June 5, 2019

The Honorable Lamar Alexander  The Honorable Patty Murray
Chairman                        Ranking Member
U.S. Senate Committee on Health, U.S. Senate Committee on Health,
Education, Labor and Pensions   Education, Labor and Pensions
428 Senate Dirksen Office Building 428 Senate Dirksen Office Building
Washington, D.C. 20510          Washington, D.C. 20510

**RE: Lower Health Care Costs Act of 2019 Discussion Draft**

Dear Chairman Alexander and Ranking Member Murray:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the discussion draft entitled “Lower Health Care Costs Act of 2019.” The AANA makes the following comments and requests regarding Title I Ending Surprise Medical Bills:

- Support the Requirement of Notification and Consent by Patients of Out of Network Providers for Non-Emergency Services
- Oppose Provisions that Strengthen Insurers’ Ability to Manipulate Reimbursement Rates in Their Favor, Further Reducing Competition and Choice at the Expense of the Patient
- Any Arbitration Methodology Should Treat Physicians and APRNs Equally
- Address Underlying Causes of Surprise Billing by Requiring CMS to Issue a Proposed Rule on Provider Non-Discrimination Provision That Requires Insurers to Pay the Same Rate for a Service and by Promoting Adequate Provider Networks

**Background of the AANA and CRNAs**

The AANA is the professional association for CRNAs and student nurse anesthetists, and AANA membership includes more than 53,000 CRNAs and student nurse anesthetists (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 continue to be 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 provide every aspect of the delivery of anesthesia services including 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 and chronic 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. According to a May/June 2010 study published in the journal of 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.\(^1\) Furthermore, an August 2010 study published in Health Affairs shows 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.\(^3\) Most recently, a study published in Medical Care June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.\(^4\)

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1 Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economic$. 2010; 28:159-169.


4 Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. Medical Care June
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, affording these facilities the capability to provide many necessary procedures. The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.

**Support the Requirement of Notification and Consent by Patients of Out of Network Providers for Non-Emergency Services**

The AANA appreciates the Committee’s dedication to resolving the issue of surprise billing. The economic burden of receiving care out-of-network can be substantial for patients, and patients should not be penalized by out of network processing in instances where there are bona fide emergencies and when patients select facilities and surgeons for healthcare services that are in-network but do not know about the statuses of other providers involved in those services.

The AANA supports requirements that stipulate that patients must receive notification about whether their providers will be out of network for non-emergency services. This notification should include a binding out of network patient responsibility balance before providing care to that patient.

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6 Liao, op cit.
Oppose Provisions that Strengthen Insurers’ Ability to Manipulate Reimbursement Rates in Their Favor, Further Reducing Competition and Choice at the Expense of the Patient

We are opposed to options that strengthen the ability of insurers to potentially manipulate rates for reimbursement in their own favor, which will ultimately reduce competition and choice at the expense of the patient. Under Options 1 and 3, the draft does not contain any provisions to ensure that the health plans act in good faith to negotiate with practitioners. Under Option 1, hospitals are required to eliminate those practitioners who are not in network, which may have occurred due to the health plan’s refusal to negotiate with a particular practitioner. Option 3 could create a median contracted rate that is below the typical in network rate, which could give insurers no reason to negotiate in good faith with in network providers. Without such protections in place, already powerful insurers gain even more leverage in the negotiation process with practitioners. This ultimately deters competition and choice giving advantages to some practitioners over others. We request that the Committee add provisions that requires insurers to negotiate in good faith with practitioners to join their networks and to add punitive measures for insurers that fail to demonstrate good faith.

Any Arbitration Process Should Treat Physicians and APRNs Equally

We are concerned that under an arbitration process advanced practice registered nurses (APRNs) could be treated unfairly and unequally to their physician counterparts solely on the basis of their licensure. Should arbitration remain an option in the draft legislation, we would request that the Committee include a provision that treats advanced practice registered nurses (APRNs) and their physician counterparts equally.

Address the Underlying Causes of Surprise Billing by Directing CMS to Issue a Proposed Rule on Provider Non-Discrimination Provision That Requires Insurers to Pay the Same Rate for a Service and by Promoting Adequate Provider Networks

We recommend that the Committee address the underlying causes of surprise billing, such as inadequate networks offered by insurers engaging in discrimination against providers based on their licensure or certification. While this is not an issue under Medicare Part B, as Medicare recognizes CRNAs as qualified providers and CRNAs must accept assignment as a condition for
payment, this is an issue with private insurers, thus potentially affecting the private payer market and Medicare Advantage plans.

Therefore, it is important to highlight the harms of discrimination CRNAs currently face in the selection criteria that 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, thus forcing them to become an out-of-network provider. Such discrimination may exacerbate surprise billing, impair consumer choice, reduce competition, and affect healthcare costs all which will negatively affect both patients and providers.

We recommend that the Committee direct CMS to use its authority to further implement the federal provider nondiscrimination law by issuing a proposed rule and ensure that qualified licensed healthcare professionals are paid the same rate for the same service. In 2010, Congress passed this 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), 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.

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7 See 42 §414.60 (c).
8 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 plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.”
To promote patient access to high quality healthcare, market competition and cost efficiency, all qualified health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure or certification. 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 of their enrollees. However, when health plans organize their healthcare delivery in such a way that discriminates against whole classes of qualified licensed healthcare professionals by licensure or certification, for example, by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, 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, and certified healthcare professionals such as CRNAs who perform the same services to the same high level of quality as other qualified providers. Furthermore, Congress and CMS should ensure that there is parity in payment for a service, regardless of the provider type. Therefore, we recommend that all qualified licensed healthcare professionals within a specific contract with an insurer should be paid the same negotiated rate for the same service, regardless of provider type.

While we recognize that CMS has developed network adequacy standards in Medicare Advantage plans and in the Marketplace, the Committee should direct CMS to do more to ensure that health carriers maintain networks in a region that are sufficient in numbers and types of providers to assure that all services to covered persons will be accessible to them without unreasonable delay. The AANA believes that patients benefit the greatest from a healthcare system where they receive easily accessible care from an appropriate choice of safe, high quality and cost-effective providers, such as CRNAs. Therefore, we request that CRNAs be included in all health carrier network plans in a region, which will help ensure network adequacy, access and affordability to consumers.
We thank you for the opportunity to comment on this discussion draft. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202.484.8400, rkohl@aanadc.com.

Sincerely,

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

cc: Randall D. Moore, DNP, MBA, CRNA, AANA Chief Executive Officer
Ralph Kohl, AANA Senior Director of Federal Government Affairs
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