Policy H-35.968, Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws, was amended at the 2012 Interim Meeting by the adoption of Resolution 241-A-12. The policy calls for the American Medical Association (AMA) to “promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act’s (ACA) ‘Non-Discrimination in Health Care’ language, including direct collaboration with other interested components of organized medicine.” The non-discrimination language in section 2706 of the ACA states that health plans may not discriminate with respect to participation in the plan or coverage against any health care provider who is acting within their scope of practice. The statute also specifically states that this is not an any willing provider requirement and that plans may establish varying reimbursement rates based on quality or performance measures.

Reference Committee B recommended that the existing Policy H-35.968 be reaffirmed in lieu of Resolution 241-A-12. That policy contains almost identical language to Resolution 241. At the 2012 annual meeting, however, the HOD voted to adopt Resolution 241 with the additional amendment that “our AMA report back at I-12 on the specific activities that have occurred regarding AMA Policy H-35.968.”

At this time, no specific lobbying effort to repeal Section 2706 has been initiated. This is due to the lack of willingness by Congress to enact necessary improvements in the ACA at this time. The AMA will continue to closely monitor this issue and work to identify opportunities to repeal Section 2706.

SECTION 2706 OF THE AFFORDABLE CARE ACT

The language that is the subject of Resolution 241-A-12 was included in the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), at the urging of Senator Tom Harkin (D-IA), long a champion of the non-physician provider community. The provision was included in the bill with the strong support of organizations representing those providers. Specifically, the language in question states:

(a) Providers.—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.
It is important to note the language specifically states that it is not to be interpreted as an “any willing provider” provision, nor does it allow for any provider to provide care that is not within their scope of practice.

EFFECT OF SECTION 2706

While the ultimate effect of Section 2706 is unknown, and no clarifying regulations have been issued, the statutory language is not without precedent.

42 U.S.C 1396u-2 is current law that regulates Medicaid managed care plans. Specifically, section 1932 (b)(7) of that statute reads:

Antidiscrimination.—A Medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization’s enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

Additionally, regulations governing the operation of Medicare Advantage plans address this same issue at 42 CFR § 422.205, stating that:

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

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

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).
(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(See 42 CFR § 422.205. See also the final rule implementing this language at 65 Fed. Reg. 126. June 29, 2000.)
While these provisions are substantially similar to the language of section 2706, they are not identical. Your Board of Trustees is unaware of any concerns raised by the Federation regarding either of these provisions, and continues to monitor all federal health care programs for inappropriate actions regarding credentialing or violations of state scope of practice statutes and regulations.

Despite the fact that the actual scope of section 2706 is limited, that fact has not prevented non-physician providers from attempting to use other similar federal statues to justify inappropriate scope expansions at the state level. The AMA remains a leader, in partnership with state and national medical specialty societies, in ensuring that states do not inappropriately expand the scope of practice for non-physician providers beyond their training and expertise as well as promoting the importance of physician-led health care teams.

Additionally, the AMA remains engaged in state and national efforts to ensure all health care professionals—physicians and non-physicians—accurately and clearly disclose their training and qualifications to patients and that they do not promote health care services that are beyond their scope. These activities are ongoing through the Scope of Practice Partnership and are critical to ensuring that patients are properly educated as to the credentials and training of all of their providers of care.

REFINEMENTS TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Since the enactment of the ACA, the AMA has continued to seek legislative and regulatory refinements as directed by the HOD including: repeal of the Independent Payment Advisory Board (IPAB), medical liability reform, private contracting, and antitrust reforms (H-165.833); Non-Discrimination in Health Care language (H-35.968); and other provisions that are not consistent with existing AMA policy (H-165.835).

Given the highly partisan environment which currently surrounds the ACA, only a handful of opportunities have presented themselves to modify specific provisions of the law. In each instance, the AMA has engaged directly with members of Congress and through physician and patient grassroots to advance these priorities. Specifically, legislation to repeal the IPAB and enact medical liability reforms consistent with AMA policy has passed the House of Representatives with the strong support of the AMA and the Federation, but has failed to advance in the Senate. Additionally, the AMA has supported the efforts of members of Congress in introducing legislation to allow for private contracting consistent with AMA policy and separately, legislation to reform the antitrust laws. Neither of these provisions, however, has advanced in the 112th Congress. AMA continues to work with the sponsors of both bills to identify opportunities for their enactment.

At this time, there has been no effort by Congress to repeal section 2706 and seemingly little interest in Congress to do so at this time. Despite the efforts of the House of Representatives to repeal the highly controversial IPAB, and the successful effort to repeal the widely criticized Form 1099 reporting requirements, few other efforts have been made to target specific portions of the law. This is due primarily to a divide in Congress over how to deal with the ACA going forward. There are members of Congress who would like to enact improvements to the ACA that are widely agreed to be necessary. The ACA was adopted in a highly partisan atmosphere and under restrictive budgetary rules that allowed only limited improvements as the two houses of Congress reconciled their versions of the bill. Unfortunately, with the limited exceptions noted, opponents of the ACA have little incentive or desire to improve the bill prior to the 2012 elections. Some have argued that to do so would make the ACA more acceptable and therefore diminish the political will
for repeal. This divide has left Congress generally unable and unwilling to make additional
targeted changes, including repeal of section 2706.

Additionally, it must be recognized that the supporters of section 2706 are, in themselves, a
significant political force with narrow and sharply defined interests, including preservation of
section 2706. A survey of recent advocacy materials of physician organizations shows little
activity within the Federation on this issue and therefore little interest by potential champions in
Congress to put themselves between two powerful health care constituencies.

CONCLUSION

To date, no specific grassroots activities have taken place as directed by H-35,968 due to the lack
of any legislative opportunity to advance repeal of section 2706. AMA staff, in collaboration with
others in the Federation, will continue to seek out opportunities to advance this policy and will
initiate specific efforts as soon is reasonable and practicable.