May 3, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9921-NC
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-9921-NC – Patient Protection and Affordable Care Act; Increasing Consumer Choice through Health Care Choice Compacts

Dear Ms. Verma:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to submit comments to the proposal CMS-9921-NC – Patient Protection and Affordable Care Act; Increasing Consumer Choice through the Sale of Individual Health Insurance Coverage Across State Lines through Health Care Choice Compacts. The AANA is firmly committed to working with the agency and other healthcare stakeholders to help achieve our common goals of promoting choice and competition, increasing access to the highest quality healthcare, reducing regulatory burdens on providers, and making healthcare more affordable for all Americans.

I. CRNAs Provide Safe, High Quality and Cost-Effective Healthcare

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 53,000 CRNAs and SRNAs, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 45 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services.
CRNAs are involved in every aspect of anesthesia services including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons. CRNAs play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals and affording these facilities the capability to provide many necessary procedures.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost-effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal Nursing Economic$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.1 An August 2010 study published in Health Affairs showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.2 Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.3 Most recently, a study published in Medical Care (June 2016) found no

1 Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.⁴

II. Preserve Federal Provider Nondiscrimination Language

The AANA welcomes the opportunity to comment on this request for information on eliminating barriers to and enhancing health insurance issuers’ ability to sell individual health insurance across state lines. The AANA believes that patients benefit the greatest from a healthcare system that includes health plans and health insurers that contain networks where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs.

The AANA is concerned about the impact that selling insurance across state lines could have on provider nondiscrimination protections that are currently required. It is not clear whether this would cause a proliferation in the number of plans that do not have to meet these requirements. If these protections are weakened, certain providers, such as CRNAs, could be prevented from practicing to the full scope of their education and practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

It is important to highlight the harms of discrimination CRNAs currently face in the selection criteria certain health plans develop which determines the selection of providers that participate in their networks. CRNAs, acting within the scope of their license or certification under applicable state law or regulation, have experienced discrimination with respect to participation in qualified health plans. Such discrimination impairs consumer choice and competition and thus impairs efforts to control healthcare cost growth. Further, this discrimination violates the federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), “Non-Discrimination in Health Care, 42 USC §300gg-5”),⁵


⁵ Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §300gg-5). The statutory provision reads as follows: “(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 healthcare 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 healthcare 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
which, prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely on the basis of their licensure. This law promotes access to healthcare and consumer choice of healthcare professionals and helps reduce healthcare costs through competition. It prohibits discrimination based on provider licensure that keeps patients from getting the care they need.

To promote patient access to high quality healthcare, market competition and cost efficiency, all health insurance plans and health insurance issuers must all avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example, patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition. Additionally, such discrimination provides incentives for the use of higher-cost providers without improving quality or access to care. Promoting nondiscrimination encourages the use of qualified, licensed healthcare professionals, such as CRNAs, who perform the same services to the same high level of quality as other qualified providers.

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Paying one qualified provider type a higher rate than another for providing the same high-quality service offers a powerful incentive to increase healthcare costs without improving healthcare quality or access, by helping to steer healthcare delivery to more expensive providers. For example, in the delivery of anesthesia services, the labor costs of anesthesiologists are approximately three times higher than those of CRNAs. Quality of care is high and continually improving, and patient outcomes by provider type are similarly excellent as measured by the published research we have already shown.

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The choice of discriminating in coverage or reimbursement against qualified licensed providers solely on the basis of licensure therefore leads to impaired access, increased costs and lower quality of care.

Furthermore, if a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. For example, if a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone.

Ensuring that qualified health plans adhere to this nondiscrimination law would promote patient access to a range of beneficial, safe and cost-efficient healthcare professionals, consistent with public interests in quality, access and cost-effectiveness. These priorities correspond with the principles advocated by the AANA, which are to provide safe, high-quality and cost-effective anesthesia care for patients. Therefore, we request that any expansion of selling individual insurance across state lines should include protections against any discrimination against providers acting within their state scope of practice laws and regulations.

III. Protect Critical Essential Health Benefits

The AANA is concerned about the impact that selling insurance across state lines could have on essential health benefit (EHBs) coverage patients currently receive. EHBs, enacted by the Affordable Care Act, are a set of ten categories of services health insurance plans must cover, including: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health services and addiction treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventative/wellness/chronic disease services, and pediatric services. We believe the practice of anesthesia and pain management care provided by CRNAs fits under many of the services listed as essential health benefits. These services provided by trained and qualified health care providers, such as CRNAs, are vital with patient care. Therefore, we request that any changes made to these rules concerning grandfathered group health plans and health insurance must protect critical EHBs to ensure access to the full range of services and providers, including CRNAs.

The goal of the Essential Health Benefits requirement was to help balance access, comprehensiveness, quality improvement and affordability for consumers purchasing health coverage. Essential Health
Benefits are necessary to ensure health coverage for patients and their elimination would create an access issue across the United States. Excluding these benefits would return us to a time when such benefits were hard to find in individual insurance and were often unaffordable when they were available.

The AANA advocates on numerous issues to help improve healthcare, patient safety and practice excellence by working to increase access to healthcare, make healthcare more affordable, and improve the quality of the care available to all patients. We urge the Departments to preserve Essential Health Benefits to allow patients to receive access to safe and high-quality health care delivery.

The AANA appreciates this opportunity to comment on this RFI. CRNAs are vital to resolving the challenges facing our nation’s healthcare system and we look forward to partnering with the agency to show the important role CRNAs can have in achieving the main goals of meaningful reform, reducing health care costs, and improving access to the highest quality healthcare. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkoohl@aanadc.com.

Sincerely,

Garry Brydges, DNP, MBA, ACNP-BC, CRNA, FAAN
AANA President

Cc:  Randall Moore II, DNP, MBA, CRNA, AANA CEO
     Ralph Kohl, AANA Senior Director of Federal Government Affairs
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