on this
8 issue. And if you have any questions regarding
9 these comments or the previous public comments
10 that NHLP submitted regarding the 2014 RFI, we're
11 happy to be in touch.

12 MS. SCHUMACHER: Thank you. Next we
13 have James Gelfand from ERIC.

14 MR. GELFAND: Thank you, Elizabeth,
15 and thank you to the departments for the
16 opportunity to participate today. I'm James
17 Gelfand, Executive Vice President of the ERISA
18 Industry Committee, or ERIC for short. ERIC is a
19 national nonprofit organization advocating
20 exclusively for large plan sponsors that provide
21 health, retirement, paid leave, and other
22 benefits to their nationwide workforces.

1 ERIC member companies do not believe
2 in discrimination. And they are laser focused on
3 ensuring that the self-insured health benefits
4 they design and offer to workers, families, and
5 retirees are high quality and affordable. Our
6 member companies engage with an array of vendors
7 to help them build a suite of benefits, construct
8 a network of providers, and design an insurance
9 program, including carriers and insurers, third
10 party administrators, administrative service
11 organizations, pharmacy benefit managers,
12 reinsurers, specialty vendors to manage specific
13 benefits such as mental health or telehealth,
14 patient advocates and navigators, care
15 coordination entities, health information
16 technology companies, consultants, data
17 management experts, and many more.

18 Sometimes plan sponsors may also
19 directly contract with providers or with health
20 systems. But regardless of whether relationships
21 between a plan sponsor and provider are direct or
22 through an intermediary, they always have the

1 same goal, which is to ensure that a sufficient
2 volume of high value care is available to the
3 beneficiary of the plan, accessible in their
4 geography, and obtainable in a timely manner.
5 ERIC member companies include all manner of
6 provider and clinician in their plans, and we
7 greatly value non-physician providers.

8 But the plan is designed based upon
9 the needs of plan beneficiaries, not based upon
10 any provider's entitlement to a network agreement
11 no matter what kind of license they may have.
12 Employer plan sponsors exercise a great degree of
13 autonomy in designing benefits, building or
14 selecting networks, and negotiating reimbursement
15 and incentives in a plan. This is by design.

16 Plan sponsors are fiduciaries under
17 the Employee Retirement Income Security Act,
18 ERISA, and are required by law to act in the best
19 interest of the plan beneficiaries. They have a
20 legal responsibility to be good stewards of the
21 money invested in employer health benefits. That
22 means selecting the right providers, paying fair

1 prices, and avoiding waste, unnecessary or
2 ineffective treatments, and all manner of low
3 value care. Congress has recognized this role
4 played by employers for more than 40 years. And
5 subsequent legislation such as the Affordable
6 Care Act and the No Surprises Act and the
7 Consolidated Appropriations Act has sought to
8 maintain this critical role. This includes
9 maintaining the discretion and flexibility for
10 employer plan sponsors to make decisions -- even
11 sometimes unpopular decisions -- in order to
12 preserve value for plan beneficiaries.

13 ERIC's member companies are aware of
14 and abide by the requirements of the ACA's
15 provider nondiscrimination provision. As others
16 have stated, that provision consists of three
17 sentences. First, a group health plan shall not
18 discriminate with respect to participation under
19 the plan or coverage against any healthcare
20 provider who was acting within the scope of that
21 provider's license. Second, the statute
22 specifically states that this is not any willing

1 provider requirement. And third, the statute
2 specifically states that this is not a
3 requirement for parity in reimbursement between
4 providers.

5 ERIC believes that these statutory
6 provisions are clear and they affirm our member
7 companies' current compliance. We further note
8 that the departments have already issued guidance
9 on these provisions. Even so, ERIC is happy to
10 engage with the departments to ensure that
11 further clarifications or the promulgation of
12 additional rules or guidance are in line with the
13 intention of the statutory provision.

14 As the departments consider further
15 guidance, it'll be important to maintain the
16 current balance, in which plan sponsors are
17 barred from improper discrimination in regards to
18 network participation but are still empowered to
19 make network and reimbursement decisions. It
20 cannot be overlooked that this new rulemaking
21 requirement was included in the same legislative
22 vehicle that included the No Surprises Act, which

1 extensively discusses both network and
2 reimbursement decisions. For example, the No
3 Surprises Act spends considerable real estate
4 detailing factors that might be taken into
5 account in an arbitration, factors that might
6 affect how much different providers might be
7 reimbursed for performing similar services, such
8 as the provider's level of training or
9 experience.

10 Clearly, Congress had no intention of
11 mandating that there be only one price for a
12 treatment or service paid by a given plan. And
13 certainly the quality is not the only factor that
14 might be used to determine different
15 reimbursement levels. The No Surprises Act also
16 considers the network status of providers and
17 facilities and acknowledges that they may change
18 at the impetus of either the plan or the
19 provider.

20 Despite significant lobbying by
21 clinicians, Congress declines to include network
22 adequacy requirements in the No Surprises Act,

1 just as they did in the Affordable Care Act for
2 self-insured plans, allowing them to decide
3 which, how many, and what kind of providers to
4 include in networks. So clearly Congress had no
5 intention of requiring a plan to accept any and
6 all providers in a given specialty or geography
7 or any provider who can perform some specific
8 service or treatment.

9 ERIC understands the departments have
10 and will continue to hear from many provider
11 groups that wish to require a plan sponsor to
12 contract with various providers or wish to
13 require a plan sponsor to pay identical
14 reimbursement to different clinicians with
15 different levels of education and different
16 amounts of training. However, a straightforward
17 reading of the statute makes clear neither of
18 these policies are permissible under the ACA.

19 Thank you for the opportunity to
20 participate today. I look forward to continuing
21 to work with the departments to ensure that the
22 nondiscrimination provision is properly

1 implemented throughout the regulatory process.

2 MS. SCHUMACHER: Thank you. Next we
3 have Katie Mahoney from the U.S. Chamber of
4 Commerce.

5 MS. MAHONEY: Thank you so much. I am
6 pleased to round out the discussion and
7 appreciate the opportunity to speak with you all
8 today. I'm the Vice President of Health Policy
9 at the U.S. Chamber of Commerce, which is the
10 world's largest business organization
11 representing companies of all sizes across every
12 sector of the economy. Our members range from
13 small businesses and local chambers of commerce
14 that line Main Streets of America to leading
15 industry associations and large corporations.

16 One thing that I wanted to start off
17 my comments by saying is that mandating benefits
18 and requiring providers does not equate to
19 access. Limiting medical management, inflating
20 payments in the name of nondiscrimination will
21 increase costs. These things do not happen in a
22 vacuum, and I think we need to keep in mind, as

1 we all focus on the importance of access, that
2 simply requiring providers to be paid in parity
3 and mandating that benefits be covered is not
4 going to equate to access due to large increases
5 in premiums that are likely to result.

6 Contrary to some of the previous
7 speakers, I'd like to suggest that there should
8 be no opponents on this issue. We're all looking
9 to improve health, drive to greater value,
10 improve outcomes, and reduce unnecessary costs.
11 The litmus tests, so to speak, and our focus is
12 the same, although we may refer to them slightly
13 differently: they are employees, patients,
14 customers, and beneficiaries.

15 We should all also agree on the goal
16 of getting individuals the right care at the
17 right time in the right setting. I want to
18 reiterate several critical elements of the
19 statutory text that I know folks have mentioned
20 but as the last speaker I want to drive home. A
21 nondiscrimination and healthcare section
22 prohibits group health plans and health insurance

1 issuers from discriminating against any
2 healthcare provider acting within the scope of
3 the practice or the provider's licensing when
4 contracting.

5 This prohibition is not -- I repeat
6 not -- as others have said, an any willing
7 provider mandate, since the subsection states
8 that plans and issuers are not required to
9 contract with any healthcare provider willing to
10 abide by the terms and conditions for
11 participation established by the plan or issuer.

12 Finally, plans, issuers, and the
13 Secretary of HHS may continue to establish
14 varying reimbursement rates based on quality and
15 performance measures.

16 The reason these three components are
17 important, and that I'm reiterating them again at
18 the end of this discussion, is quite simple:
19 flexibility and choice. As some of my colleagues
20 articulated earlier, we have seen many
21 congressional mandates with regard to benefits
22 under the Affordable Care Act in the vein of the

1 essential health benefits and small group
2 individual markets, coverage with no cost sharing
3 for preventative services, and minimum value
4 coverage for large group and self-insured plans.
5 Employers, whether offering self-insured or
6 fully-insured coverage to their employees, must
7 have the flexibility to determine the benefits
8 beyond those required by the ACA that they want
9 to provide and the providers with which they want
10 to contract. In response to employees'
11 preferences, many employers provide more
12 sensitive plans that include more cost effective
13 networks. And this is really critical and
14 important if we're going to preserve access.
15 Particularly now during COVID with workforce
16 shortages, we're seeing member businesses
17 offering ever expanding benefits, whether it's
18 more robust health benefits, greater flexibility
19 in hours or work week designations, remote work,
20 or others. And this flexibility is really
21 important as employers seek to retain, recruit,
22 and preserve their workforces. We need to make

1 sure that this flexibility remains and that, in
2 an effort to improve access, we don't increase
3 premiums and unnecessarily drive people away from
4 the robust coverage that they enjoy, however they
5 may define it.

6 With that, I'll turn it back to you,
7 Elizabeth.

8 MS. SCHUMACHER: Thank you, Katie. I
9 believe Katie was our last speaker for the day,
10 so I will turn it over to Ali at this time.

11 MR. KHAWAR: Thanks, Elizabeth. I
12 want to thank everyone who spoke for sharing your
13 perspectives on this issue.

14 I think one thing I heard a couple of
15 people acknowledge is that, as I said in the
16 beginning, this is the beginning of these
17 discussions, not the end of it. So we're looking
18 forward to continuing the engagement with all of
19 you and with other stakeholders that didn't speak
20 today.

21 And the other thing I'll say --
22 picking up on Katie's point in her remarks -- I

1 think we can also all agree that there's a shared
2 goal here, which is about making sure that we are
3 focused on think the bottom line of improving
4 healthcare outcomes. And there are different
5 perspectives on how to do that as we heard today.
6 And we're looking forward to continuing to
7 explore these issues with you.

8 So thanks again everyone for joining,
9 or for whether you spoke or listened in. And
10 we're looking forward to further conversations.
11 Take care.

12 (Whereupon, the above-entitled matter
13 went off the record at 2:22 p.m.)
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