



**Health Reform:
Provider Non-Discrimination Provision's Impact on
Health Insurance and ERISA Plans**

**Arthur Lerner
Crowell & Moring LLP**

October 2010

Harkin Amendment

- » New § 2706(a) of Public Health Service Act, created by § 1201 of Patient Protection and Affordable Care Act (“PPACA”)
 - “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.” 42 U.S.C. §300gg-5(a).
- » First federal provider non-discrimination law applicable to non-government programs
- » First provider non-discrimination law applicable to self-insured ERISA plans
- » Applies across categories of providers

To what plans does it apply?

- » “Group health plans” and “health insurance issuers offering group or individual health insurance coverage”
 - Self-insured employee health benefit plans
 - Group health insurance
 - Individual health insurance
 - Likely includes Federal Employees Health Benefits Program
 - Will apply to products sold via the new health insurance “Exchanges” starting in 2014

To what plans does it not apply?

- » Does not include Medicare, Medicare Advantage, Medicare Supplement or Medicaid
 - Medicare Advantage plans already are prohibited from discriminating, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.
 - Workers compensation, credit-only insurance, on-site medical clinics coverage, automobile medical payment insurance, liability insurance, or supplements to liability insurance,
- » Appears not to apply to “limited scope dental or vision benefits” or long-term care, home health care, or nursing home care offered in connection with a group health plan (42 U.S.C. 300gg-21c, -91(c)(2))
 - If provided under a separate policy, certificate or insurance contract; and
 - not otherwise “an integral part of the plan”
- » Specified disease or illness insurance or hospital indemnity or other fixed indemnity insurance if provided under a separate policy or contract and there is no “coordination” between those benefits and any exclusion of benefits under a group health plan of the same plan sponsor

When is it effective?



- » The beginning of the applicable plan year on or after January 1, 2014, except for “grandfathered plans”



How does “grandfathering” work?

- » Under section 1251 of PPACA, a group health plan in effect on March 23, 2010 is considered to be a "grandfathered health plan," meaning that many provisions of PPACA that apply to group health plans will not apply.
- » Regulations issued on June 17 state that the purchase of new insurance policies and/or a change in insurance carriers will cause a plan to lose its grandfathered status.
- » To maintain grandfathered plan status, plan must (1) include a statement regarding its grandfathered plan status in any plan materials provided to plan participants describing the benefits, (2) maintain records necessary to verify its status as a grandfathered plan, and (3) make the records available for inspection by participants and State and Federal agency officials.
- » Plans are allowed to enroll "new employees" and their families after March 23, 2010 without losing grandfathered plan status.

How can a plan lose “grandfathered” status?

- » Actions that would cause loss of grandfather status include:
 - Change in insurance policy or insurance carrier.
 - Elimination of all or substantially all benefits to diagnose or treat a particular condition (including the elimination of benefits for any necessary element to diagnose or treat a condition).
 - Any increase in coinsurance (and other percentage cost-sharing requirements).
 - Any increase after March 23, 2010 in fixed-amount cost-sharing requirements other than co-payments, if the increase is greater than medical inflation (from March 23, 2010) plus 15 percentage points.
 - Any increase after March 23, 2010 in fixed-amount co-payments if the increase exceeds the greater of (a) medical inflation (from March 23, 2010) plus 15 percentage points or (b) five dollars increased by medical inflation.
 - Any decrease by the employer or employee organization in its contributions for coverage, if the aggregate decrease is more than 5 percentage points below the contribution rate on March 23, 2010.
 - The imposition of a new or modified annual limit on coverage.

Changes that do not affect “grandfathered” status

- » Permissible changes that would not affect grandfathered status include:
 - Changes to premiums
 - Changes necessary to comply with Federal or State legal requirements
 - Changes to voluntarily comply with provisions of PPACA
 - Changes in third party administrators by a self-insured plan

What does it actually prohibit?

- » Bars discrimination with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law
 - Ban on discrimination regarding “participation” relates to provider network participation
 - Does “discrimination with respect to participation” only refer to plan decisions “whether or not” to contract, or does it include discrimination in the contractual terms of participation?
 - Ban regarding “coverage” reaches terms of health plan coverage and plan design, such as services covered, benefit limits, and enrollee cost-sharing

What doesn't the Harkin Amendment do?

- » Not an “any willing provider” law
 - Plans and health insurers not required to permit participation to every provider willing to accept plan terms
- » Does not require coverage of a service, if the service is uncovered regardless of who performs it
 - Other provisions, though, will make all “Exchange” plans cover what HHS determines are “essential” health services.
- » Does not prevent establishing “varying reimbursement rates based on quality or performance measures”

Examples of potentially questionable practices

- » Health insurer requires that optometrists seeking to be participating providers in health plan network must also contract to be participating providers in free-standing vision plan, but does not impose same requirement on ophthalmologists or other physicians
- » Health insurer maintains “closed” or “limited” network of podiatrists but has “open panel” approach to participation by qualified orthopedic physicians and primary care physicians
 - Could be vulnerable to charge of discrimination
 - Could perhaps be defended on ground that law does not impose “any willing provider requirement” and plan has different needs for orthopedic surgeons than for podiatrists or achieves legitimate business objectives by varying contracting approach taking into account services provided by orthopedists compared to podiatrists, and is not discriminating based on license
- » Health insurer includes optometrists or nurse midwives in network only in rural areas but not in urban areas
- » Health insurer has different fee schedule for same CPT code service based on whether service is performed by psychologist or M.D.
- » Insurer has limited network for provision of certain screening vision services (exams, etc.) for which it uses an RFP bid process to choose a vendor, but has a separate provider network for a different set of eye care services some of which are not performed in that state by optometrists, such as eye surgery? If optometrists are able to participate in bid activity for the former, but are not able to qualify for the second, is the law violated?

What are some potential battlegrounds of interpretation and application?

- » Explicit discrimination vs. discriminatory effect?
 - What if insurer requires applying professionals to demonstrate particular types of certification, training or experience that are theoretically open to non-MD practitioners, but that in actual fact they will satisfy less often than MDs?
 - What if insurer imposes new credentialing criteria that are hard for non-MDs to meet, but it grandfathered its existing network, which includes few non-MDs?

- » Compensation
 - What if insurer does not explicitly have lower fee schedule for non--MDs, but pays higher rates to some physician specialty practices due to perceived market need to have those physicians in network and they command higher rates?
 - What are boundaries around ability of plans and insurers to vary reimbursement based on “quality or performance measures”?

Enforcement and penalties

- » States may require health insurers to comply
 - Sanctions would depend on state law
- » HHS enforces for self-insured group health plans and, if state does not enforce, for health insurers
 - Civil monetary penalty → maximum \$100 per day for each “individual” with respect to which such a failure occurs
 - No penalty →
 - For any period where insurer or plan did not know, or exercising reasonable diligence would not have known, that failure to comply existed; or
 - If failure was due to reasonable cause and not willful neglect and the failure is corrected within 30 days after entity knew, or exercising reasonable diligence would have known, of the failure to comply