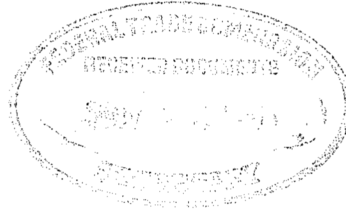

November 21, 2003

TO:
Federal Trade Commission
Office of the Secretary
Donald S. Clark
600 Pennsylvania Ave., NW
Washington, DC 20580

RE: <u>Comments Regarding Hearings on Health Care and Competition Law and Policy</u>

FROM:
American Association of Nurse Anesthetists (AANA)
412 First Street, SE, Suite 12
Washington, DC 20003
202.484.8400
Contact: Frank Purcell, Director of Federal Government Affairs

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS - FEDERAL GOVERNMENT AFFAIRS OFFICE
The Capitol Hill Office Building, 412 1st Street, S.E., Suite 12, Washington, D.C. 20003
Telephone: (202) 484-8400 ■ Facsimile: (202) 484-8408

November 20, 2003

Dr. Timothy Muris
Chairman
Federal Trade Commission
600 Pennsylvania Ave., N.W.
Washington, DC 20580

Dear Dr. Muris:

On behalf of the 30,000 members of the American Association of Nurse Anesthetists, I am happy to provide the Commission additional information in support of its joint FTC / DOJ Hearings on Healthcare Competition Law and Policy.

Though a portion of this material logically follows from the Commission's hearing of June 10, 2003, regarding quality, barriers to entry and consumer choice, it does speak to the whole scope of the joint hearings. The information we provide serves the Commission's interest in "initiatives to enhance quality of care and ensure the free-flow of information because such initiatives benefit patients," as you stated inaugurating the Commission's hearings in November 2001. We understand that the Commission already possesses a considerable past record on antitrust issues in anesthesia, from its previous healthcare hearings in the early 1990s. To update the record, therefore, we are pleased to provide the Commission select more recent literature on the market in anesthesia practice, anesthesia quality outcomes, and anticompetitive behavior in anesthesia care. Most notably, we enclose a market study of anesthesia practice provided by Dr. Jeffrey Bauer, a witness who testified before your panel June 10.

Additionally, we observe that Jerome Modell representing the American Society of Anesthesiologists (ASA) has posted to the Commission his letter of July 30, 2003. Stridently, it denounces the Commission's examining the costs associated with particular healthcare benefits as "ethically repugnant." Surely, the Commission recognizes such language seeks not to enlighten, but to end the conversation. Our experience is that illegal anticompetitive behaviors increase costs, restrict consumer choice and deny patients access to healthcare. Illegal anticompetitive behaviors in healthcare, and likewise unwarranted legal, regulatory and policy restrictions on nurse anesthesia practice, are doubly pernicious in that they yield in economic terms a "dead-weight loss" – utter waste of scarce resources that benefit neither patients nor the healthcare system, but rather enhance certain fortunes that resist being broken.

Modell's oral statement to the Commission June 10, 2003, further reveals several errors of fact. We select five for the Commission's attention.

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He states the scope of practice conflict between anesthesiologists and nurse anesthetists "stems fundamentally from the AANA's position that nurse anesthetists are qualified by their training and experience to engage independently in the practice of medicine as it relates to anesthesia care... ." This assumes subscription to the notion that anesthesia is solely the practice of medicine, an ASA chestnut. Rather, it is the *ASA's opinion* that CRNA care is the practice of medicine. The evidence is that anesthesia is the practice of nursing when provided by a nurse anesthetist.

Second, he states 45 U.S. states require nurse anesthetists to collaborate with or be supervised by a physician. The answer is 20 U.S. states require physician supervision. We are reluctant to quantify the number that require collaboration, since terminology in this field widely varies, but it is certainly less than an additional 25 states.

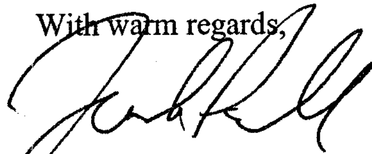
Third, he bases a "pattern" of state requirements for physician involvement upon a notion that legislators and regulators have determined that the delivery of anesthetics demands physician involvement to protect the patient. Lacking and failing to substantiate his statement with evidence in either the legislative record or anesthesia literature, his assertion is unsubstantiated.

Fourth, of the discredited Silber study upholding Modell's thesis, Silber coauthor Dr. David Longnecker MD states, "The study ... does not explore the role of (nurse anesthetists) in anesthesia practice, nor does it compare anesthesiologists versus nurse anesthetists." (Memorandum from Dr. Longnecker to CRNAs in University of Pennsylvania Health System's Department of Anesthesia, Oct. 5, 1998.)

Last, he states that since 1992 Medicare has applied "identical" supervision rules to CRNAs and to another type of provider, anesthesiologist assistants or AAs. This is false. CRNAs are eligible for direct reimbursement, with no supervision requirement included in CMS' Part B rules. AAs are not. Further, Medicare Part A requires AAs be medically directed by anesthesiologists, but makes no such requirement upon CRNAs.

Thank you again for your service to patients and healthcare providers alike by hosting such comprehensive hearings on healthcare and antitrust. If you have any further comments or questions, please contact me.

With warm regards,



Frank Purcell
Director, Federal Government Affairs

Cc: Tom McKibban CRNA MS, AANA President
Jeffery Beutler CRNA MA, AANA Executive Director

Attachments