January 9, 2015

Ms. Jolie Matthews  
NAIC Senior Health and Life Policy Counsel  
National Association of Insurance Commissioners  
444 North Capitol Street, NW  
Suite 700  
Washington, DC 20001

**RE: Revisions to Model #74 – Health Benefit Plan Network Access and Adequacy Model Act**

Dear Ms. Matthews:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the proposed changes to the National Association of Insurance Commissioner’s (NAIC) Model #74 – Health Benefit Plan Network Access and Adequacy Model Act.

The issues addressed in our comment are outlined as follows:

I. Section 5 – Network Adequacy

   **AANA Request: Require CRNAs to be Included in Health Carrier Network Plans**

   **AANA Recommendation: The Network Adequacy Model Should Include Language that Health Carriers Must Align their Health Care Network Payment Systems with the Federal Non-Discrimination Provision in the Affordable Care Act**

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists. AANA membership includes over 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals.
who safely administer more than 34 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe 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 practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic 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 are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. 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

$^1$ Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic*$, 2010; 28:159-169, available at [http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf).
supervised by physicians. 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.

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less. Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. 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. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs), such as CRNAs, be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.
SECTION 5 – NETWORK ADEQUACY

AANA Request: Require CRNAs to be Included in Health Carrier Network Plans

The AANA supports the NAIC’s updates to the Health Benefit Plan Network Access and Adequacy Model Act that require health carriers to maintain networks 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 health care 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, which will help ensure network adequacy, access and affordability to consumers. Doing so would help establish appropriate minimum standards for ensuring sufficient choice of providers within health carrier networks.

The AANA notes that CRNAs are an important type of provider with an integral role in providing anesthesia and analgesia-related care, including pain management services. They provide safe, high-quality and cost effective anesthesia care and are advanced practice registered nurses who personally administer more than 34 million anesthetics to patients each year. Furthermore, in rural communities and other medically underserved areas of the United States, CRNAs can be the sole anesthesia professionals. Their presence enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who might otherwise be forced to travel long distances for this essential care. Without strong patient access safeguards in place, we are concerned that lax network adequacy standards could limit the number of providers or the types of providers on their panels, which could severely limit patient access to needed care. Consistent with the goals and policies of the Affordable Care Act in establishing provider networks that ensure extensive access to care, we encourage health carriers to include CRNAs in their networks by expressly recognizing CRNAs

as eligible professionals in health plans networks. This would help ensure patient access to a range of beneficial, safe and cost-efficient healthcare professionals.

Such a recommendation is also consistent with the recent findings and recommendations of the Institute of Medicine, whose report titled *The Future of Nursing: Leading Change, Advancing Health* calls for removing barriers so that advanced practice registered nurses (APRNs), including CRNAs, can practice to the full extent of their education and training, indicating that APRNs play a critical role in the future of health care.7

**AANA Recommendation: The Network Adequacy Model Should Include Language that Health Carriers Must Align their Health Care Network Payment Systems with the Federal Non-Discrimination Provision in the Affordable Care Act**

While discussing health carriers supplying a sufficient number of providers in their networks, we also wanted to highlight the harms of discrimination faced by CRNAs, by health plans that 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)8. As the NAIC may be aware, the federal non-discrimination provision indicates that “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.”

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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.”
Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting 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, qualified health plans participating in health insurance exchanges or marketplaces 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.

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.\textsuperscript{9} 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. 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 health plans and health insurers 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 recommend amending the NAIC Network Adequacy model to include language requiring health carriers to align their payment systems to adhere to federal provider non-discrimination provision in the Affordable Care Act as applicable.

We thank you for the opportunity to comment on this NAIC model. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Sharon P. Pearce, CRNA, MSN
AANA President

cc: Wanda O. Wilson, CRNA, MSN, PhD, AANA Executive Director
    Frank J. Purcell, AANA Senior Director of Federal Government Affairs
    Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy