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

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

1:03 p.m.

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

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

our colleagues from the other departments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We, as in health insurance providers,

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

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

self-implementing.

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

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

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

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

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

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

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

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

We partner with our contracted

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

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

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

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

American Association of Nurse Anesthesiology.

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

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

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

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

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

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

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

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

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

important part of ending surprise billing and ensuring network adequacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

licensure.

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

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

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

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

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

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

Three, prohibit health plans, health

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

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

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

In order to properly honor the intent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As we know, Congress knows how to

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

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

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

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

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

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

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

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

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

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

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

The third issue I wanted to mention is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

recommendations.

MS. SCHUMACHER: Thank you, Kara. Next we have Laura Pickard from the American Podiatric Medical Association.

DR. PICKARD: Can everybody hear me now?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

which has a policy to only cover the procedure when furnished by an M.D. and DO. Another Fortune 500 company's group health plan imposes a dollar limit on coverage of services furnished by podiatrists that is not imposed on M.D.s and DOs. As a practical manner, the limit or cap as it's known as is so low that it effectively excludes surgical procedure by podiatrists particularly if they have billed for conservative care prior to recommending surgery.

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

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

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

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

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

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

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

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

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

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

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

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

These are health plan issuer and issuer practices that discourage our members from participating in health plan networks. And, for our members who do practice in-network, these health plan practices interfere in how they care for their patients and keep them fearful of retaliation should they appeal denials of care or complain about insurer or plan practices.

Continuing authorization for inpatient care. Patients with mental health and substance use disorder conditions who need hospitalization are extremely acute and extremely fragile.

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

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

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

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

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

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

Lastly, I want to address

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

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

substance use disorder conditions have a harder time finding care and often go without care. Thank you.

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

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

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

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

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

their costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. SCHUMACHER: Thank you, Darren. Next we have Elizabeth McCaman Taylor from the National Health Law Program.

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

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

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

NHLP urges the departments to ensure effective monitoring and transparency in the implementation of section 2706. Monitoring health plans for nondiscrimination should be ongoing and not dependent on annual compliance reviews. To that end, regulations should require that health plans provide written notice explaining the reason a health plan denies participation to a provider or groups of providers. Such procedures are already established for Medicare advantage plans. We also strongly encourage the departments to include a transparency provision in regulations so that providers, enrollees, and potential enrollees can effectively monitor provider participation in health plans, network adequacy, and can identify patterns of discrimination based upon licensure and provider type.

Next, the regulation should include

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

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

providers by excluding them from plan participation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

implemented throughout the regulatory process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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This is to certify that the foregoing transcript

In the matter of: Listening Session

Before: US DOL

Date: 01-19-22

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Neal R Gross

Court Reporter